FAMILIES OVERVIEW AND SCRUTINY COMMITTEE
1 December 2016

TITLE OF REPORT: **Children's Oral Health in Gateshead**

REPORT OF: **Alice Wiseman, Director of Public Health, Care Wellbeing and Learning**

Summary

The Director of Public Health's Annual Report 2015 highlighted that ensuring children have the best start in life is firmly established in public health thinking as the most important issue for improving health and tackling health inequalities.

Families Overview and Scrutiny Committee have agreed that the focus of its review in 2016/17 will be Children's Oral Health.

This report gives a brief overview of progress to date and details the responsibilities, key policy drivers and the commissioning principles to be applied in relation to local authorities' responsibilities for improving the oral health of children and young people, as outlined in Public Health England's evidence informed toolkit for local authorities.

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1. Progress to date

1.1 A scoping report was presented to the committee in June 2016 outlining the process of the oral health review.

1.2 A presentation was given to the committee in September 2016 by Dr David Landes from Public Health England. The presentation outlined the prevalence of problems, measures and indicators, the national policy context and factors shaping and influencing children's oral health.

1.3 Stuart Youngman, Primary Care Contract Manager for Dental Services from NHS England, presented to the committee in October 2016. The presentation gave an overview of dental services in Gateshead including capacity and take up for children, NHS commissioning responsibilities and the future direction of travel with a proposed new contract.

2. Responsibilities and policy drivers

2.1 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 1st April 2013.

2.2 Local authorities' responsibilities for improving the oral health of children and young people can be summarised as follows:

- The Health and Social Care Act (2012) amended the National Health Service Act (2006) to confer responsibilities on local authorities for health improvement, including oral health improvement, in relation to the people in their areas
- Statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas
- 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 the effects of any local water fluoridation schemes covering their areas
- Oral health surveys are carried out as part of public health England dental public health intelligence programme. Local authorities are required to participate in any oral health survey conducted or commissioned by the secretary of state
- Local authorities 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
- Commissioning arrangements for oral health improvement programmes need to be identified and understood locally. Local authorities still have the lead responsibility for oral health improvement regardless of where funding may sit since the NHS transition

2.3 Other organisations support local authorities in their lead role commissioning oral health improvement programmes. These include:

National – NHS England, Public Health England, Health Education England, National Institute for Health and Care Excellence (NICE), Health Watch England

Regional – NHS England and Public Health England regional teams

Local – NHS England Area Team, Public Health England centres, Local authorities public health, local health watch, local dental networks, clinical commissioning groups, early years providers schools, schools

These organisations can provide opportunities for integrated commissioning and delivering oral health improvement programmes.

2.4 A range of providers deliver specific oral health improvement programmes (e.g. oral health improvement teams, community dental services, general dental practices and third sector providers) and oral health improvement programmes that are integrated within local authority commissioned and internal services for children and young people (e.g. school nursing, health visiting, children's centres).

2.5 The policy drivers include:

- The government made a commitment to oral health and dentistry with a drive to:
  - Improve the oral health of the population, particularly children
  - Introduce a new NHS primary dental care contract
  - Increase access to primary care services

- The public health outcomes framework (2013 – 16) included "tooth decay in five year old children" as an outcome indicator
- The NHS outcomes framework (2014/15) included indicators related to patients experiences of NHS dental services and access to NHS dental services
- The Children and Young People's Outcome Forum report published in 2012 and its 2014 annual report recommended improved integration and greater action to reduce regional variation in child health outcomes

3. Principles of commissioning

3.1 The Marmot Review (Fair Society Healthy Lives) recommended proportionate universalism when developing strategies to improve health and reduce inequalities. This approach recommends actions that are universal but with a scale and intensity that is proportionate to the level of disadvantage.

3.2 Applying the concept of proportionate universalism to oral health improvement for children and young people means that a combination of universal and targeted activities is needed alongside specialist services. Oral health could be integrated into services at different levels through commissioner collaboration and working in line with the following principles:

3.3 **Take a life course approach**

The Marmot Review and the public health white paper 'Healthy lives, healthy people' highlighted the importance of early life interventions in improving health and reducing avoidable health inequalities across the life course.

Positive and negative effects accumulate throughout the life course and therefore the early years of a child's life are critical to their future life chances. Adopting the life course approach allows the close links between early disadvantage and poor outcomes throughout life to be broken.

