Health and Wellbeing Board

26 July 2016

Draft Oral Health Strategy For County Durham

Report of Gill O'Neill, Interim Director of Public Health, Children and Adults Services, Durham County Council

Purpose of the Report

1 The purpose of this report is to present the Health and Wellbeing Board with the draft County Durham Oral Health Strategy for agreement prior to wider public consultation. The draft strategy is attached as Appendix 2.

Background

2 The National Institute for Health and Care Excellence (NICE) Public Health 55 Guidance makes 21 recommendations to improve the oral health of our communities. The first recommendation is the development of a stakeholder group that in turn will assist in the development of a strategy to deliver the majority of the other recommendations. The oral health strategy group has been established and has developed an oral health strategy.

Oral health strategy development

3 There are 21 recommendations within the NICE guidance. These recommendations have been mapped at a high level by the oral health strategy group to consider whether they are being met across County Durham.

4 It is essential at a time of austerity that a new strategy and action plan is designed which is deliverable within existing resources and includes thinking differently and working more smartly by pooling resources.

5 The 21 recommendations can be applied to a 'settings based' approach. The strategy sets out the intentions for how the oral health strategy and action plan will be pragmatically applied by working with existing partners and stakeholders to embed oral health over the next three years.

6 Whilst the oral health strategy is developed and implemented, work is ongoing in partnership with Public Health England (PHE) to explore the possibility of water fluoridation. At this point in time PHE is awaiting feedback from Northumbrian Water around the water quality zones (the geographic measure used by the water industry) and the potential locations for water fluoridation plants.

Consultation

7 The consultation process will seek the views of key stakeholders across County Durham.

Next steps

8 Subject to approval by the Health and Wellbeing Board, this strategy will be available from 1st August 2016 for six weeks. The strategy will also seek the views of key partnership groups and Overview and Scrutiny Committees. A consultation timeline is included at Appendix 3.

Recommendations

9 The Health and Wellbeing Board are requested to:

- Agree the Draft Oral Health Strategy for wider consultation.

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Appendix 1: Implications

Finance: Identified from Public Health reserves. Feasibility study into fluoridation may also include contributions from NHS England.

Staffing: None

Risk: Timeline for fluoridation feasibility study given the complex technical challenges and stakeholder opinion surrounding the activity.

Equality and Diversity / Public Sector Equality Duty: Efforts will be made to tackle inequalities in oral health through targeted and focused interventions at specific population groups based on identified need.

Accommodation: N/A

Crime and Disorder: N/A

Human Rights: N/A

Consultation: Oral Health Strategy will be consulted upon. Consultation not required for feasibility study.

Procurement: DCC to commission targeted interventions and oral health promotion supplies.

Disability Issues: SEND schools will be targeted as part of any programme aimed at children. This will be delivered in partnership with the oral health promotion team who currently have a remit to work in this setting.

Legal Implications: Linked to procurement. Linked to the legislative process surrounding fluoridation, for which, PHE are providing guidance.

Oral Health Strategy

County Durham

2016-2019

DRAFT

Aim of Oral Health Strategy

1. To reduce the population prevalence of dental disease – and specifically levels of dental decay in young children and vulnerable groups.
2. To reduce the inequalities in dental disease.
3. To ensure that oral health promotion programmes are evidence informed and delivered according to identified need.

Background

Oral health is important for general health and wellbeing. Poor oral health can affect someone's ability to eat, speak, smile and socialise normally, for example due to pain or social embarrassment[1]. Oral health problems include gum (periodontal) disease, tooth decay, tooth loss and oral cancers. Many risk factors – diet, oral hygiene, smoking, alcohol, stress and trauma are the same as for many chronic conditions, such as cancer, diabetes and heart disease.

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. While children's oral health has improved over the last twenty years, almost a third (27.9%) of five year olds still had tooth decay in 2012[2]. Children who have toothache or who need treatment may have to be absent from school. Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012 – 13. Dental treatment under general anaesthesia presents a small but real risk of life threatening complications for children[3].

People living in deprived communities consistently have poorer oral health. However, it is noted that deprived areas with fluoridated water have better oral health than comparator communities without fluoridated water.

Vulnerable groups in society are also more likely to suffer from poor oral health. NICE guidance[4] identifies a list of vulnerable groups who require specific support to improve their oral health. These include those who are:

- Socially isolated
- Older and frail
- Physical or mental disabilities
- From lower socio economic groups

[1] NICE 2014 Oral health: approaches for local authorities and their partners to improve the oral health of their communities PH55 NICE
[2] PHE 2014 commissioning better oral health for children
[3] PHE 2014 commissioning better oral health for children
[4] NICE 2014 Oral health: approaches for local authorities and their partners to improve the oral health of their communities PH55 NICE

- Live in disadvantaged areas
- Smoke or misuse substances (including alcohol)
- Have a poor diet
- Some Black, Asian and minority ethnic groups
- Who are, or who have been in care

Diseases affecting the oral cavity

The mouth is affected by diseases such as dental caries and periodontal disease and other conditions, such as trauma, mouth cancer and developmental abnormalities, all of which can have an adverse effect on an individual's wellbeing.

