

Tackling poor oral health in children

Local government's public health role



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Introduction

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable.

Whilst children's oral health has improved over the last 20 years, almost a third of five-year-olds (Public Health England (PHE), 2012) and 12 per cent of three year olds (PHE, 2014) in England have experienced tooth decay. Dental decay is the top cause of childhood hospital admission for five to nine-year-olds, with just under 26,000 admitted in 2013/14 making 8.7 per cent of all admissions (Health and Social Care Information Centre, 2015) at an estimated cost of £14.5 million (NICE PH55 costings, 2014). In 2014/15 hospital trusts spent £35 million on extraction of multiple teeth for under 18s (National Schedule of Reference Costs 2014-15 Data for NHS trusts and NHS foundation trusts).

Significant inequalities in oral health continue to exist with children in deprived communities having poorer oral health than those living in more affluent communities. For example across local authorities in England there is huge variation ranging from 13 per cent to 53 per cent of five-year-olds having experience of tooth decay, these children have on average three teeth affected.

Children living in deprived communities, particularly those with disabilities have poorer oral health than their more affluent peers.

Poor oral health can affect children and young people's ability to sleep, eat, speak, play and socialise with other children. Other impacts include pain, infections, poor diet, and impaired nutrition and growth.

Large numbers of young children have teeth extracted under general anaesthesia in hospital because of dental decay.

Children may miss school and parents have to take time off work for their child to attend the dentist or be admitted to hospital. Oral health is an integral part of overall health. When children are not healthy, this affects their ability to learn, thrive and develop. Good oral health can contribute to school readiness and the prevention of school absence.

Together with efforts to tackle the underlying causes of diseases such as living standards, low levels of education and poverty; the focus of prevention should be on optimising exposure to fluoride, for example by brushing the teeth at least twice a day with a fluoride toothpaste and reducing both the amount and frequency of consumption of foods and drinks that contain free sugars. (Free sugar is defined as any sugar added to a food by the manufacturer, plus sugar that is naturally present in fruit juices, honey and syrup).

Poor oral health may be indicative of dental neglect and wider safeguarding issues. Dental teams can contribute to a multi-agency approach to safeguarding.



Policy context

The government has made its intention clear regarding oral health and dentistry: to improve the oral health of the population, particularly children to reform the NHS primary dental care contract and to increase access to NHS primary care dental services

NHS England's Outcome Framework (2015/16) includes indicators relating to patient experience and access to primary care dental services. It also includes improving dental health indicators, one recording tooth decay and another indicator that looks at children aged 10 or under that have been admitted to hospital to have teeth out due to decay.

The Children and Young People's Health Outcomes Forum report published in 2012 and its 2014 annual report recommended improved integration and greater action to reduce regional variation in child health outcomes.

PHE have agreed that oral health will be a priority going forward under the Evidence into Action priority Best Start in Life. The aim is to improve the oral health of children and reduce the oral health gap for disadvantaged children.

Did you know?

- Although largely preventable, tooth decay remains the most common oral disease affecting children and young people.
- 21 per cent of five-year-olds had tooth decay in south-east England compared to 35 per cent in north-west England with even greater inequalities within local authorities.
- A recent survey of three-year-olds in England found that 12 per cent had tooth decay ranging from 34 per cent to 2 per cent across local authority areas.
- In 2014/15 there were 33,781 cases of children aged 10 and under needing the removal of one or more teeth: a rise of three per cent on the previous year.
- Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2013/14.
- In 2014/15 hospital trusts spent £35 million on extraction of multiple teeth for under 18s.
- In its recent review of the evidence, Scientific Advisory Committee on Nutrition (SACN) (2015) found that high levels of sugar consumption are associated with a greater risk of tooth decay.

Local government's role in oral health improvement

Under the terms of the Health and Social Care Act (2012) upper tier and unitary authorities became responsible for improving the health, including the oral health, of their populations from April 2013.

From 1 October 2015 commissioning responsibility for the Healthy Child Programme for zero to five-year-olds transferred from NHS England to local government. This included the commissioning of health visitors, who lead and support delivery of preventive programmes for infants and children, including providing advice on oral health and on breastfeeding reducing the risk of tooth decay.

