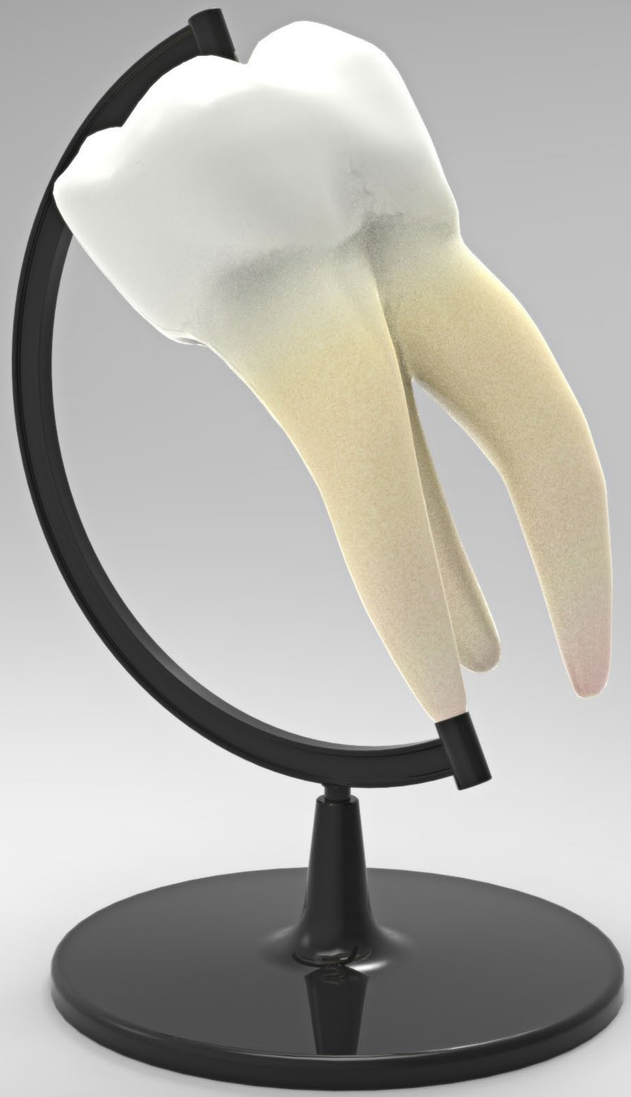
May 2022

Blackburn with Darwen Oral Health Improvement Partnership Strategy 2021 - 2026



Author: Gill Kelly, public health development manager, Public Health and Wellbeing, Blackburn with Darwen Borough Council – gillian.kelly@blackburn.gov.uk

Foreword

Good oral health has an important role to play in our general health and wellbeing. Oral diseases are common and their impact on both society and the individual is significant. Poor oral health in young children can affect their ability to sleep, eat, speak, play and socialise with other children. Although this is the same for older adults it can also affect their overall quality of life, self-esteem, social confidence, and mental wellbeing, often resulting in reduced engagement in community life, leisure and cultural activities, education and learning, volunteering and employment.

Oral health is an emerging issue amongst vulnerable older people. National data shows an increase in the retention of natural teeth which are often heavily filled and require complex dental or oral care. Alongside this, oral cancer is on the increase with evidence suggesting that tobacco, not eating enough fruit and vegetables, and drinking alcohol, all increase the risk of poor oral health. Other factors also have an impact, such as an increase in the prevalence of Alzheimer's and other dementias and long-term conditions.

Blackburn with Darwen's Oral Health Improvement Strategy aims to promote initiatives and actions across the life course to tackle a broad range of inequalities in oral health, which reflect broader health inequalities. The strategy recommends whole population and behaviour change approaches in an attempt to address some of the common risk factors associated with poor oral health. The recommendations for action in the strategy involves upstream, midstream and downstream interventions based on the best available evidence that use both targeted and universal approaches. These are weighted towards communication, culture and behaviour change, outlined in the accompanying action plan.

Tackling children's oral health is complex and bound up with issues of culture, lifestyle and deprivation. Far too many of our youngest children are having to undergo avoidable and preventable tooth extractions to remove painful and rotten teeth. A whole 'place based approach' to oral health promotion action is required, involving sustained effort, resource and commitment from all partners and residents to tackle this long standing public health issue.

Our health and wellbeing partners are committed to improving the oral health of our children and vulnerable adults, both now and over the long term, as we face the unenviable challenge of reversing our position of having the highest rate of tooth decay in our 5 year old children in England (2018/19).

Through our collective efforts, we are determined to reduce the oral health inequalities associated with access to a healthier food and drink, oral health promotion, literacy and self-care resources, and regular dental health checks for our most vulnerable children, adults and the elderly. This strategy serves as a clear call to action to all of our partners, from the public, private, voluntary community and faith sectors to focus our resources to support and enable our residents to improve the overall oral health and wellbeing of children, families and vulnerable adults.

Cllr Damian Talbot
Executive Member for
Public Health and Wellbeing

Jayne Ivory
Strategic Director of Children's
Service and Education

Abdul Razaq
Director of Public Health

Councillor Julie Gunn
Executive Member for Children
Young People & Education

Oral Health Improvement Partnership Strategy 2021 - 2026

Aim of the strategy

The aim of the oral health improvement strategy is to improve the oral health of children, vulnerable adults, and the elderly who live in supported living or in care homes.

The Vision

The long term vision is to see an increase in children starting school with a full set of healthy teeth who will then grow into adults and older adults with healthy strong teeth and gums.

The rate of decayed missing and filled teeth (dmft) will also fall year on year, with a target for Blackburn with Darwen Borough Council to match the North West rate by 2026 when the second Public Health England (PHE) commissioned survey of five year olds will have taken place.

Executive Summary

Blackburn with Darwen Borough Council is one of the more deprived local authorities in England. Poor oral health is closely linked to deprivation, and this is seen in the data for decayed missing or filled teeth (dmft) for the Borough.

Our five year olds have the highest rate of decay in England, this time by a significant margin. This is a call to action to provide long term interventions to reverse the trend year on year.
Good oral health has an important role in positive general health and wellbeing for children, vulnerable adults and the elderly, and prevention of poor oral health is a multifaceted approach involving education, healthcare, dental services, young people's services, the voluntary, community and faith sector (VCFS) and Public Health.

This strategy has been developed in consultation with partners such as NHS England (NHSE), Public Health England (PHE), the Community Voluntary and Faith sector and the Borough's Food Resilience Alliance. It includes data showing the scale of the oral health problems in the Borough, effective evidence based interventions, best practice and recommendations for collective action to improve the oral health of our residents.

The impact of these interventions will be evident in the next two to five years, measured by the surveys of five year olds in 2023 and 2025 and evaluation of the recommended interventions which are set out across the three life courses of Start Well, Live Well and Age Well. They should go a long way to improve the oral health of all our residents.

Recommendations:

Start Well:

1. Make oral health a core component of a joint strategic needs assessment and the health and wellbeing strategy. Review it as part of the yearly update.

2. Ensure all staff working with children in early years settings receive e-learning for oral health each year. Other key staff such as health visitors will receive face to face oral health training on an annual basis, from a commissioned provider.

3. Peer support in early years' settings to form parent champion networks.

4. Continue to purchase toothpaste, toothbrushes and sippy cups for our health visitors to distribute to every child at their 8-12 month check and continue to purchase and distribute a supply of adult brushes and toothpaste for our care leavers each year.

5. Source a provider to deliver and monitor a universal supervised brushing scheme in reception classes, children's centres and nurseries.

6. Explore with NHS England how dental practices can apply fluoride varnish to children in areas found to have high rates of decay and also make sure every child is registered with a dentist by one year old.

7. Update and reinstate the Smile 4 Life award scheme in all early years' settings; Give Up Loving Pop (GULP) to be rolled out across 20 primary schools with highest rates of decay.

8. Develop and deliver a targeted communications campaign between council and partners to promote good oral health. This will use the intelligence from the full dental census survey to pinpoint wards with the highest rates of decay.

Recommendations:

Live Well:

9. Purchase toothbrushes and toothpaste for our commissioned services to deliver to clients in houses of multiple occupancy (hostels) and request an evaluation of this intervention from the provider each year.

10. Services working with vulnerable adults access oral health e-learning on induction and this training will be refreshed annually.

Age Well:

The NHS guide 'Framework for Enhanced Health in Care Homes' recommends the following:

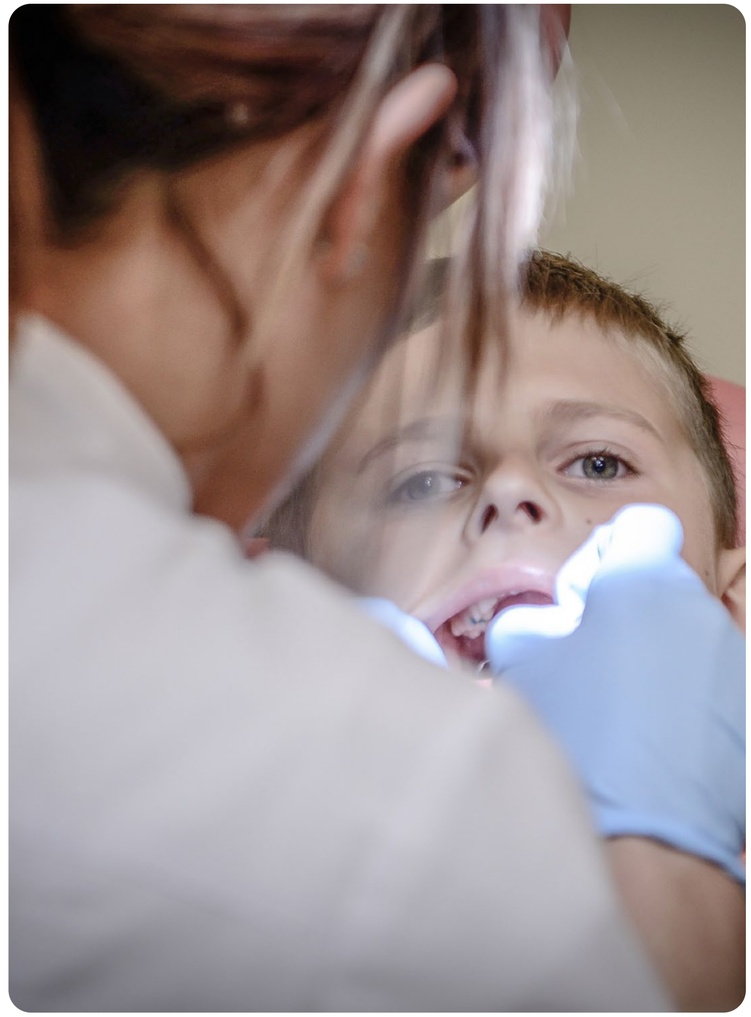
11. Every person's oral health should be assessed as part of the holistic care home / domiciliary care assessment of needs and personalised care and support planning process.

