



LONDON BOROUGH OF BARKING AND DAGENHAM

IMPROVING ORAL HEALTH IN BARKING AND DAGENHAM

ORAL HEALTH PROMOTION STRATEGY 2016 – 2020

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1. IMPROVING ORAL HEALTH IN BARKING AND DAGENHAM – OUR VISION

The London Borough of Barking and Dagenham has set out an all-encompassing vision for the delivery of health and care services: *One borough; one community; London's growth borough*. Within this vision is the ambition for children and adults who are resident in Barking and Dagenham to have the best possible oral health.

This strategy sets out the ambition to measurably improve the oral health of the resident population by 2020 especially for children and vulnerable adults. This will be achieved by increasing the uptake of regular oral healthcare, reducing inequalities in oral health and ensuring equitable access to dental services in the borough. Key priorities within the strategy are:

- Promoting positive oral health practice at individual level and healthy lifestyles in order to prevent and reduce risk factors to oral health;
- Implementing evidence-based oral health interventions that equitably improve oral health outcomes;
- Integrating the oral health strategy into local community health programmes in order to achieve maximum health impact with limited resources.

POLICY CONTEXT AND RELATED PLANS

Barking and Dagenham has a statutory responsibility to provide, or make arrangements to secure the provision of oral health surveys, oral health promotion and oral health improvement as part of overall population health improvement¹. Barking and Dagenham is responsible for improving the oral health of local people including the commissioning of oral health promotion initiatives and oral health surveys as part of Public Health England's (PHE) dental public health intelligence programme. This is supported by the dental public health expertise within PHE. NHS England is responsible for commissioning primary care and hospital dental services.

The strategy to improve oral health has been developed in line with the findings of the Joint Strategic Needs Assessment, the key priorities of Barking and Dagenham's Health and Wellbeing Strategy and the Ambition 2020 outcomes. Key national policy and related local strategies that inform the commissioning and delivery of oral health services are summarised in Appendix B. Recently published oral health guidance (PHE 2014², NICE 2014, LGA, 2014) will assist Barking and Dagenham to ensure that interventions and activities are evidence-based and meet the diverse needs of local people. The guidance advocates both universal approaches

¹ Statutory Instrument 2012 No. 3094: Dental Public Health functions – Section 4

² Commissioning Better Oral Health was published by the Department of Health and Public Health England in June 2014 ³
http://www.who.int/topics/oral_health/en

with general advice and support for all residents, together with additional targeted interventions aimed at those people at higher risk of developing oral health problems.

Delivering the strategy in partnership

Barking and Dagenham's oral health improvement responsibility is underpinned by collaborative working with key partners and stakeholders as part of the Oral Health Strategy Group. The strategy has been developed by Barking and Dagenham's Public Health Team, Leisure Services, Children's Services, Drug and Alcohol Action Team, North East London NHS Foundation Trust and PHE in partnership with the local NHS and local dentists.

2. INTRODUCTION

WHAT IS ORAL HEALTH?

Oral health refers to the physical condition and hygiene of an individual's teeth, gums, supporting bone and soft tissues of the mouth, tongue and lips. The World Health Organisation defines good oral health as being free from diseases and disorders that affect the oral cavity³. Good oral health is important for general health and wellbeing and development. In contrast, poor oral health can affect an individual's ability to eat, speak, smile and socialise normally due to embarrassment about the appearance on one's teeth and can restrict food choices. Poor oral health can aggravate existing health conditions. It can also be an indicator of neglect or difficult social circumstances. Oral health problems include gum (periodontal) disease, tooth decay (dental caries), tooth loss and oral cancers.

THE NATIONAL PICTURE

Prevalence of oral health problems in children in England

Tooth decay is the most common oral disease affecting children and young people in England³. Tooth decay (dental caries) occurs when oral bacteria produce acids that gradually soften the enamel, leading to cavities in the teeth. Differences in the prevalence levels within the age range for children are as follows:

Under 5s - In 2014 nearly 28% of five year olds in England had experience of tooth decay (in comparison to 31% in 2008) and, although the oral health of children has been improving, significant inequalities remain. Across local authorities in England there is significant variation, ranging from 13% to 53% of five year olds experiencing tooth decay, with these children having on average three teeth affected. Those living in deprived communities have poorer oral health than people living in more affluent communities, as do those in vulnerable population groups including those with disabilities⁴.



³ Public Health England 2014 Local authorities improving oral health: commissioning better oral health – An evidence-informed toolkit for local authorities

⁴ Local Government Association / Public Health England: tackling poor oral health in children: local government's public health role; October 2014
<http://www.local.gov.uk/documents/10180/5854661/L14-352+Tackling+Poor+oral+health+in+children/3dd8097f-35b7-42ba-b3c7-186266da82db>

Over 5s - In March 2015 the results of the 5th Decennial National Oral Health Survey were published. Key findings included:

- Reductions in the extent and severity of dental decay in permanent teeth for 12 and 15 year old children compared to 2003.
- Persistence of oral health inequalities with 26% of 15 year olds eligible for free school meals having severe or extensive dental decay compared to 12% of 15 year olds who were not eligible.
- More than a third (35%) of the parents of 15 year olds reported that their child's oral health had impacted on family life in the last six months; 23% of the parents of 15 year olds took time off work because of their child's oral health in that period.
- Overall, 45% of 12 year olds and 28% of 15 years olds reported that they were not happy with the appearance of their teeth and would like to have them straightened.

Risk factors and impact on health and wellbeing for children

Tooth decay (dental caries) is caused when oral bacteria produce acids that gradually soften the enamel, leading to cavities in the teeth. Sugar plays a key role in tooth decay because it fuels the acid formation by oral bacteria. Acidic food and drinks can be just as harmful as they can wear away the tooth enamel and cause tooth surface loss, making them more prone to decay and sensitivity.

