EXTERNAL SERVICES SELECT COMMITTEE – CHILDREN'S DENTAL SERVICES

Committee name	External Services Select Committee
Officer reporting	Nikki O'Halloran, Corporate Services and Transformation
Papers with report	None
Ward	n/a

HEADLINES

Members are to scrutinise action taken in Hillingdon by external partners to address health inequalities in relation to dental health.

RECOMMENDATION:

That the External Services Select Committee notes the content of the report and seeks clarification about matters of concern in the Borough.

SUPPLEMENTARY INFORMATION

On 21 May 2015, the Council's Social Services, Housing and Public Health Policy Overview Committee presented a report to Cabinet on children's oral health. During this single meeting review, Members considered information from witnesses about the work that was being undertaken in child oral health in the Borough; noting the preventative measures being taken such as the Early Years Programme and Brushing for Life campaign. Action has yet to be taken in respect of some of the recommendations. However, further to the review, progress has been made with the addition of two new general dental practices in Harefield (which previously didn't have an NHS dentist) and Yiewsley and the launch of a fluoride varnishing programme.

National trends and focus

In the UK, oral health is steadily improving for both adults and children. The proportion of adults with no natural teeth is at an all-time low, while the proportion of those with 21 teeth or more has been consistently rising. However, there are concerning levels of variation between different parts of the country and socioeconomic groups. On the whole, dental health is better in the south and east of England, and poorer in the north of England.

Poor oral health has been linked to a number of general health issues including lung disease and poor diabetic control, there is also an association between chronic gum disease and cardio-vascular disease. The cost to the NHS of treating oral health conditions is around £3.4 billion per year. Dental decay (also known as caries) and gum disease are the most common oral conditions, and are largely preventable through the maintenance of good oral health practices.

Good oral health is fundamental in facilitating good general health and wellbeing. In recent years, there has been a focus on adopting preventative strategies to combat major public health concerns facing the UK. There are large scale public health campaigns addressing widespread

concerns such as obesity and type-II diabetes. However, more needs to be done to ensure that the focus on prevention in dental health is joined up with wider efforts to prevent ill health.

Impact of COVID-19 on NHS dental services:

In addition to the ongoing issues, COVID-19 pandemic has further complicated access to dental services which have been severely limited. A report by the General Dental Council (GDC) acknowledges that the time needed to recover from this situation will be significant, where uncertainty continues about what services are available to the public and patients, and where some sections of the population are either unwilling or unable to access oral health care services. In the meantime, the needs are increasing and a Healthwatch report highlights confusion owing to lack of information. It is therefore important to establish:

a) what routine NHS and emergency dental care services are currently available?
b) how are residents being informed about the level of provision?
c) what is being done to 'catch up' with pending treatments which have been 'on hold' over the lockdowns?
d) what is being done to prevent / reduce potential inequalities?

Regional concerns and health inequalities

There are concerning levels of variation between different parts of the country and socioeconomic groups. The quality of dental health is better in the south and east of England, and poorer in the north of England. However, in 2019, those in London were the least likely to see an NHS dentist, with just 44% having had a check-up in the previous 24 months. Nationwide, the number of adults accessing NHS dental services had fallen to a 10-year low with just 50.2% of adults reporting to have seen a dentist within the previous two years. Attendance of NHS dentistry services has become of growing concern and links have been drawn between the prevalence of gum disease and individuals who do not visit the dentist regularly.

The most prominent reason cited for the lack of people accessing dental services is the increasing cost, more than a third of survey respondents (36%) admitted to sacrificing dental visits in order to keep their bank balance in check. Cost is not the only reason behind not attending a dentist. Anxiety (22%), the fear of getting bad news (18%) and work commitments (8%), are all reasons why people stay away. Since 2010, net Government expenditure in England on dental services has dropped by £550 million in real terms; over the same period, the cost of NHS dentistry services has increased by more than 30%.

NHS dental treatment is free for:

- anyone under 18 years old;
- adults under 19 years old, in qualifying full-time education;
- pregnant women, or women who have had a baby in the previous 12 months;
- being treated in an NHS hospital and your treatment is carried out by the hospital dentist; and
- those receiving low-income benefits, or if they are under 20 years old and a dependant of someone receiving low-income benefits.

