APPENDIX B

Report of the
Health and Adult Services
Select Committee:
Oral health in early years:
Scrutiny Review 2017/18

Contact:
London Borough of
Barking and Dagenham
Scrutiny
Democratic Services
Law and Governance
scrutinyinbox@lbdd.gov.uk
In 2017/18, as the Chair of the Committee, I oversaw a small-scale scrutiny review into oral health in early years. Local authorities have a responsibility for improving health, including the oral health of their populations. One of the recommendations from the Oral Health Strategy of January 2017 was to focus on the oral health of children as it is inextricably linked with the general health of the child and with health inequalities.

We therefore chose to review oral health in early years, because it would offer the opportunity to look at how we can address dental disease early in the child’s life, where the greatest difference can be made, but also enables us to focus on the most deprived communities. This enables us to target resources where they are most needed.

We know that tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2013/14 and that despite some improvement in the figures, surveys undertaken in the last two years reveal the continued poor state of children’s dental health in the Borough, compared to the national picture. From 2016 figures we know that 1,200 children in Barking and Dagenham experienced dental disease; this can affect a child’s ability to eat, speak, socialise and learn normally, as well as causing distress and pain.

During the course of the review, the Committee had the opportunity to go out into the community and see and hear for themselves the experience of parents and to also meet staff in the field who were responsible for children’s oral health promotion. The committee heard about and witnessed the good work that professionals are doing on a daily basis to promote good oral health, but also learnt about the challenges parents face in regard to caring for their children’s teeth. The views of an expert were also sought, and it was useful for the Committee to meet with the Chair of the Local Dental Committee and discuss the salient issues and challenges.

We want Barking and Dagenham to become a place where a healthy lifestyle, including good dental health is normal from the start, and where people who want to make healthier lifestyle choices, are supported to do so. This report sets out the local picture for young children’s oral health and makes recommendations that involve multi-agency action to support parents and families and that seek to embed effective oral health promotion at the most important stages of children’s growth and development.

Councillor Peter Chand
Lead Member, Health & Adult Services Select Committee 2016/17 – 2017/18
Members of the HASSC 2017/18

The HASSC members who carried out this Review were:

Councillor P Chand  
(Lead Member)

Councillor A Oluwole  
(Deputy Lead Member)

Councillor S Alasia

Councillor J Jones

Councillor E Keller

Councillor H S Rai

Councillor L Reason  
Councillor C Rice  
Councillor J White
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Recommendations arising from this Review</td>
<td>1</td>
</tr>
<tr>
<td>1. Background to the Review</td>
<td>2</td>
</tr>
<tr>
<td>2. Scoping and Methodology</td>
<td>3</td>
</tr>
<tr>
<td>3. Introduction – Oral Health in Early Years</td>
<td>5</td>
</tr>
<tr>
<td>4. The Incidence of Dental Disease in Children in Barking &amp; Dagenham and Access to Services</td>
<td>9</td>
</tr>
<tr>
<td>5. Why are Children in Barking &amp; Dagenham more likely to have Dental Disease than Children in other London areas?</td>
<td>16</td>
</tr>
<tr>
<td>6. Next Steps</td>
<td>24</td>
</tr>
<tr>
<td>Thanks</td>
<td>25</td>
</tr>
</tbody>
</table>
List of Recommendations arising from this Review

For ease of reference, the recommendations arising from this Review are provided below.

The Health and Adults Services Select Committee (HASSC) recommends that:

1. The Health and Wellbeing Board (HWB) takes action to support an integrated approach to oral health promotion across all children's services and that contract specifications for all early years’ services include a requirement to promote oral health;

2. The Committee urges NHS England to actively support the teaming up of dentists with children’s centres to encourage engagement with dental services from an early age, so that dental disease can be detected early and children get used to going to the dentist;

3. The HWB is asked to monitor and report back on the progress of the oral health strategy, including the results of the ‘Teeth for Life’ (tooth-brushing) project;

4. The HWB supports action around food outlets, cafes and restaurants as part of the drive to decrease sugar consumption and improve oral health; for example, the ‘Sugar Smart’ campaign;

5. The Committee urges NHS England to implement the initiative proposed by the Chief Dental Officer and increase dental activity by 2%, so that dentists can see children at 1 year of age.

