Policy development for oral health improvement in England.

Commissioning Better Oral Health for children and Young People.

International Centre for Oral Health Inequalities Research and Policy- June 17th 2014

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Overview

• Responsibilities for oral health improvement and addressing health inequalities
• Policy context
• Aim of CBOH for CYP
• Development process
• Contents and potential to address inequalities
Since April 2013 in England….

- New organisations
- New systems
- New accountabilities and responsibilities
- New relationships
- New ways of working
- New opportunities
Responsibilities for oral health improvement and addressing oral health inequalities

• Within the Health and Social Care Act 2012, LAs have responsibility for improving the health of their local population, including their oral health.

• LAs have a statutory responsibility to:
  • assess oral health needs, develop oral health strategies and commission or deliver oral health improvement programmes (Statutory instrument 3094)
  • Provide or commission oral health surveys as part of the PHE Dental PH Intelligence programme (Statutory instrument 3094)

• Make proposals regarding water fluoridation schemes and for conducting public consultations in relation to these (Statutory Instrument 301)
Why is CYP oral health important?

Most dental disease is preventable
Stark inequalities exist. Some of the most vulnerable, disadvantaged and socially excluded facing significant oral health problems.
Increased tooth retention in older adults has created complex issues for managing failing dentitions in frail and vulnerable elderly

Impact of poor oral health:
• Pain
• Difficulties with eating, sleeping and socialising
• School absence/school readiness
• Dental neglect and wider safeguarding issues
• Treatment
  • fear and anxiety
  • time off school and work.
• Top cause of childhood admissions to hospitals (5-9)
• Cost – 3.4 billion
Oral health is improving

Both child and adult oral health has significantly improved over the last 40 years.

Results of caries surveys of five-year-olds in England from National Child Health Surveys and NHS Dental Epidemiology Programme surveys, 1973 to 2012.
Regional and deprivation variations in children's dental health – a survey of 5 year-old children 2012

Percentage of 5 year-old children with decay experience including 95% confidence limits, by Government Office Regions, 2012

Correlation between the rate of decay among 5 year-old children and deprivation score. Lower tier local authorities in England 2012

There is regional variation in the prevalence of tooth decay in the 5 year olds surveyed.

For those 5 year olds with decay, the extent of the decay correlates with deprivation. The more deprived the area the higher the rate of decay found in the 5 year olds surveyed.

Data source/s: Public Health England National Dental Epidemiology 5-year old dmft Survey
What is the policy context?

- Government commitment to
  - Improve oral health of the population particularly children
  - Introduce new dental contract based on registration, capitation and quality
    - Increase access to NHS primary dental care services
- The Children and Young People’s Health Outcomes Framework (2014) also includes the “tooth decay in five year old children” indicator
- The NHS Outcomes Framework (2013-14) includes indicators related to patients’ experiences of NHS dental services (4a(iii) and access to NHS dental services (4.4(ii))
Reducing health inequalities

• Give every child the best start in life

• Enable all CYP and adults to maximise their capabilities and have control over their lives

• Create fair employment and good work for all

• Ensure healthy standard of living for all

• Create and develop healthy and sustainable places and communities

• Strengthen the role and impact of ill health prevention
The opportunity: a new dental public health system with an integrated approach

**Government**
- DH responsible dental contract reform programme
- National policy e.g. water fluoridation, fiscal policy, smoking

**Local authorities**
- New public health functions, helping to tackle wider determinants of health
- Lead on improving health and oral health, commissioning dental surveys, water fluoridation responsibilities
- Integrated and collaborative commissioning of oral health improvement programmes

**Public Health England**
- New, integrated national expert body
- Supporting whole system with expertise, evidence and intelligence

**NHS England**
- Delivering preventive focused health care, tackling inequalities
- LDNs enable clinically led decisions for dentistry and innovation
- Call to Action – 16th May 2014
Supporting local authorities in their oral health improvement role
Purpose of the document

• To support local authorities to commission oral health improvement programmes for children and young people 0-19 years

• To enable local authorities to review and evaluate existing oral health improvement programmes and consider future commissioning intentions

