Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 6 September 2012

Subject: Oral Health and Dentistry

Report of: Director of Public Health and Consultant in Dental Public Health

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Summary

This report will provide an overview of oral health and primary care dental services in Manchester. It sets out the context to the current reform of NHS dentistry and provides an update on the impact of poor oral health, the actions and the programmes in place or planned to improve population oral health and dental services in Manchester.

Recommendations

The Health Scrutiny Committee is asked to:

i) Note the report
ii) Comment on the specific challenges and the plans to sustain and build on recent improvements.

Wards Affected: All

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Darren King, General Dental Practitioner Gorton and Greater Manchester Local Dental Professional Network member; will also be in attendance.

Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents

are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Choosing better oral health: an oral health plan for England. Department of Health 2005 (www.dh.gov.uk/en/Publicationsandstatistics/.../DH_4123251)

Improving oral Health and Dental services 2012/14 – A narrative and vision for Greater Manchester, Greater Manchester Local Professional Network (LPN) steering group (available from Public Health Manchester,).

1.0 Background and Context

1.1 In 2010 the Coalition government published "Equity and excellence: Liberating the NHS". It proposed that dental services be commissioned centrally by the National Health Service Commissioning Board (NHS CB). The NHS Commissioning Board will be responsible for commissioning all dental services from April 2013, not just primary care (General Dental Services and Community Dental Services) but also secondary and urgent care.

1.2 Primary care teams at local level will be responsible for securing this ambition and clinical leadership and engagement must be integral to local area teams. The NHS Future Forum review in the Spring of 2011 made it clear, that clinical expertise needs to extend beyond GPs and Clinical Commissioning Groups (CCGs) to the wider clinical community and draw on the knowledge and experience of other clinicians in designing, developing and delivering health services.

1.3 There is a commitment to the introduction of a new National Health Service (NHS) dental contract to replace the 2006 dental contract based which is based on treatment activity in courses of treatments as measured by Units of Dental Activity (UDAs). The new NHS dental contract will be based on registration (dentists will have a list of patients), capitation (payments will be in part per patient on the list) and quality to evaluate dentists on the consistency and impact of the services they provide. Performance will be determined by compliance with quality and safety standards and will be informed by patient experience. It is proposed that dentists will be expected to complete a consistent oral health needs assessment on every patient and adhere to a preventive care pathway approach. Contracts will be measured by a dental quality and outcomes framework (DQOF), based on clinical outcomes and clinical effectiveness, patient safety and patient experience. This is currently being piloted in 72 practices nationally, 5 are located in Greater Manchester and one these is in Manchester (Harpurhey).

1.4 The NHS Operating Framework (2011/2012) stated that, "Primary Care Trusts (PCTs) should continue to commission improvements in access to NHS dentistry, and seek to improve efficiency through effective management of dental contracts to minimise unnecessary recalls and split courses of treatment. They should work with dentists and other agencies to promote improvements in the oral health of children". The Greater Manchester PCT cluster (NHS Greater Manchester) will remain statutorily accountable during this period of transition. A single operating model for dental commissioning across Greater Manchester has been agreed in order to ensure consistency across the 10 PCT historic footprints, maintain progress and drive continued improvement.

2.0 Introduction

2.1 Poor oral health has a significant impact on quality of life – causing pain and infection; affecting appearance and leading to a lack of confidence; the ability to eat a healthy diet and often requires uncomfortable and costly treatment

which most people would rather avoid. It affects mental health and wellbeing through pain and distress caused by toothache, lost nights' sleep, taste or odour from chronic infection, effect of decayed teeth on appearance, self esteem and self confidence and phobia or fear of dental treatment which can include admission to hospital for extractions under a general anesthetic.

2.2 Poor oral health is strongly linked to social deprivation and tooth decay is caused by the frequency and amount of sugar in the diet, lack of hygiene and lack of exposure to fluoride. Lack of effective plaque removal when brushing can cause periodontal (gum) disease which like oral cancer is also linked to tobacco use and excessive alcohol consumption – common risk factors for general health. Improving oral health would therefore also contribute to reducing obesity, other chronic disease such as heart disease, diabetes and cancer.