6. The Committee urges NHS England to actively support those dentists who underperform in activity to utilise their spare capacity to target young families to engage with their dental service;

7. The HWB, in collaboration with the British Dental Association, takes action to raise awareness of the importance of taking young children to the dentist and that it is a free service. This could include communication through images to help address the need for information in languages other than English

8. The Integrated Care Board look at the impact of dental emergencies on paediatric A & E attendance and challenge the system (Clinical Commissioning Groups) as to what is being done to address this.
1. **Background to the Review**

Why did the Health and Adult Services Select Committee (HASSC) choose to undertake a mini review on Oral Health in Early Years?

1.1 The Council’s scrutiny committees decide what topic to undertake a ‘mini’ review on based on the ‘PAPER’ criteria. The section below explains why according to these criteria, 'Oral Health in Early Years' was a good topic to review.

**PUBLIC INTEREST**

Although results of a national oral health survey of 3-year-old children in 2013 showed that oral health had improved compared to the 2010 survey, Barking and Dagenham still has worse oral health than the London and England averages. There is evidence to show that oral health in early years can negatively impact on oral health in later life, and therefore members agreed that this was an area of public interest.

**ABILITY TO CHANGE**

Members felt that oral health in early years was an area where the Committee could potentially add value by reviewing the reasons for poor oral health in early years, considering the quality of services available to residents to improve and treat oral health, and considering what further could be done to get the right messages out to parents and children about looking after children’s oral health.

**PERFORMANCE**

The 2013 survey showed that:

- 18% of Barking and Dagenham children had experienced dental disease (estimated to affect between 540 and 940 of 3-year-olds), compared with figures of 13.6% for London and 11.7% for England;
- Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2013/14
- In 2014/15 hospital trusts spent £35 million on extraction of multiple teeth for under 18s.

Based on the above data, members agreed that oral health in early years was an area where performance needed to be significantly improved.

**EXTENT OF THE ISSUE**

A national dental survey in 2015 found that almost one-third (31.4%) of five-year-olds had tooth decay in Barking and Dagenham

Based on 2016 mid-year population estimates, this equates to around **1,200 five-year-olds** in Barking and Dagenham having dental decay, if the proportion had remained constant since the survey.

**REPLICATION**

The HASSC members noted that there is an Oral Health Strategy, but that this review would seek to supplement that and not duplicate it, and also to ask the Health and Wellbeing Board to report back on the Strategy’s impact and progress.
2. **Scoping & Methodology**

2.1 This Section outlines the scope of the Review which includes the areas the HASSC wished to explore and the different methods the HASSC used to collate evidence for potential recommendations.

**Terms of Reference**

2.2. Having received a scoping report at its meeting on 20 September 2017, the HASSC agreed that the Terms of Reference for this Review should be:

i. What are the reasons for young children in Barking and Dagenham having poor oral health?

ii. What is the quality of services that are available to residents and what do they deliver to improve oral health?

iii. What are the best ways of getting the right messages out to parents about looking after their children’s oral health?

**Overview of Methodology**

2.3 The Review gathered evidence during the Committee’s meetings held between 20 September 2017 and 16 November 2017. Details of stakeholders and their contributions to this Review are outlined below.

**Presentation by Public Health on ‘Oral Health and Young People’**

2.4 On 20 September 2017, the Council’s Public Health team delivered a presentation which considered:

- 2010 oral health survey (Barking and Dagenham): three to four-year olds;
- 2013 oral health survey (national): three-year olds and five-year olds;
- Percentage of 5-year olds with experience of decay in North East London;
- Percentage of 3 and 5-year olds with experience of decay (local, London and England);
- Dental services and dental access;
- Percentage of children accessing dental services (by age and ward);
- Hospital admissions for dental extractions;
- Preventing dental decay in young children;
- Return on investment; and
- What is Barking and Dagenham doing?