Local authorities are responsible for commissioning public health services for children and young people aged zero to 19 and this provides an opportunity for councils to further develop relationships with key partners such as health visitors, family nurses, midwives, school nurses, dental teams, GPs, children's centre staff and commissioning groups.



Oral health is referenced in the 'Best start in life and beyond: Improving public health outcomes for children, young people and families' which provides guidance to support the commissioning of the Healthy Child Programme. It provides opportunities to integrate oral health improvement into service specification and an effective programme of delivery for zero to 19-year-olds.

Local authorities are also required to provide or commission oral health surveys in order to facilitate:

- assessment and monitoring of oral health needs
- planning and evaluation of oral health promotion programmes
- planning and evaluation of the arrangements for the provision of dental services
- reporting and monitoring of the effects of any local water fluoridation schemes covering their area
- the dental data required for the single data list and the public health and NHS outcome frameworks.

The oral health surveys are carried out as part of the PHE Dental Public Health Intelligence Programme. Local authorities are also required to participate in oral health surveys conducted or commissioned by the Secretary of State for Health.

Local authorities also have 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.

Ideas for success

- ✓ Ensure your Joint Strategic Needs Assessments (JSNAs) consider oral health needs, including information on vulnerable groups as recommended in recent NICE guidelines (PH55, 2014).
- ✓ Develop a locally tailored oral health strategy – ensuring it is a priority at strategic and delivery levels and that council led services and external partners are working to integrate and support preventive care.
- ✓ Promote local leadership and advocacy for oral health improvement at all levels. Including through elected members, strategic leadership through the Health and Well-being Board and council public health teams. Health leadership through NHS England area teams, dental Local Professional Networks (LPNs), and Committees (LDCs).
- ✓ PHE consultants in dental public health have a key role supporting oral health improvement across the public health and healthcare system, working closely with local authority public health teams, NHS England Area Teams, LPNs, Health Education England (HEE) and other partners.
- ✓ If the JSNA demonstrates that poor oral health of children and young people (CYP) is a significant problem, it should be a key priority for the Health and Wellbeing Board and in the health and well-being strategy.
- ✓ Use the toolkit – Commissioning Better Oral Health for CYP to ensure all services for children have integrated oral health improvement, adding value at little cost. In addition the toolkit supports the review and commissioning of new or existing oral health improvement programmes.
- ✓ Ensure a life course approach to oral health improvement is adopted, acting early and intervening at the right time. The transfer of the commissioning of the Healthy Child Programme 0-5 years to local authorities provides opportunities to integrate oral health in local service specifications.
- ✓ Everyone should receive some support through universal interventions, while children that are particularly vulnerable (eg looked-after children, those with disabilities and children from families living in poverty), should receive additional interventions and support.
- ✓ Listen to the views of CYP and their families about their teeth and mouths, put them at the heart of what you do, involving them in commissioning decisions.
- ✓ Ensure a joined up partnership approach by fully involving statutory agencies and council departments, such as planning, education and leisure. Consider appointing people in these areas to champion the oral health improvement cause.
- ✓ Get schools and early years settings on board. Ensure these are healthy settings supporting oral health improvement and empowering CYP and their carers by promoting self-care and resilience.

- ✓ All front-line staff that have contact with families with young children can help show how good oral health can contribute to general health and wellbeing and development. NICE (2014) recommends that commissioners should consider that health and social care staff working with children and young people at high risk of poor oral health should receive regular training in promoting evidence based oral health.
- ✓ Ensure all information regarding oral health improvement is consistent and evidence informed – recent publications from PHE and NICE will support this (see resources).
- ✓ Consider appointing a senior coordinator, perhaps within the public health team and a sub-committee to take responsibility for oral health.
- ✓ Involve the private sector through schemes like healthy eating awards to encourage cafés and restaurants to change menus – limiting sugar and adopting a common risk factor approach will impact on oral and general health eg obesity.
- ✓ The PHE Rapid Review to update evidence for the Healthy Child Programme (March 2015) further recommends that local authorities and health and wellbeing commissioning partners should make sure that all contract specifications for early years services should include a requirement to promote oral health and train staff in oral health promotion.



