SINGLE MEETING REVIEW: CHILD ORAL HEALTH IN HILLINGDON – DRAFT FINAL REPORT

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REASON FOR ITEM

Following the Committee's consideration of this issue, a summary of the information from the witness session and draft recommendations to Cabinet have been produced. This needs to be agreed by the Committee prior to consideration by Cabinet.

OPTIONS OPEN TO THE COMMITTEE

1. To consider and agree the information and draft recommendations to be incorporated into a report to Cabinet.

INFORMATION

Supporting Information

1. The Social Services, Housing and Public Health Policy Overview Committee, held a single meeting review on 24 February 2015. At this meeting, Members investigated the causes of poor oral health and the health implications if this was not addressed. The meeting also looked at the remedial action being taken by the Council in conjunction with partners and what might be done in the future.

The causes of poor child oral health

2. Tooth decay is caused by a combination of excess consumption of sugary foods and drinks and poor oral hygiene. If these lifestyle choices are not addressed, there is a much higher risk of further tooth decay in permanent adult teeth and throughout later life. The key point which needs to be recognised, is that tooth decay is preventable. This can be significantly reduced by eating a healthy balanced diet, limiting sugar intake, and also by brushing teeth for two minutes twice a day, using fluoride toothpaste.

Why Is It Important?

3. Dental caries[1] remains the main cause of hospital admissions for children aged under 18 years. Given the seriousness and potential ramifications of the problem,

[1] Also known as tooth decay, cavities, or caries, is breakdown of teeth due to the activities of bacteria.

the Parliamentary Health Select Committee held a one off evidence session on Tuesday 24 February 2015 to examine child oral health in England, and its findings are awaited with interest[2].

4. Recently published results of the Child Oral Health Survey (September 2014, revised January 2015) for 3 year olds show that dental health of children is particularly poor in Hillingdon with the highest rate of early childhood caries amongst London boroughs (16% against the London average of 5.3%). Since 1 April 2013, Local Authorities are statutorily required to improve the health of their population which includes oral health and the Committee welcomed the opportunities for health visitors and the Community Dental Health team to work closely with the Borough's Children's Centres for better targeting of families at higher risk.

5. Should poor oral health go unchecked, the Committee recognised this could manifest itself in a number of ways including:

6. *Affecting school readiness and education*: Whereby poor oral health could affect children's ability to sleep, eat, speak, play and socialise with other children. Bad teeth cause pain, infections, impaired nutrition and growth. It was noted that undergoing treatment would necessitate school absence and parents would be obligated to take time off work.

7. *Hospital admissions*: As previously eluded to, dental caries is the cause of highest number of hospital admissions for children aged 1-18 years in the Borough. Based on the hospital episodes data, they represent: 6% admissions for 1-18 year olds; 15% admissions for 5-9 year olds. The Committee noted that almost all these admissions were elective admissions, and were especially concerned by the high numbers of young children attending hospital to have teeth extracted or filled under general anaesthetic.

8. *Chronic Illness:* Since poor oral health shares common risk factors as other chronic diseases, officers highlighted that any action to reduce these risks (in particular sugars in the diet) would improve oral health as well as general health, especially excess weight and obesity. Good oral health is therefore vital and is an integral part of overall health.

Responsibility for Dental Healthcare and Prevention

9. NHS England (NHSE), Public Health England (PHE) and the Local Authority have joint responsibility for improving oral health. Since 1 April 2013, NHSE has had responsibility for commissioning all NHS dental services - both primary and

[2] http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/childrens-oral-health/oral/18366.pdf

secondary care. This includes developing and negotiating contracts with dentists, designing policies, procedures, guidance and care pathways.

10. PHE provide dental public health and health improvement support for local authorities and NHS England, including collaborative commissioning of oral health improvement programmes.

11. Local authorities role includes:

- Joint statutory responsibility with Clinical Commissioning Groups (CCGs) for Joint Strategic Needs Assessments (JSNAs)
- Participating in oral health surveys to assess and monitor oral health needs
- Responsibility for reducing health inequalities
- Planning, commissioning and evaluating oral health improvement programmes
- Leading scrutiny of delivery of NHS dental services to local populations
- The power to make proposals regarding water fluoridation schemes, a duty to conduct public consultations in relation to such proposals and powers to make decisions about such proposals.
- Lead responsibility for the healthy child programme (HCP) 5-19 years (and HCP 0-5 years from October 2015), the national child measurement programme and the care of vulnerable children and families (ie. looked after children, the troubled families programme)
- Safeguarding children
- Commissioning local healthy schools, school food and healthier lifestyle programmes.

Current action being taken by the Council to prevent tooth decay

12. At a local level, this means the Council's preventative agenda is being taken forward through a) action on common risk factors, and b) improving oral hygiene. Improving diet and nutrition includes providing information, reducing the consumption of sugary food and drinks and the reduction in alcohol and tobacco consumption (these risk factors are the same as for many chronic conditions, such as cancer, diabetes and heart disease). The implementation of the infant feeding policy and a new Early Years Charter based on Healthy Schools Programme with specific standards for improving food and drink available to children via children's settings.

13. Improving oral hygiene includes the commissioning of 'Brushing for Life' programme by Public Health Team as described below.

14. The Committee were encouraged that Hillingdon Public Health were working with Children's Centres, the Early Years Team and the local Community Dental Service (CDS) to prevent dental decay in children aged 0-5 years of age. In

November 2013, the Hillingdon Early Years Award was launched, which enables early year's settings to review themselves against set criteria incorporating questions on food, drinks and oral health. The award has been embedded in the Childcare and Early Years team as part of the support they offer settings to achieve quality standards.