**Meeting with Parents of young children and staff at Gascoigne Children’s Centre**

2.5 Members of the HASSC had a lively meeting with parents of young children and staff at Gascoigne Children’s Centre on 6 October 2017 to talk to them about their awareness of the importance of oral health in early years and their experience of accessing and using local dental services.
Meeting with pre-school staff at the Westbury Day Nursery

2.6 Members of the HASSC met with pre-school staff at the Westbury Day Nursery on 6 November 2017 and discussed with staff their perception of the support available to parents of young children to help them promote their child’s oral health.

Meeting with the Chair of the Local Dental Committee

2.7 On 16 November 2017 members met with the Chair of the Local Dental Committee to talk about the quality of dental health services for young children in the borough and what more local organisations could do to raise awareness of the importance of oral health in early years.

Research

2.9 During the Review, Council Officers considered the following pieces of research and evidence:

Improving Oral Health in Barking and Dagenham: Oral Health Promotion Strategy 2016-2020


Paediatric Dentistry Orthodontics
http://www.pediatricdentistryorthodontics.com

Institute of Dentistry, Barts and The London School of Medicine and Dentistry, Queen Mary University of London. The Oral Health of Three- Four-Year Old Children in outer North East London 2008 - 2010
3. Introduction – Oral Health in Early Years

What do we mean by Oral Health in Early Years and Why is it Important?

3.1 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 cavity. ¹

3.2 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 of 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.

3.3 There is a strong association between oral health and deprivation. According to the Faculty of Dental Surgeons report of 2015, the variation of tooth decay prevalence is particularly alarming among three-year-olds, with approximately 34 per cent affected in Leicester, compared with just 2 per cent in south Gloucestershire.

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

Figure 1 – anatomy of a tooth

¹ Public Health England 2014 Local authorities improving oral health: commissioning better oral health – An evidence-informed toolkit for local authorities
What can potentially happen as a result of poor Oral Health in Early Years?

3.5 Our mouths are full of bacteria; hundreds of different types live on our teeth, gums, tongue and other places in our mouths. Some bacteria are helpful. But some can be harmful such as those that play a role in the tooth decay process. Tooth decay is the result of an infection due to certain types of bacteria that use sugars in food to make acids.

When a tooth is exposed to acid frequently, for example, if you eat or drink often, especially foods or drinks containing sugar and starches, the repeated cycles of acid attacks cause the enamel to continue to lose minerals. Tooth decay can be stopped or reversed at this point. Enamel can repair itself by using minerals from saliva, and fluoride from toothpaste or other sources. But if the tooth decay process continues, more minerals are lost. Over time, the enamel is weakened and destroyed, forming a cavity. A cavity is permanent damage that a dentist then must repair with a filling.

Figures 2 and 3 show comparison between healthy teeth and tooth decay.

**Figure 2 – Normal teeth, gum and bone**

**Figure 3 – showing tooth decay**

3.6 Children’s primary (baby) teeth are more susceptible to decay than permanent (adult) teeth owing to differences in their chemical composition and physical properties. Primary teeth have thinner and often less resilient enamel that does not provide as much protection from bacteria.
Infants and toddlers’ primary teeth can 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 can spread rapidly to other teeth. ² (See Figure 4).

Dental caries in baby teeth often means dental caries in permanent teeth; this is because abscesses and infection in baby teeth can spread to the permanent teeth that are developing inside the gums. Also, during the course of tooth development, children will usually have permanent teeth sitting alongside baby teeth, so again, this increases the spread of decay from the baby teeth to the permanent ones. Where baby teeth have to be extracted because of decay, these children are more likely to develop orthodontic problems as the premature loss of primary teeth can affect the alignment of permanent teeth. Tooth misalignment makes it harder to adequately clean the teeth because food debris gets more easily trapped, thereby increasing the risk of tooth decay. Prolonged dummy or thumb sucking over a period of time can also cause misalignment of teeth.