• To provide an evidence informed approach with examples of good practice
Who is it 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
- Healthcare providers and the CYP workforce delivering population based oral health improvement programmes
Development process

- Development of scope of the work and circulation for comment
- Recruitment of multidisciplinary steering group and established ToR
- Agreement of structure of guidance
- Establishment of working groups and chapter leads
- Driver was what works the evidence based chapter

- Then commissioning and exemplars chapters followed
- Final draft for limited consultation
- Local authorities language, tone and length!
- Publication
- Intention will be reviewed and updated and further range of documents
Membership of commissioning better oral health steering group

- Chair
- Children and Young People HW directorate nomination
- Director of Public Health/CPH children’s lead
- Director of Children’s services/Early Years strategic lead (Head of Early Years)
- Children’s lead commissioner LA
- NHS England national PH commissioner
- NICE link
- LGA representative
- Councillors
- Consultants in Dental Public Health x4
- Academic Dental Public
- Dental Public Health Trainee
- Clinical Director Salaried Dental Services and GDP
- Chair National Oral Health Promotion Group – Sharon Walker
- Link with Wales and Scotland
- Consultation with third sector groups and Department of Education contact
- Professional officer health visiting DH
- Children and families partnership director
Commissioning better oral health for children and young people

• What are the LA responsibilities?
• Why is CYP oral health important?
• What can we do to improve CYP oral health – our ambition
• Commissioning what works across the life course?
• What does this mean for commissioners?
• What does good look like?
• 10 key questions for scrutiny
Our Ambition

Improving the oral health outcomes for children and young people and reducing oral health inequalities

- Taking a life course approach; acting early and intervening at the right time
- Putting children young people (CYP) and families at the heart of what we do; empowering CYP and their carers; promoting self-care and resilience
- Partnership working using an integrated approach across children's services
- Supporting consistent evidence informed oral health information
- Using, sharing and developing information and intelligence
- CYP are supported by their families, early years and schools settings and communities to maintain good oral health
- Sustaining and developing the CYP workforce
- Leadership and advocacy of a clear local vision for oral health improvement addressing health inequalities
- Access to quality local dental services focused on improving oral health
What works - background
Effectiveness Reviews of DHE

- Brown (1994)
- Schou and Locker (1994)
- Kay and Locker (1996)
- Sprod, Anderson and Treasure (1996)
- Kay and Locker (1998)
- Department of Human Services (1999)
- Watt and Marinho (2005)
- Yevlahova and Satur (2009)
Upstream - downstream interventions

- National &/or local policy initiatives
- Legislation/Regulation
- Fiscal Measures
- Healthy Settings- HPS
- Community Development
- Training other professional groups
- Media Campaigns
- School dental health education
- Chair side dental health education
- Clinical Prevention

Watt, CDOE (2007)
Public health agenda: intervention design

- Empowering
- Participatory
- Holistic
- Inter-sectoral
- Equitable
- Sustainable
- Multi-strategy

WHO (1998)
What works – process of reviewing evidence
Review process

- Recognition of pluralistic approach to evidence of public health interventions (WHO, 1998)
- Adapted methodology from CDC and CSTF
- Evidence restricted to systematic and narrative reviews
- Consider ‘totality’ of evidence based on 4 criteria
Criteria used to assess evidence

