Public Health England

Local authorities improving oral health: commissioning better oral health for children and young people

Summary version

What are local authorities' responsibilities for improving the oral health of children and young people?

- Local authorities are statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to an extent that they consider appropriate in their areas.[1]
- They are also required to provide or commission oral health surveys.[1] The oral health surveys are carried out as part of the Public Health England (PHE) dental public health intelligence programme (formerly known as the national dental epidemiology programme).[2]

Why is children's and young people's oral health important?

- **Tooth decay is the most common oral disease affecting children and young people (CYP) in England, yet it is largely preventable**. While children's oral health has improved over the past 20 years, almost a third (27.9%) of five-year olds in England still had tooth decay in 2012.[3]
- Poor oral health can affect CYP's ability to sleep, eat, speak, play and socialise with other children.[4] Poor oral health also causes pain, infections, and impaired nutrition and growth.[5,6]
- When children have toothache or need treatment, this can mean **school absence** and that families and parents have to take time off work. Oral health is an integral part of overall health. When children are not healthy, this affects their ability to learn, thrive and develop. Good oral health can contribute to **school readiness**.
- 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 (GA), presents a small but real risk of life-threatening complications for children. Tooth extractions under GA are not only potentially avoidable for most children but also costly. Extracting multiple teeth in children in hospitals in 2011-2012 cost £673 per child with a total NHS cost of nearly £23 million.[7]

1. NHS Bodies And Local Authorities (Partnership Arrangements, C.T., Public Health And Local Healthwatch) Regulations 2012. 2012: United Kingdom.
2. NHS Dental Epidemiology Programme for England. Dental Health. 2013 [cited 2013 10/10]; Available from: http://www.nwph.net/dentalhealth/
3. Public Health England. National Dental Epidemiology Programme for England: Oral Health Survey of Five-Year-Old Children 2012. A report on the Prevalence and Severity of Dental Decay. 2013
4. Nuttall N, Harker R. Impact of Oral Health: Children's Dental Health in the United Kingdom, 2003. 2004
5. Shepherd, M.A., Nadanovsky, P. Sheiham A, The Prevalence and Impact of Dental Pain in 8-Year-Old School Children In Harrow, England. British Dental Journal, 1999. **187**(1): p. 38-41
6. Clarke, M., et al., Malnourishment in a Population of Young Children with Severe Early Childhood Caries. Pediatric Dentistry, 2006. 28(3): p. 254-259.
7. Department of Health. National Schedule of Reference Costs 2011-12 for NHS Trusts and NHS Foundation Trusts. 2012.

- Dental treatment is a significant cost, with the NHS in England **spending £3.4 billion per year on dental care** (in addition an estimated £2.3 billion on private dental care), with over a million patient contacts with NHS dental services each week.[8]

Are there oral health inequalities?

- People living in deprived communities consistently have poorer oral health than people living in richer communities. These inequalities in oral health run from the top to the bottom of the socioeconomic ladder, creating a social gradient. Some vulnerable groups have poorer oral health. Stark regional differences also exist. For example, 21.2% of five-year olds had tooth decay in South East England compared to 34.8% in the North West of England, with even greater inequalities within local authority areas.[9]

What are the policy drivers?

- 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

- The public health outcomes framework (2013-16) includes “tooth decay in five year old children” as an outcome indicator.[10]

- The NHS outcomes framework (2014-15) includes indicators related to patients’ experiences of NHS dental services and access to NHS dental services.[11]

- 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.[12,13]

8. NHS England, Improving Dental Care and Oral Health - A Call for Action. 2014.
9. Public Health England. National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2012. A report on the Prevalence and Severity of Dental Decay. 2013
10. Department of Health. Improving Outcomes and Supporting Transparency: Part 1: A Public Health Outcomes Framework for England, 2013-2016. 2012.
11. Department of Health, The NHS Outcomes Framework 2014/15. 2013.https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf
12. Department of Health. Report of the Children and Young People's Health Outcome Forum 2012
13. Department of Health. Report of the Children and Young People's Health Outcomes Forum 2013/14. 2014

What can we do to improve oral health outcomes for children and young people (CYP) and reduce oral health inequalities?