3.4 **Putting children, young people and families at the heart of commissioning, empowering communities and building resilience**

Services that are co-created with professionals, children, young people, families and wider communities are more likely to produce sustainable improved health outcomes. This asset-based approach puts individuals and communities at the heart of decision making and is also in line with Gateshead Councils approach "Achieving More Together".

3.5 **Partnership working using an integrated approach**

Achieving good oral health for all children needs the support and commitment of a wide range of partners. The shared leadership at local level through health and wellbeing boards and children's trust boards, and the enhanced role for local authorities in health improvement provides multiple opportunities to improve health outcomes using an integrated approach.

The most effective way to improve oral health is to embed it in all children's services at strategic and operational levels.

3.6 **Using, sharing and developing information and intelligence**

Integrated commissioning requires commissioners to access information and data held by a number of partners. Key oral health data is held by PHE knowledge and intelligence North West (www.nwph.net/dentalhealth). PHE can provide commissioners with interpretation and local analytical support.

3.7 **Children and young people are supported by their families, early years, schools settings and communities**

The inextricable links between people and their environment means that the environments in which children and young people live need to encourage healthier lifestyles if health and wellbeing are to be improved.

Actions that could improve oral health through the environment include developing healthier children's centres and preschool settings, safe

recreational areas (preventing dental trauma), removing sweets at supermarket checkouts and introducing planning policies that promote healthier food outlets near schools.

3.8 **Sustaining and developing the children's and young people's workforce**

Implementing 'Making every contact count' gives child care professionals a responsibility to provide brief advice to improve children's overall health and wellbeing. The children's workforce can be supported through training and development to deliver appropriate evidence informed brief advice in relation to oral health across the life course.

3.9 **Leadership and advocacy of a clear local vision for oral health improvement addressing health inequalities**

Local authorities have a lead role championing oral health. Local authorities can develop oral health strategies at a local level to deliver a local vision for improving oral health, alongside general health and wellbeing. Shared leadership of the oral health agenda may help to embed oral health into the wider health and wellbeing agenda for children through integrated commissioning.

3.10 **Access to quality local dental services focused on improving oral health**

The scope of health services needs to expand to include a responsibility to improve health outcomes in addition to providing treatment. Intervening early through universal and targeted interventions reduces the need for more specialist services in later years.

Local authorities can engage with NHS England in the planning and evaluation of local dental services, influencing the preventive focus of dental services. In particular, local authorities have unique powers around health scrutiny, which enable them to review the planning, provision and operation of health services in their area.

4. Effectiveness of oral health improvement programmes – commissioning across the life course: what works?

4.1 The Public Health England evidence informed toolkit reviewed oral health improvement interventions for children and young people age 0 to 19. This included looking at a range of interventions, the target population, the strength of the evidence, impact on equalities and an overall recommendation.

4.2 The overall recommendations were classified as recommended, emerging, limited value and discouraged.

4.3 As an example interventions that were looked at included:

- **Supporting consistent evidence informed oral health information** (e.g. social marketing programmes to promote oral health and uptake of dental services by children – target population is preschool children and young people, inconclusive evidence of effectiveness, impact on equalities is uncertain/encouraging and overall recommendation found to have limited value)
- **Community based preventive services** (e.g. targeted provision of toothbrushes and toothpaste (i.e. postal or through health visitors) - target population is preschool children, some evidence of effectiveness, impact on equalities is encouraging and overall is recommended)
- **Supportive environments** (e.g. fluoridation of public water supplies - target population is preschool children, young people and whole population, strong evidence of effectiveness, impact on equalities is encouraging/uncertain and overall is recommended)
- **Community action** (e.g. school or community food co-operatives - target population is preschool, school children and young people, weak evidence of effectiveness, impact on equalities is encouraging and overall recommendation is emerging)
- **Healthy public policy** (e.g. influencing local and national government policy - target population is preschool, school children and young people, some evidence of effectiveness, impact on equalities is encouraging/uncertain and overall is recommended)

4.4 The full range of interventions and the overall recommendations will be included and explored in more detail in the interim report which will be presented to OSC in March 2017.

5. Recommendation

5.1 Overview and Scrutiny Committee is asked to note the content of this report and to provide comments on the principles of commissioning and whether these are in line with the approach the OSC wishes to adopt.

5.2 Agree to receive the interim report in March 2017 which will contain the evidence gathered to date and recommendations for future commissioning and integrated working arrangements.

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