Children's primary (baby) teeth are more susceptible to decay than permanent (adult) teeth owing to differences in their chemical composition and physical properties. In particular, primary teeth have thinner and often less resilient enamel that does not provide as much protection from bacteria. Infants and toddlers primary teeth can also be affected by an aggressive form of decay called early childhood caries. The disease is associated with the frequent consumption of sugary drinks in baby bottles or sipping cups as it occurs in the upper front teeth and spread rapidly to other teeth⁵.

More than 30% of children in England did not see an NHS dentist between 2012 and 2014⁶. Approximately 46,500 children and young people under 19 were admitted to hospital for a primary diagnosis of dental caries in 2013–14. These numbers were highest in the 5 to 9 year-old age group, which showed a 14% increase between 2010–11 and 2013–14, from 22,574 to 25,812. The second highest admissions in 2013–14 were for tonsillitis, with approximately 11,500 cases, making dental caries by far the most common reason for children aged between 5 and 9 to be admitted to hospital.

Oral diseases can have a considerable impact on a child's general health and wellbeing. Poor oral health is associated with being underweight and a failure to thrive. It also affects a child's ability to sleep, speak, play and socialise with other children. Children

⁵ RCS Faculty of Dental Surgery 2015: The state of children's oral health in England

with dental problems may not be able to gain the full benefit of their education due to increased school absenteeism as the result of hospital appointments, leading to decreased academic performance.

Prevalence of oral health problems in adults in England

- In 2009, 94% of the combined populations of England, Wales and Northern Ireland were dentate, that is had at least one natural tooth.
- 58% of adults said that they had tried to make an NHS dental appointment in the previous three years. Of these adults, 92% successfully received and attended an appointment.
- 75% of adults said that they cleaned their teeth at least twice a day and a further 23% of adults said that they cleaned their teeth once a day.
- The mean number of teeth amongst dentate adults was 25.7, with the majority of dentate adults (60 per cent) having between 27 and 32 teeth. Dentate adults had an average of 17.9 sound and untreated teeth but this varied hugely with age.

People are not only living longer but also retaining their natural teeth into old age. Changes that can occur over time in the gum tissues expose vulnerable root surfaces to the oral environment and thus, potentially to the decay process. Therefore while older people are still at risk of dental decay, gum disease and teeth wear, they are also at increased risk of developing root decay and oral cancer. The treatment needs of older people can be complex with long-term conditions, systemic disease and medication compounding oral risk factors, such as dry mouth, making oral hygiene and treatment more difficult.

Risk factors and impact on health and wellbeing: adults

The main barriers to adults and older people accessing dental services are low perception of need / oral health not given a priority, poor general health and difficulty in travelling to a practice, cost or fear of cost of dental treatment, poor nutrition, effects of dementia, decreased salivary flow and problems with dexterity (affecting use of a toothbrush).

Poor oral health, whether it is chronic or acute, may impact on nutritional intake, disrupt routine sleep patterns and affect quality of life and general health. Pain / discomfort, difficulty eating, limited food choice and lack of sleep may sometimes lead to increased agitation and anxiety, particularly in older people.

Chronic health conditions such as cardiovascular disease, aspiration pneumonia and mouth cancers can also increase the risk of poor oral health. Whilst people over 50 years of age are more at risk of developing oral cancer the incidence of oral cancer in younger adults has been increasing in recent years. Alcohol consumption, smoking and chewing tobacco are all risk factors for oral cancer and these risks are increased when two or more of these habits are present.

POPULATION GROUPS AT RISK OF POOR ORAL HEALTH

Whilst it is important to give advice and support to the whole population as to how to maintain good oral health, it is recognised that certain populations are at increased risk of poor oral health, and therefore may be in need of targeted approaches. This may be due to physical, social, environmental and lifestyle circumstances that impact on their ability to maintain good oral hygiene, consume a healthy diet or access dental services.

Vulnerable populations include those:

- Who are socially isolated or excluded or are geographically isolated;
- Who are older and frail especially those living in nursing or residential care who are often dependent on others for their diet, personal care and access to health services;
- Who have a learning disability and / or physical impairment or where reduced manual dexterity increases difficulty in cleaning their teeth properly;
- Who have a mental health condition - tend to have fewer natural teeth, more untreated decay and more gum disease than the general population;
- Who have specific clinical conditions, such as diabetes, congenital heart problems;
- Pregnant women;
- Who are from lower socioeconomic groups;
- Who live in a disadvantaged area;
- Who smoke heavily or misuse substances (including alcohol);
- Who have a poor diet;
- Who are from certain Black, Asian and minority ethnic groups identified with higher prevalence of oral health problems;
- Who are homeless or frequently move, such as traveller communities, refugees and asylum seekers;
- Who are children of parents or carers with the above risk factors;
- Who are in long-term institutional care including looked after children and those who are, or who have been, in care and older people in residential care homes.

Vulnerable groups often have unmet oral health needs. Co-morbidities, progressive medical conditions, dementia and increasing frailty all contribute to more complex oral health problems and difficulties in accessing primary care dental services or lead to infrequent contact with oral health services.

3. ORAL HEALTH NEEDS IN BARKING AND DAGENHAM

The oral health needs assessment conducted in 2015 identified the following oral health needs among residents of Barking and Dagenham:

ORAL HEALTH OF CHILDREN AND YOUNG PEOPLE: KEY POINTS

3 year olds

A local oral health survey of 3 and 4 year old children in Barking and Dagenham was carried out in 2010⁶. The findings are summarised below:

- 9% of children had experienced pain in the teeth, mouth or jaws;
- 28% had experienced dental disease and 91% of this was untreated;
- 41% of those with decay had visited a dentist in the previous 12 months;
- There were marked inequalities among ethnic groups with high rates of decay and untreated disease in Asian children;
- Asian children were less likely to have their teeth brushed twice a day than White and Black children and there were low rates of attendance among Black children.

