**MANCHESTER JOINT STRATEGIC NEEDS ASSESSMENT**

**CHILDREN AND YOUNG PEOPLE**

**CHAPTER: Childhood**

**TOPIC: Oral Health**

## Why is this important?

Oral health is poor in Manchester's child population and tooth decay continues to affect children and young people's lives (Manchester City Council (MCC), 2012, although it is largely preventable (Public Health England (PHE) 2014).

Poor oral health can have an impact on general health and quality of life as it can affect children's ability to eat, speak and socialise. Other impacts include pain, infections, poor diet and impaired nutrition and growth (National Institute for Clinical Excellence (NICE), 2014).

Children who have toothache or who need treatment may have to be absent from school. Parents may also have to take time off work to take their children to the dentist. When children are not healthy, this affects their ability to learn, thrive and develop. Good oral health can contribute to school readiness (PHE, 2014). According to the Global Burden of Disease Study in 2010, five to nine year olds in the UK experienced the most disability caused by poor oral health (PHE, 2012).

Poor oral health is strongly linked to social deprivation and tooth decay is caused by the frequency and amount of sugar (Non-milk extrinsic sugars (NME) in the diet, lack of hygiene and lack of exposure to fluoride. Unsuitable baby feeding practices, weaning habits, diet and lack of early brushing all impact on children's oral health and may also lead to a higher risk of obesity, diabetes, cardiovascular disease and some cancers in later life.

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

- improve the oral health of the population, particularly children
- introduce a new NHS primary dental care contract
- increase access to primary care dental services (PHE, 2014)

## The Manchester Picture

Manchester local authority has levels of decay that are higher than the average for England. 25% of 3 year-olds have experienced decay and the prevalence of decay that is related to long term bottle use is also higher than the national level (PHE,

2015, 3 year old survey). However Manchester continues to see a downward trend in levels of tooth decay within our 5 year old population. In 2008, 51% of our 5 yr olds in Manchester experienced tooth decay and in 2015, 32% experienced it (PHE, 2016). Manchester is still above England's average of 24% but much improved. This is great news and highlights the good effective collaborative work going on across the city, however it's still too high and unfortunately inequalities still exist between wards across the City.

There is a correlation between levels of tooth decay and social deprivation. With variation across Manchester . North Manchester has higher prevalence and severity of poor oral health and Manchester is ranked the fifth most deprived local authority in England with 40.8% of the city's Lower Super Output Areas (LOSAs) in the most deprived 10% of the country (Index of Multiple Deprivation (IMD), 2015). These key determinants need to be considered when addressing improvement in child oral health and in future service planning.

Untreated tooth decay can lead to young children needing to have teeth removed under general anaesthesia (GA); this presents a small but real risk of life threatening complications for children (PHE, 2012). The most common reason children are admitted to hospital in Manchester is to have teeth extracted. In 14-15, 87% of admissions for extraction had tooth decay as primary diagnosis (PHE, 2015). Hospital admissions for tooth decay are higher for those from more deprived areas, amongst the least deprived 10 % of the population 31.9% of admissions are for tooth decay whereas amongst the most deprived 10 % of the population 61.2% of dental procedures were due to tooth decay (NHS England, 2013). The cost of providing treatment for routine and urgent care is high (NHS England, 2013).

**What would we like to achieve?**

Oral diseases are largely preventable; and there is a need to continue and develop interventions to achieve sustained and long-term improvements in oral health and reduce inequalities. To do so, requires effective action and partnerships to address the wider determinants of health and prevent dental disease. The most effective interventions focus on broader determinants of health and oral health promotion should happen in both community and general dental practice settings. While there is a need for the oral health improvement team to provide education and the means to improve self-care oral health behaviour, there is also a clear requirement for activities to be focussed on those that maximise the impact of increased availability of fluoride to all sectors of the population whilst targeting vulnerable groups experiencing the highest levels of health inequalities, such as deprived communities, looked after children, children with special needs and homeless families with children (PHE, 2014).