Dental caries (tooth decay)

Dental caries is the most common disease of the dental tissues and affects the majority of the population. It is caused by bacteria in the mouth utilising sugars in the diet as a source of food and producing acids as a by-product. The acids dissolve away the tooth substance leading to dental decay, abscess formation and eventually tooth loss.

There is substantial evidence to show that people from socially deprived backgrounds experience considerably more dental disease than other members of the population due to lack of opportunities that would enable them to improve their oral health. The main issues are poor diet and limited access to fluorides and dental care.

Periodontal disease

Periodontal disease affects the structures which support the teeth; these are the tissues and ligaments which secure the teeth to the jaw bones. This disease is caused by a build-up of plaque around the teeth leading to the development of inflammation. The gums become swollen and bleed spontaneously. In susceptible individuals the disease progresses by destroying the supporting structures of the teeth, the teeth become loose and if unchecked the disease results in tooth loss.

Trauma

Teeth may be traumatised as a result of accidents and participation in contact sports. The upper incisor teeth are at greatest risk and experience most damage.
The most recent data for England was published in March 2015[5] using a survey of 15 year olds which found the proportion of 15 year olds affected is very similar across the three countries (England, Wales, Northern Ireland), at around 4% of the

[5] Children's dental health survey 2013, Health and social care information centre, March 2015

population and there are no significant differences related to sex, free school meals, brushing or school attendance.

Mouth cancer

Mouth cancer is the major fatal condition which affects the oral tissues. There is a high risk of developing mouth cancer in people who smoke and those who consume excessive amounts of alcohol.

Developmental abnormalities of the oro-facial tissues

Although not the result of disease processes, defects in the development of oral tissues and facial skeleton may result in teeth being displaced sufficiently that the malocclusion produced impacts on oral health. Significantly adverse alignment of children's teeth makes them more susceptible to physical disease, trauma and also impacts on personal appearance, leading to potentially low self-esteem. There are a large number of rare genetic conditions which affect the teeth and facial skeleton. The most common are clefts of the lip and/or palate.

Roles and responsibilities for oral health

With the fragmentation of the NHS in April 2013 the responsibility for dental services and oral health dispersed across various organisations. The table below briefly highlights which local organisations have responsibility for which parts of the system.

Table 1: Local organisations roles and responsibilities

Organisation	Key responsibility
NHS England (Area Teams)	Commissioning all NHS dental services – both primary and secondary care Direct and specialised commissioning
Public Health England (centres)	Provide dental public health support to NHS England and Local authorities Contribute to JSNAs, strategy development, oral health needs assessment Supporting local authorities to understand their role in water fluoridation
Local authorities (Public Health)	Jointly statutorily responsible for JSNA Conducting and/or commissioning oral health surveys to monitor oral health needs to an extent that they consider appropriate in their areas Planning, commissioning and evaluating oral health improvement programmes Leading scrutiny of delivery of NHS dental services

Local dental networks	Providing local professional leadership and clinical engagement
Provider services	County Durham and Darlington Foundation Trust hold a block contract for dental services which includes the oral health promotion team

National recommendations

Within the latest public health NICE guidance 'Oral health: approaches for local authorities and their partners to improve the oral health of their communities', there are 21 recommendations for health and wellbeing boards to consider. Table 2 below provides a list of the recommendations

Table 2: NICE recommendations

Recommendations
1. Ensure oral health is a key health and wellbeing priority 2. Carry out an oral health needs assessment 3. Use a range of data sources to inform the oral health needs assessment 4. Develop an oral health strategy 5. Ensure public service environments promote oral health (e.g. plain drinking water available, healthy vending options, promoting breastfeeding etc.) 6. Include information and advice on oral health in all local health and wellbeing policies 7. Ensure front line health and social care staff can give advice on the importance of oral health 8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health 9. Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health 10. Promote oral health in the workplace 11. Commission tailored oral health promotion services for adults at high risk of poor oral health 12. Include oral health promotion in specifications in all early years services 13. Ensure all early years services provide oral health information and advice 14. Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health 15. Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health 16. Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health 17. Raise awareness of the importance of oral health as part of 'whole school' approach in all primary schools 18. Introduce specific schemes to improve and protect oral health in primary

schools in areas where children are at high risk of poor oral health
19. Consider supervised tooth brushing schemes in primary schools in areas where children are at high risk of poor oral health
20. Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health
21. Promote a whole school approach to oral health in all secondary schools

Fluoridation

Fluoride has made an enormous contribution to the decline in dental caries over the past 60 years since research in the United States discovered that people living in an area of naturally fluoridated water had much better dental health than those who did not and, furthermore, water fluoridated at a concentration of 1 part per million did not cause significant mottling of the teeth (dental fluorosis) nor any other health related adverse effects. Fluoride produces an effect on the teeth in a number of ways that combine to slow and help prevent the decay process.