Barking and Dagenham participated in a national oral health survey of 3-year-old children in 2013. Compared to the local survey the results showed that oral health had improved with 18% experiencing dental disease. With figures for London and England at 13.6% and 11.7% respectively, oral health is much worse in 3-year-old children in Barking and Dagenham. For those with disease each child had on average 3.49 decayed, missing or filled teeth compared to 3.11 for London and 3.08 for England. There were higher rates of dental abscess at 1.9% compared to 0.5% for London.

5 year olds

A national survey of five-year-old children was carried out in 2012. The results of this survey show that the oral health of children in

⁶ London Borough of B&D, JSNA 2015 Dental health [online] available from: <https://www.lbbd.gov.uk/council/statistics-anddata/jsna/overview-2/> [Last accessed: 7 July 2016]

England continues to improve with the percentage of children who had experienced decay falling from 30.9% in 2008 to 27.9% in 2012. The percentage of children with active untreated decay also fell from 27.5% in 2008 to 24.5% in 2012. London showed no improvement with the percentage with decay experience or active untreated decay remaining the same at 32.9% and 29% respectively.

Five-year-old children in Barking and Dagenham had higher rates of tooth decay experience compared to London and England.

Older children

The findings of a national oral health survey of 12 and 15 year old children were published in March 2015. The sample was too small to report data at borough level but the headline findings were as follows:

- Reduction in the extent and severity of tooth decay in permanent teeth but large proportion of children continue to be affected by dental disease;
- Children from lower income families are more likely to have oral disease;
- 51% of 12 year olds and 60% of 15 year olds were satisfied with the appearance of their teeth and the majority were positive about their oral health;
- 23% of parents said they had taken time off work because of their child's oral health in the previous six months;
- More than three quarters of older children reported brushing their teeth twice a day.



Hospital admissions for dental extractions for children

In 2012/13 dental extraction was the highest cause of hospital admissions for children in London⁷. In Barking and Dagenham 310 children were admitted to hospital for dental extractions with 40% in the 5-9 year age group. This represented 0.5% of the 0-19 year old population, similar to that for London.

⁷ London Borough of B&D, JSNA 2015 Dental health [online] available from: <https://www.lbbd.gov.uk/council/statistics-anddata/jsna/overview-2/>

Access to dental services in Barking and Dagenham

Barking and Dagenham has more dental capacity compared to London and England. There are 27 dental practices including community/special care dental clinics. There are more dentists per 100,000 of the population (52) than London (51) and England (44). There are also more Units of Dental Activity (UDA) per 100,000 of the population (178,206) compared to London (149,280) and England (165,798).

In March 2014, 60% of children resident in Barking and Dagenham accessed dental services in the previous 24 months, similar to London but lower than the figure for England. There has been a steady increase in the number of children accessing dental services in Barking and Dagenham from 2011 to 2014.

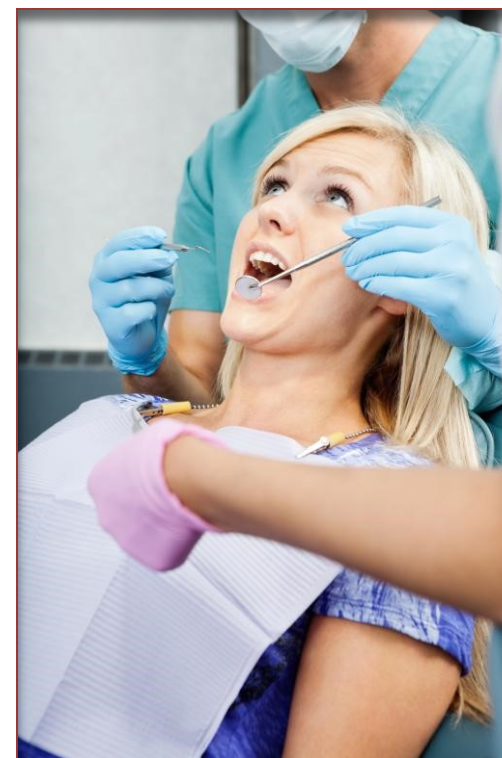
Population averages can mask inequalities in oral health. There are marked inequalities in children's oral health, with a strong association between oral health and social deprivation.

ORAL HEALTH OF ADULTS: KEY POINTS

The findings of the local 2010 oral health survey (summarised below) revealed that the dental health status of adults living in Barking and Dagenham was similar or better than the average figures for England:

- The possession of 21 or more natural teeth is used to define a minimum functional dentition to ensure good oral health. In Barking and Dagenham, 94% of adults had a functional dentition, compared to 91% in London and 86% in England;
- 63% of those surveyed were satisfied with the appearance of their teeth;
- 54% had decayed teeth compared to 28% in London and 30% in England;
- 20% had evidence of advanced gum disease compared to 10% for London;
- 64% reported that they brush their teeth twice a day compared to 77% for London;
- 50% attend for dental care only when in emergency compared to 35% for London;
- 65% access NHS dental treatment, 20% go private and 13% utilise a mixture of services.

In addition to clinical indicators of dental problems, insight work revealed the impact of poor oral health on residents' general wellbeing. In Barking and Dagenham, 47% of adults who had their own teeth reported having experienced one or more oral problems that had an



impact on some aspect of their life compared to 37% for London and 39% for England. The most frequently experienced problem was dental pain, followed by psychological impacts such as low self-esteem and confidence.

Between 2010 and 2012 the age standardised rate per 100,000 of the population for oral cancer in Barking and Dagenham was 9.2 compared to 13.5 for London and 13.2 for England⁸.