2.3 Children who are breast fed and who are weaned according to infant feeding guidelines are less at risk from tooth decay. Risk factors for tooth decay tends to be linked to bottle feeding – especially where sweetened drinks gradually replace formula milk, to weaning on to high sugar foods,. Tooth decay in young children can be an indicator of a poor family diet and future obesity and high levels of tooth decay are also closely linked to socio-economic deprivation. Therefore a healthy diet and establishing and maintaining tooth brushing twice a day with a family fluoride toothpaste are fundamental to reducing oral health inequalities.

2.4 This report will outline the current oral health needs and access to services in Manchester. It will describe some of the impacts of poor oral health, the actions and programmes in place and those that are planned to improve oral health, access to (and the quality of) dental services in Manchester. It is important to note that clinical leadership and engagement, as heralded by current NHS reform, is not a new concept in Manchester. There has been investment and recognition that good clinical leadership can deliver better outcomes in commissioning and improvements in the quality of dental care. The Consultant in Dental Public Health and local dentists are now strengthening clinical, involvement and engagement by establishing a shadow Local Professional Network (LPN) for dentistry and the report will also highlight the priorities and outcomes of this group.

3.0 Oral Health Needs in Manchester

3.1 Child Oral Health

3.1.1 Surveys of the oral health of children are carried out regularly across England as part of the NHS Dental Epidemiology Programme. These surveys use calibrated examiners (to ensure consistent measurement) and therefore allow benchmarking of the oral health of children. The surveys measure the prevalence and severity of decay in children of specific age groups. The index used is dmft/DMFT –decayed, missing or filled primary/permanent teeth. The data illustrates that child dental health remains poor across most of Greater Manchester when compared to England. Although there have been

improvements in 12 year olds; the oral health of very young children in Manchester remains poor with more than half of five year olds affected by decay by the time they reach school age. See figures 1 & 2.

This survey is likely to be repeated in 2013/14.