- Strength of evaluation and research evidence
- Impact on inequalities
- Cost/resource considerations
- Implementation issues
<table>
<thead>
<tr>
<th>Strength of evaluation and research evidence</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong evidence of effectiveness</td>
<td>One systematic review or meta-analysis of comparative studies; or several good quality randomised controlled trials or comparative studies</td>
</tr>
<tr>
<td>Sufficient evidence of effectiveness</td>
<td>One randomised controlled trial; one comparative study of high quality; or several comparative studies of lower quality</td>
</tr>
<tr>
<td>Some evidence of effectiveness</td>
<td>Impact evaluation (internal or external) with pre- and post-testing; or indirect, parallel or modelling evidence with sound theoretical rationale and program logic for the intervention</td>
</tr>
<tr>
<td>Weak evidence of effectiveness</td>
<td>Impact evaluation conducted, but limited by pre- or post-testing only; or only indirect, parallel or modelling evidence of effectiveness</td>
</tr>
<tr>
<td>Inconclusive evidence of effectiveness</td>
<td>No position could be reached because existing research/evaluations give conflicting results; or available studies were of poor quality</td>
</tr>
<tr>
<td>No evidence of effectiveness</td>
<td>No position could be reached because no evidence of impact/outcome was available at present. (This is not the same as evidence of ineffective – see below)</td>
</tr>
<tr>
<td>Evidence of ineffectiveness</td>
<td>Good evaluations (high quality comparative studies) show no effect or a negative effect</td>
</tr>
<tr>
<td>Overall recommendation</td>
<td>Strength of evaluation and research evidence</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Recommended</td>
<td>Strong/sufficient/some evidence</td>
</tr>
<tr>
<td>Emerging</td>
<td>Weak/inconclusive/no evidence</td>
</tr>
<tr>
<td>Limited value</td>
<td>Strong/some/sufficient/ weak/inconclusive/no evidence</td>
</tr>
<tr>
<td>Discouraged</td>
<td>Ineffective</td>
</tr>
</tbody>
</table>
Table 3.3: Summary of the Oral Health Improvement Programmes Overall Recommendations

<table>
<thead>
<tr>
<th>Nature of intervention</th>
<th>Intervention classification</th>
<th>Target population</th>
<th>Strength of evaluation and research evidence</th>
<th>Impact on inequalities</th>
<th>Cost / resource considerations</th>
<th>Implementation issues</th>
<th>Overall recommendation</th>
</tr>
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<tr>
<td>Supporting consistent evidence informed oral health information</td>
<td></td>
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</tr>
<tr>
<td>Oral health training for the wider professional workforce (e.g. health, education)</td>
<td>Midstream</td>
<td>Preschool, school children, young people</td>
<td>Some evidence of effectiveness</td>
<td>Encouraging/uncertain</td>
<td>Good</td>
<td>Deliverable</td>
<td>Recommended</td>
</tr>
<tr>
<td>Integration of oral health into targeted home visits by health/social care workers</td>
<td>Downstream</td>
<td>Preschool, school children</td>
<td>Sufficient evidence of effectiveness</td>
<td>Encouraging</td>
<td>Good</td>
<td>Deliverable</td>
<td>Recommended</td>
</tr>
<tr>
<td>Social marketing programmes to promote oral health and uptake of dental services by children</td>
<td>Midstream</td>
<td>Preschool, school children, young people</td>
<td>Inconclusive evidence of effectiveness</td>
<td>Uncertain/Encouraging</td>
<td>Uncertain/costly</td>
<td>Uncertain/major challenges</td>
<td>Limited value</td>
</tr>
<tr>
<td>Person-centred (one-to-one) counselling based on motivational interviewing outside of dental practice settings</td>
<td>Downstream</td>
<td>Preschool, school children (via parents), young people</td>
<td>Inconclusive evidence of effectiveness</td>
<td>Uncertain</td>
<td>Costly</td>
<td>Uncertain</td>
<td>Limited value</td>
</tr>
<tr>
<td>One-off dental health education by dental workforce targeting the general population</td>
<td>Downstream</td>
<td>Preschool, school children</td>
<td>Evidence of ineffectiveness</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Discouraged</td>
</tr>
</tbody>
</table>
### Table 3.4: Additional Information about Oral Health Improvement Programmes