**Figure 4 – Baby bottle tooth decay**

What should parents be doing to ensure good Oral Health in their children?

It is never too early to start looking after children’s’ teeth and adult dental problems almost always start in childhood, so the establishment of good routines in the early years are key to having healthy adult teeth. Such routines should be based around keeping sugary foods to the minimum and twice daily brushing by the parent/carer from the time that the first tooth appears, which is usually by the time the child has reached 1 year. A pea-sized amount of toothpaste should be used, and the child should be taught to spit out the excess toothpaste rather than rinse, so that the fluoride from the toothpaste stays in the mouth giving maximum protection for the teeth. This is also the right time to start taking a child to the dentist, so that the progress of the baby teeth can be monitored, and the dentist can keep a check for the onset of any dental decay.

² RCS Faculty of Dental Surgery 2015: The state of children’s oral health in England
All the baby teeth, which are 20 in total, will have usually erupted by the time a child is about 3 years old, but it is a process that varies greatly between children. (See Figure 5 below).

**Figure 5 – Diagram showing complete set of First Teeth**

<table>
<thead>
<tr>
<th>Baby Teeth</th>
<th>Age Tooth Comes In (months)</th>
<th>Age Tooth Is Lost (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upper Teeth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Incisor</td>
<td>9.6</td>
<td>7.0</td>
</tr>
<tr>
<td>Lateral Incisor</td>
<td>12.4</td>
<td>8.0</td>
</tr>
<tr>
<td>Canine (Cuspide)</td>
<td>18.3</td>
<td>11.0</td>
</tr>
<tr>
<td>First Molar</td>
<td>15.7</td>
<td>10.0</td>
</tr>
<tr>
<td>Second Molar</td>
<td>26.2</td>
<td>10.5</td>
</tr>
<tr>
<td><strong>Lower Teeth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Molar</td>
<td>26.0</td>
<td>11.0</td>
</tr>
<tr>
<td>First Molar</td>
<td>15.1</td>
<td>10.0</td>
</tr>
<tr>
<td>Canine (Cuspide)</td>
<td>18.2</td>
<td>9.5</td>
</tr>
<tr>
<td>Lateral Incisor</td>
<td>11.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Central Incisor</td>
<td>7.8</td>
<td>6.0</td>
</tr>
</tbody>
</table>
4. The Incidence of Dental Disease in Children in Barking & Dagenham and Access to Services

Members received information on the extent of dental disease in children in the Borough and how it compares with the incidence of dental disease nationally and London, which is discussed in this Section.

Oral Health Survey 2010

4.1 An oral health survey of nearly 1000 three to four-year-old children living in Barking and Dagenham, Redbridge and Waltham Forest was undertaken by the Institute of Dentistry; Barts and The London School of Medicine and Dentistry, and Queen Mary, University of London in 2008 - 2010.

4.2 Figure 7 shows results from the survey in 2010 which found that 28% of three and four-year olds in Barking and Dagenham 2010 had dental disease.

Figure 7

<table>
<thead>
<tr>
<th>Proportion of three and four-year-olds with dental disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>No dental disease</td>
</tr>
<tr>
<td>72%</td>
</tr>
</tbody>
</table>

Of those children with dental disease, approximately 91% had disease that was untreated.

4.3 As well as comparisons between boroughs and genders, the survey also looked at comparisons between ethnic groups. With regard to tooth decay, the survey found that 30.49% of Asian children had experienced dental decay, compared to 24.39% of white children and 23.11 black children. In terms of sugar consumption, greater numbers of Asian children exceeded The World Health Organisation’s (WHO) daily sugar intake recommendation, compared to black or white three-four-year old...
children and additionally, the parents of Asian children were more likely to report toothbrushing less than twice a day than the parents of White children or Black children.

A 2016 report on the prevalence and severity of dental decay in 5-year olds by Public Health England continued to show that nationally, Asian children at five years of age had an average of 1.5 decayed teeth in comparison to an average of 0.7 decayed teeth in White and Black children, as shown in figure 8 below.

