Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 19th September 2012
Subject: Oral Health of Children
Report of: Director of Public Health

Summary

This report provides an overview of the oral health of children in Manchester as one of the priority themes of the Joint Strategic Needs Assessment (JSNA). 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, services and programmes in place or planned to improve child population oral health; and suggests the contributions other partners can make to this important area of mutual interest.

Recommendations

1) Note the report and be aware that improving the oral health of young children would provide a foundation for improved general health and life chances for children in Manchester.
2) Comment on how the Board can help address some of the challenges and support the prevention programmes underway or planned

Board priorities addressed:

Getting the youngest people in our communities off to the best start.

Educating, informing and involving the community in improving their own health and wellbeing.

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1.0 Introduction

1.1 Oral health is poor in the Manchester population and the main conditions, dental decay (caries) and poor gum health (periodontitis) are widespread. Much could be done to control these largely preventable conditions and the costs of providing treatment for routine and urgent care are high. Indeed the extraction of decayed teeth is the main reason for admission of young children to hospital.

1.2 Children who are breast fed and who are weaned according to infant feeding guidelines are less at risk from tooth decay Dental decay is caused by children who have a diet which is high in both the frequency and amount of, sugar consumed, along with a lack of hygiene which results in many young children in Manchester having infrequent exposure to fluoride. Many children only access primary dental care services once there is a problem, thereby missing out on early detection of decay, and interventions such as the application of fluoride varnish. This is an effective preventive intervention that has been shown to reduce the incidence and severity of decay if applied at least twice a year.

1.3 In Manchester at least 26% of 3 year-olds were found, in a survey conducted last year, to have one or more teeth affected by decay and yet only 29% of children age 3 and under had accessed primary dental care in the same period. The disease process starts early and therefore many children are missing out on receiving effective preventive advice in an ‘early help offer’ that could prevent the disease and its impact and severity. Furthermore over 50% of 5 year olds in Manchester have experience of decay, compared with 31% in England as a whole, and 8% have experienced extractions because of decay, many of them in hospital under a general anaesthetic. In some wards almost 80% of children are affected before they reach school.

1.4 In 2009 the National Institute for Health and Clinical Excellence (NICE) recognised dental neglect as a type of child neglect. The recommendations relate to two aspects of dental neglect: firstly persistent failure by parents/carers to obtain NHS treatment for a child’s dental decay and secondly the possibility of maltreatment or oral injury. The consequence of untreated dental diseases for children can be significant. Not only do many children affected experience pain and discomfort, they can lose sleep, confidence and it can restrict their play activities and concentration at school and nursery.

2 NHS reforms and dentistry

2.1 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 CB 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.
2.2 NHS CB at local level (Greater Manchester Local Area Team) will be responsible for commissioning services and securing clinical engagement and expertise. 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 Greater Manchester Local Professional Network (LPN) for dentistry.

2.3 There is a commitment to the introduction of a new National Health Service (NHS) dental contract to replace the 2006 dental contract 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. Elements of this are currently being piloted in 72 practices nationally, 5 national pilot practices are located in Greater Manchester and one these is in Harpurhey.

2.4 Finally 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.

3 Oral health needs of children in Manchester

3.1 The JSNA provides further detailed information, drawing from the information surveys, on the oral health of children that 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. As Figure 1 highlights 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.
3.2 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. 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*

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>% children in poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wigan</td>
<td>19%</td>
</tr>
<tr>
<td>Bolton</td>
<td>25%</td>
</tr>
<tr>
<td>Bury</td>
<td>19%</td>
</tr>
<tr>
<td>Rochdale</td>
<td>29%</td>
</tr>
<tr>
<td>Manchester</td>
<td>42%</td>
</tr>
<tr>
<td>Oldham</td>
<td>30%</td>
</tr>
<tr>
<td>Salford</td>
<td>30%</td>
</tr>
<tr>
<td>Stockport</td>
<td>16%</td>
</tr>
<tr>
<td>Tameside</td>
<td>24%</td>
</tr>
<tr>
<td>Trafford</td>
<td>16%</td>
</tr>
<tr>
<td>England</td>
<td>21%</td>
</tr>
</tbody>
</table>
Addmissions to Hospital

3.3 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.

3.4 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. 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

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

4. Action being taken for Manchester children

4.1 Much has been done in Manchester to tackle levels of dental disease but many families with young children on lower incomes face a number of challenges; some parents find it very difficult to promote good oral health due to affordability of fruit and vegetables, toothpaste and brushes; for many it is not the norm to access preventative services in the absence of painful illness and finally and a lack of information and poor communication about services can be a barrier.