<table>
<thead>
<tr>
<th>Nature of intervention</th>
<th>Publications Reviewed</th>
<th>Further Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral health training for the wider professional workforce (health, education, others)</td>
<td>Rogers, 2011 [38]</td>
<td>Definition: Oral health training for the wider health, social and education workforce - based on capacity building (i.e. increasing knowledge and skills of others) to support oral health improvement in their daily role. More strategic means of health education - ensuring oral health messages are appropriate and consistent across the board. Examples of interventions: Training health visitors and teachers to provide oral health education and pharmacists to deliver oral health advice, supporting the wider public health workforce and decision makers (i.e., councilors, Directors of Public Health) Key points • Evidence is limited to impact evaluation studies. Lack of randomised controlled trials • Good in terms of cost as it is building capacity among those already delivering services rather than establishing new services. • Could be linked in to an ‘accreditation of settings’ scheme.</td>
</tr>
<tr>
<td>Integration of oral health into targeted home visits by health/social care workers</td>
<td>Rogers, 2011 [38]</td>
<td>Definition: Integration of oral health into targeted home visits by health/social care workers based on building the capacity of health/social care workers to provide oral health support during their visits. Examples of interventions: Integrating key oral health messages into the Family Nurse Partnership programme which supports new mothers, integrating key oral health messages into support provided as part of the Troubled Families programme Key points • Targeted at vulnerable families at higher risk of oral disease. • Based on integration of oral health component into existing support programmes, rather than establishing specific oral health home visits. • Regular update training required for health workers carrying out home visits.</td>
</tr>
<tr>
<td>Social marketing programmes to promote oral health and uptake of dental services amongst children</td>
<td>Gordon et al., 2006 [40], Stead et al., 2006 [41], Janssen et al., 2013 [42]</td>
<td>Definition: Using commercial marketing techniques to influence target audiences and promote healthy behaviour. Examples of interventions: Media campaigns to promote the importance of good oral health and raising awareness of the availability of NHS dental services – based on extensive consumer research (focus groups etc.), segmentation and targeting of specific population groups. Key points • Evidence weak/inconclusive, particularly on the long term impact. Studies largely based on nutritional interventions, physical activity and substance abuse programmes • Costly if extensive consumer research is carried out. Some suggestion that online interventions cost less and have greater reach. • Sustainability of impact likely to be an issue. • Intervention has the potential to address inequalities by specific targeting of population groups with accurate segmentation of the population. • See notes on ‘Facilitated access to dental services’ for further information about increasing uptake of services.</td>
</tr>
</tbody>
</table>
What works: main recommendations
Recommended interventions

- Oral health training for the wider professional workforce (e.g. health, education)
- Integration of oral health into targeted home visits by health/social care workers
- Targeted community-based fluoride varnish programmes
Recommended interventions

• Targeted provision of toothbrushes and tooth paste (i.e. postal or through Health Visitors)
• Supervised tooth brushing in targeted childhood settings
• Healthy food and drink policies in childhood settings
Recommended interventions

- Fluoridation of public water supplies
- Targeted peer (lay) support groups/ peer oral health workers
- Influencing local and national government policies
NICE Guidance

NICE guidance

• Local authority strategies to improve oral health particularly among vulnerable groups (release for consultation 1\textsuperscript{st} April)

• Promoting oral health - the patient experience (short)- Guidance for dental health practitioners on effective approaches to promoting positive oral health behaviour (scope currently out to consultation)

• Oral health in residential and nursing homes (standard)- Guidance for carers working in residential care settings (including nursing homes, residential care homes) on promoting oral health, preventing dental health problems and ensuring access to dental treatment (commencing later this year)
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• Commissioning frameworks that integrated oral health within existing programmes e.g. 0-19 healthy child programme
• Commissioning specific oral health programmes based on needs and evidence of what works
• Review existing programmes
  • Meet local needs
  • Upstream, mid and down, targeted and universal
  • Engaging partners, collaborative commissioning and pooled budgets
• Cost benefit analysis
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Exemplars and case studies
- Local planning and the food environment
- Healthier eating policies in schools
- Accreditation schemes in early years settings
- Training the CYP workforce
- Community fluoride varnish programmes
- School based tooth-brushing programmes
- Re-orientating services
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Local government’s new public health role

Key questions for scrutiny of oral health improvement delivery

1. What are the oral health needs of children and young people in your local area?
   - Do you have information and intelligence regarding the oral health of children and young people (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?
Next Steps

- Publish Thursday 19th June
- Letter to all DsPH from Kevin Fenton
- Working with LGA and Centre for Public Scrutiny to develop guidance based upon CBOH launch Autumn
- Support regional and local launches
- Publication of NICE guidance review required?
- CBOH- Elderly in residential care homes?
- Major research agenda