There is a need to emphasise the availability of free NHS dental treatment, specifically for those receiving low-income benefits, as access to these services remains low for this demographic. During the current situation, it is even more important to promote NHS dental services and increase availability, especially among population groups and communities which are traditionally

known to not access these services.

Lifestyle choices impact on a person's oral health - for example, tobacco use and drinking alcohol above the recommended levels are risk factors for oral cancer. The combined effect of drinking alcohol and using tobacco multiplies the risk of developing mouth cancer. Other factors, often associated with socio-economic circumstances, such as poor diet, contribute to health inequalities and a divide in the quality of oral health from the most deprived to the least deprived areas.

Hillingdon

There are a number of dental health concerns within the Borough. However, one had been prioritised as forming part of Hillingdon's Health and Wellbeing Strategy for 2018-21. Namely, that young children in Hillingdon have levels of dental decay that are higher than the average for England. The level of dental decay in Hillingdon for 0-5 year olds is 32.5% compared to the average for England (23.3%) and London (25.7%). This paints a picture of a localised issue in West/North-West London as Harrow also experienced a high proportion of child dental decay at 34.2%. The prevalence of decay was attributed to long term bottle use, this suggests that action to discourage long term bottle use and sugary drinks consumption will be needed if oral health levels are to be improved.

A 2010 Oral Health Needs Assessment, conducted by NHS Hillingdon, found that in Hayes and Harlington there was a particularly high unmet need in both referral for specialist services and community dental services.

'The Sugar Tax' - Practical implications on dental health

The Government's Soft Drinks Industry Levy (SDIL), more commonly known as the sugar tax, was introduced in April 2018 as part of the childhood obesity strategy; the measure introduced levies of 24p per litre for drinks containing >8g of sugar per 100ml and 18p per litre for drinks containing 5-8g of sugar per 100ml. Its aim was to reduce sugar consumption, a leading cause of dental caries[1], by persuading companies to reformulate their high sugar brands and avoid paying the levy.

In the two years preceding the introduction of the tax, many soft drinks manufacturers reduced the sugar content of their beverages in preparation for the levy; because of this, HMRC reduced their revenue forecast from the levy to £275m from an initial £520m during the first year of operation. Total SDIL receipts for the financial year 2019/2020 were £336 million and for the financial year 2018/2019 were £240 million[2].

The revenue generated from the SDIL was to be earmarked to help fund physical education activities in primary schools, the Healthy Pupils Capital Fund and provide a funding boost for breakfast clubs in over 1,700 schools. However, as the primary objective of the levy was to tackle childhood obesity rates, there were calls from the Global Child Dental Fund for 20% of the proceeds to be reinvested into innovative oral health prevention strategies.

Research on the practical implications of the UK's SDIL on dental health is in its early stages;

[1]Sugars and Dental Caries: Evidence for Setting a Recommended Threshold for Intake., Advances in Nutrition. 2016 Jan; 7(1): 149–156. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4717883/

[2] Soft Drinks Industry Levy Statistics Commentary 2020: https://www.gov.uk/government/statistics/soft-drinks-industry-levy-statistics/soft-drinks-industry-levy-statistics-commentary-2020#soft-drinks-industry-levy-receipts

however, a 2019 Dutch-German study found that a 20% taxation on sugary beverages would result in a €159m saving in terms of dental care expenditures[3]; concluding that an intervention of this kind could substantially improve oral health and reduce the caries-related economic burden.

There are frequent calls for the sugar tax to go further and cover other confectionary products. Although soft drinks account for 10% of a child's sugar intake, confectionaries such as sweets, ice cream and puddings make up more than a fifth of their sugar intake. The early successes of the SDIL in changing the behaviours of soft drinks manufacturers has fuelled calls for a more extensive sugar tax, particularly to help address wider health problems (29% of UK adults classified as obese and nearly five million people living with type-II diabetes).

Responsibilities

Dentistry can be separated into two distinct strands: general dental services and community dental services. Both of these strands are commissioned by NHS England (NHSE) with the advice of Public Health England (PHE); locally, this feeds down to North West London CCG. Most dentistry within the Borough is provided by private practitioners paid to deliver frontline NHS services, most of whom also provide, on a commercial basis, services which the NHS does not provide, largely cosmetic. This differs from the way in which GP surgeries function.