Access to dental services in Barking and Dagenham

In March 2014:

- 52% of adults living in Barking and Dagenham accessed dental services in the previous 24 months compared to 44% for London and 51% for England.
- There has been a steady increase in the number of adults accessing dental services in Barking and Dagenham with the level of service use higher than that for London and England.
- There is very little variation in child and adult access rates in Barking and Dagenham wards. Approximately 12% of children and adults who are resident in Barking and Dagenham access dental services in other boroughs.

VULNERABLE GROUPS

The 2010 survey found that people with learning disabilities had more missing teeth, fewer filled teeth and more untreated diseased teeth than the general adult population surveyed. This suggests that, when people with learning disabilities do access dental services, they are more likely to have teeth extracted instead of restorative treatment such as fillings or crowns due to the extent of the oral health problem.

A report published by Public Health England (PHE) entitled Tackling poor oral health in children – Local government's public health role (2014) shows that tooth decay is the most common oral disease affecting children and young people in England. Furthermore, tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012-13¹⁸

The prevalence of gum diseases increases with age and in older adults is more commonly seen in females. People aged 75 and above and people with dementia are at increased risk of gum disease because of poor oral hygiene and the inability to maintain

⁸ Public Health England. Dental health: Admission to hospital for extraction of one or more decayed primary or permanent teeth 0 to 19 year olds, 2011/12 and 2012/13.
<http://www.nwph.net/dentalhealth/extractions.aspx>

self-care. A high prevalence of gum disease in older adults should be of concern because it directly increases the patient's risk of developing root decay, as well as tooth loss with resulting deficient masticatory ability, nutrition and speech, which can affect a person's quality of life¹⁹.

Reported oral health related quality of life is worse in the population with serious mental illness and in one study 80% of adults with serious mental illness reported having one or more dental impacts compared to 39% from the general population the most frequently reported impact being pain in the mouth. Fear and anxiety, in conjunction with the added issue of dental teams reluctant in treating patients with mental illness, has resulted in high levels of mentally ill people failing to seek a dental practitioner. Fear and anxiety of attending the dentist may have significant quality of life consequences, especially on an individual who is already coping with a mental illness²⁰.

This demonstrates the need for early interventions and more comprehensive preventive dental and oral health procedures for the general population and vulnerable groups in particular.

4. KEY PRIORITIES FOR IMPROVING ORAL HEALTH IN BARKING AND DAGENHAM

Defining oral health priorities in Barking and Dagenham

An oral health partnership strategy group was established in 2015. The group utilised the needs assessment to make recommendations for local priorities and develop the high-level oral health strategy incorporating community-based interventions and activities. The strategy includes universal actions for all local communities and actions targeted to address the needs of the most vulnerable groups.

Based on the evidence of need for oral health services, the recommendation was to focus on children (pre-school and school age), young people and adults whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services.

THE KEY PRIORITIES

Priorities for oral health promotion and service delivery in Barking and Dagenham are to:

- A. Promote and protect oral health by raising awareness about oral health;
- B. Improve diet and reduce consumption of sugary food and drinks, alcohol and tobacco (and thereby improve general health as well);
- C. Encourage people to go to the dentist regularly;
- D. Address inequalities in oral health;
- E. Improve access to local dental services particularly for priority groups; F. Improve oral hygiene;
- G. Promote the provision of preventive dental care;
- H. Increase early detection of mouth cancer and dental decay;
- I. Increase exposure to fluoride.

5. EFFECTIVE INTERVENTIONS FOR IMPROVING ORAL HEALTH

Evidence-based interventions for improving oral health

This section outlines the interventions and activities that have evidenced effectiveness in achieving the key objectives of preventing poor oral health, improving oral health and reducing oral health inequalities in the UK. Some of these interventions may involve a universal approach whilst others may be targeted to address oral health needs in specific population groups and geographic areas. Key outcomes from the recommended interventions are also summarised in the outcome triangles in Appendix C. The evidence base will inform the interventions and activities included in the strategy delivery plan.

Effective interventions for improving oral health in children

The following measures are identified as being effective in improving oral health in children:

IMPROVE DIET AND REDUCE THE CONSUMPTION OF SUGARY FOODS, DRINKS, ALCOHOL AND TOBACCO
<ul style="list-style-type: none">• Healthy food and drink policies in childhood settings• Influencing local and national government policy and fiscal policy in relation to food, infant feeding, smoking and alcohol (risk factor approach)
INCREASE THE AVAILABILITY OF FLUORIDE
<ul style="list-style-type: none">• Targeted provision of toothbrushes and toothpaste• Targeted community-based fluoride varnish programmes• Fluoridation of public water supplies
IMPROVE ORAL HYGIENE
<ul style="list-style-type: none">• Targeted peer (lay) support groups and peer oral health workers• Oral health training for the wider professional workforce• Supervised tooth-brushing in targeted childhood settings• Integration of oral health into targeted home visits by health and social care workers
ADDRESS INEQUALITIES IN ORAL HEALTH
<ul style="list-style-type: none">• Integration of oral health into targeted home visits by health and social care workers• Targeted provision of toothbrushes and toothpaste (e.g. postal or through health visitors)• Targeted community-based fluoride varnish programmes• Supervised tooth-brushing in targeted childhood settings

INCREASE ACCESS TO DENTAL SERVICES

There is only weak evidence to suggest that intensive home visits by dental co-ordinators may increase access to dental service. It is therefore the responsibility of all services to seize opportunities to:

- Signpost parents to primary dental care, and
- Ensure that information is available on how to access dental care, and the associated costs/eligibility for support with healthcare costs.

Table 1: Evidence-based interventions for improving oral health in children (NICE 2014)

Effective Interventions for improving oral health in adults and vulnerable adults

With regard to adults and vulnerable adults effective interventions include training of the wider professional workforce including skills training for carers. Other programmes include targeted provision of high strength fluoride toothpaste and mouth cancer screening for people who are at high risk. Overarching strategic outcomes to determine the effectiveness of the programmes include a change in the oral health related quality of life and reduction in active dental caries and gum disease are listed in Appendix C.

