Oral healthcare for Older People 2020 Vision

Check-up January 2012
Foreword

When the British Dental Association released its report, Oral Healthcare for Older People 2020 Vision in 2003, it was apparent that the UK required extensive reforms to cope with its ageing population. There have been many reforms proposed and guidance papers issued to assist commissioners and practitioners to improve their services, but, somehow, service provision remains lower than is required. This check-up looks at our 2003 recommendations for improving the oral health of older people and provides an opportunity for a mid-point review of our original document.

Despite the high policy profile of the health needs of the ageing population and the resulting impact on health and social care services, it remains clear that many older adults are under-served by those responsible for their health and wellbeing and many concerns remain about the future. The government has emphasised a new approach to measuring success – no longer will a purely financial model be used to assess how well the nation is1. 1.3 million older adults are financially deprived, but the Department for Work and Pensions has suggested that a further 900,000 are “materially deprived”: that is, lacking access to services or feeling the impact of isolation. This shift is part of a wider attitude shift that suggests that financial independence is not enough to indicate wellbeing. We believe that good health is central to improving outcomes for older adults and good oral health is a key part of that.

The lack of consistency of provision and a holistic approach to wellbeing is clearly shown by the neglect of oral health in mainstream services. Where government recognises that dental and oral care should be provided, it is often expressed as little more than a footnote. The results of poor oral health or poor access to dental services are, however, a significant problem for those who do not receive the dental care that they need. Although many older adults have good oral health and access to services, a significant percentage rely on services provided through care homes, arranged by family members or carers, or are limited in accessing services as a consequence of reduced mobility. Poor access to routine preventive and expert dental care can lead to poor oral health, and this can have a devastating impact on overall health. This can manifest itself in many ways; from pain and ulcers caused by ill-fitting dentures to dehydration and malnutrition caused by difficulties with eating. There is also the very important social aspect of oral health. Older adults need to interact with their peers and carers and poor oral health can have a negative impact on their ability to do so and affect their self-esteem, exacerbating problems of isolation and loneliness. Good oral health is as much a matter of dignity as a health necessity.

As the population continues to age, more challenges will emerge in delivering care for older adults. While aspects of oral health may continue to improve thanks to generations with access to fluoride toothpaste, the next generation of older adults - the “heavy metal generation”2 - will
bring their own challenges because of the large amount of restorative work many have had and will continue to need as they age. Other non-dental factors will also have an impact, such as an increase in the prevalence of Alzheimer’s and other dementias.

The diverse range of circumstances that have to be addressed in relation to older adults hides an underlying inconsistency. The term “older adult” is applied in a variety of ways and to different cohorts of people. The result is that a fit and healthy 65 year-old is classed together with a frail and vulnerable 95 year-old. This gap of 30 years would not be applied at any other point in life. This short check-up cannot address the complexities that the application of this terminology brings and we hope that government and other policy makers will take this into account.

In 2003, the UK was in an economic boom. Now we have entered the much publicised “age of austerity”, with no definite end in sight or guarantee of a return to previous public spending levels. The NHS and Social Care Services in England are in the process of the largest reforms in their history, with a commitment to save £20 billion by 2014. These factors, alongside financial constraint and structural reform, provide a great opportunity to re-evaluate priorities and assess how we can make meaningful recommendations to ensure that dental and oral health are integrated into the health and wellbeing of older adults.

Robert Kinloch
Chair
British Dental Association’s UK Healthcare Policy Group


2 Using Professor Steele’s definition of a “group between 30 and 65 could be identified who had experienced high levels of disease which had been treated by fillings and other restorations (the “heavy metal generation”) and who will have high maintenance needs as they age”.


Introduction

In May 2003, the British Dental Association published *Oral Healthcare for Older People: 2020 Vision*. This policy document was produced in response to concerns from the BDA's membership about whether those responsible for planning and delivering dental care were prepared for the evolving oral health challenges of the ageing population. The report made 21 recommendations to improve the oral healthcare of older adults. To date, the BDA considers that only seven of these recommendations have been met in full. With the NHS, public health and social care services in England in the middle of the most comprehensive reforms for over 60 years, the BDA has taken the opportunity to review its original report.

This short report provides a check-up on the 21 recommendations, and updates demographic information and recommendations for how commissioners and social care services can ensure that the oral health needs of their patients are met.