The Hillingdon Health and Wellbeing Strategy for 2018-21 noted the formation of the North West London Sustainability and Transformation Partnership (NWL STP). The Health and Wellbeing Strategy also highlighted the 10 transformation themes and 5 overarching delivery areas which were key to improving health outcomes in North West London. Delivery area 1 pertains to 'Prevention and Wellbeing' with good children's dental health forming an integral part of it. This is to be facilitated by transformation theme 7, 'Integrated Care for Children & Young People', a key outcome of which being to increase the dental health of 0-4 year olds to the national average by 2021. Children's dental health formed part of the strategy in direct response to the high proportion of children in the Borough with dental decay. However, the Health and Wellbeing Strategy does not detail any key actions or outcomes for the dental health of adults.

Select Panel Creation and Terms of Reference

At its meeting on 18 December 2019, the External Services Select Committee agreed the Terms of Reference for a Select Panel to undertake a review of dental service provision for children and young people in the Borough and the effectiveness of preventative measures taken by partners in relation to caries and other oral health issues. The Select Panel's Terms of Reference for the review set out the objectives of the review:

1. To gain a thorough understanding of the current dental service provision offered to children and young people within the Borough and to consider possible areas for improvement;
2. To explore the current situation in relation to the dental health of children and young people in the Borough and to consider how this can be improved on;
3. To identify barriers to attendance – reasons for current low attendance rates and what can be done to address this issue;
4. To review current and future plans by health partners to prevent incidences of caries and to improve oral health;
5. To examine best practice elsewhere through case studies, policy ideas and witness sessions;

[3] *The caries-related cost and effects of a tax on sugar-sweetened beverages.,* Public Health. 2019 Apr; 169: 125–132. https://www.sciencedirect.com/science/article/abs/pii/S0033350619300344

6. To review the current policies, legislation, research and campaigning by Government to improve children's oral health and to explore best practice and advice that could be adopted by the NHS; and
7. After due consideration of the above, to bring forward recommendations to Cabinet for Council endorsement, before being sent to health partners to consider.

Select Panel Witness Session – Information gathered

The first meeting of the Select Panel took place on 12 February 2020, just before the Covid-19 pandemic put the country into lockdown. The aim of this meeting was to gain a more thorough understanding of current dental provision for children and young people and the challenges faced, with a focus on preventative action, possible solutions and access to services.

At this meeting, Panel Members observed that many other London boroughs were doing significantly better than Hillingdon in terms of children's oral health and commented that it would be useful to draw on their experience and establish what they were doing differently. It was noted that Bexley is a similar borough to Hillingdon, yet that borough appears to be achieving better results.

Community dental services had previously been the responsibility of Central and North West London NHS Foundation Trust (CNWL) but the contract was awarded to Whittington Health NHS Trust (WH) in April 2019. The transition to a new provider had meant that a new premises was required but building work had been needed to improve accessibility to the new which had impacted access to community dental services for a significant period of time. Work at the Uxbridge Community Dental Clinic in Redford Way had been completed with a new lift giving access to the first floor facilities.

In February 2020, there were 33 dental practices in Hillingdon and a total of 308,000 units of dental activity (UDAs) had been commissioned for Hillingdon. These units are utilised exclusively for NHS work and are a measure of work done during dental treatment but have no uniform financial value. The value of a unit will vary across practices and the figures used to generate UDA are not standardised across the board and are higher in areas where there are fewer NHS dentists. More complex dental treatments count for more UDAs than simpler ones, for example a filling would equate to approximately 3 units while more complex work might equate to up to 12 units. Units of dental activity are allocated per practice and there is no optimum number but circa 6,000 units per year is thought advisable. UDA contracts were awarded in 2006 based on historic activity so were very out-of-date and it is unclear whether NHSE is commissioning sufficient UDAs to meet the needs of Hillingdon residents.

All dentists are allocated a number of UDAs annually to use between 1 April and 31 March. Those dentists who have large contracts are often unable to meet their targets but any funds that they are unable to spend during the year would be clawed back by NHSE. This money would not be made available to other dentists in the area as the funds are not ring-fenced. In 2019, in London alone, £10m was clawed back and none of this money was re-invested in dental practices. As a result of this funding method, patients sometimes struggle to register with an NHS dentist.