Encourage dental teams to give dietary advice in dental practice as this promotes good oral health

Encourage tooth brushing twice daily with a fluoride toothpaste in order to prevent dental decay and gum disease in adults

Support behavioural interventions as they contribute to dental anxiety reduction and result in improved dental attendance in adults

Support programmes using more innovative approaches than the medical/behavioural model as they have more potential for achieving longer-term behaviour changes.

The use of tailored approaches based on active participation and addressing social cultural and personal norms offer longer-term changes in behaviour compared with simple one off interventions

Develop oral health promotion programmes combined with skills training for carers as this can benefit older adults

Encourage the use of high concentration fluoride toothpaste and fluoride varnish as this can prevent or reverse tooth decay in older adults

Where appropriate encourage dentists to use the traumatic restorative technique (ART) as this is an effective method of treating root caries in older adults

Table 2: Evidence-based interventions for improving oral health in adults

National guidance for oral health in care homes should be implemented including oral health assessments and development of individual oral health care plans for residents⁹.

⁹ NICE will be publishing guidance on oral health for adults in care homes in July 2016

APPENDIX A - POLICY AND GUIDANCE

A number of policy documents have been issued in relation to improving oral health and commissioning dental services for children and adults.

National policy drivers

The Government made a commitment to improve oral health and dentistry with a drive to:

- Improve the oral health of the population, particularly children
- Introduce a new NHS dental contract based on registration, capitation and quality
- Increase access to primary dental care services¹⁰

Public Health England advice¹¹ and NICE guidelines (PH55)¹² were issued in 2014 to support local authorities and their partners in their role to improve health in local communities. Recommendations include:

- Ensuring that oral health is a health and wellbeing priority and included in the
- Conduct an oral health needs assessment, using a range of oral health epidemiological data sources
- Develop an oral health strategy
- Ensure that frontline health and social care staff can give advice on the importance of oral health;
- Promote a whole school approach to oral health in primary and secondary schools.

Public Health Outcomes Framework (2013-16) - The PHOF encourages the prioritisation of oral health improvement by including a measure of the oral health of five-year-old children as a key indicator. PHOF indicator 4.2 measures the *'mean severity of tooth decay in children aged five years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted decayed/missing/filled teeth (d3mft)'*. Local authorities use this indicator to monitor and evaluate children's oral health improvement programmes¹³

NHS Outcomes Framework (2014-15) includes indicators related to patients' experiences of NHS dental services (4aiii) and access to NHS dental services (4.4ii).¹⁴

¹⁰ NHS England 2014; Department of Health 2010)

¹¹ Public Health England (2014). Local authorities improving oral health: commissioning better oral health - An evidence-informed toolkit for local authorities https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBO_HMmaindocumentJUNE2014.pdf

¹² Oral health: local authorities and partners; October 2014 <https://www.nice.org.uk/guidance/ph55>

The Children and Young People’s Health Outcomes Framework (2014) and strategy recommends that an integrated and partnership approach be adopted to improve health outcomes for children and young people and includes the indicator to measure tooth decay in children aged 5.

Local policy

Barking and Dagenham has a statutory responsibility to ‘provide, or make arrangements to secure the provision’ of oral health surveys and oral health promotion and oral health improvement as part of overall population health improvement¹⁵. This is supported by the dental public health expertise within Public Health England. NHS England is responsible for commissioning primary care and hospital dental services.

Joint Strategic Needs Assessment <https://www.lbbd.gov.uk/wp-content/uploads/2015/09/7.14-Dental-Health.pdf>

Health and Wellbeing Strategy https://www.lbbd.gov.uk/wp-content/uploads/2014/11/JHWS_A4_30-9-15_RF.pdf

Children and Young Peoples Plan <https://www.lbbd.gov.uk/council/priorities-and-strategies/corporate-plans-and-key-strategies/children-and-young-peoples-plan/>

Ambition 20/20 <https://www.lbbd.gov.uk/council/priorities-and-strategies/vision-and-priorities/overview/>

¹³ Department of Health 2012 <https://www.gov.uk/government/collections/public-health-outcomes-framework>

¹⁴ Department of Health 2012b <https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015>

¹⁵ Statutory Instrument 2012 No. 3094 : Dental Public Health functions – Section4 http://www.legislation.gov.uk/uksi/2012/3094/pdfs/ukxi_20123094_en.pdf

Oral health needs assessment 2015 <https://www.lbbd.gov.uk/wp-content/uploads/2015/09/7.14-Dental-Health.pdf>

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

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf

Oral health: approaches for local authorities and their partners to improve the oral health of their communities; October 2014

<https://www.nice.org.uk/guidance/ph55/resources/guidance-oral-health-approaches-for-local-authorities-and-their-partners-toimprove-the-oral-health-of-their-communities-pdf>

Local Government Association / Public Health England: tackling poor oral health in children: local government's public health role; October 2014 <http://www.local.gov.uk/documents/10180/5854661/L14-352+Tackling+Poor+oral+health+in+children/3dd8097f35b7-42ba-b3c7-186266da82db>

Oral health promotion approaches for dental practitioners. NICE public health guideline - Publication expected October 2015

<http://www.nice.org.uk/Guidance/InDevelopment/GID-PHG60>

Oral health in nursing and residential care. NICE public health guideline. Publication expected June 2016

<http://www.nice.org.uk/Guidance/InDevelopment/GID-PHG62>

APPENDIX B - EFFECTIVE INTERVENTIONS AND OUTCOMES FOR IMPROVING ORAL HEALTH

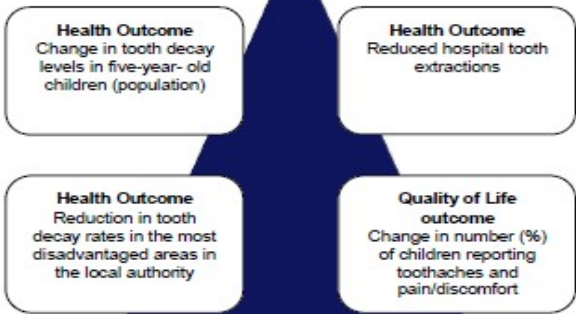
Effective Interventions and outcomes for improving oral health in children