Figure 1. Prevalence of tooth decay in 12yr olds in Greater Manchester 2008-2009

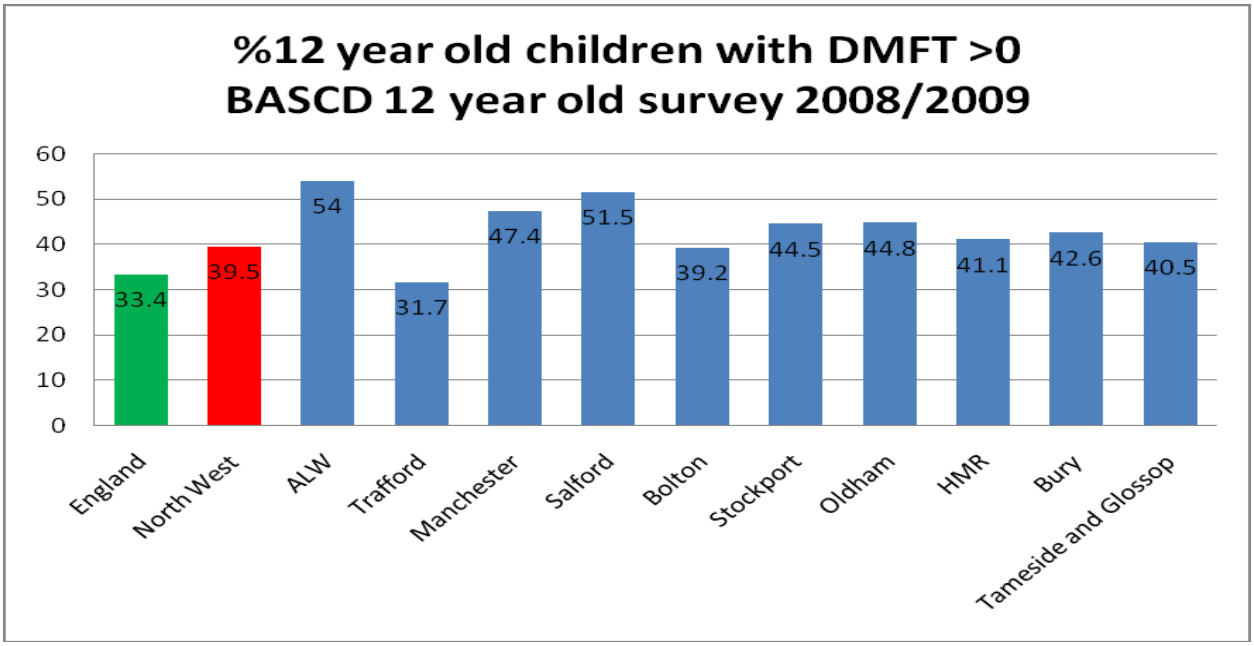
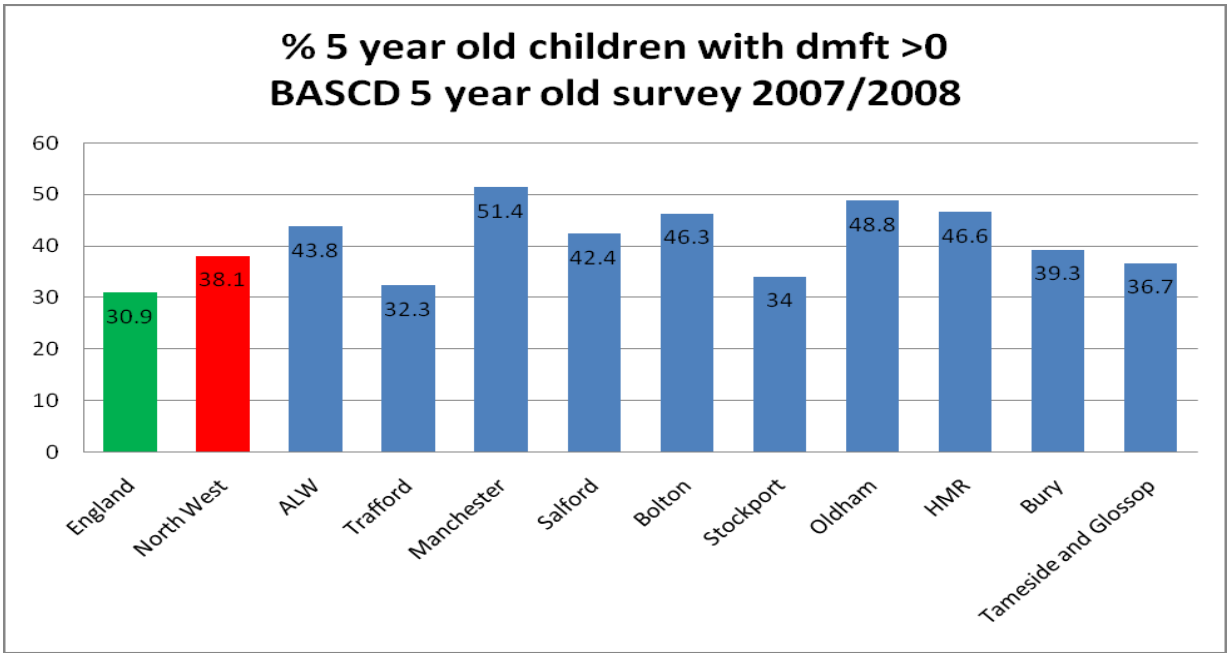


Figure 2. Prevalence of tooth decay in 5 yr olds in Greater Manchester 2007-2008



3.1.2 There are variations in socio-economic deprivation and health inequalities across each constituent local authority area as well as within the Greater Manchester area. There is an association between an increase in social deprivation and child tooth decay. These key determinants need to be considered when addressing improvement in child oral health and in future service planning see. The Manchester Family Poverty Strategy (2012 – 15) reports that 42% of children in Manchester are growing up in poverty, twice the national rate (see table 1).

Table 1: % Children living in poverty *Source: Poverty map 2010*

Local Authority	% children in poverty
Wigan	19%
Bolton	25%
Bury	19%
Rochdale	29%
Manchester	42%
Oldham	30%
Salford	30%
Stockport	16%
Tameside	24%
Trafford	16%
England	21%

These figures correlate strongly with data from each local authority area on the survey of 5 year-olds (see appendix 1). Furthermore a specific Manchester survey carried out in 2010/11 confirmed that the disease process starts early and reported that at least 23% of 3 year-olds in the city have one or more teeth affected by decay.

Admissions to Hospital

3.1.3 The admission to hospital for the extraction of teeth as a result of dental decay is the most common reason for children to be admitted in Manchester. The surgical procedures, whilst conducted in a safe environment, do impact on the children and their parents. Furthermore the actual and opportunity costs for these procedures are of interest to health service commissioners, given NHS funding constraints.