Unit allocations vary across practices and, if a practice has no UDAs remaining, they would be unable to accept any new patients until the new allocation of UDAs was released. Dental practitioners therefore have to do private work to enable them to survive. Some practices have

negotiated exempt-only contracts whereby they are only obliged to treat children, those on benefits, etc.

NHSE had launched Starting Well 13 - A Smile4Life Initiative which was a programme of dental practice-based initiatives aimed to reduce oral health inequalities and improve oral health in children under the age of five years. The programme would focus mainly on those children who were not currently visiting a dentist and under one-year-olds. It would ensure that evidence-based preventive advice about reducing sugar intake and increasing the exposure to fluoride on teeth was given to parents. Practices had been invited to tender for this service (worth approximately £30,000 - £40,000 per annum) in addition to their allocation of UDAs. The initiative had already proved to be successful in the north of England.

A survey of 3 year olds carried out in 2012 showed that 16% of 3 year olds in Hillingdon (the highest in the country - compared with 3.9% in England) had incisor caries (decay of front teeth) which showed how dental decay started at a very early age and could be related to poor infant feeding practices. The 2012 data is quite old so a new survey of 3 year olds was undertaken and was underway back in February 2020. As such, it is anticipated that more up to date information should now be available.

The survey in 2012 showed that NWL was generally the worst affected area in London with the highest rates of dental caries. NWL also had the highest number of hospital extractions. As the data was based on a survey of 250-300 children per borough, further analysis to examine smaller areas, e.g., electoral wards or ethnic population, was not particularly reliable. In addition, there had been a campaign to encourage parents to register children with local dentists and, in 2015, a fluoride varnish project involving local dentists had taken place in local schools situated in areas of high need.

It is thought that the variation in children's dental decay could, in part, be attributed to the fact that, in some regions, fluoride is added to the water (and children's dental health is significantly better in those areas); this is not the case in London. Water fluoridation is not implemented everywhere due to strong opposition to it as a number of people believe fluoride to be poisonous and are concerned that the fluoridation of water could cause bones to become weaker. At present, 10% of the water in the UK is fluoridated.

Obesity and poor diet are other contributing factors to children's dental decay and the situation is generally worse in the south of the Borough. Modification of lifestyle choices of newly arrived populations is also particularly challenging.

At the Select Panel meeting on 12 February 2020, a local dentist advised the that he had been working with a number of primary schools across the Borough for approximately 12 years to raise awareness of the importance of oral health. He regularly spoke at school assemblies and invited groups of under 5-year-olds to attend 1½ hour sessions at his dental practice during which their teeth would be checked, fluoride varnishing applied and advice given. It had become apparent that many of these children had never visited a dentist before which was very concerning. This dentist provided information to school nurses to cascade to the children and this approach seemed to work well and make a real difference.

In the past, maternity dental packs were routinely given to new mothers but this is no longer the case. Many parents lack awareness and understanding of the need to look after their children's teeth from a very early age. Staff at children's centres are expected to promote oral health, as

are school nurses and health visitors (every family receives a mandatory visit from a health visitor contracted by Children's Services). In reality, this does not always happen and there are currently no KPIs in relation to the work of school nurses and health visitors.

There was a drive to re-procure the 0-19 service and, in December 2019, Cabinet agreed a one-year extension to the contract, with a review of its specification and scope to reflect the need for oral health promotion. It had been proposed that KPIs be put in place to ensure that the service was delivered at the level required, particularly in the south of the Borough. It was anticipated that this contract would be re-tendered and awarded by the end of the 2020/2021 financial year 2021.

Health beliefs and communication difficulties can, at times, act as barriers to maintaining the oral health of children; it is likely that different work will be required in the south of the Borough. Another challenge is in relation to religious beliefs in that some patients of Islamic faith are reluctant to allow fluoride varnishing as they believe it was contrary to their religion. A statement advising that this was not the case has been released by the Sharia Council but, back in February 2020, had not been widely communicated. However, it is acknowledged that fluoride varnishing per se is not the answer - behaviours need to change too.