2003 Recommendations

The 2003 recommendations have been classified according to three criteria:

▲ Not met

▲ Partially met

▲ Met

Those recommendations which are still relevant but have not been legislated for or recognised as good practice by government have been classified red▲. This includes recommendations, the spirit of which is still current, though the wording or terminology may have been superseded.

Recommendations which have been met in part, or by one or more of the devolved nations, have been classified as partially met▲. This includes recommendations, the spirit of which is still current though the wording or terminology may have been superseded.

Recommendations that have been met in full have been classified as met▲. This only includes recommendations which would still be current had they not been met and does not include recommendations that are no longer relevant owing to other factors.

▲1. The new locally-commissioned system for the delivery of NHS primary care dentistry in England must take account of the needs of older people and the demographic and clinical changes identified in this paper.

▲2. Local health authorities must look creatively at dental provision for older people and tie in dentistry with other services, such as general medical practice, chiropody and pharmacy. Voluntary organisations and day centres are also means through which care can be brought to people (using mobile units).

▲3. Work on new NHS Clinical Pathways for dentistry must reflect the needs of the older persons population and ensure that further clinical challenges for dentists treating older patients in the future are not inadvertently created.
4. A free oral health risk assessment should be available to patients from age 60, with referral to a dentist for a strategic long-term oral healthcare plan offered to those identified as likely to need complex restorative care.

5. Residential care homes should be required to provide potential residents and their carers with basic information on quality-of-life indicators relating to oral health. This would enable potential residents to prioritise their oral health requirements, thereby facilitating freedom of choice. There should also be basic local standards relating to the oral healthcare of residents with which homes would have to comply – for example, scheduled visits by a dental professional.

6. Marking of existing dentures for easy identification in residential homes should be available free to patients on the NHS.

7. Local health authorities should be encouraged to place simple contracts with local practices to provide care to a small number of residential care and nursing homes, with portable equipment for domiciliary work being made available on loan.

8. England, Wales and Northern Ireland should follow Scotland in passing legislation to enable people suffering some form of mental incapacity to appoint a Welfare Power of Attorney, normally a relative or carer, empowered to make decisions as regards appropriate healthcare on behalf of the person.

9. The BDA (with others) should produce information templates for older people, carers and residential care homes about oral healthcare, services and costs that can be adapted by local health authorities and voluntary organisations.

10. Research, including controlled trials, should be undertaken, exploring ways of encouraging effective self-care by older people, and the results should be piloted.

11. NHS dental information and forms should be available in a variety of languages, in Braille and in large print format.

12. Information about full and partial exemption from NHS dental charges should be simplified and publicised to older people and carers.

13. Translation services and health advocates should be widely available, to make oral health services more accessible to older people from ethnic minorities.

14. Planned reform of NHS dental charges should take account of the growth in the older persons population and the fact that older people are more likely to require more complex treatment and also tend to be among the least able to afford to pay. Free NHS examinations should be available to patients aged 65 and over across the UK.

15. The undergraduate dental curriculum should continue to include teaching of complete and partial dentures, and should also give students experience of domiciliary visits and care homes.
16. Continuing Professional Development and postgraduate courses must be offered to equip dentists and dental care professionals (DCPs) with the clinical and communication skills they will need to treat the large caseload of older people by 2020.

17. Special care dentistry must become a recognised specialty.

18. Community Dental Services (CDS) should be resourced properly to enable CDS dentists to provide specialist services and clinical leadership to dentists and DCPs providing care for older people.

19. Anti-discrimination training should be introduced as part of the curricula for dental undergraduates and student DCPs.

20. Companies dealing in products related to oral health should recognise the potential market represented by older people who want to preserve good oral health and appearance and develop appropriate products and advertising campaigns.

21. Dentists should be able to prescribe any drug in the British National Framework’s Dental Formulary for NHS patients for dental use. The de facto inability of dentists to prescribe artificial saliva makes this of particular relevance to the treatment of older people.

Assessment

A new set of recommendations can be found towards the end of this document. They include updated versions of some of the recommendations that have not been met.

As is clear above, the BDA considers that eight recommendations have not been met at all, six have been partially met and only seven recommendations have been achieved in full.