We also recognise that it is fundamentally important to focus on upstream evidence informed actions to address what creates inequalities and that cause both poor general and oral health (PHE, 2014)

The public health outcomes framework (PHE, 2016-19) includes " Reduce the proportion of five year old children free from dental decay" as an outcome indicator.

The Children and Young People's Health Outcomes Forum report published in 2012 and its 2014 annual report recommended improved integration and greater action to

reduce regional variation in child health outcomes.

**What do we need to do to achieve this?**

We need to adopt an integrated approach with partners for oral health improvement, including NHS England, Public Health England and Clinical Commissioning Groups with the focus on people whose economic, social, environmental circumstances or lifestyle place them at increased risk of poor oral health or make it difficult for them to access dental services.

Ensure all local authority services for children and young people (CYP) have oral health improvement embedded at a strategic and operational level.
We need to continue to support CYP through their families, early years, schools, and community settings to maintain good oral health, adopting a place based approach and provide access to quality local dental services focused on improving oral health and giving every child the best start in life.

We need to continue to commission the Oral Health Improvement Team (OHIT) in line with the document 'Local authorities improving oral health: Commissioning better oral health for children and young people (PHE 2014) and 'Oral Health: Approaches for local authorities and their partners to improve oral health of their communities' (NICE 2014) to provide the activity informed evidence based practice to ensure scientific rigour.

We need to continue to contribute to the reduction of caries in young children and young people by increasing exposure to fluorides by widespread distribution of free toothbrushes and toothpaste; running of supervised brushing schemes at early years provisions; provision of fluoridated milk in primary schools and fluoride varnish applications via primary school nurseries and within general dental practices and continue to build on strengths of current oral health promotion activities and link messages and activity to general health and wellbeing.

**What are we currently doing?**

- Continuing to contribute to the reduction of caries in young children and young people by increasing exposure to fluorides by widespread distribution of free toothbrushes and toothpaste via health visiting and outreach teams; running of supervised brushing schemes at early years provisions, provision of fluoridated milk in primary schools and fluoride varnish applications via primary school nurseries and within general dental practices.
- Improving home care, increasing attendance with a primary care dentist and increasing the proportion of children receiving fluoride varnish applications twice a year by running Manchester Smiles Buddy Practice programme.
- Increasing knowledge of professional partners by training education, health and social care partners with regard to the key oral health messages as evidenced in the 3rd edition of Delivering Better Oral Health: an evidence based toolkit for prevention (PHE 2014).
- Continuing to influence primary dental care providers to maintain and intensify

prevention activity within their practise and school community via the Buddy Practice Programme. This would require the commissioning and contracting to continue to include this with key performance indicators backed by education, training and increased skill mix. A key activity of the OHIT is the 'Prevention in Practice Award' scheme.
- Continuing to support the adoption of healthy food and drink policies in all early years and young people's care sites.
- Developed a core offer of oral health improvement for early years incorporating all relevant performance measures.

**Community and Stakeholder Views**

As part of the Manchester Smiles Buddy Practice Programme which aims to increase access to dental care among young children and their families and increase the proportions that receive fluoride varnish applications the OHIT carried out a feedback questionnaire with parents/carers following visits to school.

When asked what they liked about the programme:

'My child feels less scared about visiting the dentist'.

'I didn't have a dentist for the family before but now I have for all the children, it is good'.

'I liked it very much and it is good because I now brush the children's teeth and they spit out and not washing the mouth'.

Key school staff were also asked to feedback on the impact they feel the programme has had on the children.

'One particular Roma family have accessed dental care with the help of the Roma speaking teaching assistant and staff from this programme. This has meant one child in-particular has received the treatment he desperately needed'.

'Lots of children start school here without a dentist; I think it is because they don't see it as a priority. This programme is good because it highlights it with the parents'.

'I had one boy in my class who had very bad teeth, I was concerned and even made sure mum attended when the dentist visited so she would be able to listen, be aware and hopefully make a further appointment and I will keep checking'.

**References and Links**

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**Other related JSNA topics**

- Healthy Weight
- Safeguarding

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