3.1.4 Referral to hospital for extraction is undertaken when a child either needs extensive extractions, or would be unlikely to co-operate with the procedure without general anaesthetic, or where there is sepsis (infection) which would make local anaesthetic ineffective, or a combination of these.

3.1.5 It is a major concern that the admissions have increased and that the number of very young children receiving this care is increasing. Given that this is a preventable condition, this is the unacceptable consequence of poor oral

health in Manchester. Table 2 below provides data comparing hospital admissions between 2005/6, 2008/9 and 2010/11 the trend is very worrying. It is also important to note that an even greater number of extractions are carried out in general dental practice/ community dental services with local anaesthetic.

Table 2

Extraction episodes for children and adolescents aged 0-19 in North West Region admitted to hospital for extraction during **2005/6, 2008/09 & 2010/11**, by children resident in Manchester (surgical removal or simple extraction of tooth)

	0-4 yrs	5-9 yrs	10-14 yrs	15-19 yrs	All child ages	Total number of extraction episodes
MANCHESTER PCT 2010/11	180	696	261	207	1344	1344
MANCHESTER PCT 2008/9	236	565	308	180	1,289	1,289
MANCHESTER PCT 2005/6	209	457	191	117	974	974

3.2 Adult Oral Health

3.2.1 The results of the most recent national Adult Dental Health Survey (2009) demonstrate an improvement in most of the indicators of oral health and disease nationally. These surveys are completed every ten years.

3.2.2 The headlines for England are:

- The proportion of edentulous adults (no natural teeth) has fallen from 28% in 1978 to 6% in 2009 – a major change within the timeframe of a generation
- For dentate (adults with teeth) individuals, periodontal (gum) disease remains a significant problem with only 17% of dental adults having “very good” periodontal health
- 23% of adults reporting current dental pain had one or more teeth affected
- The highest prevalence of decay was in the age-group 25 to 34 (36%).

3.2.3 The average values for England must be viewed in terms of the higher levels of deprivation in Manchester and are likely to be much higher for adults in the city.

4.0 Improving Access to Services

4.1 Increasing access (and equality of access) to NHS dental services has been and remains a priority in Manchester. Significant progress has been made through robust contract management, new procurement and health improvement initiatives, to improve not only overall access numbers but

inequalities in access. There is a need to ensure that this progress is sustained and built on.

4.2 The lack of access that resulted in queues around the dental hospital (as featured in national media in 2007/8) was resolved through:

1) Investment in primary care,
2) The establishment of a local helpline linked to daily protected access appointment slots in 30 practices across the city
3) Procurement of extended opening hours in a number of new practice contracts.

In addition a targeted Manchester Smiles/buddy practice scheme has also had an impact as described in the case study in section 5 of this report.