12. Care homes should have an oral health policy in place with one staff member taking responsibility for this policy within the home. This should be clearly aligned to NICE guidance 48 Oral Health for Adults in Care Homes.

13. Every person's oral health should be enquired after and/or observed regularly by care home staff as part of their usual hygiene routine, and they should have access to routine dental checks and specialist dental professionals as appropriate. Local systems should work collaboratively to provide access to appropriate clinical dental services for people living in care homes.

14. Staff employed by care home providers should undertake training in oral healthcare to support delivery of oral health assessments and daily mouth care for individuals, and maintain this knowledge and skill through ongoing professional development.

15. Adult Social Care to co-ordinate oral health e-learning for all staff working in care homes or who support our vulnerable elderly residents who live in their own homes. This will take place on induction and as annual refresher training. The oral health champion identified in recommendation 2 above will receive more in depth annual training from the commissioned oral health improvement training provider.



Introduction

People living in deprived communities consistently have poorer levels of oral health than people living in more affluent areas[1]. The prevalence of tooth decay, tooth loss, oral cancer and gum disease follows this social gradient. Blackburn with Darwen Borough council has an Indices of Multiple Deprivation (IMD) poverty deprivation score of 42, which is the highest of any upper tier local authority (UTLA) in the North West. The Borough also has the 2nd highest proportion of children <16 years (31.4%) living in absolute poverty in the North West.

Blackburn with Darwen Borough Council now has the highest proportion of its five year olds experiencing decay, in the whole of England.

Poor oral health can affect the ability of children to sleep, eat, speak, play and socialise with other children. Other impacts include pain, infections, poor diet, and impaired nutrition and growth which affect the ability of the child to learn, thrive and develop. To benefit fully from education children need to be healthy and ready to learn. Children with special educational needs and disabilities (SEND) need extra support.

Oral health among children aged five years attending mainstream schools is a useful indicator to measure the impact of interventions to improve general health and wellbeing (including parenting, weaning and feeding practices and nutrition) and school readiness. This metric is currently measured every two years and is commissioned by local authorities as a statutory requirement.

Older people's oral health is determined by behaviour and choices but also vulnerability, and good oral health improves quality of life. Older adults, especially the homeless, substance misuse clients, those with a learning disability or mental illness and the elderly living in care homes or with home help, need to have extra help maintaining a healthy mouth.

The two main oral diseases, dental decay and periodontal disease, share the same risk factors as other chronic diseases and conditions, such as heart disease, cancer, strokes, diabetes and obesity – the latter two being risk factors for severe COVID-19, so prevention is key.

The Pennine Lancashire Integrated Care Partnership have also prioritised oral health and their Business Intelligence Leadership Team have produced a NHS Right Care 'Where To Look Pack' 2019/20 (see Appendix 3) focusing on dental caries in children. Their recommendations are integrated into the Start Well recommendations later in this report.

A life-course approach to chronic disease development therefore highlights the importance of early childhood factors in the development of chronic ill-health, including oral diseases.

[1]Health Matters: Child dental health - Public health matters (blog.gov.uk)

Part 1 – Start Well

Current Situation

Blackburn with Darwen now has the highest % of five year olds with decayed missing or filled teeth in England, with 51% of five year olds having at least one decayed missing or filled teeth (see Figure 1). This data is taken from the 2019 Public Health England (PHE) dental epidemiology survey in which 282 other local authorities in England took part (43 provided no data). The survey is completed each year, and is a function of the oral health responsibilities transferred to local authorities from the NHS as part of the Health and Social Care Act 2012. Blackburn with Darwen Borough Council commissions the University of Central Lancashire to perform this statutory function. Whilst five year olds are surveyed every two years, each subsequent year is pre-determined by PHE (it has previously been adults seen in a dental practice, 3 year olds, 10 year olds and 12 year olds). See Oral Health - Roles and responsibilities for further details.

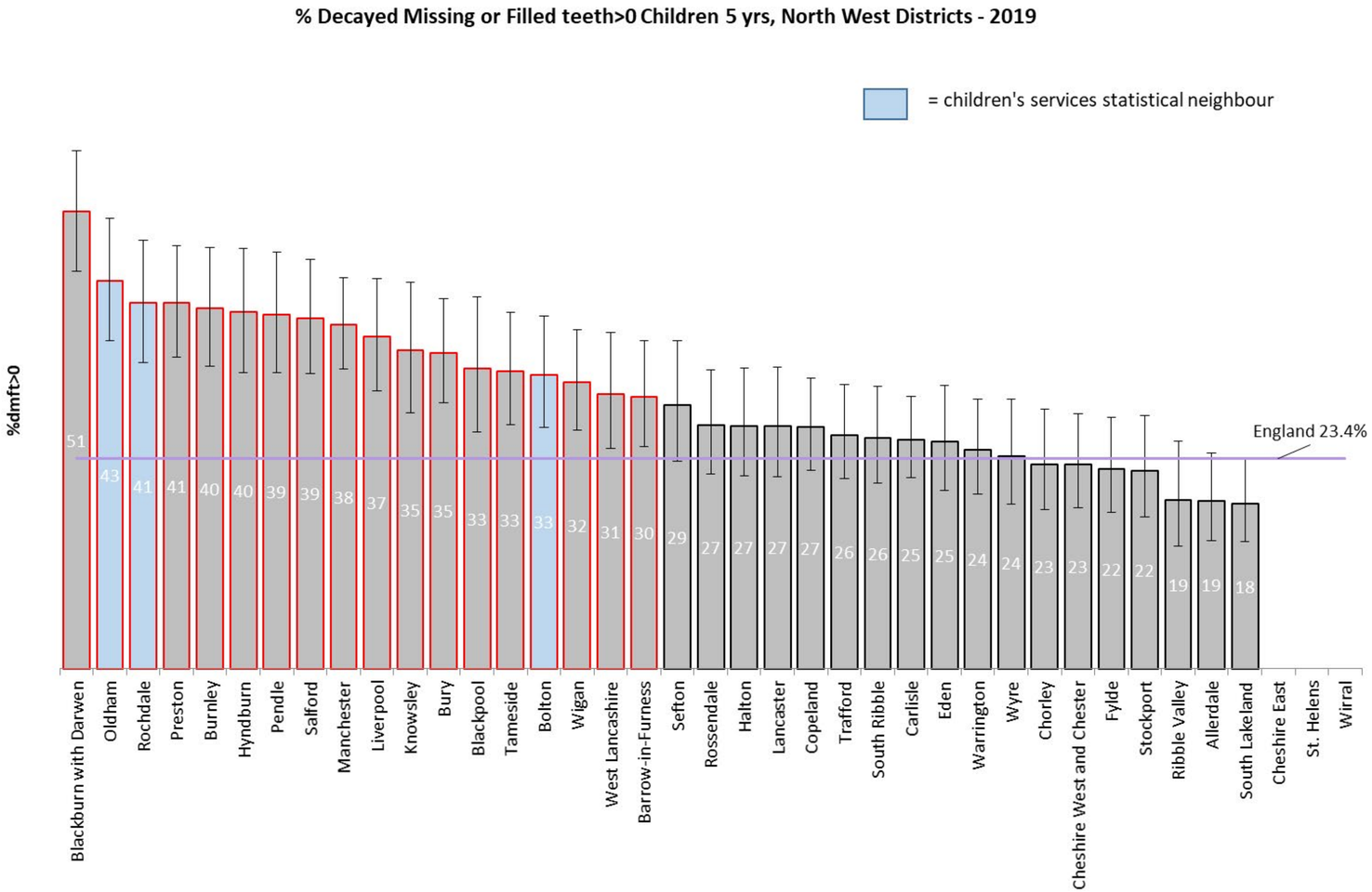


Figure 1: Proportion of 5yr olds with decayed, missing or filled teeth, North West, 2019
Source: PHE Fingertips 2020

Dental decay occurring in the first two or three years of life can affect the smooth surfaces of upper front teeth and can affect many other teeth as well. This type of decay (early childhood caries) occurs more often in some ethnic groups and is usually associated with long term use of a baby bottle containing sugared drinks, especially if given at night (NICE, 2008). The 2013 survey of three year olds found that 9% had early childhood caries across Blackburn and Darwen, which was higher than the North West (5%) and England (4%) averages. Higher proportions of children from Pakistani and Bangladeshi heritage groups experienced early childhood caries in some of our statistical neighbour local authorities. The numbers were too low for Blackburn with Darwen Borough Council to show any significance, but higher proportions of children from Pakistani and Bangladeshi heritage groups also experienced early childhood caries here too.

To allow for statistical analysis by ethnicity, the dental survey data was requested from PHE for Pendle and Burnley. The data for these boroughs and Blackburn with Darwen Borough Council's was combined to give a much bigger sample size for more accurate findings. This analysis by ethnicity showed that Asian children living in Blackburn with Darwen, Burnley and Pendle borough councils (combined) have a statistically significantly higher proportion of three and five year olds experiencing decay than white children.

