

National Assembly for Wales
Children and Young People Committee

Inquiry into children's oral health

February 2012



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National Assembly for Wales
Children and Young People Committee

Inquiry into children's oral health

February 2012



Children and Young People Committee

The Committee was established on 22 June 2011 with a remit to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters encompassing: the education, health and wellbeing of the children and young people of Wales, including their social care.

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Welsh Labour
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Angela Burns

Welsh Conservatives
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Recommendations

Recommendation 1. The Welsh Government should publish the annual monitoring reports of the *Designed to Smile* programme in addition to the final evaluation report. (Page 11)

Recommendation 2. The Welsh Government should ensure that action is taken to better educate parents about *Designed to Smile*, ensuring consistent messages are given to parents about the importance of getting fluoride onto children's teeth as part of homebrushing. (Page 13)

Recommendation 3. The Welsh Government should ensure that data on the number of general anaesthetics administered to children and young people for dental work in Wales is collated and reported as part of the monitoring of *Designed to Smile*. (Page 16)

Recommendation 4. The Welsh Government should set out how it plans to ensure the effective implementation of the 0-3 year old element of *Designed to Smile*, and specifically how it intends to involve key agencies in promoting the scheme such as NHS Health Visitor Services, given that there is no additional resource for this. (Page 19)

Recommendation 5. The Welsh Government should set out how it intends to improve the oral health of all children in Wales, including those who are not currently targeted by *Designed to Smile*, and what role the Community Dental Service will play in this. (Page 23)

Recommendation 6. The Welsh Government should consider the evidence for incorporating *Designed to Smile* into the school curriculum to ensure it is better integrated into initiatives such as Healthy Schools. (Page 25)

Recommendation 7. The Welsh Government should make changes to the NHS dental contract to enable better integration of prevention and treatment across dental practices and to ensure it encourages dentists to undertake preventative work with children. (Page 28)

Recommendation 8. Local Health Boards should be required to publish information on their annual expenditure on the *Designed to Smile* programme, including any extra investment they have provided to the Community Dental Service to support this work. For every Local Health Board it should be possible to see how much money is being spent on improving the oral health of children and the take up of the scheme in their areas in order to assess consistency across Wales and value for money. (Page 30)

Recommendation 9. The Welsh Government should ensure that *Designed to Smile* is central to its National Oral Health Plan for Wales; it should set out the Welsh Government's long term commitment to the programme and how this will fit with other Government programmes and initiatives, as well as providing a fuller picture of how dental services for children are currently being accessed across Wales and how this will change in the future. In particular, the role of the Community Dental Service (CDS) needs to be clearer, including how access arrangements to the CDS are set up and what action will be taken to address the inconsistency in CDS service provision across Wales. (Page 31)

Recommendation 10. The Welsh Government should keep under review the evidence for fluoridating water supplies in Wales. (Page 33)

Introduction

1. Good oral health is a fundamental element of good general health; dental decay is a widespread cause of pain and infection that impacts on life satisfaction in much the same way as other diseases. Poor oral health has a significant impact on quality of life, causing pain and embarrassment, limiting function and being costly to treat.
2. Although preventable, dental decay is still the most common childhood disease, and the dental health of children in Wales is amongst the worst in the UK.
3. A significant number of school children are affected by dental decay, with disease levels being highest in deprived areas. The prevalence of dental caries remains high, and is strongly related to socio-economic status and lifestyle, resulting in oral health inequalities throughout Wales.
4. The most recent Child Dental Health Survey found that over 50 per cent of five year old children in Wales suffer dental decay. In addition, dental epidemiological surveys have shown an increased severity of dental disease in those children who suffer from the disease.
5. The Welsh Government has previously stated that this is unacceptable when dental decay is avoidable and when effective prevention is a realistic goal.
6. In November 2007, the former Minister for Health and Social Services, Edwina Hart AM, announced the development of a National Oral Health Action Plan for Wales, setting out a range of actions designed to improve oral health and meet the dental targets set in the strategy 'Eradicating Child Poverty in Wales – Measuring Success'.
7. Central to a National Oral Health Action Plan is the Child Oral Health Improvement Programme, *Designed to Smile*,¹ which is being delivered through a strengthened public dentistry role for the Community Dental Service (CDS).

¹ Welsh Health Circular (WHC), [WHC\(2008\)08](#), *Designed to Smile – a National Child Oral Health Improvement Programme*, 14 March 2008

Designed to Smile

8. *Designed to Smile* is the Welsh Government's national child oral health improvement programme published in March 2008. It is an NHS dental programme funded by the Welsh Government to help children to have healthier teeth.² There are many parts to the programme including tooth brushing; healthy eating and drinking; fissure sealant and fluoride varnish; and dental screening.

9. The original *Designed to Smile* Programme launched on 30 January 2009 had two elements: a supervised tooth brushing scheme for 3-5 year olds; and a promotional programme for 6-11 year olds. The programme was targeted at young children in areas of greatest need; it was initially piloted in selected areas e.g. Flying Start areas, covering North Wales and South Wales.

10. Following the implementation of the initial pilots, the former Minister for Health and Social Services announced in October 2009 that the programme would be enhanced and expanded to eventually cover all parts of Wales.³ The programme was expanded to include a third component providing oral health from birth to 3 years old.⁴

11. In a Ministerial statement⁵ published on 14 January 2011, the former Minister for Health and Social Services stated that progress had been made across Wales. The Minister also stated that all Community Dental Services in Wales are now delivering the *Designed to Smile* Scheme.