Overarching outcomes for children

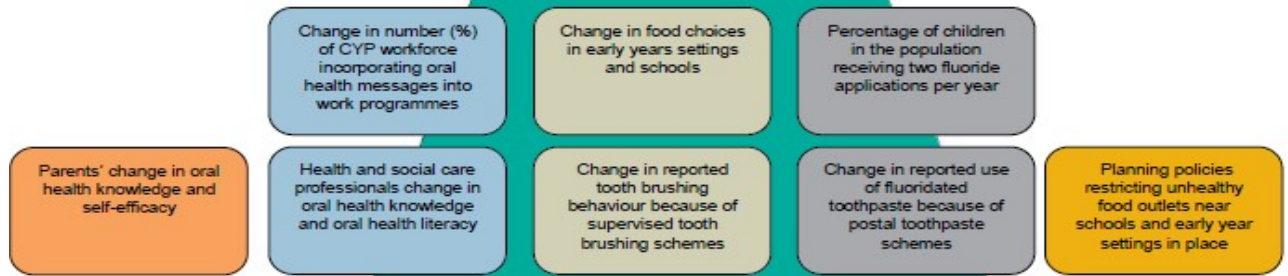
- Changes in tooth decay levels in 5 year old children (Public Health Outcomes Framework Indicator 4.2)
- Reduction in decay rates in the most deprived areas
- Reduced hospital admissions for tooth extractions
- Change in the number (%) of children reporting toothaches and pain

Figure 1: Effective interventions and outcome measures for oral health improvement programmes for children and young people (overleaf)

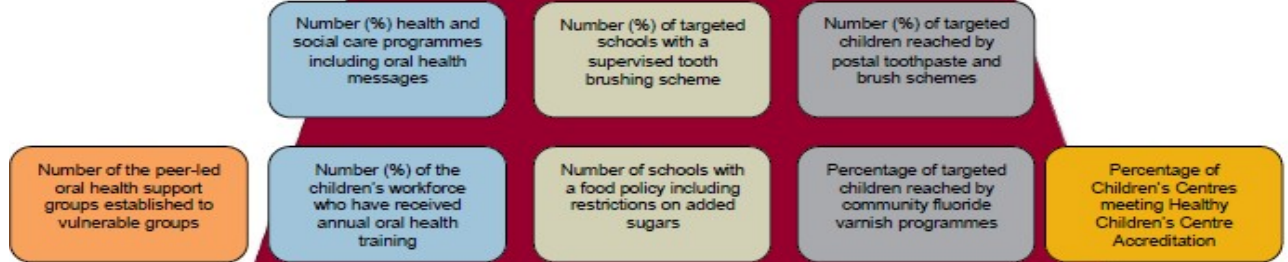
Overarching Strategic Outcomes



Intermediate Outcomes



Service outcomes



Recommended Interventions



Key performance indicators for children

- Number (%) of the children's workforce including health visitors and school nurses who have received annual oral health training
- Number (%) of schools with an oral health indicator for the healthy schools programme
- Number (%) of targeted children reached by a fluoride varnish programme
- Number (%) of targeted children reached by a supervised brushing programme □ Number (%) of targeted children reached by the brushing for life programme
- Number (%) of Children's Centres meeting Healthy Children's Centre accreditation
- Number of peer-led oral health support groups established to support vulnerable groups

Intermediate outcomes for children

- Change in the number (%) of CYP workforce incorporating oral health messages into work programmes
- Number (%) of targeted children receiving two fluoride varnish applications per year
- Parents change in oral health knowledge and self efficacy
- Health and social care professionals change in oral health knowledge and oral health literacy
- Change reported in tooth brushing behaviour because of supervised tooth brushing programme
- Planning policies restricting unhealthy food outlets near schools and early year settings in place

Future outcomes for children and young people

- Every child and young resident of Barking and Dagenham to be registered with a dentist (by 2020?)

Effective Interventions for improving oral health in adults and older adults

Figure 2: Effective interventions and outcome measures for oral health improvement programmes for adults and older adults (overleaf).

Overarching Strategic Outcomes

Health Outcome
Reduction in tooth decay rates and gum disease in older adults

Quality of Life outcome
Change in the reported oral health quality of life in older adults

Intermediate Outcomes

Change in number (%) of older adult workforce incorporating oral health messages into work programmes

Change in food choices in care homes

Percentage of older adults in the population receiving two fluoride applications per year

Older adults change in oral health knowledge and self-efficacy

Health and social care professionals change in oral health knowledge and oral health literacy

Change in oral health status as a result of systematic use of oral health assessments and care plans

Change in reported use of high strength fluoridated toothpaste

Service outcomes

Number (%) health and social care programmes including oral health messages

Number (%) of targeted care homes with an oral health assessment and care plan

Number (%) of targeted older adults who have received high strength fluoride toothpaste and fluoride varnish

Number of the peer-led oral health support groups established to vulnerable adults and older adults

Number (%) of carers and other health professionals who have received oral health training

Number of care homes with a food policy including restrictions on added sugars

Number of high risk adults screened for mouth cancer

Recommended Interventions

Community Action
Targeted peer (lay) support groups /peer oral health workers

Supporting consistent evidence informed oral health information
Oral health training of the wider professional workforce including skills training for carers
Integration of oral health into health and social

Supportive Environments
Standards for care homes should reflect an oral health assessment, an oral care plan and the impact of healthy food choices

Community-Based Preventive Services
Targeted use of high strength fluoride toothpaste and varnish
Targeted screening for oral cancer for high risk adults and older adults

Healthy Public Policy
Influencing local and national government policies

Effective interventions

Table 1: Evidence-based interventions for improving oral health in adults (NICE 2014) (see page 17).