15. Additional work includes: the Hillingdon Early Years Nutrition Network (HEYN) which is implemented in early years' settings, where they have to meet set nutritional standards in order to achieve Healthy Early Years status. Alongside this, there is the 'Healthy Early Years Menu Checklist' for them to work through in order to serve food that fits with current nutritional guidance and advice. Monthly dental drop-ins are offered by the Community Dental Health Promotion Team at Cornerstone; Harefield; Nestles; Charville Children's Centres and any parents experiencing problems or searching for information can be directed to these sessions. The Community Dental Health Team pilot is currently under way for engaging dental practices to model a partnership working between dentists and local children centres and potentially other settings over time.

16. At the Committee meeting, Members were provided with Brushing for Life packs which provide a toothbrush, fluoride tooth paste (of varying strength according to age) and information of brushing, including frequency and duration. The benefits of the programme are:

- Improving the life chances for children in areas of deprivation by giving information, advice and training to parents and working actively to prevent decay and reduce morbidity in teeth.
- Establishing prevention in the Paediatric Dental Care Pathway so that children who do not at present attend a dentist are encouraged to attend; and less likely to suffer as a result.
- Promoting the correct use of fluoride toothpaste which is proven to be a major factor in preventing dental decay.
- Reducing the fear of visiting the dentist which is a major barrier to seeking care early.
- Encouraging the regular and early attendance at a dentist in order to identify disease earlier and reduce the likelihood of long term effects. Currently, late uptake of care generates increased episodes of pain and sepsis requiring more urgent treatment. This also increases the likelihood of the need for treatment in hospital and under general anaesthesia.

17. In view of the current action, the Committee recommended that:

Cabinet notes and commends the preventative work currently being taken; and agrees that this work should continue such as the Early Years Programme and Brushing for Life campaign

18. In 2014, an evaluation of these programmes showed that:

- Knowledge about visiting dentists had improved with 79% of parents thinking that children should attend the dentist before the age of 2 years (60% before BFL initiative). A 21% increase has been reported in visits to dentists since the BFL initiative.
- A 13% increase in the number of parents reporting brushing their children's teeth twice daily.
- There did not appear to be a significant change in overall knowledge of age to start brushing (57% when the teeth erupt).
- More parents appeared to be aware of the correct amount of toothpaste and there was a reduction in the number of parents using too much paste from 27% to 15% with no parents reporting using no paste after the training.

19. Stemming from this assessment, the following gaps were identified and earmarked as future priorities:

- Access to NHS dentistry is poor in certain parts of the Borough. For example, there are currently no dentists in Harefield.
- Uptake of dental services by young families is poor despite the fact that dental care for children is free. Families are not registering children with dentists.
- Some parents have reported to Community Dental Health Team that they are being turned away by dentists when they try to make an appointment for their under 3 year olds. Mystery calling and shopping by the Community Dental Services Team has also demonstrated this. This has been raised at the Local Dental Committee and the Community Dental Health Team are awaiting a response.
- Uptake of preventative treatment: fluoride varnish (FV) once a year for every child over 3, especially those at higher risk is also poor. Parents do not recognise risk factors early enough to take children for FV.
- Diets need to be improved for families, especially those with young children who may need help with cookery skills, knowledge and awareness about harms of sugary foods, home economics to plan low cost healthy meals.
- Training and consistent messaging via frontline staff working with young families needs to be supported on an ongoing basis.

Raising Awareness and Possible Future Action

20. At the meeting, the Committee heard how NHS dental practice numbers had declined in the Borough from 44 in 2009 to 36 in 2015. Anecdotal evidence was also cited suggesting that some parents had experienced difficulty registering their children with a dental practice. However, contrary to the perception there might be capacity issues, Kelly Nizzer, Regional Lead (North West London, NHSE) Dental and Ophthalmic Services, confirmed that sufficient dental units are in place to provide dental services to residents. This assertion illustrates that the

main reason why children's oral health has declined is not service related, but appear to indicate that parents lack sufficient information, advice and guidance to make informed choices and to begin a dental hygiene regime for their children at an earlier / appropriate age. Taking this forward, the Committee made a number of observations, including the opportunities to integrate dental information (such as dental registration, fluoride varnishing and brushing advice) into 'Bounty Packs' (provided to expectant mothers) and other carriers such as NHS registration letters or even stamping reminders onto envelopes, so diffusing this message would be cost neutral. Further suggestions included investigating how the Council's existing resources, such as the website and Hillingdon People might be used to improve oral health in the future.

21. Claire Robertson, PHE, highlighted that PHE had arranged for a pilot to begin in 10 schools across the Borough and pending the analysis of these results there was the opportunity to consider how this initiative might be expanded. Reference was made by both witnesses to the collaborative work which had been undertaken and how both NHSE and PHE had contributed to the Council's public health and preventative role.

22. On this basis, the Committee agreed the following recommendation:

Notes the current delivery of a partnership project (between NHSE, Hillingdon Council and PHE) to improve the uptake of dental services by young children.

23. Discussing how oral health in children could be improved, the Committee raised a number of salient points and asked those present about the current performance of dental services. The Committee enquired about what performance indicators were in place, how these were measured and what action plans were either in place or being developed to monitor service uptake and effectiveness. From the discussions which took place, it is evident there is scope to improve and develop performance information across all three organisations responsible for oral health and the Committee requested that a baseline, beginning in early 2015 should be established so this could be used as a yard stick to monitor future progress. To take this important request forward, the Committee recommended that:

Cabinet: Asks officers to prepare a report (incorporating key performance indicators) in partnership with PHE and NHSE on the uptake and effectiveness of dentistry services for children and for this to be referred to the Cabinet Member for Social Services, Health and Housing and to the External Services Scrutiny Committee or Health and Wellbeing Board as appropriate for consideration in 2016.