**Figure 8**

**Rates of tooth decay by ethnicity among children**

- **Asian**
  - Experience of dental decay: **30.49%**
  - Average decayed teeth at 5 years: **1.5**

- **White**
  - Experience of dental decay: **24.39%**
  - Average decayed teeth at 5 years: **0.7**

- **Black**
  - Experience of dental decay: **23.11%**
  - Average decayed teeth at 5 years: **0.7**


**Oral Health Survey 2013**

4.4 A survey amongst three-year old children in 2013 showed that dental health in Barking and Dagenham had improved on the 2010 figures. However, as Figure 9 shows it was still worse compared to children’s dental health in London and England. The graph shows that 18% of Barking and Dagenham children had experienced dental disease, compared with figures of 13.6% for London and 11.7% for England.
Figure 9

% of 3-year olds with tooth decay


2015 Oral Health Survey

4.5 Members were informed that a national dental survey in 2015\(^3\) found that almost one-third (31.4%) of five-year-olds had tooth decay in Barking and Dagenham.

As figure 10 shows, this was significantly higher than England (24.7%), but not London (27.2%)

Based on 2016 mid-year population estimates, this would equate to around **1,200 five-year-olds** in Barking and Dagenham having dental decay, if the proportion has remained constant since the survey.

9.9% of five-year-olds in Barking and Dagenham (compared with 8.2% in London and 5.6% in England) experience an aggressive form of dental decay.

---

Comparison figures of dental decay in 3 and 5-year-olds

4.6 Members were informed about the rise of dental decay between the ages of 3 and 5 years.

Figure 11 shows comparison figures for dental decay in three and five-year olds in the Borough, in comparison to London and England. In each case it shows that decay rises quite significantly between the ages of 3 and 5 years of age.

Figure 12 shows the incidence of decay in five-year-old in Barking and Dagenham, as compared to other areas in North East London.
Figure 11


Figure 12

Accessing Local Dental Services

4.7 Barking and Dagenham has 57 dentists per 100,000 population, more than both London and England. There are 27 dental practices including community/special care dental clinics. There are also more units of dental activity (UDA)* per 100,000 population (168,123) compared with London (142,365) and England (158,977). 45.5% of children resident in Barking and Dagenham accessed dental services in the 12 months to March 2017. This figure is similar to London (see figure 13 below).

Figure 13

![Bar chart showing percentage of children accessing dental services by age in Barking and Dagenham and London.](image)

Source: NHS Digital 2017

Other Available Sources of Advice

The Barking and Dagenham Oral Health Promotion Strategy identified the following sources of advice that are currently available to families in the Borough:

4.8 Early Years – Children Centres and Nurseries promoting good oral health

These centre programmes target families attending children’s centres and children’s centre staff, and involve a variety of oral health initiatives that facilitate the national drive to reduce dental disease among children. The 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.

---

* Improving Oral Health in Barking and Dagenham: Oral Health Promotion Strategy 2016-2020
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 (OHCs) that will be assigned to individual children’s centre/cluster/managers.

OHCs 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 General Dental Practitioners (GDP)/community dental service;
- Oral health sessions, displays/campaigns for the centre; and
- Working with clinical teams to arrange outreach check-up programmes for all red and amber families and signposting green families to GDP.

4.9 Early Years Training Programme:

The training programme facilitates the national drive to reduce early onset of dental disease among children using people who work with early years and aims to target Health Visitors, School Nursing Teams, Children Centres, Community/Nursery Nurses, Foster Care and Child Minder Leads.

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; and
- Apply information learnt to promote oral health within their work role.

4.10 Teeth for Life Project

This is a pilot, commissioned by Public Health, which will run for a year to help teach pre-school children the importance of tooth brushing and how to brush properly. Sixty-one pre-schools/day nurseries have agreed to take part in the programme whereby toothbrushes and toothpaste are supplied for each child. Staff at each of the participating centres have been given training so that they can implement the programme correctly.