Supporting consistent evidence informed oral health information

- Oral health training for the wider professional workforce including skills training for carers as this can benefit older adults
- Integration of oral health into targeted home visits by health and social care workers

Community based preventive programmes

- Targeted use of high strength fluoride toothpaste and fluoride varnish for at risk adults and older adults
- Targeted screening for oral cancer for adults and older adults who are at high risk
- Encourage dental professionals to deliver tobacco cessation interventions as they may be effective in helping tobacco users to quit

Supportive environments

- Standards for care homes for older people should reflect an oral health assessment and oral care plan
- Standards for care homes for older people should reflect the impact of healthy food choices and sugar consumption on the maintenance of good oral health

Community action

- Targeted peer (lay) support groups/peer oral health workers

Healthy public policy

- Influencing local and national government policies

Expected outcomes

Intermediate outcomes

- Change in reported use of high strength fluoride toothpaste
- Health and social care professionals change in oral health knowledge and oral health literacy
- Change in the reported oral health of older adults as a result of systematic use of oral health assessments and development & implementation of oral health care plans



Future outcomes for adults

- Every adult resident in Barking and Dagenham to be registered with a dentist (by 2020)

Key performance indicators

- Number (%) of health and social care programmes with oral health messages
- Number (%) of carers who have received oral health training
- Number (%) of frail adults who have received an oral health assessment and care plan
- Number (%) of targeted older adults who have received high strength fluoride tooth paste or fluoride varnish
- Number of peer-led oral health support groups established to support vulnerable adults and older adults
- Number of mouth cancer awareness sessions delivered
- Number of targeted adults screened for mouth cancer
- Number of adults and older adults referred to tobacco cessation services



APPENDIX C - OVERVIEW OF LOCAL ORAL HEALTH SERVICES

Dental services in Outer North East London

Programme 1: Infant and Primary Schools

This is a signposting and information oral health programme consisting of a mail out pack which includes:

- Information on how to set up/develop a School Snack Policy
- Laminated Dental First Aid Poster –What to do if an adult tooth is knocked out – Helping to reduce dental injuries.
- Catalogue to loan resources that support school teaching of dental health.
- Appropriate dental health web sites for teaching/education.
- List of local NHS dentists
- Pro forma for referral into the Community Dental service explaining criteria for referral.

Target: parents, teachers, Sencos, Healthy Schools Co-ordinators and school support staff.

Programme 2 Senior Schools

A signposting and information programme consisting of a mail pack which includes:

- Laminated Dental First Aid Poster – What to do if an adult tooth is knocked out. This simple advice can prevent a teenager requiring a denture by their own tooth being implanted correctly, it will also help reduce dental injuries
- List of local NHS dentists
- Pro forma for referral into the Community Dental service explaining criteria for referral.

Target: students, teachers, Sencos, Healthy Schools Co-ordinators and school support staff.

Programme 3 New Intake Children - Reception year

An information welcome starter card for children starting school.

Target: Reception class children and their families, teachers, Senco's and school support staff.

Programme 4 Dental Programme for Special Educational Needs Schools

A school tooth brushing programme is set up and maintained by the oral health team in Special Educational Needs Schools. The aim of the programme is to have daily supervised tooth brushing at school in addition to any tooth brushing that happens at home. Training is provided for all staff involved. Equipment provided includes toothbrush holders and covers, toothpaste at optimum fluoride level, toothbrushes and appropriate labelling, poster to be displayed near brushing area.

Target: Children attending Special Educational Needs schools, and staff.

Programme 5 Early Years – Children Centres and Nurseries promoting good oral health

The programme involves a variety of oral health initiatives that will facilitate the national drive to reduce dental disease among children. Using children's centres and nurseries our local strategic objective is to improve oral health outcomes for the more vulnerable groups in our communities by focusing on children living in communities of relative deprivation, and children with learning difficulties.

The programme involves training staff in Children's Centres and identifying a nominated lead for oral health. The oral health lead for Children's Centres is responsible for identifying and nominating Oral Health Champions that will be assigned to individual children's centre/cluster/managers. Oral health champion's (OHC) are responsible for

- Implementing the standardisation of the oral health leaflets throughout all centres
- Responding to oral health enquiries from families attending centres
- Sign-posting to local GDP/community dental service
- Oral health sessions, displays/and campaigns for the centre.
- Working with clinical teams to arrange outreach check-up programmes for all red and amber families and signposting green families to General Dental Practitioners.

Target: families attending Children Centres, Children's Centre staff.

Programme 6 Oral health training for all who work with Early Years

This training programme facilitates the national drive to reduce early onset of dental disease among children using people who work with early years.

Training objectives are to enable participants to

- Recognise the factors that contribute to poor oral health
- Understand how good oral health contributes to overall health and wellbeing
- Understand that dental diseases are mainly preventable
- Understand the role of fluoride in prevention
- Realise the importance of early and regular dental attendance
- Apply information learnt to promote oral health within their work role

Target: Health Visitors, School Nurses Health Visitor teams, School Nurse Teams, Children Centres, Community/Nursery Nurses, Foster Care and Child Minder Leads.

Programme 7 Vulnerable Adults programme

This programme is an oral health training schedule for any staff or people who work with vulnerable adults, including older people and people with learning disabilities.

Target: Staff and carers from Care and Nursing Homes, Residential homes, Day centres for older cared for adults, adults with learning disabilities. District nurses, Adult speech and language therapists.

Programme 8 Vulnerable Adults Signposting programme

A poster campaign which aims to raise awareness of the signs and symptoms of oral cancer, and encourage early presentation.