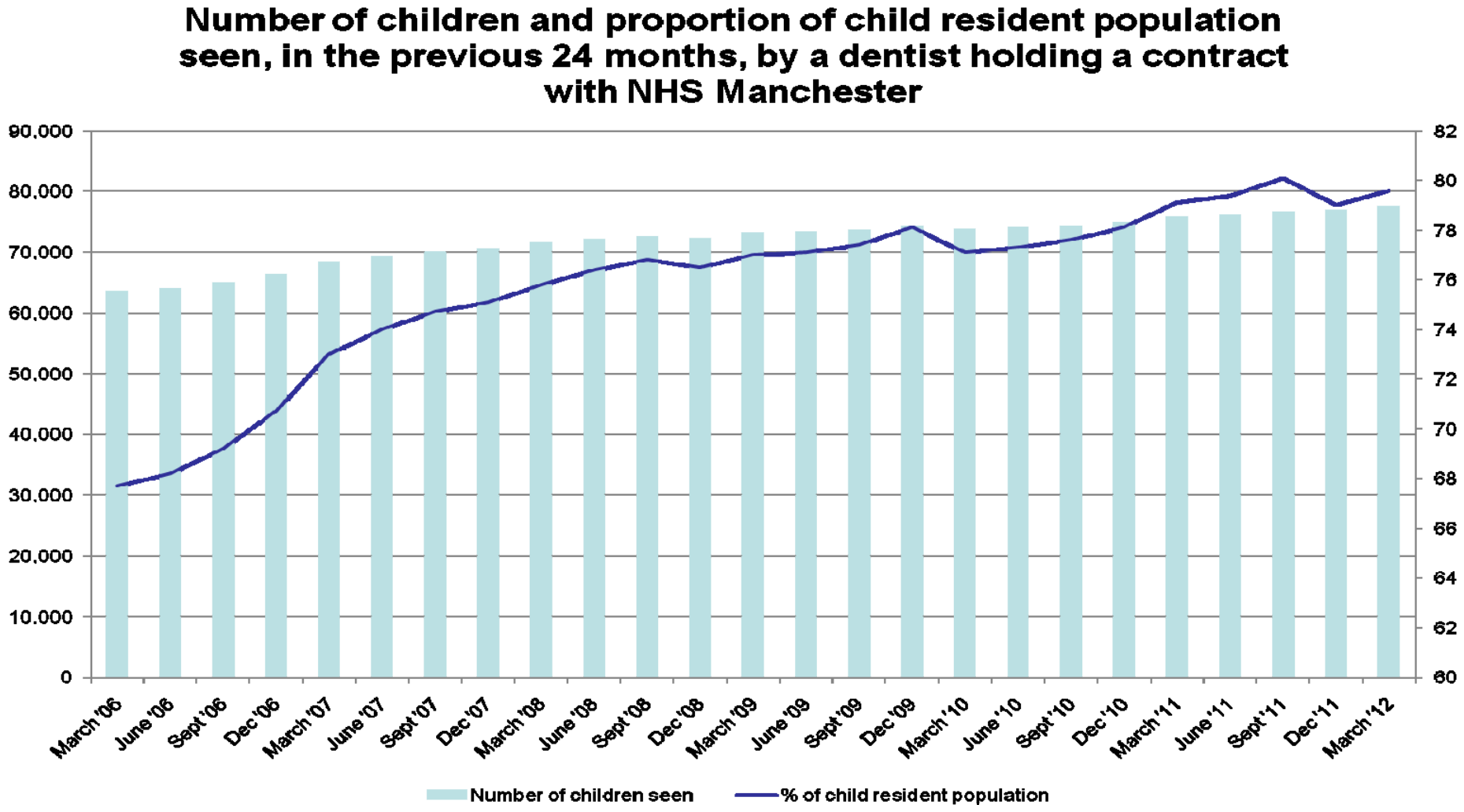
4.3 The challenge is now to maintain and improve on these levels of dental access across Manchester during this transition period of NHS Reform. Table 3 illustrates the changing picture of dental access for Manchester and recent performance reports confirm that access has improved since 2007 (Source: Department of Health Information Centre (DHIC)).

Table 3 :DHIC access figures
– % of Manchester population attending a dentist in previous 24 month period

Actual access of the Manchester population (24/12 to Dec '07)	57.8%
Actual access of the Manchester population (24/12 to May '11)	58.95%

4.4 The most significant change in access figures has been achieved for children and initiatives such as Manchester smiles are having a real impact as Figure 3 demonstrates.

Figure 3: The number and proportions of children attending NHS dental services has increased



5.0 What else would make a difference?

5.1 The most effective population measure to improve oral health in Manchester would be to increase exposure to fluoride by adjusting the concentration of fluoride in water to one part per million. The Strategic Health Authority (SHA) explored the feasibility of this safe effective public health measure for the North West in 2007/8.

5.2 There was considerable health sector and Local Authority (LA) support for the measure to be introduced in Greater Manchester, however, the outcome of a judicial review of the SHA public consultation process in Southampton delayed progress. Although the judicial review found that the SHA process had been fair; a water fluoridation scheme has yet to be implemented.

5.3 The North West SHA, the body responsible for completing a public consultation, is to be abolished in 6 months time and Public Health England (PHE), yet to be formally established, is to have a national fluoride lead. Therefore the feasibility of this will be revisited for Greater Manchester once the new structure of PHE is operational in April 2013. In the meantime programmes that increase childhood exposure to fluoride such as the dental milk scheme and early years/school fluoride toothpaste distribution schemes (see 5.5) will be maintained and strengthened.

5.4 Although access to services is important, poor dental health is not caused by not attending a dentist as the prevention of dental decay is all about effective daily self care and healthy habits. Dental decay is prevented by: restricting the frequency of sugary in drinks and snacks, twice daily brushing with family fluoride toothpaste, starting with a smear of toothpaste from when the teeth appear in the month at about six months of age.