Key questions to ask when assessing local oral health improvement delivery

Local authorities have a key role in the scrutiny of oral health improvement and dental service provision. Bringing together public agencies and organisations to establish the extent to which poor oral health is prevalent in local areas and to ask questions about planning for better outcomes from services. Some questions might include:

1. What is the local picture? Do you have information and intelligence regarding the oral health of CYP? Oral health can differ from ward to ward and between ethnic and vulnerable groups.
2. Is oral health included in the JSNA and the Health and Wellbeing Strategy and is this underpinned by more detailed oral health needs assessments and strategic documents?
3. Do you have a local oral health strategy in place to address oral health issues? Is there an integrated approach to oral health improvement across children's services and the children's workforce?
4. Has oral health improvement been integrated across the council departments considering the wider determinants of health, for example influencing planning decisions regarding food outlets?
5. Are commissioned programmes appropriate to local needs, informed by local information and intelligence and supported by the best available evidence?
6. How is success being measured? Schemes to improve oral health can take a long time to result in measurable progress as demonstrated by health outcome measures. Have appropriate intermediate process outcomes been considered that will provide assurance that progress is being made?
7. Is the CYP's workforce supported through training and development (as part of their induction and regular updates) to deliver for oral health improvement locally?
8. What engagement processes do you have to collect the views of CYP and are there examples of how their views influenced decision-making?
9. Is there reasonable and equitable access to local dental services and are these focused on prevention and the needs of CYP?



Case studies

Building Brighter Smiles – Bradford Metropolitan District Council

Faced with very poor oral health in young children and significant inequalities throughout the district, Bradford Metropolitan District Council has prioritised the oral health of young children, including it within their Health and Wellbeing Strategy and Inequalities Action Plan. The council commissions a series of oral health improvement programmes focused on young children's oral health called 'Building Brighter Smiles' (BBS). These programmes have population-wide and targeted elements and include breast feeding advice, partnership working with health visitors, community-based fluoride varnish applications, a dental health award programme promoting a healthy diet in pre-school settings and toothpaste and brushing programmes in schools and mosques.

Training and regular updates in evidence based oral health practice to professionals working with children and young people, is embedded within BBS, to communicate consistent oral health and general health messages to ensure widespread impact. Training is integral to the health visitor led 'Brushing for life' programme where health visitors distribute fluoride toothpaste and toothbrushes. They also give evidence-based oral health advice to support parents of young families. The intervention is incorporated within the healthy child programme service specification. Dental practices in Bradford are supported to re-orientate their services towards prevention through the Health Promoting Dental Practices Award. Contract performance monitoring ensures delivery of the

programme and outcome measures of oral health are beginning to show some improvement.

Smile4Life – Lancashire and Cumbria

Children in Lancashire and Cumbria have poorer dental health compared to children in other parts of England. The Smile4Life programme was developed in partnership with local authorities to address this problem. The programme aimed to reduce tooth decay in children, laying a solid foundation for their good oral health throughout life. The approach focused on sustained behaviour change, supported across the health and social care systems in Lancashire and Cumbria, with interventions informed by 'Delivering Better Oral Health.' Smile4Life was designed to support everyone who had a role in the development of CYP.

Four key areas for action provided the framework for implementing the programme. These related to facilitating healthier diets, regular and appropriate tooth brushing, adopting healthier lifestyles and regular access to dental services. An important aspect of the programme was equipping the wider workforce to support programme delivery. This involved a cascade training approach involving the CYP, and voluntary sector workforce in children's centres and other early years settings. Experienced NHS oral health promoters trained nominated oral health champions using a standardised training package and web-based resources. The oral health champions then shared and helped to deliver evidence-based oral and general health messages within their workplaces.

Suffolk Smiles part of the Healthy Child Programme – Suffolk County Council

Whilst oral health in Suffolk is generally good, just over 18 per cent of five-year-olds already have dental decay and in some parts of the county nearly a quarter have one or more decayed teeth. Some of these children already have three to four decayed primary teeth by the time they start school. The health of its children is a priority for Suffolk and good oral health is an important part of general health and wellbeing.