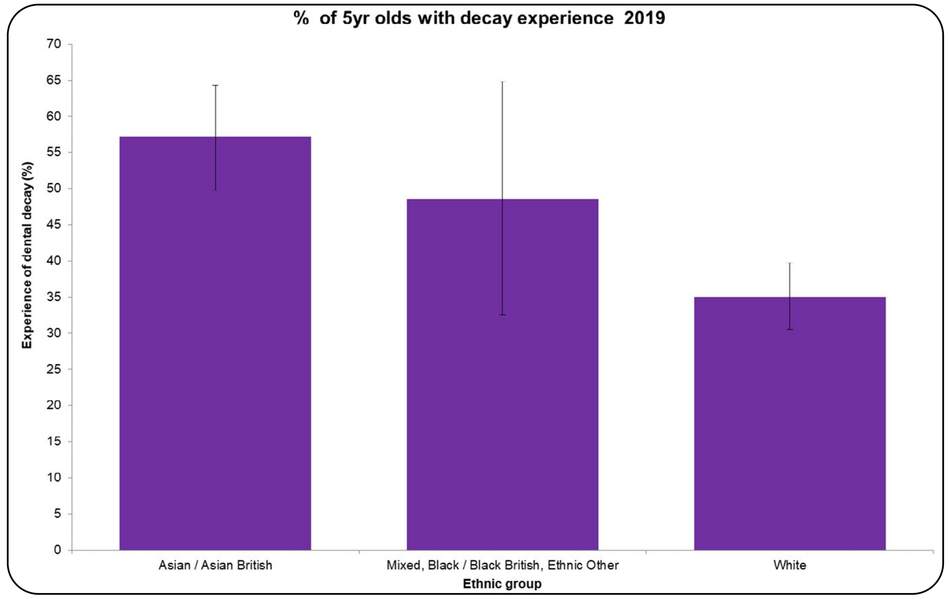


Figure 2 % of five year olds experiencing decay by ethnicity, Blackburn with Darwen, Burnley & Pendle combined. Source: PHE Dental epidemiologist 2020.

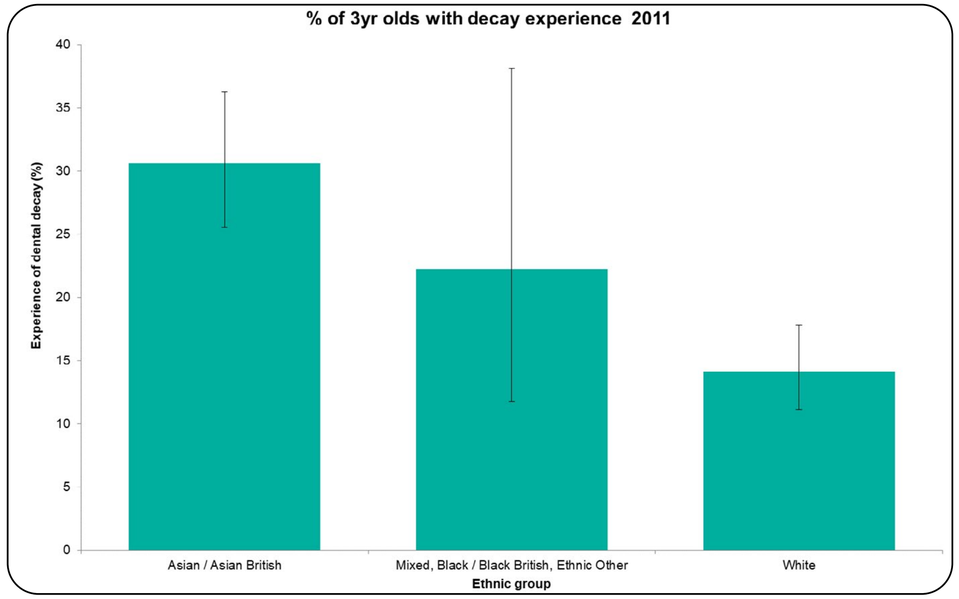


Figure 3: % of three year olds experiencing decay by ethnicity, Blackburn with Darwen, Burnley & Pendle combined. Source: PHE Dental epidemiologist 2020.

Deprivation

Analysis by the commissioning support unit shows that most children aged 0-5 in Blackburn with Darwen live in the most deprived decile (as is the picture for Pennine Lancashire) so the link between poverty and decay is strong.

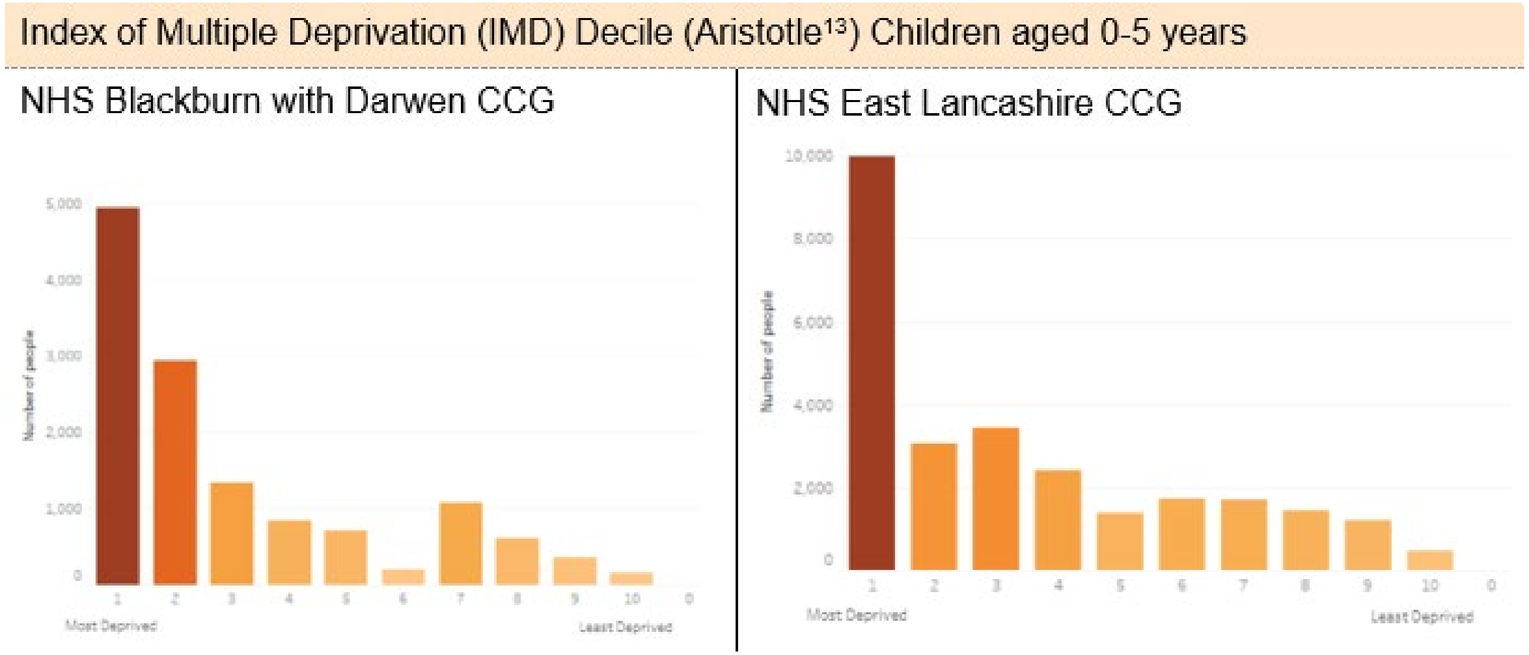


Figure 4: % of the population by age band by deprivation decile
Source: Commissioning Support Unit Aristotle Population Health Management tool 2019/20

Hospital episodes for tooth extraction

Dental extractions are the most extreme result of poor oral health, and the most common single reason for hospital admissions for young children aged 5 to 9 years of age in England[2]. Blackburn with Darwen Borough Council has the second highest rate for hospital admissions for dental caries for 0-5 year olds in the North West with 905 admissions per 100,000 children aged 0-5 (crude rate) – see Figure 5.

Children have extractions carried out in hospital mainly because they need general anaesthetic for the procedure. They may be very young or uncooperative, have multiple teeth requiring extraction or have very broken down teeth or infection.

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	34,771	286.2	283.2	289.3
North West region	–	7,045	446.8	436.4	457.3
Blackpool	–	320	1,055.1	948.8	1,184.2
Blackburn with Darwen	–	350	905.6	808.3	1,000.1
Liverpool	–	770	726.7	676.3	779.9
Wigan	–	485	725.2	659.2	789.5
Bolton	–	485	692.7	631.1	755.7
Lancashire	–	1,600	654.8	623.1	687.7
Manchester	–	720	529.1	491.8	569.9
Tameside	–	260	495.5	433.5	555.5
Oldham	–	280	462.4	409.8	519.9
Rochdale	–	250	455.9	399.4	514.1
Salford	–	285	450.1	400.8	507.2
Knowsley	–	160	446.0	377.0	517.7
Stockport	–	270	420.8	373.6	475.7
Bury	–	175	404.5	342.5	464.2
Sefton	–	180	342.6	297.9	400.6
St. Helens	–	85	228.7	182.6	282.8
Trafford	–	120	223.8	183.8	265.6
Cheshire East	–	90	122.0	96.9	148.4
Warrington	–	45	103.5	75.5	138.4
Halton	–	25	89.2	60.6	135.9
Cheshire West and Chester	–	55	81.2	59.9	104.1
Wirral	–	20	30.3	18.5	46.8
Cumbria	–	20	22.8	14.8	36.6

Figure 5: number and crude rate of hospital admissions for 0-5 year olds for dental caries, north west – 2017/18 -2019/20
Source: PHE fingertips 2020

[2]Hospital Episode Statistics (HES) 2019

Trend

Figure 6 shows Blackburn with Darwen Borough Council having the same proportion of five year olds experiencing decay as thirteen years ago, with the proportion of children experiencing decay back up to 51% - from a high of 56% in 2014/15.