5.5 In the absence of water fluoridation and in order to make improving oral health everyone's business the following programmes are underway:

- There has been a local launch to establish the Department of Health Prevention toolkit in Manchester to all general dental practices. This toolkit provides evidence informed information that dental teams can use to advise parents and patients how they can best look after their own dental health. It also advises dentists on the best preventive treatments they can provide for their patients
- The Dental Health Helpline will continue to operate to give access to appointment slots across the city.
- Dental milk scheme – the largest in Europe with 10,000 primary school children choosing to drink fluoridated milk at school –the supplier will change for the 12/13 school year and discussions have commenced about a change in concentration
- Manchester Oral Health Improvement team are commissioned to purchase over 10,000 Brushing for Life scheme packs per year, containing family fluoride toothpaste, toothbrush, trainer cup and leaflet, for distribution by Health Visitors to parents of children from 8 months onwards. These encourage parents to get their children off the bottle and onto a cup by the

age of one and to start supervised twice daily tooth brushing when the first tooth comes through. The use of children's toothpaste is discouraged and a smear of family fluoride toothpaste being used instead.

- Supervised brushing at Children's Centres and nursery classes ensures that 4,000 pre-school children per day have additional fluoride provided in the form of toothpaste. The scheme has recently expanded to private nurseries and childminders.
- Education on maintaining good dental health is provided in a variety of settings, to the public, other health and social care workers and to carers. Manchester's Dental Public Health has produced a booklet – 'The Good Teeth Guide for parents of children with extra needs' for wide distribution and use through all relevant agencies.

Case Study: Manchester Smiles/ Buddy Practice Scheme

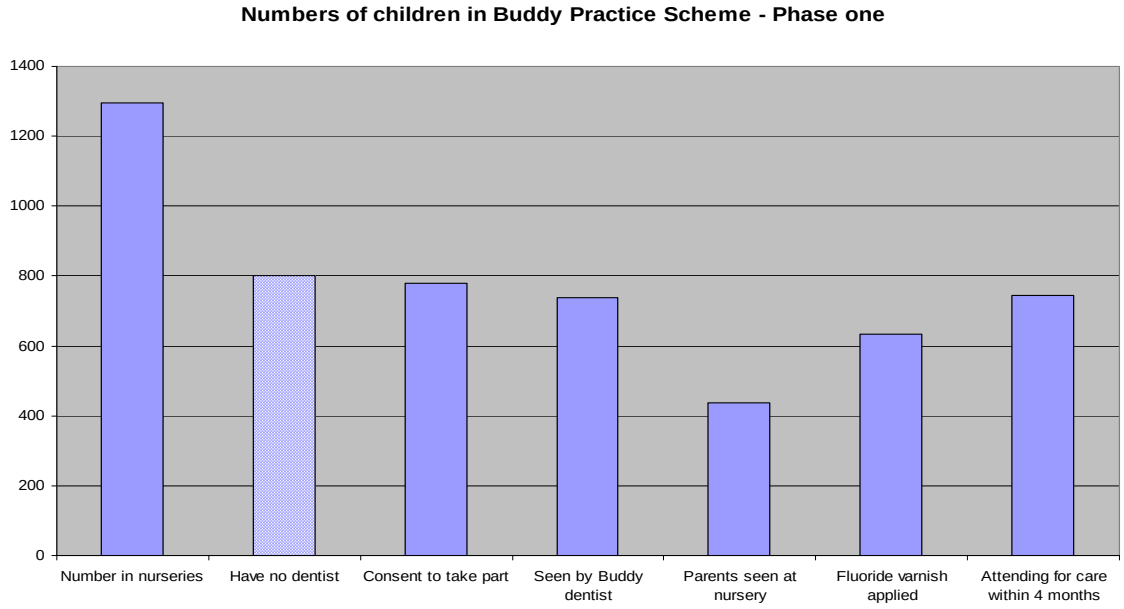
1. The benefits of evidence based preventive advice and the application of fluoride varnish in a clinical setting for dental decay reductions are clear. There were a proportion of children in Manchester whose parents and/or carers were unable or unwilling to ensure that they attended a dentist to receive preventive advice and interventions. Although just 70% of children in the city were in contact with dental services, within a 24 month period prior to this initiative, this left almost 30% who were not.