To help improve oral health for children and give them the best start in life Suffolk County Council are developing their oral health improvement strategy and programmes for delivery. This includes providing a new oral health pack from January 2015 to be given to every mother at their child's eight to nine month check. The pack will include a child's toothbrush, fluoride toothpaste and a leaflet about oral health and reducing sugar intake. Health visitors are also giving advice on diet, feeding and weaning, caring for children's teeth, tooth brushing and how to find a local dentist. The programme is planned to run for five years and the evaluation will look at a number of outputs and outcomes including uptake of the service, oral health outcomes and attendance at local dentists.

Book and Brush at Bedtime with Dinosaur Douglas – The London Borough of Hammersmith and Fulham

The new 'Book and Brush at Bedtime' project is part of a wider oral health promotion programme for children and young people in the borough. This project focuses on younger children and includes:

- training of health and social care professionals working with younger children

- the provision of fluoride toothpaste and brushes and development and sharing of resources
- support for children's centres in organising oral health activities with tailored oral health information for parents by their nominated oral health champions.

The book 'Dinosaur Douglas and the Beastly Bugs,' written by a local author, uses the lens of establishing bedtime routines to promote both good oral health behaviours, (including brushing teeth with a fluoride toothpaste last thing at night before you go to sleep) and reading bedtime stories (to help support the development of literacy and pre-literacy skills and school readiness). This approach is based on existing evidence which shows that developing good bedtime routines early means they are then taken forward into the rest of childhood and adult life.

The book has also been read with groups of young children in local libraries and children's centres, alongside distribution of fluoride toothpaste and brush packs. This supports messages delivered at parenting workshops and develops health promoting, supportive environments. Community champions in the area have also been supporting the promotion of child oral health as part of their wider early years work. They have also conducted insight work on child oral health locally, and have been providing peer support for oral health to parents in children's settings and at community events.

Healthy baby infant feeding policy – Manchester

Very young children in Manchester were found to have high levels of tooth decay. Prolonged bottle feeding, often with sugared drinks, was of particular concern in this area. This led to the widespread support to revise the infant feeding policy. A broad stakeholder group comprising health visitors, paediatricians, speech and language therapists and oral health improvement practitioners agreed to changes to this policy

for baby feeding and weaning. Following this there was wide support for a programme to encourage parents to discard feeding bottles at the appropriate developmental stage. This programme aimed to tackle the culturally embedded custom of prolonged bottle-feeding particularly at night, by encouraging parents to stop using a baby feeding bottle by the time their child was 12 months old. Parents were also encouraged to change to water or milk as the drink of choice.

The programme was evaluated and showed that parents who had received trainer cups and proactive messages from healthcare workers in the test areas had better knowledge about bottle feeding and better reported home care habits changing from bottles to cups.

Daily supervised teeth brushing in schools – Teeside

A scheme ran in Teeside aimed at improving the oral health of young children by providing materials for supervised teeth brushing in schools. Schools in the most socially deprived areas were targeted for the intervention and invited to take part. Nursery and reception children in 58 schools joined the programme and school staff supervised tooth brushing on a daily basis. The NHS originally funded the programme, however the local authority public health department have provided the funds for resources (toothbrushes, fluoride toothpaste and toothbrush racks) to run the school programme since 2013.

PHE dental public health epidemiology programme data in 2012 was used to monitor changes in tooth decay levels. The data suggested a reduction in tooth decay levels in brushing schools compared to schools not participating in the scheme.

Smile Award Plus – Buckinghamshire County Council

To improve the oral health of early years children and their families, Buckinghamshire County Council have commissioned the 'Smile Award Plus' programme. This programme takes a population-approach by supporting oral health improvement through the development and accreditation of health promoting environments within early years settings.

The Smile Award Plus programme supports these settings to implement evidence-based oral health improvement actions and accredits those that are successful.

Accredited settings will:

- have a 'tooth friendly' food and snack policy, limiting sugary snacks and providing water and milk in preference to sugary and acidic drinks
- have staff trained to give consistent and evidence-informed oral health information to children and their families
- promote oral health messages via a variety of methods including displays and information, specific oral health education sessions, supermarket and garden visits, fruit and vegetable tasting and growing activities, promoting and providing healthy snacks, and providing open cups for use instead of bottles within their settings.