The first recommendation – that the new locally-commissioned system for the delivery of NHS primary care dentistry in England must take account of the needs of older people – has been deemed unmet because of the huge range of inequalities that exists in the provision of dental health care for older adults. Only when a truly concerted effort to maximise provision and minimise inequality of access to care is made will this recommendation be satisfied. We are hopeful that the current NHS reforms in England will provide an opportunity for these services to improve.

In 2008, special care dentistry was recognised as a specialty by the General Dental Council. Although this is to be welcomed, it is clear that much more needs to change if services for older adults are to be in a position to offer the care required. Continued training for all those involved in caring for older people’s oral health

Residential Oral Care Sheffield (ROCS) covers 55 care homes in Sheffield with seven general dental practitioners (GDPs) under the supervision of a specialist gerodontologist. The GDPs carry out pre-screening with the manager, a screening visit, a post-screening meeting with the manager, treatment visits and referral to specialist care if required. Oral health promotion is central to delivery. It works within a fixed budget on an agreed sessional basis. This investment helps avoid more costly care later on.

The scheme was established in 2000 to establish more routine care for older adults in care homes. Treatment is provided either on a domiciliary basis, at the surgery or referred as required.
must be available to ensure that the small cohort of special care dentists are not overwhelmed by the demands of an ageing population with complex needs. Although many older adults will have complications and require specialist care, this will not be true of all older adults and adequate provision of general dental care for otherwise healthy older adults must be available too.

The six partially-met recommendations have been met in one or more of the four nations, have been met in part or are being taken forward at the moment. Recommendation 2 – that local health authorities must look creatively at dental provision for older people and tie in dentistry with other services - is a clear example of the problems facing both devolved and locally-led services. There are some instances of good practice in the co-operation between local authorities and local health representatives. Without stronger, and enforceable, nationally-led dental requirements there is a danger that in any future system, dental care for vulnerable older adults will be subject to even more of a “postcode lottery”.

Recommendations 4 and 5 are closer to being met in the devolved nations and this achievement is welcomed, though more progress is needed:

**Wales:** free dental examination for all at the age of 60

**Scotland:** free dental examinations for all; *National Care Standards: Care Homes for Older People* includes standards on dental care

**Northern Ireland:** Community Dental Services service level agreement includes an annual oral health assessment for every care home resident.

In England, compliance with Care Quality Commission (CQC) guidance requires care home and social care providers to secure health maintenance for those in their care, which includes the provision of dental and oral healthcare. Despite this regulatory requirement, BDA research has shown that some care homes and social care providers have trouble finding dentists and arranging domiciliary care. Many care homes, especially those with good links to the salaried dental services, however, seem to have routine check-ups and good services. The approach of some providers, however, remains waiting until something goes wrong before arranging dental care. It seems that a lack of communication has resulted in commissioners not commissioning a service that is required and care homes not receiving the service because they are not informing the commissioner of the need. As a result, training for care provider staff is poor and there is a lack of appropriately qualified dentists in this area.

The BDA calls for equity across the UK, in keeping with the NHS tradition of fairness in the provision of service. Recommendation 7 on the provision of services in care homes is not universal in its application. There are many instances of good practice of Primary Care Organisations helping local practices to provide care in a number of residential and care homes. There is still some way to go, however, before this can be considered to have been achieved.

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3 The Community Dental Service is now referred to as the Salaried Service, except in Northern Ireland

4 “Special Care Dentistry is that branch of dentistry which provides preventive and treatment oral care services for people who are unable to accept routine dental care because of some physical, intellectual, medical, emotional, sensory, mental or social impairment, or a combination of these factors. Special Care Dentistry is concerned with the improvement of oral health of individuals and groups in society who fall within these categories. It requires a holistic approach that is specialist-led in order to meet the complex requirements of people with impairments”. - *Training Programme in Special Care Dentistry* British Society of Disability and Oral Health 2008.
Recommendation 9 – the provision of information and guidance - has been met. The BDA has published guidance on looking after the oral healthcare of older adults (*Caring for your teeth*). There is also a wide range of information and guidance from specialist societies. Recommendation 14 - assessing the growth of the older adult population - was reiterated in Professor Steele’s *Independent Review of NHS Dentistry in England*, much of which is being taken forward by the Department of Health in 2011-14.