2. It was considered likely that these infrequent and non-attenders would be at greater risk of developing dental decay. It was thought that they would have benefit from early prevention intervention and some of them might be experiencing discomfort; if their dental treatment needs were not being met. This project aimed to find these 'missing thousands' of children and ensure that they did not miss key preventive interventions and advice, they would have received, had their parents and/pr carers accessed primary dental care services. The initiative aimed to ensure schools and dental practices were linked up to safeguard children and support parents and/or carers take responsibility for oral health improvement. Schools, dental practices, salaried services and others were involved.

3. The scheme brought primary dental care dental practices and schools together in partnership. Parents of children in nursery classes were asked about their child's dental attendance and those children who either had no dentist or who had not attended for some time were identified. The parents of non-attending children were then invited to a 'meet the dentist' session at the school. These took place at 'drop off and pick up' times and were planned on two or three consecutive mornings in the nursery classrooms. At these sessions members of the project team attended with the local primary care dentist who worked in partnership with them. Each child had a brief examination and fluoride varnish was applied. Specific advice was given to parents about home care for their child and what they should expect when they attended, with their child, a dental practice in Manchester.

4. Establishing a regular attendance pattern was emphasised and assisted, either by the clinician or a member of the Oral Health Improvement Team. Details of the partner practice were given and that of the dental Helpline to assist parents to make appointments elsewhere if they chose. All children were also given toothbrushes (1450 parts per million Fluoride) and a toothbrush. The attendance of each of the children was checked following the 'meet the dentist' sessions. After 2 months a second set of sessions was run for those children who had still not attended. The process was repeated a third time. After this follow up the small number of children, with identified clinical need, who had still not been taken to a dentist, was notified to the Safeguarding team.

5. To date 28 practices and the community dental services are involved. Almost 1000 children under 5 who had not previously accessed primary dental care have now done so. In addition the practices reported that parents and/or carers who had not been attending a dentist regularly have now connected back with services. (see graph below).



6. Outcomes and Impact of Manchester Smiles
   i) Many young children and their families are now benefitting from contact with preventively orientated clinical services that might not have done so.
   ii) Many children who had been suffering pain and infection have received care.
   iii) A large number of children have received an application of fluoride varnish, an evidence based intervention to help control decay.
   iv) Many children, as a result of the scheme, have increased their attendance at school and the ability to concentrate on school work, following the resolution of previously untreated symptoms.
   v. A few children, who had decay diagnosed, and whose parents and/or carers, despite two reminders, lacked capacity or neglected to ensure they received appropriate treatment services are being followed up by school nursing services and the safeguarding team.

5.0 The priorities for Manchester going forward

5.1 Continue to focus oral health improvement activities on young children aged 0-5, ensuring increased exposure to fluoride, linking with all partners providing services to this group and their families. Children's oral health is one of the priority themes of the Manchester Joint Strategic Needs assessment and this will be presented to the Manchester Health and Wellbeing Board on 19th September 2012.

5.2 Avoid unnecessary childhood hospital admissions through the monitoring and reporting of these admissions, the redesign of the general anaesthesia pathway and the establishment of a paediatric dental professional network.

5.3 Strengthen clinical leadership through the formal establishment of the Local Professional Network (LPN) by October 2012 (see 5.2), to stimulate and steer the specialist paediatric dental LPN. The paediatric LPN will lead a task to achieve improvements in access and quality of primary care for young children in Manchester through redesign the general anaesthesia care pathway.

5.4 Linking oral health improvement messages to general health and well being and developing capacity within communities to improve their own oral health through effective engagement.

5.5 Target cost effective, evidence based treatments and preventive interventions at those who need them most.

5.6 Ensure continued improvement in access to NHS dental services across Manchester and respond efficiently to barriers to access.

5.7 Continue to effectively commission dental services within primary and secondary care in Manchester, to improve oral health and dental care provision for residents of Manchester.

5.8 Ensure that following the transfer of the dental public health function to Public Health England that a strong interface with Public Health Manchester and Manchester City Council is maintained.

5.9 Oral health has been confirmed as a priority for all three Manchester Clinical Commissioning Groups –and this means that all three groups have included improving oral health within strategic planning and priorities for action.

5.10 Identify opportunities for a campaign approach working with Manchester residents and families. One such campaign in Australia called "Lift the Lip" encouraged everyone to be aware of good oral health and to recognise dental disease or signs of neglect of hygiene in very young children. Anyone involved with children can and should be taking an interest in oral health and can look at the condition of teeth and gums by getting a young child to 'lift the lip' – as the mouth is a mirror to good general health and their diet in general.