² All of the *Designed to Smile* services and all NHS dental treatments for children are free.

³ Welsh Government, Edwina Hart (Minister for Health and Social Services), [Dental Contact Review and Designed to Smile](#), 2009

⁴ Further information on the preventative programme for children under 3 is available on the [Designed to smile webpages](#).

⁵ Welsh Government, Edwina Hart AM (Minister for Health and Social Services), [Thousands of children benefit from brushing scheme](#), Cabinet Written Statement, 2011

The Committee's inquiry

12. In light of this statement from the then Minister and the importance of children's oral health, the Children and Young People Committee agreed to undertake their first inquiry into children's oral health.

13. The Committee agreed the following terms of reference for the inquiry:

To examine the effectiveness of the Welsh Government's *Designed to Smile* programme in improving the oral health of children in Wales, particularly in deprived areas.

In particular the Committee agreed to:

- consider the take up of -
 - the supervised tooth brushing scheme for 3-5 year olds,
 - the promotional programme for 6-11 year olds;
- consider whether the investment has delivered improved health outcomes for the most disadvantaged children and young people;
- evaluate whether the programme is operating consistently across Wales in all areas of need;
- consider how effective the expansion of the programme has been, particularly in relation to 0-3 year olds;
- consider whether the programme addresses the needs of all groups of children and young people;
- explore the extent to which the *Designed to Smile* programme has been integrated into wider local and national initiatives such as the Welsh Network of Healthy School Schemes and Flying Start;
- consider the current and potential implications for paediatric dentistry, including reviewing the strengthened role of the Community Dental Service in children's public health.

14. In addition to the areas for consideration identified at the outset of the inquiry, the following issues emerged while taking evidence which are also covered in this report:

- monitoring and evaluation of the programme;
- funding for the delivery of *Designed to Smile*;
- National Oral Health Plan for Wales;
- fluoridation.

15. A list of witnesses who provided written and oral evidence for this inquiry can be found at Annex A, B and C.

Monitoring and evaluation

16. The Welsh Government's Programme for Government published in September 2011 included as a key action the implementation of the *Designed to Smile* programme to improve the oral health of children. This was supported by the Welsh Government through funding of Local Health Boards (LHBs) of £3.7 million per year.

17. Most stakeholder evidence highlighted that it was too early to confirm whether the *Designed to Smile* programme was delivering improved health outcomes for children, although a number of witnesses drew attention to the Childsmile programme, which had been operating in Scotland for a number of years and had been shown to be beneficial. Future epidemiological surveys of children will ultimately show if dental decay in children in Wales has reduced. However, other evaluations of the programme focussing on 'process outcomes' have been conducted and reported to the Welsh Government, providing information on the progress of the *Designed to Smile* programme, which elements of the programme might need improving and details of programme expenditure.

18. The first monitoring report, which was produced in December 2010, focused on the pilot areas. The next stage of the monitoring will cover the first full year of the roll out of the programme and was due at the end of December 2011. The evaluation data will give information on every LHB and the take up of the scheme in their areas.

19. Professor Ivor Chestnutt from Cardiff University School of Dentistry explained that the final evaluation of *Designed to Smile* is in two parts. The first part, process monitoring, provides the statistical returns and is monitored closely in terms of the number of children and participating schools. The second part, the more formal evaluation, will seek the views of staff, head teachers and parents and children who participate in the programme. This should give a more comprehensive picture of service delivery across Wales. The final evaluation report of the initial three year cycle of the *Designed to Smile* programme is due to be published toward the end of January 2012.

Recommendation: The Welsh Government should publish the annual monitoring reports of the *Designed to Smile* programme in addition to the final evaluation report.

Take up of the supervised tooth brushing scheme for 3-5 year olds and the promotion programme for 6-11 year olds

Take up and participation in the scheme

20. The initial aim of the *Designed to Smile* Programme was to establish a supervised tooth-brushing scheme, using fluoride toothpaste, for 3-5 year olds. In October 2009, the Welsh Government announced an expansion of the scheme into deprived areas in all parts of Wales. As well as rolling out the scheme beyond the existing pilot areas, the additional funding allowed the scheme to be extended from 3-5 year olds to include six year old children and a nursery-based programme for the youngest children under the age of three.

21. The evidence collated so far suggests there has been good uptake of the scheme in the targeted schools.

22. The Welsh Oral Health Information Unit (WOHIU) is responsible for collating data from the programme. Figures on the take up of and participation in the programme for April 2010 to March 2011 showed that the take up rate of the settings (i.e. schools and nurseries) targeted during the reporting period across Wales was 80.9%. Across Wales, 93 schools declined to take part in the scheme during April 2010 to March 2011. The highest number of refusals were reported by Cardiff and Vale University Health Board and Aneurin Bevan Health Board with 51 and 21 refusals respectively.

23. David Davies, Clinical Service Manager/Senior Dental Officer of the Abertawe Bro Morgannwg University Health Board Community Dental Service, told the Committee that he believed the main reason for head teachers refusing to take part in the scheme was:

“a fear of the unknown, and of integrating a possibly time-consuming activity into an already busy day.”⁶

24. In his experience, such issues could be overcome by *Designed to Smile* teams working with schools to put in place systems to minimise the impact on teaching staff.