There are about three pre-schools not taking part; reasons were to do with their capacity to take on a new project and others were concerned about how they would manage the toothbrushing as they had large numbers of children attending their setting. However, these pre-schools may engage in the project at a later stage.

Health visitors are also involved in supporting the project, but already undertake oral health promotion as part of their contact with families when children are one year old and two and a half years old; this includes the handing out of a baby toothbrush. Parents are encouraged to refer to the red child health book and
complete the pages where they can mark off that their child’s teeth have come through. Health visitors are also responsible for families who are not registered with a GP and who are living in the area temporarily, which may include those in hostel accommodation and other places of residence that are temporary or transitory.
5. Why are Children in Barking & Dagenham more likely to have Dental Disease than Children in other London areas?

5.1 This section discusses the possible reasons behind why the rates of dental disease are higher in the borough than the London and national averages.

5.2 Members found that there are a variety of factors that are likely to be contributing to a high burden of dental disease in early years in Barking and Dagenham because of what we already know about the health demographics in the Borough; but also by what was evidenced by their visits to the Children’s Centre and the Day Nursery, and meeting with the Chair of the Local Dental Committee. Below we discuss in further detail, members’ findings from these visits.

Visit to Gascoigne Children’s Centre to meet with Parents and Staff

5.3 Members of the HASSC scrutinised the experience of children in the borough through their parents and Children Centre staff. Below we highlight some of the statements made (by staff and parents) during this session which gave members an indication of the key issues that may be contributing to poor oral health in early years in the borough.

Key messages from the Visit

There was some lack of awareness or understanding about how best to look after children’s teeth: for example,

- The importance of taking care of baby teeth, fuelled by the myth that these are going to fall out anyway, so they do not really matter; as one parent remarked -

  'Looking after milk teeth isn’t important as they fall out'.

- The importance that diet plays in promoting healthy teeth and about the factors that increase the risk of tooth decay.

- The importance of providing a healthy diet, limiting sugary food and drink and especially not giving milk in bottles at night: as one member of staff commented -

  'One message that still does not appear to have been made clear is the negative impact of bottle feeding children milk at night whilst they are sleeping – that the sugars from the milk can cause tooth decay.'
• The importance of taking your child to the dentist from an early age;
• That visits to dentists are free for children and for the mother during pregnancy and for a year after having a baby; some parents commented -

'Going to the dentist is expensive!'

'I think there should be an oral health week and businesses should be encouraged to attend our malls and centres to give out advice and free check-ups for parents and children.

• The importance of brushing twice a day from a very early age and the importance of routine. As evidenced from talking to the Children’s Centre staff, a significant proportion of families lack routines with their children and this affects the care of teeth: for example children may fall asleep before the parent or carer gets round to brushing their teeth, or if the children resist teeth brushing, the parent may leave it to avoid conflict. It is one of the aims of Children Centre staff to help and encourage families to establish routines and thereby include dental care as part of that, but staff cannot reach those families who do not engage with the centres. As staff remarked -

'We find that the parents who struggle to establish a routine for their children seem least equipped to support their child’s oral health. It is very important for services to advise parents of the importance of establishing a routine for their child to provide normality and wellbeing for the child.'

There was also strong consensus amongst the Centre staff that health visiting staff should discuss the importance of oral health with parents from the outset and give advice on when to take the baby to the dentist and how to look after his or her teeth when they emerge. Staff commented -

'Health clinics are crucial as at this stage parents are very receptive to new messages. The majority of parents want to speak to the health visitor and even the most vulnerable will attend these clinics.'
5.4 Members took from this session that that:

**Knowledge and attitude toward teeth:**
- Some parents think caring for milk teeth isn’t important as the teeth will fall out
- Some parents think that taking their children to the dentist will be expensive – when it is free
- Some parents avoid conflict by not being firm in requiring their children to brush their teeth.

**Knowledge about and attitude towards dentists:**
- For some parents, there still exists a ‘dread’ factor in going to the dentist, often borne from their own childhood experience which they then pass on to the child.