Evidence suggests the dip in 2012 was as a result of a large Primary Care Trust-funded fluoride varnish scheme involving the then dental nurse teams based in Accrington and Burnley. There was a Keep Smiling Scheme, Smile for Life and an active oral health promotion scheme with a fluoride toothpaste distribution programme.

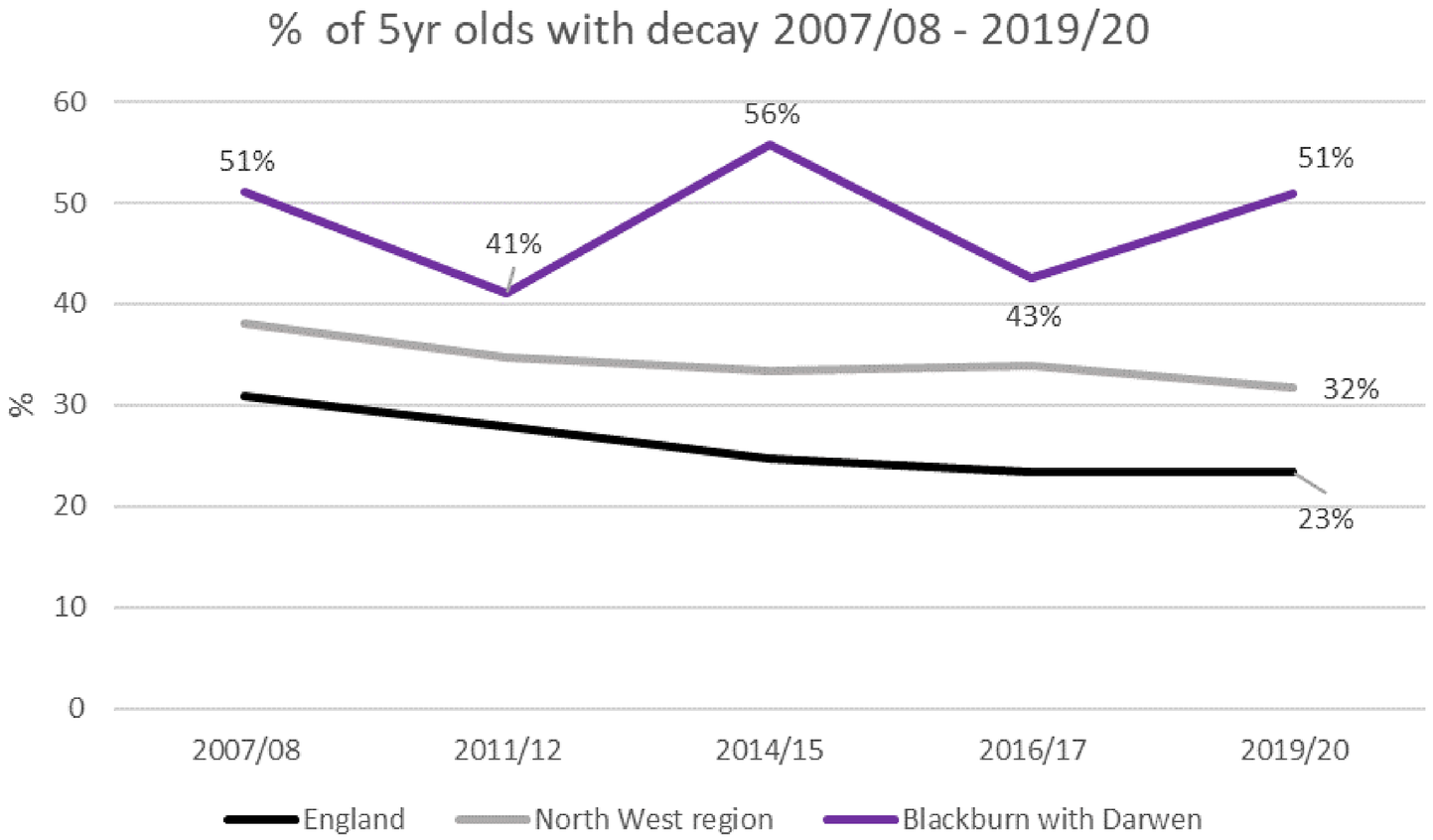


Figure 6: The proportion of five year olds experiencing >0 dmft, 2007/08 – 2019/20
Source: PHE fingertips 2020

School Health Needs Assessment questionnaire

Dental visits

The school health needs assessment questionnaire was a paper questionnaire sent to parents of children in reception, and is completed by children in years 6 and 9. It asks many questions to determine need for a one to one visit from the school nurse, but also asks if the child has been to the dentist in the last 12 months. Figure 7 shows the situation is getting worse with over 20% of five year olds not seeing a dentist in the previous 12 months and an increasing proportion of year 9 students not visiting the dentist. One Voice surveyed some of its members in 2019 and found that a proportion of parents from South Asian heritage didn't feel you needed to register your child with a dentist until they started school.

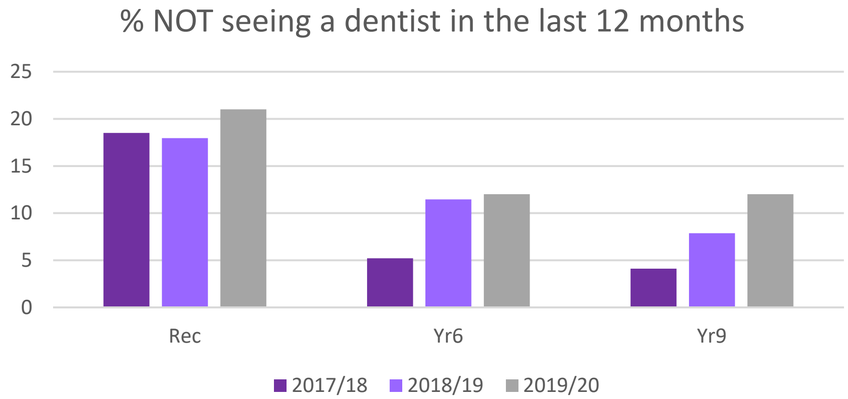


Figure 7: % of children not seeing a dentist by school cohort over time

Tooth Brushing

The proportion of school children informing the school nurse team they did not brush their teeth twice the previous day is also increasing, with the figure doubling from 4% for our year 9's to 8% and increasing for year 6's each year. Results from the One Voice survey also showed some parents believed tooth brushing was only necessary in the morning.

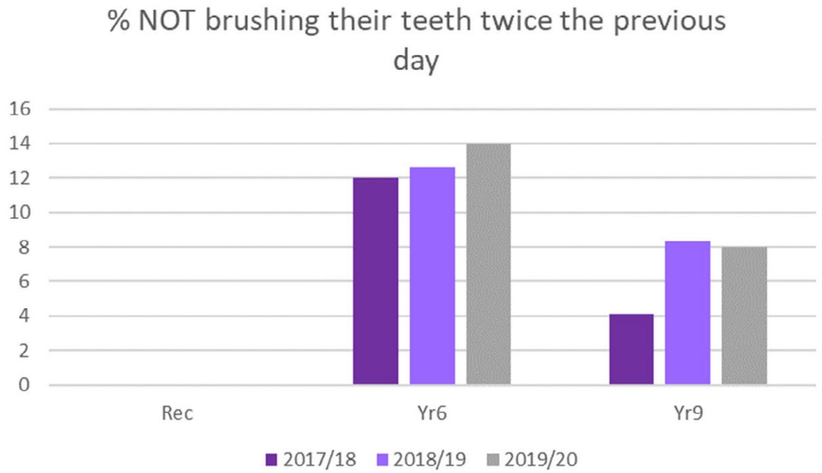


Figure 8: % not brushing their teeth twice the previous day

Oral Health - Roles and responsibilities

The Health and Social Care Act 2012 redistributed resources and responsibilities previously held by Primary Care Trusts. Since April 2013 the roles and responsibilities of Local Authorities, NHS England and PHE in relation to oral health and care are:

Local Authorities have responsibility for improving oral health in the population and there is a Public Health Outcomes Framework (PHOF) measure that relates to this (dental decay among five year olds). We are therefore responsible for commissioning actions and programmes to tackle poor oral health and reduce inequalities. Some of these involve services provided and commissioned by the Local Authority such as Health Visiting and School Nursing Services. In addition local authorities are responsible for monitoring general and oral health and undertaking health needs assessments relating to oral health. This responsibility is supported by the PHE Dental Public Health Epidemiology Programme which facilitates national surveys of a variety of population groups and aims to provide estimates of oral health at local authority level. This programme usually requires local authorities to commission local fieldworkers to undertake local surveys according to a national protocol. Blackburn with Darwen Borough Council have commissioned the dental school at the University of Central Lancashire to provide this service, and the council are in the process of determining an oral health improvement service, as per our responsibilities under the Health & Social Care Act 2012.

NHS England (NHSE) are responsible for commissioning all primary, specialist and hospital preventive and clinical care for oral conditions. This covers general dental practices, access centres and community dental services for primary care, a range of providers for specialist care and dental and general hospitals for inpatient and outpatient care.

Office of Health Improvement and Disparities has a responsibility to provide high level expertise on oral health to support and add value to local authorities and NHS England teams. For example, PHE facilitates and supports the Lancashire and South Cumbria Oral Health Improvement group.

Other Local Authorities - our statistical neighbours' children's oral health interventions

Bradford is one of the most deprived areas in England, with a high prevalence of dental disease in 5 year olds. The local authority recently revised its oral health strategy to highlight areas for improvement and interventions include a community-based fluoride varnish programme, supervised tooth brushing in early year's settings and training for the early years and dental workforce. In addition there is a targeted programme with children attending mosque study classes and Islamic schools.
https://publichealthmatters.blog.gov.uk/2017/06/19/health-matters-tackling-child-dental-health-issues-at-a-local-level/

Oldham - The 2016/17 Public Dental Health Epidemiology Programme for England, oral health survey of five-year-old children living in Oldham showed that dental decay levels decreased significantly to three in ten (34.8%). Oldham has an early years tooth brushing programme called 'Smiles Matter' with nurseries and reception classes taking part in supervised tooth brushing programmes to improve their children's oral health. Children are given a free toothbrush and helped each day to brush their teeth with toothpaste containing the correct amount of fluoride. All children receive a free pack to take home with a toothbrush, fluoride toothpaste and an information leaflet.