6. Summary

As the report highlights a lot of progress has been made in recent years but much remains to be done and it will be important to deliver the ten key priorities above. The Committee are asked to comment on the plans and priorities and identify any areas for further scrutiny.

Appendix 1 - Manchester LA 5 year survey results benchmarked & highlighted in green

NHS Dental Epidemiology Programme For England

5-Year-Old Survey 2007/08 - Average d3mft

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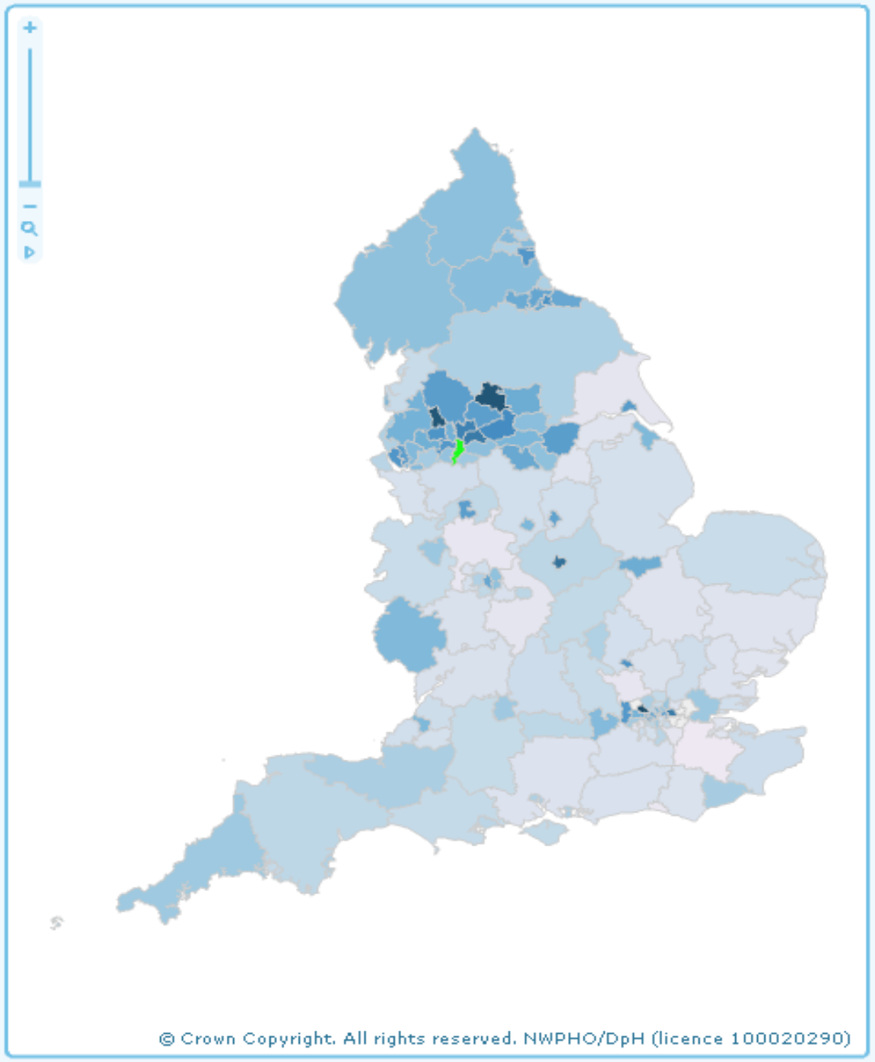

5-Year-Old Local Authority Survey 2007/08

GOR/SHA Name	Indicator
ENGLAND	1.11
East Midlands	1.02
East of England	0.83
London	1.31
North East	1.45
North West	1.52
South Central	1.00
South East Coast	0.72
South West	1.04
West Midlands	0.97
Yorkshire and the Humber	1.51

LA/PCT Name	Indicator
Ashton, Leigh and Wigan	1.57
Barking and Dagenham	No Data
Barnet	1.15
Barnsley	1.49
Bassetlaw	0.63
Bath and North East Somerset	0.75
Bedfordshire	0.78
Berkshire East	1.42
Berkshire West	1.02
Bexley	No Data
Birmingham East and North	1.33
Blackburn with Darwen	2.41
Blackpool	1.47
Bolton	1.91
Bournemouth and Poole	1.04