⁶ ROP [para 47], 13 October 2011, Children and Young People Committee

25. The child participation rate for the supervised tooth-brushing programme, for eligible children during the same period, was 93.4%. The monitoring data presented to the Committee suggested that child participation and reported frequency of tooth-brushing in participating schools and nurseries was high across Wales. However, there were local variations in the take up of the supervised tooth-brushing programme – for example, the participation rate ranged from 94.9% in Abertawe Bro Morgannwg University Health Board area to 75.8% in Hywel Dda Health Board.

Home-brushing

26. One of the difficulties of the scheme was the monitoring of the home-brushing element. Professor Chestnutt explained that this formed part of the overall assessment work that was being done to look at parents' attitudes to the programme. He told the Committee that it would be difficult to quantify the level of home-brushing but highlighted the importance of monitoring parents' attitudes to ensure that brushing in school was supplemented by brushing at home.

27. There was anecdotal evidence to suggest there had been some improvement in this area. For example, in their written evidence, Vale of Glamorgan Flying Start said:

“Some parents have advised the settings that at home children are asking to have their teeth brushed after meals, so the programme has a positive effect on home life.”⁷

Recommendation: The Welsh Government should ensure that action is taken to better educate parents about *Designed to Smile*, ensuring consistent messages are given to parents about the importance of getting fluoride onto children's teeth as part of homebrushing.

⁷ Children and Young People Committee, *Inquiry into Children's Oral Health in Wales*, Written Evidence from Vale Flying Start, CYP(4) COH02

Improved health outcomes for the most disadvantaged children and young people

Child dental health surveys

28. Information about the dental health of the population is gathered through surveys undertaken at varying time intervals across the UK and locally across Wales. In terms of measuring ‘improved health outcomes’, national surveys of oral health are key to providing the hard clinical evidence upon which the *Designed to Smile* programme will be assessed.

29. Surveys of child dental health are undertaken by the British Association for the Study of Community Dentistry. The surveys focus on the number of decayed, missing and filled teeth (DMF). Surveys are undertaken with five year olds and twelve year olds every few years.

30. A number of witnesses highlighted the recent difficulties with data collection. In the past, surveys had relied on ‘negative consent’. This had changed and positive consent was now needed to examine children. The British Dental Association was concerned that this could be more difficult to obtain, especially in lower socio-economic areas of Wales.

“If parents have to sign a form and send it back, we will get less of them back than if we were able to use negative consent because, in the same way, people do not bother to say that they do not want it.”⁸

31. Maria Morgan from the British Association for the Study of Community Dentistry was keen to point out that it was not necessarily a case of parents refusing to allow their children to take part in the surveys,

“It is not about parents of children from deprived areas denying consent; it is about them not opting in. It is not about denying consent; that is a distinction.”⁹

32. The impact of this change was already becoming apparent, with the Committee being told that the number of children in the last survey was about 30 per cent less than previous years. However, Members heard that it was unlikely that the consent arrangements would change because the decision had been taken on the basis of legal advice.

⁸ ROP [para 73], 21 September 2011, Children and Young People Committee

⁹ ROP [para 350], 29 September 2011, Children and Young People Committee

Child poverty oral health targets

33. The Committee heard that there was a widening gap between the oral health of children from the most deprived and the least deprived families in Wales. Under the *Eradicating Child Poverty in Wales – Measuring Success* strategy, the dental targets set were that by 2020 the dental health of 5 year olds and 12 year olds in the most deprived fifth of the population would improve to that presently found in the middle fifth.

34. Professor Chestnutt explained that the changes in the arrangements for the collection of the epidemiological data meant that it had been necessary to ‘re-base the baseline for the targets and then reset the targets.’¹⁰ Members were told that there had been a loss of trend data as a result of changes to consent arrangements but that a new baseline, using data gathered in 2007-8 had been set, which would be used for the evaluation of *Designed to Smile*. The Committee was told that the 2007-8 data coincided with the start of *Designed to Smile*.

35. Specifically, the British Association for the Study of Community Dentistry told the Committee that data on the number of teeth affected by decay, either by being decayed, by having been extracted or filled in children in deprived communities would be used to assess achievement of the Welsh Government’s child poverty targets.

Tooth extraction

36. The Committee was shocked at the extent to which general anaesthetics were being used on children for dental work. Approximately 9000 children were treated under general anaesthetic in Wales in 2010 – on average two children in a class of 30 five year olds.

37. In his written evidence, Dr Hugh Bennett from Public Health Wales told the Committee,

“This is unacceptable for what is an almost totally preventable disease. It is an avoidable risk to child health and wellbeing that would not be tolerated in other diseases.”¹¹

38. A view supported by the British Society of Paediatric Dentistry. Dr Mechelle Collard told the Committee,

¹⁰ ROP [para 60], 3 November 2011, Children and Young People Committee

¹¹ Children and Young People Committee, *Inquiry into Children’s Oral Health in Wales*, Written Evidence from Public Health Wales Dental Health Team, CYP(4) COH21

“Decay rates are shocking in Wales, and the number of children having general anaesthetics for extractions is disgraceful. It is absolutely shocking. We have almost failed with the adult population – we are not getting anywhere with it. Every day in Wales children come in and we say to the parents that their child needs a general anaesthetic and to have 12 teeth out and rather than these parents looking shocked, horrified and appalled, they turn around and say, ‘It’s fine, I’ll sign the consent form; I did this last year for my other son’. It has become acceptable to have a general anaesthetic to have your baby or adult teeth out.”¹²

39. They also suggested that the Welsh Government should be monitoring the use of extractions under general anaesthetics among children as part of *Designed to Smile*,

“That might be one of the few ways to monitor whether child health is improving, because a large number of our children seem to end up going down that route.”¹³

A view supported by a number of other witnesses.