Settings are assessed and reaccredited every two years. To date 94 per cent of children's centres have achieved accreditation.

Evaluation suggests that behaviour changes are being made by families in response to this, including dietary changes, appropriate bottle and dummy use, introduction of open cup drinking and improved compliance with tooth brushing.

Want to know more?

Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities (PHE, 2014)

This toolkit provides support for local authorities on commissioning oral health improvement programmes for children. It details what works and what this means for commissioners.
<https://www.gov.uk/government/publications/improving-oral-health-an-evidence-informed-toolkit-for-local-authorities>

Oral health: local authority oral health improvement strategies (National Institute for Health and Care Excellence, Guidelines PH55, 2014)

This guideline makes recommendations on undertaking oral health needs assessments, developing a local strategy on oral health and delivering community-based interventions and activities.
<http://www.nice.org.uk/guidance/ph55>

Delivering Better Oral Health Third Edition (PHE, 2014)

This toolkit provides evidence-based advice and interventions to improve oral health.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319471/DBOHv3JUNE2014.pdf

Dental public health intelligence programme (North West Public Health 2013)

Provides data on oral health at a local level.
<http://www.nwph.net/dentalhealth/>

Carbohydrates and Health Report (The Scientific Advisory Committee on Nutrition, 2015)

This report shares its main findings of its review of the evidence on carbohydrates and health and sets out its recommendations.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/445503/SACN_Carbohydrates_and_Health.pdf

National Dental Epidemiology Programme for England: oral health survey of five-year-old children (2012)

Most recent reports of the dental health of five-year-olds and three-year-olds.
<http://www.nwph.net/dentalhealth/reports/DPHEP%20for%20England%20OH%20Survey%203yr%202013%20Report.pdf>

National children's dental health surveys (Health and Social Care Information Centre (HSCIC), 2013)

Provides oral health clinical and questionnaire data on all ages children to regional level.
<http://www.hscic.gov.uk/article/3740/Dental-Health-Survey-of-Children-and-Young-People>

Best start in life and beyond - Guidance to support the commissioning of the Healthy Child Programme 0-19: Health Visiting and School Nursing services (Public Health England, 2016)

This is a series of supporting guides to assist local authorities in the commissioning of health visiting and school nursing services to lead and coordinate delivery of public health for children aged zero to 19.

<https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning>

Rapid Review to Update Evidence for the Healthy Child Programme 0-5 (Public Health England 2015)

The purpose of this rapid review is to update the evidence and synthesise relevant systematic review level evidence about 'what works' in the following key areas: parental mental health; smoking; alcohol/drug misuse; intimate partner violence; preparation and support for childbirth and the transition to parenthood; attachment; parenting support; unintentional injury in the home; safety from abuse and neglect; nutrition and obesity prevention; and speech, language and communication.

<https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence>

NHS Outcomes Framework: February 2016 Quarterly Publication (HSCIC 2016)

Indicators are used to hold NHS England to account for the outcomes it delivers through commissioning health services.

<http://www.hscic.gov.uk/catalogue/PUB20090/nhs-out-fram-ind-feb-16-comm.pdf>

Children and Young People's Health Outcomes Forum

The Children and Young People's Health Outcomes Forum (CYPHOF) is an independent advisory group of professionals and representatives from across the children's sector who advise on how to improve children and young people's health outcomes. The forum has written a number of reports.

<https://www.gov.uk/government/groups/children-and-young-peoples-health-outcomes-forum>

Commissioning of public health services for children (Department of Health, 2014)

A series of documents focusing on early years high impact areas to support local authorities in commissioning children's public health services.

<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children>

National Schedule of Reference Costs 2014-15 Data for NHS trusts and NHS foundation trusts

Information about how NHS expenditure was used to provide healthcare by NHS trusts and NHS foundation trusts. Reference costs are the unit costs to the NHS for providing defined services in a given financial year to NHS patients in England. They are collected and published annually.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477262/3._National_schedule_of_reference_costs_-_spell_costs.xlsx

LGA children's health microsite

A dedicated web resource to children's health issues, including tools and support for councils and their partners.

<http://www.local.gov.uk/childrens-health>



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