4.2 Population level activities and city-wide programmes continue to be commissioned by dental public health and are delivered by the Citywide Oral
Health Improvement Team (OHIT), based with the Care Trust. Examples of programmes and action include:

- Provision of free trainer cups to parents of babies from the age of 6 months onwards
- Provision of free adult strength toothpaste and toothbrushes for children aged 1 to 4 years
- Supervised daily tooth brushing at nurseries attached to primary schools, private nurseries and Children’s Centres
- Facilitation of dental milk to consented children at participating primary schools and special schools

4.3 In addition there has been an increased emphasis on preventive activity by primary dental care providers through more effective contracting and commissioning. Delivery against key performance indicators is backed up by education, training and an increased skill mix in primary care dental teams. The OHIT now runs a ‘Preventive Practice Award’ scheme to encourage this shift in approach.

4.4 The ‘Manchester Smiles’ Scheme links practices with nearby primary schools with the aim of encouraging regular attendance at dental practices and the provision of fluoride varnish for young children identified as not attending for routine care. A full description of this scheme is provided in the appendix 1 and it has contributed significantly to the increase in the number of Manchester children seen by a dentist in the period up to March 2012 (see Figure 3, Appendix 2).

5 How can the Health and Wellbeing Board help?

5.1 The NHS Future Forum’s January 2012 report on public health set out a clear case for changing the culture of the NHS and other frontline services so that staff take every opportunity to talk to the public and patients about how to improve their health – making “every contact count”. It is this message and change in culture that the Health and Wellbeing Board can play an important role in. There is a real opportunity to create a new balance between the prevention of dental disease and its treatment which would better meet the needs of children in Manchester. The poor oral health experience of so many children must be viewed as more than an issue for dentistry. Improving the oral health of young children in Manchester will rely on collaboration. Effective partnerships are needed to break the cycle of poor oral health and the Health and Welling Board are well placed to support the dental community in making this happen.

5.2 There is a need to integrate improving oral health other key strategies and business plans. South, Central and North Clinical Commissioning Groups have included oral health as a priority area in their overall strategies and other partners are asked to consider the information contained in JSNA in the next planning round.
5.3 Poor access to services 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.
However there is need to refresh communications so that families with children can access services in a timely manner, organisations represented on the Board can assist with this.

5.4 The Board can support:
• the training of early years and education staff in particular so that all know, understand, can pass on and apply the key dental health messages listed in appendix
• the adoption of healthy food and drink policies in all child play, education and care sites, including those for pre-school children, primary, secondary and special schools, and homes for Looked After Children.

5.5 Debate and hopefully support any future public consultation on water fluoridation in Greater Manchester and in the meantime support the continuation of the dental school milk programme

5.6 Endorse the first task of the Greater Manchester Dental LPN (see 2.2), which relates to the ‘Improvement of oral health and oral care management of young children under five not in contact with services’. The reduction of avoidable hospital admissions will require support from acute trusts as well as primary dental care.

5.7 Co-sponsor a future social marketing campaign based on the Australian “Lift the Lip” campaign that encouraged local communities to address the oral health needs of children living in their areas.

6 Summary

6.1 The oral health in young children is an accurate mirror to the quality of their diet, parenting and living conditions in general. Poor oral health is a timely indicator of sub-optimal diet and parenting in early life. Poor baby feeding practices, weaning habits, lack of hygiene and diets high in sugar lead not only lead to poor dental health but also to higher risks of obesity, diabetes, cardiovascular disease and some cancers in later life. Poor oral health leads to a restriction in a child’s ability to eat, speak and socialise.

6.2 The Health and Wellbeing Board can support efforts to reduce oral health inequalities in Manchester children and impact positively on future life chances.
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 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, that 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, 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 toothpaste 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).

Figure 2

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.
Appendix 2: The number and proportions of children attending NHS dental services has increased (see Fig 3 below)

Number of children and proportion of child resident population seen, in the previous 24 months, by a dentist holding a contract with NHS Manchester
Appendix 3

Key oral health messages from Delivering Better Oral Health: an evidence based toolkit for prevention published by the Department of Health 2007

- Breast feeding and healthy weaning provide the foundation for good oral health
- Ensure only milk or water is used in bottles and that the use of bottles is discouraged from one year onwards
- Limit how much and how often sugar-containing food or drinks are consumed
- Start to brush with a family fluoride toothpaste from when the first baby tooth shows in the mouth around six months
- Brush twice daily, especially last thing before bed and in the morning
- Supervise children when brushing to ensure correct amount and concentration of fluoride toothpaste is used and that they spit out rather than rinse after brushing
- Brush all surfaces of all teeth
- High acidity drinks such as colas, isotonic sports drinks and acidic fruit juices can erode the enamel of teeth and in addition have high sugar content which causes teeth to decay