Why prevention must be targeted, creative and multi-faceted

Caroline Holland looks at the initiatives and people making a difference to children's oral health.

Giving every child the best start in life is crucial to addressing health inequalities.[1] So said Professor Sir Michael Marmot, Director of the UCL Institute for Health Equity, highlighting in 2010 the devastating impact of poverty on health and wellbeing in his report: Fair Society Healthy Lives. The principle of every child having the best start in life may seem obvious but, to anyone in dentistry, the statement highlights an unfortunate truth: not enough has been done to help prevent children suffering with caries-related dental decay. Every year there are tens of thousands of children – more than 44,000 in England to be precise – who go into hospital to have teeth taken out under general anaesthetic. Sometimes children as young as two or three have ALL their teeth extracted. This is a terrible start to that child's experience of dentistry and has become a horrifying fact of life.

Prevention has always been the answer. But it's only in the last few years that prevention has been embedded in programmes which are given the impetus to reach those who need it the most. In 2016, Public Health England's Child Oral Health Improvement Programme Board set out how to achieve its ambition of every child growing up free from dental decay.[2] For too long, the 2006 GDS contract has been seen as a barrier to progress. Now, innovative thinking has led to the overlooked concept of 'Flexible Commissioning' (FC) being adopted in order to foster change. FC allows commissioners to disconnect units of dental activity (UDAs) from treatments and to fund specific initiatives. With poor oral health being inextricably linked to poverty,[3] targeting is particularly important.

One of the places where flexible commissioning is being put to good use is Greater Manchester, where, prior to 2017, an estimated £20 million was spent annually on treating dental decay. The area has its own

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devolved Health and Social Care Partnership, allowing professional teams to advance their own strategies via Managed Clinical Networks. These professional groups, in which clinicians and commissioners work together to ensure services meet the needs of local populations, are well established, including for paediatric dentistry.

In 2017, the dental community in Greater Manchester announced its ambitious vision for change. GDP Mohsan Ahmad, Chair of the Local Dental Network, wrote the foreword to a document[4] setting out the three-year plan, stressing that dental teams would play an essential part, by engaging communities to value good oral health, driving improvement in outcomes.

If all goes according to plan, flexible commissioning across Greater Manchester should result in a number of practices being accredited as Child Friendly Dental Practices. They will be expected to carry out the locally developed Baby Teeth do Matter online training and provide evidence-based treatments, such as placement of preformed metal crowns using Hall Crowns or Silver Diamine Fluoride (SDF) application in order to arrest caries and reduce the number of children being referred into secondary care for extractions. If this was a good idea a few years ago, it's essential now that secondary care appointments are in such high demand. The Dental Check by One campaign,[5] recently reinvigorated by the British Society of Paediatric Dentistry, is also central to an accredited Child Friendly Dental Practice.

In January of last year, the Greater Manchester Health and Social Care Partnership (GMHSCP) launched[6] a £1.5 million programme to reduce dental decay. Jo Dawber is the GMHSCP project manager for Oral Health Transformation under the leadership of Consultant in Dental Public Health, Emma Hall-Scullin.

Social challenges are considerable in Greater Manchester which has four of the 13 national priority areas set out in Starting Well: A Smile4Life initiative:[7] Bolton, Oldham, Rochdale and Salford.

One of Jo's first jobs was to ensure that there was a network of trained primary care 'dental champions' who would lead the way in improving dental care in early years settings through supervised toothbrushing schemes. Jo provided the training for 20 champions who together brought 150 early years settings into the programme. She also oversaw the purchasing of toothbrushes and toothpastes in bulk quantities which went into dental packs.

Jo said: 'Interest in the programme from Early Years providers has been nothing less than fantastic. We have done a lot of learning but our motto was "Every problem has a solution". It's about making sure that parents and carers had a voice and doing what we can to make a difference to the children of Greater Manchester.

'Until COVID-19, we had 40,000 children toothbrushing on a daily basis. Since COVID-19, nobody has disengaged.'

With dental practices and many early years settings closed, Jo described how everyone involved in the programme did what they could to ensure children still got their toothbrushing packs. Using voluntary services, food banks and aid workers, they wanted every child who needed a pack to get one. Forty thousand, two hundred and seventeen packs were distributed when the pandemic was at its height.

Another important aspect of their work is to engage with health visitors and ensure they are training to deliver key oral health messages to new parents. Once the pandemic was underway and health visitors could no longer go out to parents' homes or provide clinics, the team worked with midwives. They also distributed – electronically - the videos[8] made by the British Society of Paediatric Dentistry and Brush DJ with Dr Ranj in the pandemic.