40. Lesley Griffiths, Minister for Health and Social Services highlighted some of the difficulties in obtaining robust data on extractions under general anaesthetic,

“... it is very hard to know exactly how many take place, because it can take place in a variety of settings. It is therefore quite difficult to get robust numbers for that.”¹⁴

but confirmed that Public Health Wales was undertaking an exercise to analyse the available data on the number of general anaesthetics administered in Wales.

Recommendation: The Welsh Government should ensure that data on the number of general anaesthetics administered to children and young people for dental work in Wales is collated and reported as part of the monitoring of *Designed to Smile*.

¹² ROP [para 250], 29 September 2011, Children and Young People Committee

¹³ ROP [para 233], 29 September 2011, Children and Young People Committee

¹⁴ ROP [para 84], 3 November 2011, Children and Young People Committee

Consistency in programme delivery across Wales in all areas of need

Local variation across Wales

41. From the autumn school term of 2008, *Designed to Smile* was rolled out in two 'super pilot' areas covering the North Wales region and a substantial part of central South Wales. In October 2009, the Welsh Government announced an expansion of the scheme into deprived areas in all parts of Wales. Members were told that there was inconsistency in programme delivery across Wales because the scheme was rolled out at different times, and so the super pilot areas were at a more advanced stage of implementation than the rest of Wales.

42. A number of witnesses stated that when the announcement of the expansion of the programme was made in October 2009, it was acknowledged that it would take time for the Community Dental Service (CDS) in some parts of Wales to get the scheme fully implemented. There had been staged implementation, with the expectation that by the end of 2010/11 the expanded and enhanced *Designed to Smile* scheme would be up and running in areas of need across Wales.

43. The fact the scheme was initially rolled out in pilot areas, and that the capacity and staffing of the CDS in different parts of Wales at the time of the scheme's expansion was more advanced in some areas, has had a bearing on the implementation of the *Designed to Smile* programme across Wales. However, most witnesses said they were confident that these inequities were being addressed, and some suggested that the delay in roll-out had actually provided opportunities for others to learn from the experiences of the pilot areas.

44. In their written evidence, Betsi Cadwaladr University Health Board said,

“Inevitably, the two pilot areas will have developed further than other areas in Wales as they have been operating longer. However, much of the initial period was spent in development work from which other areas have been able to benefit.”¹⁵

¹⁵ Children and Young People Committee, *Inquiry into Children's Oral Health in Wales*, Written Evidence from Betsi Cadwaladr University Health Board, CYP(4) COH24

45. In her evidence, the Minister confirmed that all areas had moved beyond the start-up and implementation phase and were now delivering the programme. However, some expansion was still occurring in relation to the 0-3 age group (see section below).

Expansion of the programme in relation to 0-3 year olds

46. The Committee heard that, as this group were not in full time education, they were potentially harder to target so additional work had been required to establish links with health visitors and others in health and social services who worked with children. In their evidence, the British Dental Association raised some concerns about exactly how the 0-3 year old element of *Designed to Smile* was being implemented in different areas and the challenges in reaching into playgroups and pre-school activities.

“In deprived areas there is evidence that this age group will not normally have contact with a dental care professional. Parents often are not regular dental attenders – often seeking care only when in pain and historically, the community dental service has not been able to reach into playgroups and pre-school activities.”¹⁶

47. Public Health Wales also suggested that prior to the launch of *Designed to Smile*, oral health promotion had been patchy and unco-ordinated at this level. However, in his oral evidence to the Committee, Dr Hugh Bennett talked about work being undertaken in the Abertawe Bro Morgannwg University Local Health Board area to help address this,

“During the past nine months, they have started to think about how they can reach children in the 0-3 age group and their parents and grandparents, because these days a lot of grandparents are involved in caring for young children. Some of the groups they have reached out to include breastfeeding support groups and various child minder groups, importantly linking in with the health visitor services. They have now made contact with 29 different organisations, or even child minders, and a large proportion of those have already started tooth-brushing programmes.”¹⁷

¹⁶ Children and Young People Committee, *Inquiry into Children's Oral Health in Wales*, Written Evidence from British Dental Association, CYP(4) COH13

¹⁷ ROP [para 13], 29 September 2011, Children and Young People Committee

48. The Minister for Health and Social Services acknowledged that there was some further development and refinement of the programme to be undertaken in relation to this target group. In her follow up evidence, she confirmed that NHS Health Visitor Services did not receive additional funding to support their involvement in the *Designed to Smile* programme. The Minister also stated that data on the number of Health Visitors involved in the delivery of *Designed to Smile* was not known.

Recommendation: The Welsh Government should set out how it plans to ensure the effective implementation of the 0-3 year old element of *Designed to Smile*, and specifically how it intends to involve key agencies in promoting the scheme, such as NHS Health Visitor Services, given that there is no additional resource for this.