**Healthy Eating:**
- Evidence suggests that in certain sectors of the local population, such as certain Asian communities, some foods that have a significantly high sugar content are consumed as part of normal diet and there may be a lack of awareness about just how badly these can affect children's teeth.

**Borough Demographics**
- Demographic changes in the borough, which include a transient population, has meant that there is a significant proportion of families that face a range of very challenging circumstances (housing problems or domestic violence, for example), who may not always engage with services that can help them; and
- There will be families who are being housed in hostels around the borough and who may lack the resources to care for their children's teeth adequately. This is a continuing challenge and there is further work to be done on how we effectively engage and support those families who are the most vulnerable in the borough, particularly as we seek to realise the Borough Manifesto of ‘No-One Left Behind’.

Recommendations arising from this session are as below.

**RECOMMENDATION 1**
The Committee recommends that the Health and Wellbeing Board takes action to support an integrated approach to oral health promotion across all children's services and that contract specifications for all early year’s services include a requirement to promote oral health; this should include very early oral health promotion by health visitors to help prevent tooth decay from sweetened dummies, prolonged use of milk in bottles and other sweet foods.
RECOMMENDATION 2
The Committee recommends that NHS England actively supports the teaming up of dentists with children’s centres to encourage engagement with dental services from an early age, so that dental disease can be detected early and children get used to going to the dentist.

Visit to the Westbury Day Nursery to meet with Pre-School Staff

5.5 Members of the HASSC scrutinised children’s experience of pre-school in a meeting with pre-school staff. They met to discuss their experiences of oral health in early years and consider the advice given by the Centre.

Key messages from the Visit

- The nursery encourages oral health as part of a broader health promotion focus, for example- healthy eating, no sweets or fruit juice, and only water and milk;

- Most parents react positively to this approach but not always – sometimes children are sent with biscuits for breakfast or some are sent with bottles. Staff have to educate the parents rather than the children;

- Some parents react with cringing at the mention of dentists, so obviously some people hold personal feelings which may affect their attitudes towards dental care.

- Only 2/3 parents said they didn’t want their children taking part in the tooth brushing project.
The recommendations arising from this session are as below.

RECOMMENDATION 3
The Committee recommends that the Health and Wellbeing Board monitors and reports back on the progress of the oral health strategy, including the results of the ‘Teeth for Life’ (tooth-brushing) project.

RECOMMENDATION 4
The Committee recommends that the Health and Wellbeing Board supports action around food outlets, cafes and restaurants, as part of the drive to decrease sugar consumption and improve oral health; for example, the ‘sugar smart’ campaign.
Meeting with the Chair of the Local Dental Committee

5.6 Members of the HASSC met with the Chair of the Local Dental Committee, Mr Bhawnesh Liladhar to discuss the potential reasons for poor oral health in early years in the Borough and what more can be done to address the causes.

Key messages from the Meeting

- **Often, the first visit to the dentist is when child is in pain, so negative association with dentists is made that endures;**

- **The current dental NHS contract provides no incentive to increase activity and provide for more patients, once the stipulated contract activity is achieved;**

- **But there are dentists in the borough who have not completed their contract activity;**

- **The possible reasons for higher rate of decay in Asian children is a lack of awareness in the community of importance of good oral care habits and diet is often higher in sugar than in other communities;**

- **The new Chief Dental Officer has proposed an initiative to increase the NHS contract value by 2% allocated for seeing children at 1 year specifically;**

- **A potential way to encourage dentists who have not completed their contract activity level is to twin these practices with children’s centres so that they can provide preventative advice to parents and treat children where necessary;**

- **Borough demographics have changed a lot over past decades and English may not be the first language. This combined with fear means people don’t go or take their children to the dentist.**
5.7 Members noted that approximately 45% of the population do not visit the dentist as often as they should. Often, the child’s first visit to the dentist is when they are in pain, which is not the best time as this is when they will need treatment. The single most common reason for the hospital attendance by children aged between five and nine is tooth decay, which is indicative of how much prevention work there is to do and how much extra is being spent, which could be avoided.