Another area of the country where flexible commissioning has been embraced is in North Yorkshire and Humber. As in Manchester, programmes are geared to funding GDPs to provide prevention as well as building links between dental practices early years settings and health visitor and social care teams. The beauty of the flexible commissioning approach, according to Simon Hearnshaw, the Chair of the Local Dental Network, is that there is no additional cost. The region's In Practice Prevention programme[9] uses trained dental nurses to deliver patient-centred evidence-based prevention pathways targeted at children who have dental decay or are being referred for GA extraction.

Simon said: 'In simple terms, the flexibly commissioned resource pays for the ring-fenced time to deliver key messages and interventions and to encourage and support behaviour change. Over two and a half years more than 17,000 targeted one-to-one prevention appointments have been delivered to children with disease.'

He has been working with Ingrid Perry, a practice manager at a myDentist practice in Hull and one of the Urgent Dental Care Centres during the pandemic. She is helping to devise a toolkit to support the training of oral health educators in myDentist practices who will be part of the FC initiative.

Ingrid Perry

Their job is critical, says Ingrid, because of the high number of patients who were unable to see a dentist during lockdown: 'Prevention is the way forward and we are going to see more of a need for it now. By working collaboratively with multiple stakeholders such as health visiting and school nursing teams flexible commissioning will have a positive impact on not only the dental health but also the general health of our local communities, especially in areas of severe social deprivation where you find the highest disparities in health.'

With many of the most deprived areas of the UK in the North of England, it's no surprise that targeted prevention is being driven hard. Positive support for oral health prevention nationally continues to emerge and momentum is building. A key development was the Green Paper published last year[10] in which the Government committed to put prevention at the heart of all its health and social care decision-making. In terms of school toothbrushing schemes, the Government said it wanted to reach 30% of the most deprived 3-5-year-olds by 2022. The Green Paper advocated that funding barriers to fluoridating water should be removed and local authorities which pursue water fluoridation should be rewarded by allowing them to benefit from the savings achieved via fewer fillings and extractions. Water fluoridation requires no behaviour change and the evidence shows that it is highly effective in reducing dental

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decay and delivers the most benefit to the most deprived.[11]

Dental health should now be included in the curriculum in both primary and secondary schools[12] in England while a powerful new announcement this month[13] from the Royal College of Paediatrics and Child Health (RCPCH) reinforces the importance of all aspects of prevention of dental disease:

- Going to the dentist, ideally starting before the age of one
- A healthy diet
- Toothbrushing with a fluoride toothpaste
- Fluoride in water working with fluoride in toothpaste to provide an extra layer of protection.

Another essential weapon in the prevention armamentarium is dietary advice. The mother of all prevention schemes is NHS Scotland's Child Smile[14] which incorporates guidance on nutrition and the frequency of sugar consumption.

Dental health in Scotland is improving and the target of 60% of 11-year-olds having no obvious decay has been met. Meanwhile, Designed to Smile, the programme in Wales to reduce dental decay in children, is ten-years-old and is also bringing down dental decay.[15]

In England, dentists look enviously at Scotland and Wales which both have national prevention programmes. This is deemed impossible in England because since 2012, public health has been the remit of local authorities.[16]

To return to health inequalities, earlier this year and ten years on from the Marmot Review, the Health Foundation showed,[17] shockingly, that social inequalities are now worse than they were a decade ago, especially for women.

Intractable problems need a creative response and one is social prescribing, an approach to health which recognises that illness can be caused by environmental or social factors. Its role was also recognised in the Green Paper on Prevention. Jo Ward chairs the North West social prescribing network and has led on the development of a new handbook - *The National Women and Children's Creative Health Handbook: Wellbeing by Design* - which includes a section on oral health. This is yet more welcome evidence that the mouth is now being considered integral to health and wellbeing and that the methodology needs to be targeted and creative.

New figures[18] for general anaesthetics to remove teeth in children showed that there has been an 8% decrease in the number of 5-9-year-olds being referred into hospital for extractions between 2017/18 and 2018/19. This is welcome progress – but who knows what the impact of COVID-19 will be? Is it possible to maintain the progress that's been made?

With the country still in crisis from COVID-19, we don't have that answer, nor do we know what will happen to the work of Public Health England now the government is abolishing it, or to the Prevention Green Paper and other government commitments, but we do know that in order to be effective, prevention programmes must be funded, targeted, multi-faceted and creative. And we have an impressive groundswell of people and organisations working to give children a better start to life.

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