Access to the programme for all children and young people

Children resident in deprived communities

49. The Committee heard that tooth decay was more widespread and more severe in children from disadvantaged communities. *Designed to Smile* was therefore a targeted programme; it targeted young children in areas of greatest need and was not aimed at all children in Wales. The scheme was targeted and priority given to areas on the basis of deprivation and epidemiological data on oral health provided by the WOHIU. Most witnesses supported this approach, highlighting that children in deprived areas were more likely to experience dental decay. The British Dental Association told the Committee,

“There is evidence in deprived areas across the UK that deprivation and poor oral health go together – it is one of those public health definites.”¹⁸

50. However, the British Society of Paediatric Dentistry disagreed, stating that the scheme should be expanded to all areas and not just targeted in deprived areas. In their written evidence they advocated,

“Emphasis on prevention at both individual and population levels through the use of community and school-based programmes which target ALL children, including pre-school and vulnerable populations.”¹⁹

51. The Minister confirmed her intention to continue to target the programme in those areas where a greater proportion of children have experienced tooth decay and said that she did not have any plans to make *Designed to Smile* universal to all children in Wales,

“There are no plans to have this scheme extended to every child across Wales. We do not have the resources to do that.”²⁰

¹⁸ ROP [para 23], 21 September 2011, Children and Young People Committee

¹⁹ Children and Young People Committee, *Inquiry into Children’s Oral Health in Wales*, Written Evidence from the British Society of Paediatric Dentistry, CYP(4) COH10

²⁰ ROP [para 65], 3 November 2011, Children and Young People Committee

52. Some witnesses expressed concerns that the programme was, at the moment, designed for a particular cohort of children and that as a result, some children with poor oral health were being missed, particularly where there were pockets of deprivation in more affluent areas.

53. David Davies told the Committee,

“There is a misconception that because someone lives in a more affluent area, they will have better teeth than people who live in less affluent areas. However, that is not the case. One possible weakness of the programme is that, because we are looking to go into designated deprived areas, we might be missing children in other areas who could benefit from our help, and that will grow as time passes.”²¹

54. Whilst, in their written evidence, Neath Port Talbot Council for Voluntary Service also said,

“It is important that the delivery of the programme takes account that families who are disadvantaged do not necessarily live in a deprived area and therefore actions should be taken to ensure the D2S programme is delivered throughout the whole of the Neath Port Talbot area.”²²

55. Professor Chestnutt told the Committee that even in the most affluent areas – in the most affluent fifth – about 20 per cent of children would have suffered tooth decay. However, he went on to say that in the most deprived areas, somewhere between 60 and 70 per cent of children would have tooth decay.²³

56. The Minister confirmed that *Designed to Smile* had targeted around 62,000 children to date, which equated to almost half of those children aged 3-6.

²¹ ROP [para 24], 13 October 2011, Children and Young People Committee

²² Children and Young People Committee, *Inquiry into Children’s Oral Health in Wales*, Written Evidence from Neath Port Talbot CVS, CYP(4) COH17

²³ ROP [para 63], 3 November 2011, Children and Young People Committee

Local flexibility within the programme

57. Public Health Wales told the Committee that there was local flexibility within the *Designed to Smile* programme, which allowed schools and other establishments which might not automatically fall within the scope of the programme to be included. This decision was taken by the CDS based on local need,

“Within a particular area, if the local CDS knows that there are localities or institutions such as special needs education units for children that lie outside the defined borders of a target area, they can take the programme to them. That is the strength of it: it is not rigid and it can be flexible.”²⁴

58. Whilst Members supported this, they felt that more could be done to target specific groups of children such as those with a learning disability or children who spend long periods of time in hospital with severe and chronic health conditions.

59. Mechelle Collard told the Committee about the work she carried out at Morryston Hospital,

“... I constantly get children who have special needs, and autistic children and sick children, referred to me. There is nobody else to see them.”²⁵

60. Members of the Committee expressed particular concerns during the evidence sessions about those children who were not included in *Designed to Smile* and who never went to the dentist, and who therefore, might be falling through the net. The CDS should be engaging with all schools and should pick up children with poor oral health (even if that school was not eligible for *Designed to Smile*). The CDS did have a traditional role in picking up some of those harder to reach groups, in particular through the role of the CDS in school screening, which was outside the *Designed to Smile* programme. As part of the school screening programme, parents should be alerted to the state of their child’s oral health and whether the child needed treatment. However, it was unclear from the evidence whether school screening took place in every school. Concerns were also raised about the uptake of treatment by parents where issues with poor oral health had been identified.

²⁴ ROP [para 10], 29 September 2011, Children and Young People Committee

²⁵ ROP [para 268], 29 September 2011, Children and Young People Committee

61. Dr Sue Greening, British Dental Association, told the Committee,

“... the Community Dental Service is there to pick up children, and we try to target children and send out information to families. The evidence is that it is not just dentistry – those families do not take up maternity or antenatal services, either. There is a group in the population that does not take up services.”²⁶

62. In her follow up evidence the Minister provided data on the number of children screened by the CDS who were not included as part of the *Designed to Smile* programme, though the Committee were told that Aneurin Bevan Health Board had linked their child screening with *Designed to Smile* and so their figures were not recorded in the information provided. In Wales, screening remains one of the statutory duties of the CDS. Under this arrangement, dentists visited schools and carried out a very general inspection of all children to identify treatment need. A note was then sent home with the child advising parents that the child either saw a General Dental Practitioner or was offered treatment via the CDS. The Minister stated that

“there are mixed views within the NHS on the efficacy of school screening, which has seen England abandon the practise.”²⁷

Recommendation: The Welsh Government should set out how it intends to improve the oral health of all children in Wales, including those who are not currently targeted by *Designed to Smile*, and what role the Community Dental Service will play in this.

²⁶ ROP [para 28], 21 September 2011, Children and Young People Committee

²⁷ Children and Young People Committee Paper CYP(4)-01-12(p6), *Inquiry into Children's Oral Health*, Letter from Minister for Health and Social Services, 12 January 2012

Integration of the programme with other local and national initiatives

Healthy Schools and Flying Start

63. Local Health Boards and Public Health Wales stated in their evidence that the integration of *Designed to Smile* with other Government initiatives, especially the Healthy School Scheme had varied greatly across Wales.