There is compelling evidence that fluoride is effective in reducing decay and that water fluoridation is the most effective way of using fluoride to reduce decay. Other fluoride interventions, such as fluoride toothpaste and fluoride varnish, are also important, effective ways of reducing tooth decay and there is an even greater reduction in decay levels when, for example, fluoride toothpaste is used together with water fluoridation. Consequently this oral health strategy for County Durham includes due consideration of water fluoridation as part of a series of oral health promotion initiatives – including other fluoride based interventions and initiatives aimed at improving diet and nutrition.

Fluoride tooth brushing schemes

The use of fluoride toothpaste has been shown to reduce levels of dental decay by 37% and the increased use of fluoride toothpaste has been largely responsible for the reductions in dental decay that have been observed over the last 20-30 years.

Published research has indicated that supervised tooth brushing schemes are effective in reducing levels of dental decay and that there remains a significant reduction in decay levels between children in test and control groups at 30 months after the programme ended.

Evidence also shows that the introduction and uptake of a tooth brushing program contributed positively to the dental health of children and reduced dental health inequalities.

Tooth brushing schemes are to be established in targeted early year's day care facilities in County Durham whilst promoting dental registration with families through universal health visitor services.

Fluoride varnish

Fluoride varnish is one of the best options for increasing the availability of topical fluoride, regardless of the levels of fluoride in the water supply. High quality evidence of the caries-preventive effectiveness of fluoride varnish in both permanent and primary dentitions is available and has been updated recently. A number of systematic reviews conclude that applications two or more times a year produce a mean reduction in caries increment of 37% in the primary dentition and 43% in the permanent. Schemes will be explored during the implementation of this strategy.

County Durham: oral health current picture

Access to dental services

A study on access to dental services carried out in 2010/11 (most recent data available) showed significant variations across the wards in the county with populations living in the poorest wards having the lowest uptake.

Perceptions surveys have been undertaken to understand why adults do not register with dentists. Two of the most significant barriers include complexity of the forms to fill in and dentist phobias.

NHS England is leading a review of the national general dental contract. Part of the consultation is regarding how primary dental health services can deliver more on oral health promotion activities and reduce oral health inequalities. The outcomes of the consultation are awaited.

Oral health status

Children: Data from the last large scale dental survey (2012) of five year old children's oral health in County Durham shows wide variations in dental disease experience between different wards, from 61% of children having had decay experience in Woodhouse Close (Bishop Auckland) to just 6% in Chester-Le-Street South. This highlights a need to narrow the gap in oral health inequalities. Oral health of five year olds is part of the children's public health outcomes framework.

Adults: There are no regular local surveys undertaken of adult dental health at a local authority level. The best data available is from the last national adult health survey which took place in 2009. The smallest geography available is at a North East level. The survey showed that 92% of the North East population had some teeth. 82% had 21 or more teeth which is the limit allowed by dentists to

demonstrate functionality. 65% of North East residents participating in the survey reported regular dental attendance above the England average of 61%.

Elderly population: With an aging population, the increase in dementia and older people retaining their teeth, there is a need to consider how the oral health of this growing vulnerable population will be managed. The challenge this group presents is the support required to maintain their oral health and how health and social care provide supportive environments to maximise their oral health and avoid unnecessary and expensive dental treatment. A recent local evaluation completed within County Durham care homes[6] has identified the complex oral health care needs of those living in residential care. The system must come together to support this vulnerable group and reduce escalating costs which are preventable.

Partnerships and governance

The development of this strategy has been led by a multi-disciplinary steering group consisting of members of the local dental network, paediatrician, dental anaesthetist, Durham County Council children's services, health visiting services, Durham County Council commissioning for adult services, public health and Public Health England.

There has also been a consultation process to ensure the views of stakeholders have been taken into consideration.

The Oral Health Steering Group is accountable to the Children and Families Partnership and the Health and Wellbeing Board.

Outcome measures for strategy

Percentage improvement: child population averages for decayed, missing and filled teeth, proportion of children with no decay experience.

Challenges going forward

The gap in oral health inequalities between children living in deprived communities and those in less deprived communities needs to reduce. Targeted work must also continue with vulnerable groups such as those with poor physical and mental health and the frail elderly population.