The BDA remains very concerned that salaried dental services are not resourced appropriately as we called for in recommendation 18 from 2003. The BDA’s survey of Clinical Directors earlier in 2011 revealed that shortfalls in funding remain a major concern. Rather than increasing funding levels, we have seen them drop consistently since 2003 to the detriment of patients. If oral health for vulnerable groups, including older adults, is to be provided at an appropriate level, more funding must be made available.

**Demographic information**

The BDA’s 2003 report cited predictions on the number of over-65s, the number of older adults in residential care, and the number who will be edentulous.

<table>
<thead>
<tr>
<th>Demographic Information</th>
<th>2003</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predicted total UK population</td>
<td>63.9 million (2020)</td>
<td>69.958 million (2021)</td>
</tr>
<tr>
<td>Predicted proportion of the population over 60 and under 16</td>
<td>21% over 60 (2020)</td>
<td>Approximately 25% over 60 (2020)</td>
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<td></td>
<td>20% under 16 (2020)</td>
<td>Approximately 17.6% under 14 (2020)</td>
</tr>
<tr>
<td>Predicted number of people of a pensionable age</td>
<td>12.1 million (2020)</td>
<td>12.906 million (N.B. the pension age increases) (2021)</td>
</tr>
<tr>
<td></td>
<td>11.81 million (actual in 2008)</td>
<td>12.1 million (actual 2010)</td>
</tr>
<tr>
<td>Older adults in residential care</td>
<td>375,000 (460,000 predicted 2020)</td>
<td>404,000 (551,000 predicted 2021)</td>
</tr>
<tr>
<td>Alzheimer’s and other dementias</td>
<td>845,000 (2020)</td>
<td>1.4 million (2038)</td>
</tr>
<tr>
<td></td>
<td>840,000 (2010)</td>
<td>820,000 (2010)</td>
</tr>
<tr>
<td></td>
<td>750,000 (2003)</td>
<td></td>
</tr>
<tr>
<td>Dentate adults</td>
<td>87%</td>
<td>94% (excluding Scotland)</td>
</tr>
<tr>
<td></td>
<td>50% of over 60s</td>
<td>85% 65-74</td>
</tr>
<tr>
<td></td>
<td>19% (1998) of over 85s, 56% predicted in 2018</td>
<td>53% of over 74s</td>
</tr>
<tr>
<td>Median age of UK</td>
<td>38.4 (actual in 2003)</td>
<td>40.3 (predicted 2021)</td>
</tr>
<tr>
<td>Life expectancy from 60</td>
<td>Men: 20.1</td>
<td>Men: 22.3k</td>
</tr>
<tr>
<td></td>
<td>Women: 23.3</td>
<td>Women: 25k</td>
</tr>
</tbody>
</table>
In 2003, it was predicted that the proportion of over over-65s would rise from 15.7 per cent to 18.9 per cent, that there would be an increase in the ethnic diversity of the age group, and that men and women would continue to age at different rates.

The figures used in the 2003 report appear to be more optimistic than current predictions. Given the increasing size and age of the population, it is even more important that the recommendations below are addressed as soon as possible. The increasingly large older adult population will bring with it all the health complications discussed in our 2003 report. The figures for Alzheimer’s and other dementias, type 2 diabetes, blindness and stroke are also increasing with the demographic predictions, adding further complications to care provision.

A diverse cohort

Older adults do not form a single demographic, but instead include a diverse cohort of individuals with a wide range of needs, expectations and aspirations. There is a wide range of issues within each age bracket and, as the pension reforms are established, more people will be working for longer, which will once again alter the health needs and expectations of older adults and the services required to meet them. Alongside these shifts in health needs, expectations are changing around dental functionality and appearance.

Functionality is vital to ensuring that people remain healthy and able to lead independent lives. Having good functional dentition, ideally one’s own teeth to minimise any complications with dentures, ensures that people are able to maintain good nutritional habits more easily and live free from unnecessary pain and discomfort.

Good oral health is being recognised as a core enabler of social interaction and general wellbeing. Older adults, especially the most vulnerable, require social interaction and the protection of dignity and aesthetic appearance, and these needs must be addressed. Having functional teeth and gums helps maintain independence in the most vital ways, such as preserving confidence in eating and talking. An ageing population will need access to an appropriately staffed service, capable of helping them safeguard these basic activities. The Adult Dental Health Survey (ADHS) indicates that the number of adults with no natural teeth is shrinking rapidly and, as general oral health improves, this is likely to decrease still further. Having only a small number of natural teeth brings with it its own complications and there must be no assumption that an ageing and partially-dentate population does not require highly-trained dental professionals.