64. Cerys Humphreys, Senior Health Promotion Practitioner for the Ceredigion Public Health Team said in her written evidence,

“Whilst I can only comment on the situation in this county, it is my view that *Designed to Smile* has not been fully integrated into the Healthy Schools Scheme. While initial links were made between the two schemes, both are seen as a separate entity and do not fully work together.”²⁸

65. The Committee heard that often in the past oral health promotion and treatment had taken a piecemeal approach. The Minister stated that *Designed to Smile* had provided the opportunity for a national and consistent approach to be introduced in collaboration with other service teams. She said that

“a strength of the programme is its’ emphasis on strong linkage and partnership working between health and other agencies and services i.e. education.”²⁹

66. However, she did recognise that links with other programmes such as Healthy Schools and Flying Start needed to be strengthened to ensure consistent action and messages.

67. Members were told that the evaluation report of the pilot programme (December 2010) included investigation into how well schools felt *Designed to Smile* fitted with their curriculum and other health promotion programmes. The evaluation surveyed 298 schools taking part in the super pilot areas.

²⁸ Children and Young People Committee, *Inquiry into Children’s Oral Health in Wales*, Written Evidence from Ceredigion Public Health Team, CYP(4) COH03

²⁹ Children and Young People Committee Paper CYP(4)-07-11(p1), *Inquiry into Children’s Oral Health*, Written evidence from Minister for Health and Social Services, 3 November 2011

68. The Healthy School Co-ordinators told the Committee that *Designed to Smile* had struggled because it was not part of the curriculum and was therefore seen as something extra for schools. They confirmed that in ‘healthy schools’, they tried to incorporate *Designed to Smile* but stated that

“if a school has to do away with something, the first things to go are those that are not part of the curriculum.”³⁰

69. They believed that *Designed to Smile* did not have as much importance in a school because it was not part of the curriculum.

70. They went on to say that partnerships were more established in some parts of Wales but that all of the partnerships were developing with time. They explained that relationships tended to be stronger in the pilot areas and that it had been easier to form stronger links where the Healthy School Co-ordinator had been based in Public Health Wales as opposed to being based in education.

Recommendation: The Welsh Government should consider the evidence for incorporating *Designed to Smile* into the school curriculum to ensure it is better integrated into initiatives such as Healthy Schools.

³⁰ ROP [para 108], 13 October 2011, Children and Young People Committee

The current and potential implications for paediatric dentistry and the role of the Community Dental Service in children's public health

Community Dental Service (CDS)

71. *Designed to Smile* is delivered by the CDS. Members heard that one of the benefits of using CDS teams was that they had local knowledge and retained a degree of flexibility in responding to localised need. In some areas of Wales the CDS had, in the past, lacked investment. *Designed to Smile* had enabled the capacity and staffing of the CDS in different parts of Wales to be developed and expanded.

72. The Minister explained that

“the additional funding provided to LHBs has enabled the CDS to provide oral health care and promotion in areas where dental services have not always been accessed or easily available.”³¹

73. It is a matter for the LHBs to determine the appropriate level of CDS across their areas. Witnesses suggested that the CDS had a stronger presence in some areas than in others. Dr Hugh Bennett told the Committee,

“Over the last six or seven years, there have been a couple of reviews of the community dental service. They showed us that, in some parts of Wales, the community dental service is quite strong. The Cardiff and Vale community dental service may well be the largest example of that type of service in the UK.”³²

74. He went on to say,

“However, in other parts of Wales, particularly west Wales, the story is not as good. Historically, there has been disinvestment in the services. What saved the community dental service in the Hywel Dda Local Health Board area is the fact that the three smaller community dental services of Ceredigion, Carmarthenshire and Pembrokeshire

³¹ Children and Young People Committee Paper CYP(4)-07-11(p1), *Inquiry into Children's Oral Health*, Written evidence from Minister for Health and Social Services, 3 November 2011

³² ROP [para 44], 29 September 2011, Children and Young People Committee

came together by default because of the reorganisation, so it has more critical mass.”³³

75. The Committee felt there was a general lack of knowledge about the role of the community dental service.

76. A view supported by David Davies, who told the Committee,

“Part of the *Designed to Smile* role - and, I think, a very important part - is raising awareness of the benefits of good oral health, but also of the role of the community dental service. It makes people aware that we exist. There is a great deal of confusion among the public about exactly what dentists do, what the hospital services do, what general practitioners do, what the community dental service does and how you get seen by a dentist. A lot of people just do not know.”³⁴

Dental contract

77. The *Designed to Smile* programme is focused on preventative care. Members expressed concerns about whether the work done with young children to introduce them to a better level of oral hygiene would be sustained in the longer term. The British Dental Association highlighted the importance of changing attitudes so that parents took their children to dentists for regular check-ups to maintain good oral health as opposed to only accessing services to seek treatment when they had a problem.