Target: adults attending Health Centres, Pharmacists, Libraries.

Programme 9 Work programmes for vulnerable adults

A training programme delivered to adults with learning disabilities or adults who experience mental health problems. Each session is tailored to meet the needs of the participants

Target: vulnerable adults

Programme 10 Substance & Alcohol Misuse team oral health training

A training programme which aims to raise awareness of oral health issues pertaining to substance misuse and alcohol users. This includes

- Increasing knowledge of the oral health issues and barriers to accessing care, experienced by people that abuse alcohol/substances.
- Awareness of oral health messages
- Ability to provide tailored oral health information for clients
- Awareness of the early warning signs of oral cancers, and those groups who have an increased risk of developing the disease.
- Ability to signpost people to access dental care/out of hours emergency dental care.

Target: People who use Substance & Alcohol Misuse services and staff

Programme 11 Support National Campaigns

National Smile Month - May – June

Oral Cancer Awareness Month – November Stop

Smoking Campaigns

Supports other national events such as Parkinsons Week, Action on Stroke Month, Older People's Day and Alzheimer's Day.

Programme 12 Support Local Campaigns

Includes Stop Smoking events, NELFT Health and Wellbeing day, Autism Awareness Month/Day.

APPENDIX D - COMMISSIONING MAP FOR DENTAL SERVICES IN BARKING AND DAGENHAM

NHS England London region is responsible for the commissioning of all clinical dental services. They commission the following dental services:

- General dental services – high street dentists
- Community dental services – dental services for the vulnerable and people with special needs
- Out of hours urgent care dental services – dental services for evenings, weekends and bank holidays
- Primary care specialist dental services – dental services for people requiring complex endodontics (root canal), periodontics (gum disease) and prosthodontics (dentures, crowns and bridges)
- Hospital dental services

Local authorities are responsible for the commissioning of the following non- clinical oral health services

- Oral health improvement programmes
- Oral health surveys as part of local and national epidemiology programmes

APPENDIX E - CLINICAL GOVERNANCE

Dental care in Barking and Dagenham is provided by Dental Professionals who must be registered with the General Dental Council and meet their standards.

There are nine principles they must follow:

- Put patient's interests first
- Communicate effectively with patients □ Obtain valid consent
- Maintain and protect patients' information
- Have a clear and effective complaints procedure
- Work with colleagues in a way which is in patients' best interests
- Maintain, develop and work within professional knowledge and skills
- Raise concerns if patients are at risk
- Make sure personal behaviour maintains confidence in them and the profession

The Care Quality Commission inspectors use professional judgement, supported by objective measures and evidence, to assess dental services against five key questions:

C	Caring - staff involve and treat people with compassion, kindness, dignity and respect.
R	Responsive - services are organised so that they meet people's needs.
E	Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

W	Well-led - the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.
S	Safe - people are protected from abuse and avoidable harm.

Useful websites

General Dental council www.gdc-uk.org

Website details for British National Formulary and Children's British National Formulary <http://medicinescomplete.com/mc>,

Website details for Management of Dental Trauma www.dentaltraumaguide.org

Early detection and prevention of oral cancer https://www.bda.org/dentists/policy-campaigns/public-health-science/public-health/Documents/early_detection_of_oral_cancer.pdf#search=early%2520detection%2520and%2520prevention#

National Institute for Clinical Excellence <http://pathways.nice.org.uk>

Scottish Dental Clinical Effectiveness Programme <http://www.sdcep.org.uk/>

Faculty of General Dental Practice <http://www.fgdp.org.uk/>

Care Quality Commission www.cqc.org.uk

Appendix F – Oral Health Promotion Action Plan

No.	Area of work	Action	Who
1.	Parenting		
1.1		Provide oral health resource packs at antenatal classes in Children's Centres	Children's Services
1.2		Develop educational oral health programmes for parenting classes	Children's Centres
2.	Infancy		
2.1		Ensure oral health input into infant feeding guidelines	NELFT
2.2		Distribute free toothbrushes and toothpastes to every child in the borough at 8 months (to include weaning/drinking cups) and focus on children up to 2 years	Children's Services
3.	Pre-school		
3.1		Place an emphasis on parents through Children's Centres and other Early Years settings and promote the values of good oral health through knowledge and oral health behaviours and promoting self care	Children's Centres
3.2		Develop supervised tooth brushing protocol	NELFT
3.3		Supervised tooth brushing sessions targeted at special schools and areas in the borough where there is the greatest need	NELFT
3.4		Develop oral health booklet for pre-schoolers	Children's Services

3.5		Establish an accreditation process for early years settings that offer healthy food/snack policies and daily supervised tooth brushing	Children's Services
4.	School		
4.1		All schools offered opportunity to be involved in supervised tooth brushing programme	Education Services
4.2			
4.3		Develop oral health education resource for schools	PHE
5	Raising Awareness		
5.1		Develop communication plan to support National Smile Month and Mouth Cancer Awareness annual campaigns	Communications and Marketing
5.2		Actively participate in annual National Smile Month and Mouth Cancer Awareness annual campaigns, the British Dental Association's 'Make a meal of it' campaign (damage done to the oral health of children by sugary and acidic food and drink)	Communications and Marketing
6.	Training		
6.1		Conduct oral health workshops for all front line staff including early years settings	NELFT
6.2		Incorporate oral health input into early years training programmes provided in the borough	NELFT
7.	Vulnerable Groups		
7.1		Ensure the oral health needs of newly arrived children in the borough are identified and met through collaborative working	Children's Services
7.2		Ensure the oral health needs of looked after children in the borough are identified and met through collaborative working	Children's Services

7.3		Ensure the oral health needs of disabled children in the borough are identified and met through collaborative working	Children's Services
8.0	Older People		
8.1		Ensure that preventive packages are developed. Including older people living independently, in assisted housing and those in nursing and residential homes.	Adults Care and Support