Oldham also run an annual 'Big Brush' in November when they encourage all parents in Oldham to back a borough-wide dental campaign to help local children brush up on their tooth care. Throughout the month, children's centres and many nurseries are involved in the Big Brush campaign and some children receive oral health packs containing toothpaste, toothbrushes, timers and written information.

Rochdale - The rate of decay in Rochdale's five year olds has fallen from 47% in 2017 to 41% in 2019. They had commissioned:

1. Borough wide fluoride varnish programme for children aged 3-5 yr. old in both private and Local Education Authority (LEA) nurseries and reception classes.

2. Public Health England transformation fund programme for tooth brushing in schools, taking place in LEA and private day nurseries for children aged 2-5 yr. olds.

3. "Brushing for Life", a Health Visitor led family fluoride tooth brushing scheme for children aged 9 month and 2 yrs. delivered during child assessment visits.

4. "Bump to Baby", a maternity family fluoride toothpaste scheme which helped to create links to promote dental attendance during the ante natal and post-partum periods.

5. Tooth Time, within both LEA and private nurseries. A family fluoride toothpaste scheme which children took home promoting good oral hygiene habits with family or significant carer.

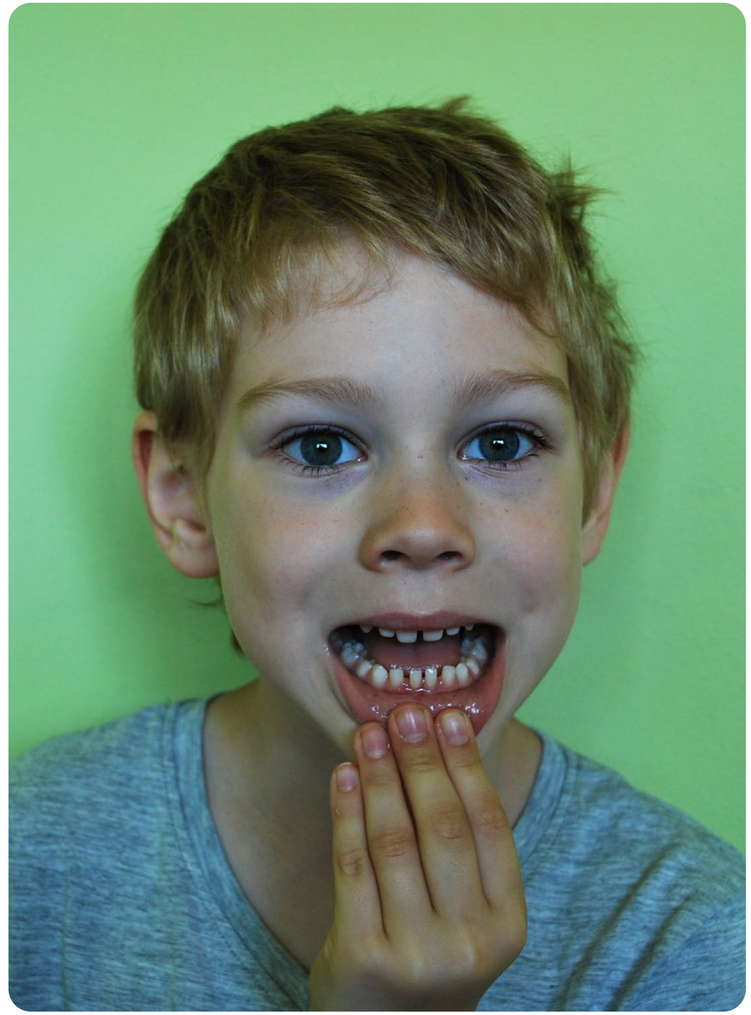
6. The Golden Grin Award scheme designed for all early years settings based on healthy snacking and none food rewards.

7. Referral programme to Living Well Oral Health specialist, for children and families with additional needs. It delivered 1:1 support to improve oral health and support dental attendance.

8. The design and delivery of oral health learning packages for LEA staff and private day nurseries to roll out in class.

9. The loan of resources to support the training packages and delivery of programmes in both LEA and private early years settings.

10. Learning packages in oral health for child minders.



Bolton - The proportion of five year olds with decay in Bolton is 33%, down from 38% in 2017 (and has been declining every survey since 2008). Bolton also has an oral Health Improvement Department based within Bolton NHS Foundation Trust.

The Council has a number of oral health improvement schemes:

1. Brushing for Life (Children aged 8mths) is a health visitor led programme, designed to promote regular brushing of children's teeth. Health visitors provide oral health advice and support for parents and babies at the eight month assessment, along with giving them a toothbrush, toothpaste and an information leaflet.

2. The oral health improvement team offer information and support within a number of children's centres across Bolton. Parent and baby Sessions give early advice for parents on preventing dental decay. The oral health improvement team also explain the importance of early dental attendance and supply a dental access voucher if required.

3. The Dental Access Voucher Scheme aims to ensure that vulnerable children, including looked after children and children on a safe guarding plan are able to access care with a local dentist quickly. The programme has been running in Bolton since 2005 with support from a number of local dental practitioners.

4. Brush Bus - since 2007, children in Bolton have benefited from a supervised Brush Bus programme with many schools, nurseries and special schools taking part. Schools are still posting their Brush Bus activities on their websites.

Evidence based Interventions for consideration for Blackburn with Darwen Borough Council

NICE produce a full list of recommendations for oral and dental health in many settings, outlined in Appendix 2.

PHE's Commissioning Better Oral Health is a guide for local authorities. The Health and Social Care Act (2012) amended the National Health Service Act (2006) to transfer responsibilities to local authorities for health improvement, including oral health improvement, in relation to the people in their areas. Local authorities have specific dental public health functions and are statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas.

Appendix 1 details the interventions that PHE say local authorities should consider commissioning that are recommended. It also shows those interventions with limited or no value.

Return on investment

The responsibility for providing oral health improvement interventions falls on Local Authorities and the benefits of better oral health to us as a community are:

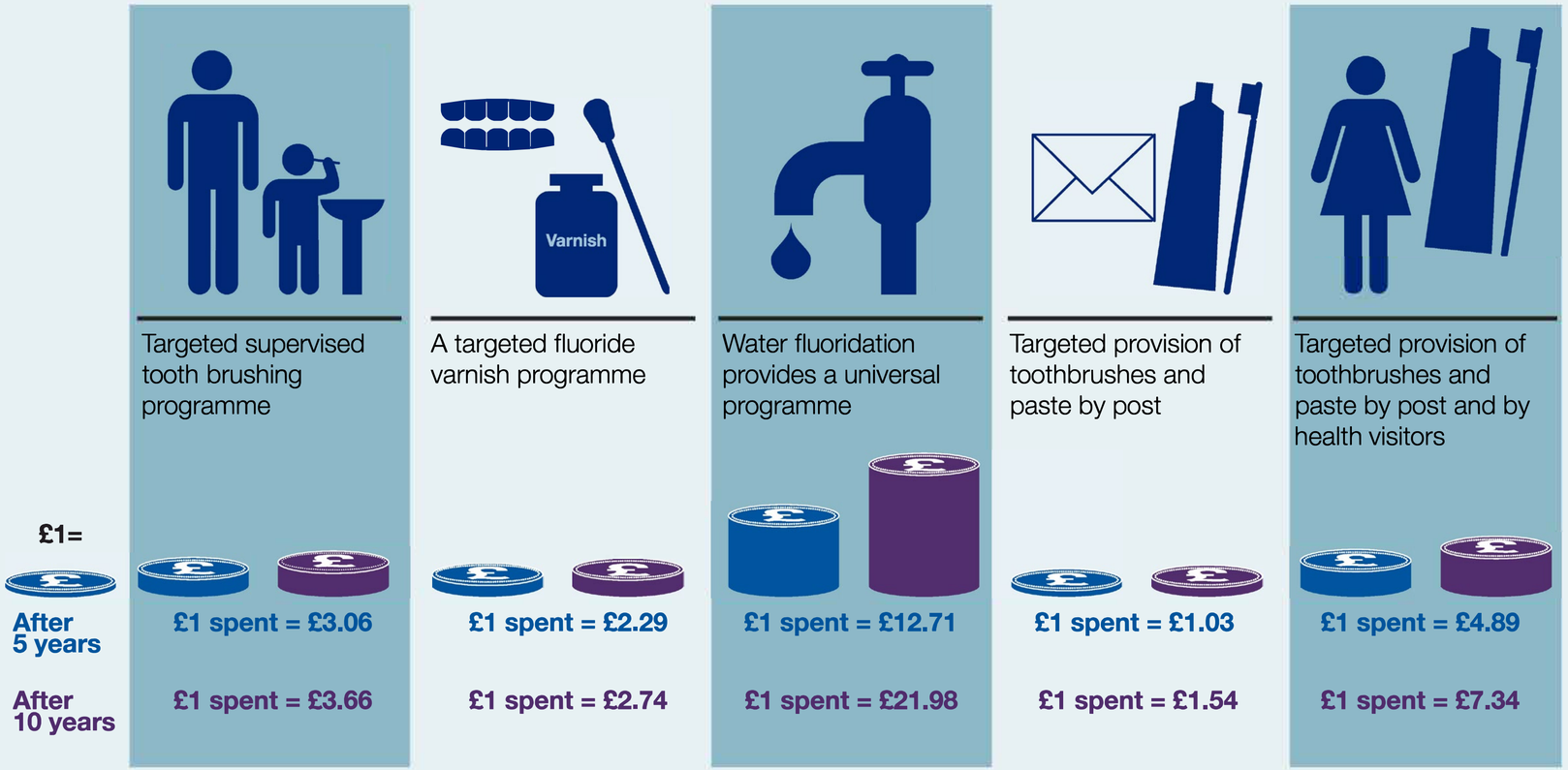
1. Improved school attendance due to fewer absences due to tooth ache / tooth extraction hospital episodes.
2. Better long term health due to the links between poor oral health in childhood and adulthood and chronic illness (Anja Heilmann, 2015)
3. Improved Public Health Outcomes Framework (PHOF) indicators for the council.