78. Stuart Geddes told us:

“Historically, parents in deprived areas do not go to the dentist on a regular basis - they tend to seek treatment when they have a problem, and they adopt that approach for their children as well. That is what we are trying to stop.”³⁵

79. Members also questioned the extent to which this was dependent on access to NHS dentists, particularly in deprived and rural areas. A problem acknowledged by the British Dental Association,

³³ ROP [para 45], 29 September 2011, Children and Young People Committee

³⁴ ROP [para 39], 13 October 2011, Children and Young People Committee

³⁵ ROP [para 31], 21 September 2011, Children and Young People Committee

“There is also the general problem of access to dentistry in rural areas. Unless they are branch practices, it is often difficult to establish a practice in a very rural area.”³⁶

80. In terms of reviewing the dental contract to ensure it encouraged dentists to undertake preventative work with children, the Minister explained that the Welsh Government was currently running a pilot scheme, which started in April 2011, which rewarded prevention and quality and removed the current system of remunerating dentists. The pilot scheme would run for two years.

81. The British Society of Paediatric Dentistry reiterated the importance of reviewing the dental contract, stating that the way dentists were currently remunerated meant that they often did not spend enough time with children.

“the difficulty with dentistry and the contracts that we have is that, if you work in a practice, you get paid for what you do, but you do not get paid for getting a five-year-old to come in three times, sit in a chair, and get used to things so that they are ready to accept dental treatment.”³⁷

82. They argued for better integration between prevention and treatment across dental practices. They also stated that specialist paediatric dentists could be used to carry out this work. Dr Shannu Bhatia told the Committee,

“Prevention and treatment have to go side by side, so you are treating the children who already have holes in their teeth, but you are also emphasising prevention, so that other teeth do not get holes in them. ... Of course, sometimes, GPs cannot provide as much of their time, and that is where we perhaps need more specialist paediatric dentists in Wales to carry out this work.”³⁸

Recommendation: The Welsh Government should make changes to the NHS dental contract to enable better integration of prevention and treatment across dental practices and to ensure it encourages dentists to undertake preventative work with children.

³⁶ ROP [para 101], 21 September 2011, Children and Young People Committee

³⁷ ROP [para 260], 29 September 2011, Children and Young People Committee

³⁸ ROP [para 263], 29 September 2011, Children and Young People Committee

Funding for the delivery of Designed to Smile

83. Funding of £3.7 million per year was allocated to LHBs for the *Designed to Smile* programme. The Minister confirmed in her evidence to the Committee that this funding was ring-fenced and monitored through the LHB annual accounts process and external independent evaluation was also undertaken by Cardiff University.

84. The British Dental Association told the Committee there had been initial delays with the release of funds by finance directors in some areas but they were confident that these problems had been overcome.

85. As previously stated, the *Designed to Smile* programme targeted young children in areas of greatest need. However, the Committee were told that there was local flexibility within the programme to allow the inclusion of schools that might not automatically fall within the scope of the programme.

86. Professor Chestnutt told the Committee,

“Obviously, we have to target the programme in those areas where a greater proportion of children have experienced tooth decay. The programme is targeted based on Communities First areas and our knowledge from the local epidemiology. If there is a school in a pocket of deprivation within a more affluent area there is a degree of flexibility to allow it to be targeted outside the original list of schools set up.”³⁹

87. The Minister stated that the CDS were well placed to provide input based on local need. However, there were resource implications for LHBs. Members were told that some LHBs had added resources to the ring-fenced *Designed to Smile* money because they wanted additional schools included in the scheme.

88. David Davies told the Committee,

“A lot of schools are learning that the Designed to Smile programme is valuable and could help them, and we are therefore being approached to go into other areas as well as the designated areas

³⁹ ROP [para 63], 3 November 2011, Children and Young People Committee

that we have already been into. So, as time goes by, we will reach the other less deprived areas, where there are pockets of deprivation.”⁴⁰

Recommendation: Local Health Boards should be required to publish information on their annual expenditure on the *Designed to Smile* programme, including any extra investment they have provided to the CDS to support this work. For every LHB it should be possible to see how much money is being spent on improving the oral health of children and the take up of the scheme in their areas in order to assess consistency across Wales and value for money.

89. Members were also told that while the budget for *Designed to Smile* was ring-fenced, it fell to the CDS to deliver the programme’s objectives, working with its partners. The British Dental Association told the Committee that in terms of programme delivery to 0-3 year-olds, the CDS was relying on its links with health visitors and other professionals. The Minister confirmed in her follow up evidence that additional resource was not provided to those services. She told the Committee,

“NHS Health Visitor Services do not receive additional funding to support their involvement in the *Designed to Smile* programme. *Designed to Smile* forms part of their mainstream health promotion advice and support to parents, working in partnership with key agencies.”⁴¹

90. The British Dental Association explained in their evidence that it was a good decision to ring-fence the dental budget in view of the tight finances of LHBs to ensure that LHBs spent the money on *Designed to Smile* and strengthening the CDS. The Welsh Government was ultimately reliant upon the LHBs allocating expenditure appropriately to meet its policy commitments in reducing children’s oral health inequalities.

⁴⁰ ROP [para 24], 13 October 2011, Children and Young People Committee

⁴¹ Children and Young People Committee Paper CYP(4)-01-12(p6), *Inquiry into Children’s Oral Health*, Additional information from Minister for Health and Social Services, 12 January 2012

National Oral Health Plan for Wales

91. The Minister confirmed that the Welsh Government was developing a National Oral Health Plan for Wales; a draft of which was expected by February 2012. It would stress the need for prevention of poor oral health as well as treatment of disease with a particular focus on those groups who had persistently high levels of disease such as children under five. The plan would align oral health with public health through links with smoking, alcohol consumption and child nutrition.

