JSNA Chapter – Children and Young People's Oral Health

Topic information	
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Executive summary

Introduction

Oral health is an important part of general health and wellbeing and should not be considered in isolation. Whilst there have been welcome improvements in the oral health of children in England, significant inequalities remain. Oral disease can have detrimental effects on an individual's physical and psychological well-being and reduces quality of life.

The World Health Organisation defines oral health as 'a state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing. 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 well-being' (WHO, 2012).

As well as causing pain or infection, poor oral health can be associated with low weight and failure to thrive in infancy. The impacts are not only limited to the individual but also the family and society, including school absence, and the need for parents to take time off work to attend hospital appointments related to dental decay. Good oral health can therefore contribute to school readiness.

Risk factors for oral diseases include poor diet, particularly one high in quantity and frequency of sugar consumption, poor oral hygiene, tobacco use and harmful alcohol use. These are also risk factors for the four leading chronic diseases – cardiovascular diseases, cancer, chronic respiratory diseases and diabetes – and oral diseases are often linked to chronic disease.

The most common oral disease in children is dental caries. Prevalence of gum (periodontal) disease is low in children and oral cancers are considered to be rare in children (Cancer Research UK 2016) .

The prevalence of oral disease varies by geographical region. In Nottingham, the proportion of five-year-olds free from dental decay was 64.4% (England - 75.2%) (Public Health England 2016b).There is also a social gradient in relation to experience of dental caries, which in both children and adults is higher among poor and disadvantaged population groups.

The burden of oral diseases and other chronic diseases can be decreased simultaneously by addressing common risk factors (Public health England 2016b).

Good oral health can be promoted by:

- increased access to and use of fluoride
- reducing the frequency and quantity of sugar consumed;
- encouraging effective daily oral hygiene
- seeking regular dental care
- preventing tobacco use and decreasing alcohol consumption in the adolescent years, to reduce the risk of oral cancers, periodontal disease and tooth loss in adulthood

Access to good quality dental services is essential not only to treat dental disease but also to promote preventive care. Even when there is good availability of dental services the uptake of these services is lower amongst those living in deprived areas, those on low incomes and with lower levels of educational attainment.

Unmet needs and gaps

- The proportion of children (under 18 years), and particularly very young children living in Nottingham and accessing dental services is low compared to the Midlands and England
- There is anecdotal evidence that first dental attendance is frequently symptomatic and not preventive.
- Although the rate of fluoride varnish application for children in the City is good, there is considerable room for improvement to ensure universal access to two applications per year for each child.
- There is a belief amongst the population that access to dental services is poor. This together with poor rates of patient satisfaction with NHS Dental Services and the reasons for this dissatisfaction are unclear and warrant further investigation.
- Making Every Contact Count is an important approach to ensuring oral health messages are delivered at every opportunity. However, local evidence collected from

front line workers would suggest that this is not happening systematically and more work needs to be done to embed this approach across the workforce.

Recommendations for consideration by commissioners

1. As responsibility for commissioning for oral health is shared between local authorities and NHS England, commissioners should work together collaboratively, with support from PHE and other stakeholders to improve the oral health of the population of Nottingham.

2. Ensure that opportunities to 'Make Every Contact Count' with children, young people and their families are maximised by collaborative working across health, social care and education, which is underpinned by co-ordinated training to ensure delivery of consistent evidence based oral health promoting messages.

3. Consider continued commissioning of a supervised tooth brushing programme for nurseries/primary schools with possible expansion of the service to further early-years settings, taking in to account current financial pressures and budget cuts.

4. Explore the feasibility of a water fluoridation scheme as one of a range of interventions to improve oral health in Nottingham City.

5. Give consideration to commissioning a targeted fluoride varnish application programme, drawing on the experience of other programmes and previous local experience.

6. Explore appropriate incentives to encourage dental services to contribute to both oral health and wider health and well-being by shifting their focus from being primarily treatment focussed to a preventive focus.

7. Explore the development of an accreditation programme for local NHS dental practices to encourage provision of child-friendly preventive focussed services.

8. Encourage parents in the City to attend a dental practice with their child before their first birthday, followed by regular visits to help children familiarise well with the environment and maintain good oral health.

9. Through their commissioning decisions commissioners should ensure equitable access to NHS dental services within reasonable travel time for every citizen in the City. This should include access to urgent care and out of hour's dental services.

10. Ensure that information about how to access NHS Dentistry is easily available to all sectors of the community, including new residents, through a wide range of agencies.

11. Explore the perception of lack of access to NHS Dental Services and the reasons for the poor level of patient satisfaction reported by City residents, then using this information to support future commissioning decisions.

12. Develop commissioning of consultant led paediatric dental services, care pathways and managed clinical network based on the NHS England Paediatric Dentistry Commissioning guidance (NHSE, in draft).

13. Develop local pathways and protocols to ensure appropriate information sharing occurs between agencies involved in the care of children and young people, including dental practices, to identify children for whom dental neglect may be part of wider neglect / child protection concerns.

14. Review current protocols and procedures for ensuring that all looked after children who are the responsibility of the local authority have access to appropriate dental care.

15. Where resources dictate that programmes or services need to be targeted the focus should be on the provision of services for children and young people and families especially those living in local areas that are the most deprived.

16. Ensure access to appropriate resources to support promotion of good oral health and access to services. This should include working collaboratively with the population groups themselves and services they are in contact with together with interpretation and translation Services. This may include the translation of oral health promotion materials for non-English speaking parents/careers, but may also include the provision of pictorial resources.

17. Encourage the use of protective sports equipment, for example gum shields, and safe physical environments where children play to reduce the risk of dental injuries.

18. Encourage the prescription of sugar free medicines for children and those with special needs who are at higher risk of dental caries (decay).