Figure 9 highlights those interventions that are cost effective:

Public Health England

Return on investment of oral health improvement programmes for 0-5 year olds*

Reviews of clinical effectiveness by NICE (PH55) and PHE (Commissioning Better Oral Health for Children and Young People, 2014) have found that the following programmes effectively reduced tooth decay in 5 year olds:



All targeted programmes modelled on population decayed, missing or filled teeth (dmft) index of 2, and universal programme on dmft for England of 0.8. The modelling has used the PHE Return on Investment Tool for oral health interventions (PHE, 2016). The best available evidence has been used in this tool and where assumptions are made these have been clearly stated.

Recommendations

Recommendations to improve the oral health of children and young people across Blackburn with Darwen Borough Council

(also aligns the Pennine Lancashire recommendations – see Appendix 3 for details)

» **Recommendation 1:**
Make oral health a core component of a joint strategic needs assessment and the health and wellbeing strategy. Review it as part of the yearly update.

Sub recommendations to improve intelligence are:

Recommendation 1a: Discuss with our epidemiology provider (UCLan dental school) the cost of a full census survey of five year olds across the Borough (planned for school term 2020/21) to pinpoint wards with high rates of decay, and to allow full analysis by ethnicity, to enable targeted interventions at the right population (currently only 250 children per district are randomly selected across the Borough).

Recommendation 1a has now been completed.

Recommendation 1ai: discuss with the provider a contract variation for the 2023/24 survey to again conduct a full census survey of five year olds.

Recommendation 1b: Set up a group that has responsibility for an oral health JSNA and who will monitor the oral health improvement action plan that aligns with this strategy.

Recommendation 1b is now established

Recommendation 1c: Blackburn with Darwen Borough Council's 'Eat Well, Move More, Shape Up' (EWMMSU) strategy is to include oral / dental health improvement and the oral health improvement action plan will be approved by the board and monitored as part of the EWSUMM strategy action plan.

Recommendations

» **Recommendation 2:**
Ensure all staff working with children in early years settings receive e-learning for oral health each year. Other key staff such as health visitors to receive face to face oral health training on an annual basis, from a commissioned provider.

Recommendation 2a: Ensure the 0-19 service and our early years' services, including child minders and foster carers, create an account and undertake annually the NHS Health Education England's oral health training for the wider professional workforce, to ensure they convey healthy oral health messages appropriately to the community / children in care / when they visit vulnerable people / families, especially those in more deprived areas and South Asian Heritage communities.

Recommendation 2b: For more in depth continuing professional development, the council will commission an oral health improvement training provider to deliver bespoke face to face training across the three life courses Start Well, Live Well and Age Well. The main target audiences for Start Well will be health visitors, early year's staff in our children's centres and key workers in nurseries and social care staff working with children in our care.

» **Recommendation 3:**
Peer support in early years' settings to form parent champion networks.

Recommendation 3: Blackburn with Darwen Borough Council will participate in the Food Active 'Kind to Teeth' parent champion's pilot.

Training for parents champions to start September 2021

Recommendations

» **Recommendation 4:**
Continue to purchase toothpaste, toothbrushes and sippy cups for our health visitors to distribute to every child at their 8-12 month check and continue to purchase and distribute a supply of adult brushes and toothpaste for our care leavers each year.

Blackburn with Darwen: Continue to fund the purchase of toothpaste, toothbrushes and sippy cups for our health visitors to distribute to all of our young children at their 8-12 month old check and purchase toothbrushes for our children in care and our care leavers. The provider will at the same time deliver oral health improvement messages at these visits.

Pennine Lancashire: The Pennine Integrated Care Partnership also recommend The Children and Young People Commissioning Team explore the current NHSE work of Starting Well and other opportunities with partner organisations, to increase awareness amongst parents and action/communicate services that support young children in the prevention and early detection of dental caries. CCGs have opportunities to communicate advice and commission maternity and child-health services, both directly and with partner healthcare organisations.

» **Recommendation 5:**
Source a provider to deliver and monitor a universal supervised brushing scheme in Reception classes, children's centres and nurseries.

Blackburn with Darwen: Commission a provider to support the delivery of a targeted supervised brushing scheme (Brush Bus) in Reception classes, children's centres and nurseries, including special schools. Note there is a link between being overweight, poor nutrition and subsequently poor oral health in children (PHE, 2019) so the Recipe for Health scheme is also running in these settings.

(Note we have 6000 children in N1, N2 and reception across 112 settings)

Pennine Lancashire: The Pennine Integrated Care Partnership also recommend the CCGs' Children and Young People Commissioning Team explore opportunities with local Public Health partners to increase the regularity of tooth-brushing amongst young children.

Recommendations

» **Recommendation 6:**
Explore with NHS England how dental practices can apply fluoride varnish to children in areas found to have high rates of decay and also make sure every child is registered with a dentist by one year old.

Blackburn with Darwen: NHS England commission dentistry. The oral health strategy group will develop and deliver a targeted fluoride varnish scheme for 2-5 year olds using the clinical rooms in children's centres. NHSE are also discussing restarting the Start Well Scheme for dental practices. This scheme funds NHS dentists to attract more children under five year to register with a dental practice and will help towards making sure every child is registered with a dentist by aged 1 year old.

Pennine Lancashire: The Pennine Integrated Care Partnership also recommend using a Population Health Management approach to supplement their original Right Care data. The paper highlights that there are health inequalities in respect to NHS Dentist attendance across many of the districts that make up Pennine Lancashire. Rural populations in both CCGs show lower percentage attendance at NHS Dentists than non-rural areas (for children aged between 0 and 9 years old).

Low dental access rates for young children is thought to be a contributing factor to the poor state of child oral health. NHS Digital report that currently only 13% of children under 2 years of age are visiting a NHS Dentist each year. They recommend the Population Health Management Group explore opportunities to include dental caries prevention and oral health awareness for young children and families, as part of any holistic approach to mitigating health inequalities aligned with high deprivation.

Recommendations

» **Recommendation 7:**
Update and reinstate the Smile 4 Life award scheme in all early years' settings; Give Up Loving Pop (GULP) to be rolled out across 20 primary schools with highest rates of decay.

Blackburn with Darwen: Work with PHE and early years' settings to help plan and coordinate a Smile 4 Life programme across all early years' settings. This will help these settings satisfy the statutory framework for the early years' foundation stage 'safeguarding and welfare requirements for health' (food and drink policies)

Blackburn Rovers Football Club will support Food Active and their Healthier Stadia programme to deliver the GULP campaign to 20 primary schools with highest rates of decay (determined using the full oral health census survey data).

Pennine Lancashire: The Pennine Integrated Care Partnership also recommend: Both CCG populations have a higher percentage of children recorded as obese compared to the English rate (26% of East Lancs children aged 4 to 11 years and 19% of children in BwD – 4.6). They recommend the Children and Young People Commissioning Team and the Population Health Management Group explore opportunities (with partner organisations) to promote improved diets for children with reduced sugar intake, and the importance of good oral hygiene.

» **Recommendation 8:**
Develop and deliver a targeted communications campaign between council and partners to promote good oral health. This will use the intelligence from the full dental census survey to pinpoint wards with the highest rates of decay.

Part 2 – Live Well

Adults

Intelligence to support interventions to support adults' and the elderly's mouth care is scarce. However in 2019 PHE informed local authorities that they were to commission a survey of adults in dental practices. Not all authorities took part, and in many, the sample was too small to publish, but what we have is interesting (all bars except those with a green highlight (statistically better than the England rate) are not statistically different from the England rate). Blackburn is ranked 4th behind three Merseyside local authorities. The sample was just 100 adults hence why it is no different to the England rate. Still, 36% had active decay on their visit to the dentist.