BDA care home research

Throughout the spring and summer of 2011, the BDA conducted interviews with 13 care homes from around the UK. We combined the data from these surveys with information collected from our annual survey of Clinical Directors of Salaried Primary Dental Care Services and a literature review.

The literature showed high levels of unmet dental need in care home residents and this was supported by evidence gathered in interviews with care home managers. The Clinical Directors surveyed also confirmed that provision of dental care in care homes was less than ideal. Levels of training among care home staff for oral health was patchy, though most received some form of instruction from a senior colleague on their induction. Formal instruction from a dental professional was less common. Problems could be exacerbated by the higher staff turnover in

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5 The collection and classification of data is not consistent, hence there is some disparity in the type of data being compared here, so not all is directly comparable.
care homes and their attitude towards performing oral health functions which were often regarded as the least desirable aspects of providing care.

Our research shows that while knowledge and care is improving, there is still a lot to do to develop standardised care and integrate oral health into the daily routine of residents. As the number of people expected to live in care homes or be reliant on a carer increases, it is vital that services become integrated to provide a holistic approach to care.

**Adult Dental Health Survey 2009**

In March 2011, the latest ADHS was released by the NHS Information Centre. This survey is compiled every ten years to assess the dental health of the population in England, Wales and Northern Ireland. As predicted, the latest ADHS showed that the oral health of adults in England, Wales and Northern Ireland is improving, with only six per cent having no natural teeth, compared with 13 per cent in the 1998 survey. The prediction was that in 2008, eight per cent of older adults would have no natural teeth. Eighty-six per cent of adults have functional dentition (21 teeth or more), which demonstrates a marked increase since 1978. There is also a strong correlation to socio-economic status, functional dentition and regular dental attendance.

The connection between age and functional dentition is very clear: 47 per cent of those aged 85 years and over have no teeth whatsoever, compared to one per cent of those aged 45-54, while five per cent of 55-64 year olds are edentulous. There is also a strong correlation between edentulousness and country of residence:

![Image from the Adult Dental Health Survey 2009](image)

Although oral health continues to improve, it is clear that issues remain and that, as the population ages and risk factors for poor oral health continue to be prevalent, we must put in place a system of oral health care for older adults that is adaptable and addresses the particular issues facing older adults. Those who will enter later life in the next 30 years will have different dental health requirements and expectations from the current generation. Edentulousness may
not be as prevalent now as it was 30 years ago, but we face continuing challenges to preserve and improve the oral health of older adults. We must also remember that the state of the mouth is only one part of delivering oral health care. As the population continues to age, mental health issues will become more prevalent, bringing their own particular challenges to maintaining good oral health, including issues around polypharmacy and contraindications.

Financial information

The BDA's 2003 report assessed the relative incomes of those on a pension and their spending patterns. Recent reports show current pension rates and make predictions about the future.

<table>
<thead>
<tr>
<th>2003</th>
<th>2011</th>
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<tbody>
<tr>
<td>Recently retired couples pension pension</td>
<td>£331 per week (2000/01)</td>
</tr>
<tr>
<td></td>
<td>£454 per week (2008/09)</td>
</tr>
<tr>
<td>Over 75s couple pension</td>
<td>£276 per week (2000/01)</td>
</tr>
<tr>
<td></td>
<td>£377 per week (2008/09, after housing costs)</td>
</tr>
<tr>
<td>Access to computers</td>
<td>17% of two person households had internet access at home (2002)</td>
</tr>
<tr>
<td></td>
<td>64% aged over 65 have never used the internet</td>
</tr>
</tbody>
</table>

The population is ageing with more money and increased access to modern forms of communication. With an increase in access to the internet, expectations of form and function change as more older adults consider proper function and aesthetic appearance to be an important part of oral health. The generation of property owners is entering the 60+ demographic and an increased number have used computers in their work. This affects expectations in their home life, including access to information and delivery of services. While it is important that the most vulnerable members of society have access to specialist care, it is also important to ensure that not all older adults are classified as being in need of specialist care. The older adult cohort covers a broad range of ages, with many being computer-literate and affluent. This affluent, independent and computer-literate group have expectations that match younger generations' but often have an oral health status that does not. These considerations highlight the vast range of people captured by the term “older adult”.