5.8 The national contract, commissioned by NHS England, is set up in a way that limits the numbers of patients that can be seen each year by dentists who hold NHS contracts. The outcome of this is that if a dental service sees more that the numbers of allocated patients they will not receive payment for this. As dental surgeries are small businesses this could have knock on effects for keeping the service running and employing staff. In LBBD there are some dentists that do not achieve the amount of activity that has been set for them, so there is potential for teaming these dentists up with Children’s Centres or schools and thereby increasing their activity.

5.9 Mr Liladhar informed the Members that the new Chief Dental Officer has proposed to the Government that increasing the NHS contract value by 2% could increase dentists’ capacity and enable them to see children at the age of 1 year, as has been recommended by NICE and which is supported by dentists nationally.

5.10 In answer to why Asian children have a higher rate of tooth decay than other children (see section 4.3), Mr Liladhar commented that people from the Asian communities are much less likely to visit the dentist; only doing so, if they are in pain. The survey of 2010\(^5\) did provide some evidence of this in that the percentage of Asian children who last visited a dentist in response to a dental problem was higher than Black or White children. There may be a lack of awareness of what constitutes good oral care habits in this community, for example, many parents do not brush their teeth at night (when evidence shows that doing so is very important), and these habits are then passed on to children. Furthermore, the diet in these communities can be very high in sugar so the combination means a greater incidence of dental decay in these children.

5.11 Mr Liladhar commented that in his experience, it can be a challenge to get information across to communities for whom English is not the first language. People may not understand that they are entitled to free dental care and other benefits. This issue is further complicated if residents need a translator at a dentist, they must pay themselves. Sometimes the parent asks their child to translate, which is not ideal as the dentist cannot always have confidence that everything has been translated correctly, and that they have the required consent. There are information leaflets in some dental practices, but these are all in English.

5.12 Mr Liladhar commented oral health in early years has improved over the years but this can be attributed to the promotion of fluoride toothpaste; dentists have more of a preventative role to play, if they can get families to attend their practices.

5.13 Finally, Mr Liladhar commented that the level of poverty and deprivation in Barking and Dagenham is a key factor in the oral health of children in the borough, in terms of lack of awareness and lack of engagement with dental services.

\(^5\) Institute of Dentistry, Barts and The London School of Medicine and Dentistry, Queen Mary University of London. The Oral Health of Three- Four-Year Old Children in Outer North-East London 2008 - 2010
This session led members to recommend that:

**RECOMMENDATION 5**
The Committee recommends that NHS England implement the initiative proposed by the Chief Dental Officer and increase dental activity by 2%, so that dentists can see children at 1 year of age.

**RECOMMENDATION 6**
The Committee recommends that NHS England actively support those dentists who underperform in activity to utilise their spare capacity to target young families to engage with their dental service.

**RECOMMENDATION 7**
The Committee recommends that the Health and Wellbeing Board, in collaboration with the British Dental Association, takes action to raise awareness of the importance of taking young children to the dentist and that it is a free service. This could include the provision communication through images to help address the need for information in languages other than English.

**RECOMMENDATION 8**
The Committee recommends that the A & E Delivery Board look at the impact of dental emergencies on paediatric A & E attendance and challenge the system (CCGs) as to what is being done to address this.
6. Next Steps

6.1 This report and its recommendations will be submitted to the Health and Wellbeing Board and relevant health partners, who will decide whether to agree the recommendations. An action plan will be drawn up describing how the recommendations will be implemented. In approximately six months’ time, a monitoring report explaining the progress of the implementation of the recommendations and whether anything could be said of the early impact they have had will be produced.
The HASSC would like to extend its thanks to the following for contributing to this Review:

- The Early Intervention Worker, Locality Manager and Senior Locality Manager at Gascoigne Children’s Centre;
- Mr B Liladhar, Chair of the Local Dental Committee; and
- The Nursery Manager and Early Years Advisory Teachers at the Westbury Day Nursery

Members also thank the following Council officers for their support during this Review:

- Mary Knower: Public Health Strategist
- Masuma Ahmed: Democratic Services Officer