Recommendation: The Welsh Government should ensure that *Designed to Smile* is central to its National Oral Health Plan for Wales; it should set out the Welsh Government's long term commitment to the programme and how this will fit with other Government programmes and initiatives, as well as providing a fuller picture of how dental services for children are currently being accessed across Wales and how this will change in the future. In particular, the role of the CDS needs to be clearer, including how access arrangements to the CDS are set up and what action will be taken to address the inconsistency in CDS service provision across Wales.

Fluoridation

92. The Minister highlighted the importance of fluoride availability in improving oral hygiene and stated that this would be achieved through programmes such as *Designed to Smile* which increased fluoride availability to children.

93. A number of witnesses raised the possibility of using alternative methods of getting teeth in contact with fluoride, such as the provision of fluoridated water or milk.

94. Mechelle Collard of the British Society of Paediatric Dentistry, said:

“...it has such huge benefits for dental health, and we know that, in Wales, we have the worst teeth in the UK for five-year-olds, so it is undoubtedly something that we should be looking at.”⁴²

95. Whilst in his written evidence, Huw Thomas, former Chief Executive of Gwynedd Health Authority said,

“Dental caries is a preventable disease. Wales is wasting precious resources on treating a condition which could be substantially reduced by the introduction of fluoridation of water supply, where this is cost effective and where there has been an effective process of public consultation.”⁴³

96. However, in her evidence to the Committee, the Minister made it clear that she had no plans to fluoridate water supplies in Wales.

“I have no current plans to fluoridate water supplies in Wales. We have to acknowledge that the scientific evidence supports the case for water fluoridation as having significant health benefits. However, there are no plans to do so at the moment.”⁴⁴

97. In response to a question from the Committee, the Minister also stated that she had no plans to fluoridate the water available to children in schools because,

⁴² ROP [para 246], 29 September 2011, Children and Young People Committee

⁴³ Children and Young People Committee, *Inquiry into Children's Oral Health in Wales*, Written Evidence from Huw Thomas, CYP(4) COH18

⁴⁴ ROP [para 133], 3 November 2011, Children and Young People Committee

“The clinical evidence is that the amount of water that a child would drink at school would not be of that big a benefit.”⁴⁵

Recommendation: The Welsh Government should keep under review the evidence for fluoridating water supplies in Wales.

⁴⁵ ROP [para 145], 3 November 2011, Children and Young People Committee

Annex A – Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at:

<http://www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=1305>

21 September 2011

Dr Sue Greening
Stuart Geddes

British Dental Association Wales

29 September 2011

Hugh Bennett

Public Health Wales

Dr Mechelle Collard
Dr Shannu Bhatia

British Society of Paediatric Dentistry

Dr Nigel Monaghan
Maria Morgan

British Association for the Study of
Community Dentistry

13 October 2011

David Davies

Abertawe Bro Morgannwg University
Health Board Community Dental Service

Paula Roberts
Mary MacDonald
Carol Maher

Healthy Schools Network

3 November 2011

Lesley Griffiths

Minister for Health and Social Services

Annex B – List of written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at:

<http://www.senedd.assemblywales.org/ielssueDetails.aspx?Id=1528&Opt=3>

Date	Organisation	Reference
21 September 2011	British Dental Association Wales	CYP(4)-02-11(p1)
29 September 2011	Public Health Wales	CYP(4)-03-11(p1)
29 September 2011	British Society of Paediatric Dentistry	CYP(4)-03-11(p3)
29 September 2011	British Association for the Study of Community Dentistry	CYP(4)-03-11(p4)
13 October 2011	Abertawe Bro Morgannwg University Health Board Community Dental Service	CYP(4)-05-11(p1)
13 October 2011	Healthy Schools Network	CYP(4)-05-11(p2)
3 November 2011	Minister for Health and Social Services	CYP(4)-07-11(p1)

Annex C – Consultation responses

The following people and organisations responded to the call for evidence. All responses can be viewed in full at:

<http://www.senedd.assemblywales.org/mglIssueHistoryHome.aspx?lId=1528&Opt=0>

CYP(4) COH01	GISDA
CYP(4) COH02	Vale of Glamorgan Flying Start
CYP(4) COH03	Ceredigion Public Health Team
CYP(4) COH04	Ceredigion Children and Young People’s Partnership
CYP(4) COH05	Baglan Education and Training Centre
CYP(4) COH06	Lynne Perry, Independent Health Improvement Adviser
CYP(4) COH07	Abertawe Bro Morgannwg University Health Board
CYP(4) COH08	Karen Trigg, Cardiff PSE Advisory Teacher and Health Schools Team Leader
CYP(4) COH09	Cardiff University School of Dentistry
CYP(4) COH10	British Society of Paediatric Dentistry
CYP(4) COH11	Welsh Local Government Association
CYP(4) COH12	Flying Start
CYP(4) COH13	British Dental Association Wales
CYP(4) COH14	Abertawe Bro Morgannwg University Health Board Community Dental Service
CYP(4) COH15	Aneurin Bevan Health Board Community Dental Service
CYP(4) COH16	All Wales Special Interest Group/Special Oral Health Care
CYP(4) COH17	Neath Port Talbot Council for Voluntary Service
CYP(4) COH18	Huw Thomas
CYP(4) COH19	Down’s Syndrome Association
CYP(4) COH20	Jig-So Children’s Centre

CYP(4) COH21	Public Health Wales Dental Public Health Team
CYP(4) COH22	Dr Hugh Bennett
CYP(4) COH23	Cardiff and Vale University Health Board
CYP(4) COH24	Betsi Cadwaladr University Health Board