Our ambition:

- put CYP and their families at the heart of commissioning
- adopt an integrated approach with partners for oral health improvement, including NHS England, PHE and clinical commissioning groups. Ensure all local authority services for CYP have oral health improvement embedded at a strategic and operational level
- see commissioning for oral health improvement across the life course, giving every child the best start in life and adopting the principle of proportionate universalism
- address the underlying causes of health inequalities and the causes of poor general and oral health though upstream evidence-informed actions
- use, share and develop information and intelligence
- sustain and develop the CYP workforce
- support CYP through their families, early years, schools and community settings to maintain good oral health
- provide leadership and advocate a clear local vision for improving oral health and addressing oral health inequalities
- access to quality local dental services focused on improving oral health

Commissioning what works across the life course

- Local authorities can commission a range of different oral health improvement interventions. However, no single ‘magic bullet’ exists. One important consideration in deciding what interventions should be delivered is the evidence base for the intervention.

- The randomised controlled trial represents the ‘gold standard’ form of evidence to assess the effectiveness of clinical treatments in clinical practice. However, public health interventions in population health can use a broader range of evidence and assess the totality of evidence.

- A review was carried out following a pragmatic approach and involving a broad range of evidence to summarise the totality of evidence underpinning oral health improvement. This framework of evidence can support local authorities to review local oral health needs, plan integrated oral health programmes and review current or planned commissions of oral health improvement programmes. It can underpin the development of local frameworks for oral health improvement commissioning. It also provides examples of a range of outcome measures and financial models.

What does good commissioning look like?

- Commissioning frameworks should ensure that oral health improvement is integrated within existing programmes such as the healthy child programme 0-19 years

- Commissioning specific oral health programmes based on the totality of the evidence and needs of the population

- Reviewing commissioned oral health programmes to ensure that programmes:
    - meet local needs
    - involve upstream, midstream and downstream interventions that involve both targeted and universal approaches
    - consider the totality of evidence of what works
    - engage with partners integrating commissioning across organisations and across bigger footprints as required

- Local authorities have unique powers around health scrutiny, which enable them to review the planning, provision and operation of health services in their area (See appendix 1, Ten key questions for the scrutiny of oral health improvement delivery).

Financial considerations

- Local authorities currently use a range of approaches to maximise the value of investment and the evidence of return on investment. Some local authorities may not have used these tools in the context of oral health improvement. These methods

include using pooled budgets, collaborative commissioning across organisations and geographies, and using cost benefit analysis tools. These methods can be used in oral health improvement commissioning to maximise value in terms of oral health improvement for spend.

Who is the guidance for?

The document provides guidance to support commissioning of evidence-informed oral health improvement programmes for:

- elected members and strategic leaders
- health and wellbeing boards
- directors of public health
- consultants in dental public health and public health
- commissioners in local authorities
- local oral health improvement and oral health promotion teams
- health care providers and children and young people workforce delivering population based oral health improvement programmes

Further information

- The full document produced to support local authorities is available on the PHE website and titled ‘Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities’.

Appendix 1. Ten key questions to ask – improving the oral health of children and young people

Local authorities' public health role

Key questions to ask when assessing local oral health improvement delivery

1. What are the oral health needs of children and young people (CYP) in your local area?
    - Do you have information and intelligence regarding the oral health of CYP and the services that are available, benchmarking to similar authorities and local neighbours?
    - Does this identify vulnerable groups and those most affected?
    - Does it identify inequalities within the district?

2. Is oral health included in a joint strategic needs assessment (JSNA) and the health and wellbeing (HWB) strategy and is this underpinned by more detailed oral health needs assessments and strategic documents?

3. Do you have a local oral health strategy in place to address oral health issues? Is there an integrated approach to oral health improvement across children's services and the children's workforce?

4. Are commissioned programmes appropriate to local needs and informed by the information and intelligence locally?

5. Are the oral health improvement programmes that you commission supported by the best available evidence?

6. Are your oral health improvement programmes monitored and evaluated and what are the outcomes, outputs and impact? These may be short, medium and long-term outcomes, and include both quantitative and qualitative measures.

7. Do you have an identified lead or established leadership and advocacy for oral health improvement and commissioning? Are there mechanisms in place to oversee accountability, delivery and engagement with partners?

8. Are the children's workforce supported through training and development to deliver for oral health improvement locally?

9. What engagement processes do you have to collect the views of CYP and have their views influence decision-making?

10. Is there reasonable and equitable access to local dental services and are these focused on prevention and the needs of CYP?

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

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