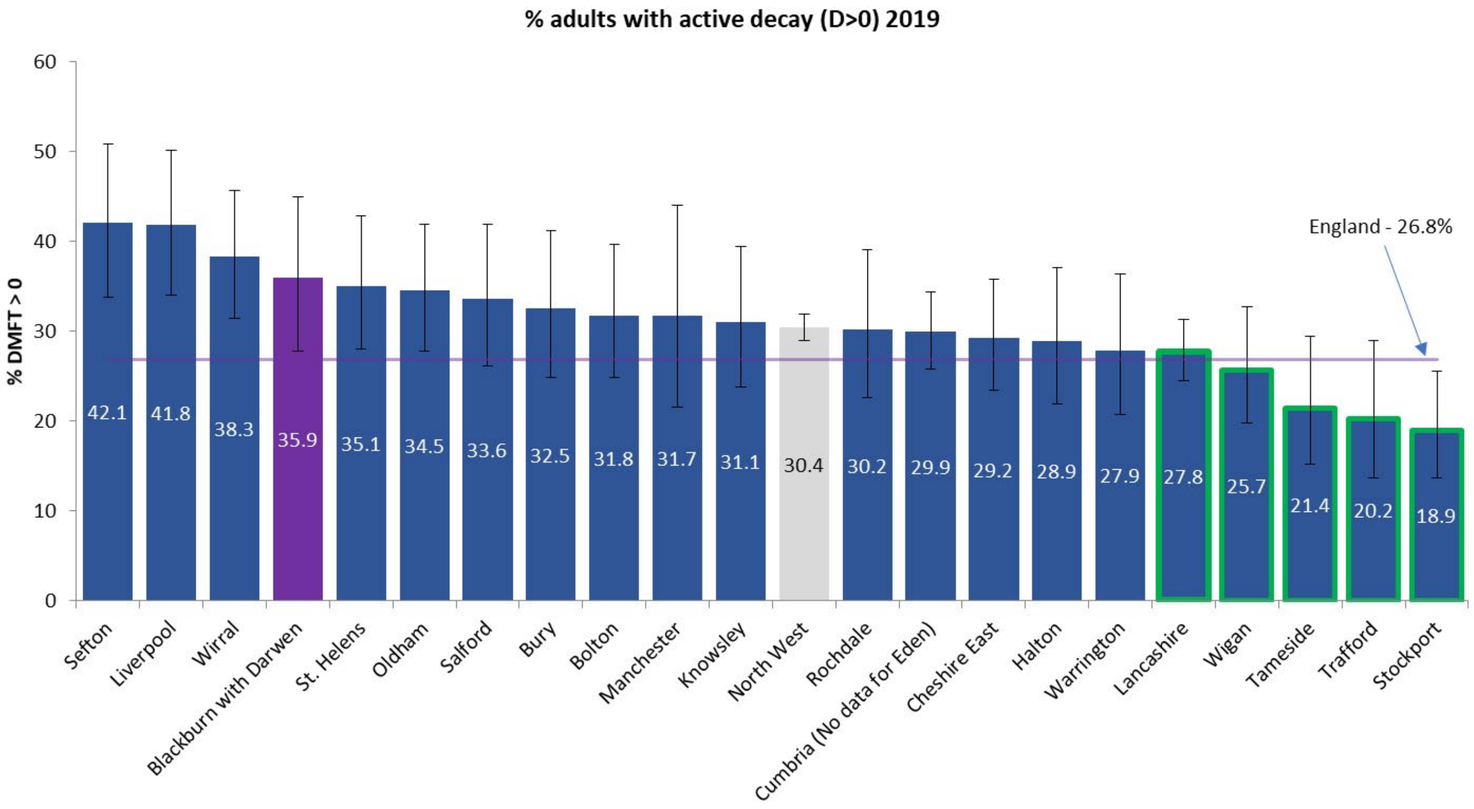


Figure 10: % of adults checked in a dental practice with active decay
Source: PHE PHE March 2020

Oral Health Improvement Activity - gaps

Black and Asian populations

The Health and Social Care Act 2012 redistributed resources and responsibilities previously held by Primary Care Trusts. Since April 2013 the roles and responsibilities of Local Authorities, NHS England and PHE in relation to oral health and care are:

Barriers to access: Several qualitative studies have explored the barriers to accessing dental services by people from black and minority ethnic groups. Barriers identified included: language issues, a mistrust of dentists, organisational issues for those in large families, cost, anxiety, cultural misunderstandings and concern about standards of hygiene (Newton J T, 2001), (Scambler, 2010). The type of barrier identified differed between ethnic groups, though mistrust of dentists was common to all groups (Newton J T, 2001).

Cost: In terms of cost, while NHS dental services for children are free, adults pay for dental care unless they are exempt from payment. Those who wish to apply for exemption must complete a number of lengthy forms which may be difficult for patients with language and literacy difficulties.

Language: Language problems have been cited as a barrier to black and minority ethnic groups accessing dental services. Language barriers may exacerbate the complexities of issues including the charging and appointment system, use of technical terminology, and the need for dentists to obtain both a medical history and informed consent from patients. While interpreting services for use by dental practices are available in some areas, in others there is a lack of resources for interpreting services. Where an interpreter is not available dentists may have to turn patients away or communicate through their friends, families or other patients (Thalassis, 2009). Whilst anxiety is a barrier to accessing dental treatment for both black and minority communities and the general population (Croucher, 2006) Gibbons et al 2000, cited in (Mullen, 2007) such problems may be exacerbated by communication problems.

Mistrust of dentists: Again, mistrust of the dentist occurs in the general population as well as across black and minority ethnic groups. A study of people from black and minority ethnic groups in London found that participants felt that they received a poorer service as a result of their background and believed that dentists did not respect them, listen to them or care about them as much as they did other patients. In turn, they perceived this as the cause of clinical errors, pain, teeth being extracted without all other treatment being exhausted, treatment being rushed and a lack of thought to the true cause of oral problems (Thalassis, 2009).

Culture and religious influences: Little research has been conducted on the cultural and religious barriers to people from black and minority ethnic groups accessing a dentist and the impact this has on oral health. An impact for some patients may come from the gender of the dentist. For example, one study found that some Indian and Pakistani women did not want to visit a male Indian or Pakistani dentist, although they were happy to visit a white British male dentist (Mullen, 2007). A potential impact for dentists may be that for those who work in areas with a high proportion of Muslim patients they will experience a reduction in the use of dental services during the fasting month of Ramadan (Darwish, 2005). This is because dental treatment may result in breaking the fast as water may be swallowed during treatment.

Oral Health Improvement Activity - gaps

Adult groups prone to poor oral health

PHE have compiled a report on Inequalities in oral health in England. Overall, the available evidence suggests high levels of need among our vulnerable populations.

Substance misuse: Many drugs can cause a craving for sugar, such as sweets and fizzy drinks, which can cause tooth decay.

Drugs such as Methamphetamine and Heroin can also cause you to have a dry mouth. Because there is a reduced saliva flow in the mouth, this can also lead to tooth decay and gum disease.

Some drugs, such as Ecstasy and Cocaine can lead to jaw-clenching and tooth grinding. This can result in cracked or broken teeth, as well as headaches and jaw pain.

Alcoholic drinks such as white wine, beer and cider can be very acidic. This will cause erosion of the enamel on your teeth, possibly leading to pain and sensitivity. Unmet alcohol need in BwD is 83%[3]. Mouth cancer is also at increased risk by some of the above behaviours, and dentists now routinely screen their patients more so if they admit to the above, to detect mouth cancer early.

[3]National Drug Treatment Monitoring System

Oral Health Improvement Activity - gaps

Homeless people tend to experience very poor health[4]. Sex workers in the Borough are also generally homeless. There are high incidences of physical illness, mental-health problems and substance misuse among the homeless population (including sex workers). These forms of ill health often combine with each other, and are both causes and consequences of homelessness.

Research shows high levels of oral and dental disease among homeless people, both in absolute terms and relative to the rest of the population. This is attributable to the following risk factors:

- Chaotic lifestyle, with no established routines of eating and oral hygiene
- Low priority given to healthy eating and oral hygiene
- Acceptance of poor dental health and poor dental appearance as the norm
- Limited access to hygiene facilities
- Low disposable income
- Lack of awareness of diet and oral hygiene issues
- Mental-health problems
- Substance misuse

The main clinical conditions encountered among homeless people are:

- caries (decay), particularly around the necks of teeth
- deep periodontal (gum) disease
- trauma (damage due to accidents or violence)
- a need for dentures
- broken or ill-fitting dentures
- soft tissue conditions - mostly infections but also cancerous, or potentially precancerous, lesions

For this particular service group, a more flexible approach is required especially in regards to any dental appointments. Appointments with consequences of no attendance (such as being removed from the service or an ‘opt-in’ system) act as a deterrent for accessing future treatment, as does perceived stigma and stereotyping from professionals/services. Frequently there is non-attendance from individuals for a variety of reasons e.g. the service user did not have the means to attend the appointment be this due to lack of transport, the cost of transport, because the distance is too far to the clinic or because the service user forgot about the appointment because of their chaotic lifestyle.

When discussing their oral hygiene, the homeless population also mention a lack of self-confidence and self-esteem. This often leads people to believe they are not ‘worthy’ of treatment and so they feel they have no choice but to accept this.

PHE have published a quick guide to a healthy mouth in adults.

[4]The dental health of homeless people’ – British Dental Association

Oral Health Improvement Activity - gaps

People with Learning Disabilities: PHE identified several individual level barriers for people with disabilities in their report 'Inequalities in Oral Health' these being:

Individual Barriers

- Inability to tolerate treatment
- Lack of knowledge of accessing oral healthcare services
- Lack of social support

Organisational Barriers

- Difficulties in finding a dentist willing to provide treatment
- Shortage of dentists with adequate knowledge, training and confidence in caring for people with disabilities
- Lack of perceived need for training
- Lack of awareness of legal responsibilities as service providers towards overcoming barriers
- Communication barriers
- Poor patient management skills and perceived negative attitudes of dental staff
- Dental professionals perceive the additional time and effort required to treat patients is not fairly compensated by the remuneration system
- Lack of availability of domiciliary equipment
- Lack of information on oral health and oral healthcare services in the appropriate format
- Physical barriers to accessing dental services such as finding suitable transport along with the lack of availability of accessible waiting areas and toilet facilities
- Oral health knowledge and oral health beliefs of carers and their expectations of dentists
- Oral health perceived as a low priority among other health problems
- Lack of continuity of care and a lack of collaboration between and within

These lead people with disabilities to experience inequalities accessing services, experiencing caries and tooth loss and trauma induced dental injury.

Recommendations

Recommendations to improve the oral health of vulnerable adults across Blackburn with Darwen Borough Council

» **Recommendation 9:**
Purchase toothbrushes and toothpaste for our commissioned services to deliver to clients in houses of multiple occupancy (hostels) and request an evaluation of this intervention from the provider each year.

Recommendation 9a: NHSE to link with substance misuse services and pharmacies to distribute toothpaste and tooth brushes to certain service users on prescription.

Part 3 – Age Well

Older people with good oral health can eat and drink properly and actively take part in life. This means that they can often stay independent for longer and can recover from episodes of frailty more quickly. Older people living in care homes are however more likely to have experienced tooth decay and the majority of residents with one or more natural teeth will have untreated tooth decay[5].