The reinstatement of free dental packs on discharge from maternity units, together with verbal advice, would be invaluable. The Select Panel also suggested that The Personal Child Health Record (also known as the PCHR or 'red book') that is given to parents/carers at a child's birth should include information about dental health. Members also felt there was a need to strengthen the role of health visitors and school nurses in relation to the oral health of children.

It appears that the NHS model focusses on commissioning services to treat the problem rather than to prevent it from occurring in the first place. The NHS plan highlighted the importance of prevention work and taking a population approach. It is not clear how dental services are embracing the application of these aspects.

It is thought that education is key and that there would be benefits in schools linking up with dental practices to promote the oral health message. A programme of supervised toothbrushing was in operation within Hillingdon before the pandemic and ten schools had signed up to it. Some schools had refused to do so, perhaps due to time constraints.

Select Committee Witness Session – Reconvening the review

The Select Committee reconvened the review and held a second witness session on 16 June 2021 which was attended by representatives from the Local Dental Committee, Hillingdon Public Health and Whittington Health NHS Trust / Managed Clinical Network for Paediatric Dentistry in NWL. Given the ongoing pandemic, representatives from some organisations had been unable to attend this meeting. As such, where appropriate, it was agreed that informal virtual meetings would be arranged for the Chairman and the Labour Lead with external organisations.

BACKGROUND PAPERS

21 May 2015: Social Services, Housing and Public Health Policy Overview Committee Report: Children's Oral Health

POSSIBLE KEY LINES OF ENQUIRY

1. Across all partners, what budget is available for children's dental care?
2. What are the limitations of the current contracts with dental practices? How could this be improved?
3. What improvements (if any) could be gained from the ability to commission dental services locally?
4. Is there a single source of information for residents to access in relation to all dental services?
5. How is information about dental services (access and availability) currently publicised?
6. How is dental health linked to physical health with regard to health planning in the Borough?
7. Which practices had had unspent UDAs at the end of the year (before COVID, and since) which was clawed back by NHSE? How much did this equate to in total and UDAs per person?
8. What is the impact of COVID on the a) availability b) uptake of routine NHS appointments?
9. What efforts are being made to make populations aware about dental services available to them?
10. Does the allocation of UDAs for a particular practice take account of the local health inequalities and level of dental caries in children?
11. What impact had the NHSE programme Starting Well 13 - A Smile4Life Initiative had? How many Hillingdon practices have participated in this initiative?
12. Following the 2012 survey of 3 year olds which showed that 16% of 3 year olds in Hillingdon had incisor caries, a new survey was underway in February 2020. What was the outcome of this survey with regard to Hillingdon?
13. What are the up-to-date figures in relation to dental caries and uptake of services in Hillingdon, London and England as a whole?
14. What has been achieved to date with regard to dental caries and children's dental health in Hillingdon?
15. What NHS dental services are available to 0-19 year olds in Hillingdon?
16. What recent oral health improvements have there been for children and adults in England (and, more specifically, Hillingdon if that information is available)?
17. What dental care services are commissioned for care homes in Hillingdon?
18. What domiciliary services are commissioned in England/Hillingdon?
19. What community dental services are commissioned by NHS England?
20. What community dental services are provided in Hillingdon? Have the access issues highlighted in the past been resolved?
21. What is the eligibility criteria for accessing community dental services?
22. Is there sufficient capacity in community dental services provision in Hillingdon?
23. What are the waiting times for an appointment?
24. What are the challenges faced by patients trying to join a practice list as an NHS patient?
25. What charges are made for patients that do not turn up for their appointments?
26. What range of dental treatment can patients get on the NHS?
27. Are older/elderly people entitled to free dental treatment?
28. What arrangements are in place for those people on low income with regard to receiving dental treatment?
29. What action has been taken by PHE to:
    a. provide dental public health and health improvement support for the London Borough of Hillingdon and NHS England, including collaborative commissioning of oral health improvement programmes.
    b. contribute to Hillingdon's Joint Strategic Needs Assessments (JSNA), strategy development, oral health needs assessment.
    c. address oral health inequalities in Hillingdon.

d. ensuring patient safety and governance systems.
e. inform and develop national oral health policies and clinical guidelines.
f. support Hillingdon in its role in relation to water fluoridation.