Due to the overlap with other health promotion messages for many other preventable conditions, such as diabetes, there is benefit in combining approaches and making sure oral health is embedded into other health promotion work rather than a stand-alone topic.

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[6] Ahmad, B., 2015 oral health care provision for the elderly in residential care homes in County Durham: An evaluation of need and strategy document

The strong and newly emerging evidence[7] regarding the impact on sugar on the obesity epidemic is an opportune time to combine efforts on tackling obesity and oral health inequalities.

The 21 NICE recommendations can be applied to a 'settings based' approach. The remainder of this strategy sets out the intentions for how the oral health strategy will be delivered practically by working with existing partners and stakeholders to embed oral health over the next three years while we remain committed to progress the feasibility of fluoridation.

The first four NICE recommendations refer actions already underway such as the development of a strategy and reviewing the available epidemiological data.

Action Plan

Early years settings ACTION	**Lead**	**Timeline**	**NICE Recommendations**
1. Increase breast feeding initiation by 5% 2. Increase breastfeeding at 6 – 8 weeks by 5% 3. Breastfeeding friendly venues – UNICEF accreditation maintain status 4. Increase dental registration in families in 30% most deprived MSOAs 5. Plain drinking water in public sector venues is main drink available 6. Provide a choice of sugar free foods – including vending machines 7. Oral health part of early years strategy			5. Ensure all public service environments promote oral health 6. Include information on oral health in local health and wellbeing policies 7. Ensure frontline health and social care staff can give advice on the importance of oral health 8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health 12. Include oral health promotion in specifications for all early years services 13. Ensure all early years

[7] Public Health England, 2015. Sugar Reduction 'The evidence for action'

8. Training on oral health promotion given to front line practitioners 9. Targeted oral health promotion work for vulnerable groups: SEND and vulnerable parent pathway 10. Align dental practices to children centre cluster areas 11. Deliver and evaluate a three year tooth brushing scheme in targeted nurseries, working with local dental network			services provide oral health information and advice 14. Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health 15. Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health

Primary school setting (age 5 – 11 years) ACTIONS	**Lead**	**Timeline**	**NICE Recommendation**
1. Increase number of schools following national school food plan: ensure plain drinking water available and sugar free snacks 2. Encourage schools to include oral health as part of the curriculum – PSHE resources easily available 3. School Nurses to promote dental registration at parent sessions 4. Local dental network (LDN) to establish 'pop up' dental clinics' within schools			17. Raise awareness of the importance of oral health, as part of a 'whole school' approach in all primary schools 18. Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at risk of poor oral health 19. Consider supervised tooth brushing schemes for primary schools in areas where children are at high risk of poor oral health

to increase dental check-ups and dental registrations 5. Oral health promotion team to work with special schools through the academic year 6. Training sessions delivered to special school support staff on oral hygiene and health promotion 7. Deliver and evaluate a three year targeted tooth brushing scheme working with the local dental network to deliver intervention			20. Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health

Workplace and community setting ACTIONS	Lead	Timeline	NICE Recommendations
1. Make plain drinking water available in community venues 2. Provide a choice of sugar free food, drinks and snacks, including from vending machines 3. Encourage and support breastfeeding 4. Healthy living pharmacy – SMILE campaign delivered annually 5. Oral health in Health at Work campaigns			5. Ensure public services promote oral health 6. Ensure front line health and social care staff can give advice on the importance of oral health 10. Promote oral health in the workplace

Vulnerable group (children and adults at high risk of poor oral health) ACTIONS	Lead	Timeline	NICE Recommendations
1. Oral health promotion team to work specifically with special schools and those educated outside of mainstream 2. Explore feasibility of minimum set of standards for oral health within care home contracts e.g. oral health assessment on admission to care home, oral health care plan established and regularly reviewed – quality metrics 3. Include training and support in residential care homes on importance of oral hygiene and dual training on dementia care as part of contract 4. Label dentures to reduce loss and cost of replacement 5. Align dental practices to each residential care home to ensure a general dentist is available for advice/guidance			7 Ensure front line health and social care staff can give advice on importance of oral health 8 Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health 9 Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health 12. Commission tailored oral health promotion services for adults at high risk of poor oral health

Appendix 3: Draft Consultation Timeline For Oral Health Strategy

Meeting	Date	Purpose
Health and Wellbeing Board	26th July 2016	Agree draft for wider consultation
Six week public consultation: • Including targeted consultation with Foundation Trusts and CCG's	1st August – 12th September 2016	Consultation
Children and Families Partnership	13th September 2016	Consultation
Children & Young People Overview and Scrutiny committee	29th September 2016	Consultation
Adults Wellbeing & Health Overview and Scrutiny committee	4th October 2016	Consultation
Health and Wellbeing Board	17th November 2016	Agreement of strategy