Poor oral health can cause pain and discomfort and can impact on a person's quality of life by affecting their behaviour and self-confidence as well as their ability to smile, communicate, eat and swallow. Poor oral health is also linked with pneumonia, diabetes, coronary heart disease, strokes and peripheral vascular disease. Also some prescription medicine can cause mouth problems especially when taken in combination, such as mouth thrush and dry mouth, affecting the ability to swallow – which in its worst case scenario, can lead to malnourishment.

Effective daily mouth care can maintain and/or improve oral health in older people, as such, all care providers have an essential role in assessment, care planning and ensuring good daily mouth care.

The Care Quality Commission (CQC) 2019[6] report indicated that too many people living in care homes are not being supported to maintain and improve their oral health.

Further, every residents / client's hydration and nutrition should be reviewed regularly and included in their care plan. The care home should have a nutritional screening policy in place with one staff member taking responsibility for this policy within the home. Staff employed by social care providers should undertake clinical training and professional development, which is critical in promoting good nutrition for older people. Further, every care home should have an oral health policy in place with one staff member taking responsibility for this policy within the home. This should be clearly aligned to NICE guidance 48 Oral Health for adults in care homes.

PHE has a toolkit for care homes e-learning is available free for all staff.

[6]CQC (2019) Smiling Matters: oral healthcare in care homes www.cqc.org.uk/publications/major-report/smiling-matters-oral-health-care-care-homes

Recommendations

The Framework for Enhanced Health in Care Homes, Version 2 March 2020 recommends the following for older adults:

- **Recommendation 11:**
  Every person's oral health should be assessed as part of the holistic assessment of needs and personalised care and support planning process in care homes / domiciliary care.

- **Recommendation 12:**
  Care homes should have an oral health policy in place with one staff member taking responsibility for this policy within the home. This should be clearly aligned to NICE guidance 48 Oral Health for Adults in Care Homes.

- **Recommendation 13:**
  Every person's oral health should be enquired after and/or observed regularly by care home staff as part of their usual hygiene routine, and they should have access to routine dental checks and specialist dental professionals as appropriate. Local systems should work collaboratively to provide access to appropriate clinical dental services for people living in care homes.

- **Recommendation 14:**
  Staff employed by care home providers should undertake training in oral healthcare to support delivery of oral health assessments and daily mouth care for individuals, and maintain this knowledge and skill through ongoing professional development.

- **Recommendation 15:**
  Adult Social Care to co-ordinate oral health e-learning for all staff working in care homes or who support our vulnerable elderly residents who live in their own homes. This will take place on induction and as annual refresher training. The oral health champion identified in recommendation 12 above will receive more in depth face to face annual training from the commissioned provider (see Start Well recommendation 2b).

Governance

The five year Blackburn with Darwen oral health improvement partnership strategy will be monitored by the oral health improvement strategy group which is a multi-agency / partnership group established in April 2021. Its main purpose is to determine how to tackle the causes of poor oral health and improve, in the long term, oral health outcomes across the life course.

Membership includes PHE, NHS England, Health Watch BwD, several community voluntary and faith sector organisations representing our South Asian heritage communities and vulnerable adults, dental practices, early years' settings and the council's elected members for Children, Young People & Education, Adults Social Care and Public Health & Wellbeing.

The group meet quarterly and is chaired by the Public Health team's lead on oral health. Actions are minuted and reported on at subsequent meetings until completed. Reporting arrangements will be via the Public Health & Wellbeing senior policy team (led by the elected member for Public Health & Wellbeing).

The Chair will also feed back to the Children's Partnership Board, the Eat Well Move More Shape Up group (including the Food Resilience Alliance group), Live Well, Age Well and the Lancashire & South Cumbria oral health improvement group led by PHE.

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- Adults & Prevention Senior Policy Team (Sep 2021) - presentation of findings and recommendations
- BwD Food Resilience Alliance group (Sep 2020) - presentation of findings and recommendations
- Care Network (Aug 2021) – feedback on recommendations
- Change Grow Live / Inspire BwD (June 2021) - feedback on recommendations
- Children & Education Senior Policy Team (Feb 2021) - presentation of findings and recommendations
- Children's Partnership Board (July 2021) - presentation of findings and recommendations
- East Lancs & BwD CCG, Pennine Lancashire Children and Young Peoples Transformation Programme, Priority scoping workshop, Oral Health (July 2021) - presentation of findings and recommendations
- Eat Well Move More Shape Up group (Sep 2020) – presentation of findings and recommendations
- Gypsy Traveller Liaison Officer (June 2021) - feedback on strategy and recommendations
- Healthwatch public consultation (July 2021) - feedback on recommendations
- IMO (Apr 2021) – feedback on strategy and recommendations
- Lancashire & South Cumbria NHS Foundation Trust (June 2021) - feedback on strategy and recommendations
- One Voice (Apr 2021) – feedback on strategy and recommendations
- Parents in Partnership (July 2021) - feedback on strategy and recommendations
- Public Health & Wellbeing Senior Policy Team (Feb 2021) - presentation of findings and recommendations

Appendices

Appendix 1: PHE recommendations

Commissioning better oral health for children and young people

Table 3.3. Summary of the oral health improvement programme's overall recommendations

Nature of intervention	Intervention classification	Target population	Strength of evaluation and research evidence	Impact on inequalities	Cost/resource considerations	Implementation issues	Overall recommendation
SUPPORTIVE ENVIRONMENTS							
Fluoridation of public water supplies	Upstream	Preschool, school children, young people (whole population)	Strong evidence of effectiveness	Encouraging/ uncertain	Good/uncertain	Deliverable	Recommended
Provision of fluoridated milk in school settings	Midstream/ downstream	Preschool, school children	Inconclusive	Uncertain	Uncertain	Uncertain/ major challenge	Limited value
COMMUNITY ACTION							
Targeted peer (lay) support groups/peer oral health workers	Midstream	Preschool, children, young people	Sufficient evidence of effectiveness	Encouraging	Good	Deliverable/ uncertain	Recommended
School or community food co-operatives	Midstream	Preschool, school children, young people	Weak evidence of effectiveness	Encouraging	Good	Deliverable/ uncertain	Emerging
HEALTHY PUBLIC POLICY							
Influencing local and national government policies	Upstream	Preschool, school children, young people	Some evidence of effectiveness	Encouraging/ uncertain	Good	Deliverable/ uncertain	Recommended
Fiscal policies to promote oral health	Upstream	Preschool, school children, young people	Some evidence of effectiveness	Uncertain	Good	Deliverable/ uncertain	Emerging
Infant feeding policies to promote breastfeeding and appropriate complementary feeding practices	Midstream/ upstream	Preschool	No evidence of effectiveness	Encouraging/ uncertain	Good	Deliverable	Emerging

Appendices

Appendix 1: PHE recommendations

Commissioning better oral health for children and young people

Table 3.3. Summary of the oral health improvement programme's overall recommendations (continued)

Nature of intervention	Intervention classification	Target population	Strength of evaluation and research evidence	Impact on inequalities	Cost/resource considerations	Implementation issues	Overall recommendation
COMMUNITY-BASED PREVENTIVE SERVICES							
Targeted community-based fluoride varnish programmes	Downstream	Preschool, school children	Strong evidence of effectiveness	Encouraging/ uncertain	Uncertain/costly	Deliverable/ uncertain	Recommended
Targeted provision of toothbrushes and tooth paste (ie. postal or through health visitors)	Downstream	Preschool, school children	Some evidence of effectiveness	Encouraging	Good use of resources	Deliverable	Recommended
Targeted community-based fissure sealant programmes	Downstream	Preschool, school children	Sufficient evidence of effectiveness	Uncertain	Costly	Uncertain/major challenges	Limited value
Targeted community-based fluoride mouth rinse programmes	Downstream	School children	Sufficient evidence of effectiveness	Uncertain	Uncertain	Deliverable/ uncertain	Limited value
Facilitating access to dental services	Downstream	Preschool, school children	Weak/inconclusive	Uncertain / unlikely	Uncertain	Uncertain/major challenges	Limited value
Using mouth guards in contact sports	Midstream	School children	Some evidence of effectiveness	Uncertain	Uncertain	Uncertain	Limited value
SUPPORTIVE ENVIRONMENTS							
Supervised tooth brushing in targeted childhood settings	Midstream	Preschool, school children	Strong/sufficient evidence of effectiveness	Encouraging/ uncertain	Good/uncertain	Deliverable/ uncertain	Recommended
Healthy food and drink policies in childhood settings	Midstream/ Upstream	Preschool, school children, young people	Some evidence of effectiveness	Encouraging	Good	Deliverable	Recommended

Appendices

Appendix 2: NICE guidelines - Oral health: local authorities and partners health guideline

Recommendation 1 Ensure oral health is a key health and wellbeing priority
Recommendation 2 Carry out an oral health needs assessment
Recommendation 3 Use a range of data sources to inform the oral health needs assessment
Recommendation 4 Develop an oral health strategy
Recommendation 5 Ensure public service environments promote oral health
Recommendation 6 Include information and advice on oral health in all local health and wellbeing policies
Recommendation 7 Ensure frontline health and social care staff can give advice on the importance of oral health
Recommendation 8 Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health
Recommendation 9 Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health
Recommendation 10 Promote oral health in the workplace
Recommendation 11 Commission tailored oral health promotion services for adults at high risk of poor oral health
Recommendation 12 Include oral health promotion in specifications for all early years services
Recommendation 13 Ensure all early years services provide oral health information and advice
Recommendation 14 Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health
Recommendation 15 Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health
Recommendation 16 Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health
Recommendation 17 Raise awareness of the importance of oral health, as part of a 'whole-school' approach in all primary schools
Recommendation 18 Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health
Recommendation 19 Consider supervised tooth brushing schemes for primary schools in areas where children are at high risk of poor oral health
Recommendation 20 Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health
Recommendation 21 Promote a 'whole school' approach to oral health in all secondary schools
Finding more information and resources

Appendices

Appendix 3: Pennine Integrated Care partnership's dental caries data pack

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Author: Gill Kelly, public health development manager, Public Health and Wellbeing, Blackburn with Darwen Borough Council – gillian.kelly@blackburn.gov.uk