Independent older adults have more income than before, but as can be expected, health takes up a greater proportion of that income. Dental health must remain affordable and a priority for older adults to ensure that they can continue to lead comfortable and independent lives. Oral health education at any age will improve dental outcomes. The BDA supports the government’s agenda to help people live in their own homes for as long as possible. If this is to be possible, home visit services will need to be more widely commissioned.

Existing guidance

There are many successful local schemes that address oral healthcare for older adults (see ROCS above) and the specialist dental societies and older adult charities provide information on oral healthcare for older adults. The British Society of Gerodontology and the British Association

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6 The 2009 report did not include Scotland
7 “Edentulous” describes a person with no functional teeth
for Disability and Oral Health have both published comprehensive guidance for the provision of care for older adults. These efforts are to be applauded, as are the guidance documents from the Scottish Government for care homes which mention the importance of oral care. It is encouraging to note that older adults were recognised as an important and distinct cohort within those proposals.

Sufficient guidance and knowledge exists on the delivery of oral health care for older adults. It is clear, however, that it is not being appropriately delivered in all cases and that the oral health of older adults must be prioritised if it is to be effective. The focus must be on tackling the barriers to the application of guidance to care and commissioners must be sensitive to the whole person in their care and not marginalise dental and oral healthcare.

**Next steps**

The health and wellbeing of older adults has rightly become a more prominent policy focus in recent years, and the BDA welcomes the progress that has been made on improving care and the financial status of older adults. Oral healthcare continues to be marginalised and dental care commissioning for older adults needs to be improved and improved quickly. This can only be achieved through the recognition by government of the importance of oral health in protecting the dignity and independence of older adults. Progress has been made but much more needs to be done to ensure that the advances made are not temporary, and that services continue to improve and be integrated fully into our expectations of healthcare. Dental care may appear to be only a small aspect of health, but it plays an important role in safeguarding the wellbeing of the whole body.

It is time for dentistry to stop being marginalised in healthcare, and to be recognised as an essential part of good health and wellbeing.

The BDA’s UK Healthcare Policy Group has updated the 2003 report’s recommendations that it considers are still relevant:

1. NHS primary dental care services must take account of the needs of older people and the clinical changes associated with an ageing population. The BDA will continue to push for greater integration between health and social care to ensure that good oral health structures are in place to deal with the oral health needs of an ageing population.

2. Those responsible for the health and wellbeing of older adults, whether in sheltered accommodation or care homes, should provide residents with basic information on quality of life indicators relating to oral health. This would enable residents to prioritise their oral health requirements. There should also be basic local standards relating to the oral healthcare of residents with which homes would have to comply – for example, regular checks by staff on tooth brushing and cleaning of dentures.

3. Integrated clinical pathways for dentistry must be developed with the profession that reflect the needs of the older population.

4. Free and comprehensive oral health assessments must be properly funded for those aged over 60, regardless of circumstance and with equitable access across the UK.

5. Information about full and partial exemption from NHS dental charges should be simplified and publicised to older people and carers.
6. Marking of dentures for easy identification in residential care homes and hospital settings should be routine.

7. CPD and postgraduate courses must be offered nationally to equip dentists and DCPs with the clinical and communication skills they will need to treat the increasing number of older people.

The BDA’s research into dental services in care homes showed that barriers continue to exist which prevent the provision of good oral healthcare in these settings. Following this research, the BDA’s UK Healthcare Policy Group has developed some initial recommendations that it considers would improve the provision of care:

8. Standardised assessments should be carried out by a dentist on all people admitted to a care home.

9. Specialised consultation rooms should be provided on site to improve domiciliary care, in all new care homes. Existing care home providers should take all reasonable actions to ensure that there is a suitable setting for dental examinations on their premises.

10. As a principle underpinning all care, provision of care should be for the convenience of the patient and not the providing organisation.

The current NHS reforms, public health and social care system reviews present the most favourable conditions to improve the oral health care for older adults.
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o. Guidelines for the oral healthcare of Stroke Survivors British Society of Gerodontology 2010

1 All data from Oral Healthcare for Older People British Dental Association 2003