AGENDA ITEM NO: 23

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**12 September 2017**
Report By:	**Louise Long** **Corporate Director, (Chief Officer)** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/38/2017/HW**
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Subject:	**NHS GG&C Oral Health Directorate Report: Inverclyde HSCP (2016)**		

1.0 PURPOSE

1.1 The purpose of this paper is to bring to the attention of the Integration Joint Board, the publication of the above report. This report outlines the activities related to oral health within Inverclyde for 2016 and provides an overview of ways some of the aligned activities are delivered by the Health Improvement & Inequalities and Children & Families Teams.

2.0 SUMMARY

2.1 The report highlights that progress is being made in improving oral health, particularly in addressing inequalities linked with deprivation and at the same time recognises there is still much work to be done.

Further, it is recognised by NHS GGC Oral Health Directorate that in order to continue to achieve these improvements, there is the ongoing commitment to collaborative ways of working and continuing partnership working and community development approaches.

2.2 The report is rightly weighted towards performance data that will inform future ways of working, building upon ways to address some of the known challenges, which cut across wider preventing dental decay approaches and other resources currently offered by the Oral Health Directorate and the HSCP.

2.3 There is a comprehensive set of recommendations that are suggested by the Oral Health Directorate that have informed further recommendations, both in response and to enable future ways of collaborative working and in order to improve on oral health outcomes.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the content of this paper and the positive progress made, whilst recognising that there is still a need for further improvement.

Louise Long
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4.0 BACKGROUND

4.1 The Scottish Government has set targets for child dental health that by 2022, there should be a 10% increase in Primary 1 and Primary 7 children who have no obvious dental decay.

Child Oral Health in Inverclyde remains poor and improvements have not been at a level found elsewhere in NHS Greater Glasgow & Clyde. Registration of very young children with an NHS dentist remains low and needs to be addressed.

4.2 Oral Health services in Inverclyde are currently delivered by the three separate teams- Oral Health Directorate, the HSCP's Health Improvement & Inequalities Team and the HSCP Children & Families Team.

The ways in which these are operationally delivered are described in the following sections.

4.3 General Dental Services

There are 10 independent contractor practices providing NHS dentistry in Inverclyde. These practices provide General Dental Services (GDS) and in addition 3 practices provide sedation services. Inverclyde has one practice that provides only orthodontic services meaning no patients are registered with them for GDS.

Data available from Information Services Division (March 2016) shows the proportion of patients registered in Inverclyde is:

- 92.3% Children (compared to 93.7% Scotland: 94.3% GG&C)
- 89.7% Adults (compared to 90.0% Scotland: 93.9% GG&C)

The registration data for Inverclyde is consistently lower than the data for Greater Glasgow & Clyde and for Scotland. The Oral Health Directorate suggests this might be attributed to the number of patients, particularly adults, who may be registered with non-NHS dentists, or may travel outside of Inverclyde for dental treatment. As data is not collected for non-NHS practices, it is not possible to determine numbers of patients seeking treatment outside of the NHS. Given the levels of socio-economic deprivation in Inverclyde however, it seems unlikely that we would have a higher than average leaning towards private practices as opposed to NHS dentistry.

This explanation can be further challenge with regard to children, as dentists may hold list numbers with NHSGG&C to provide NHS dental registration and treatment for children, whilst providing non-NHS treatment for parents.

More detailed data on dental registrations from Information Systems Division highlights an issue relating to registration of very young children (aged 0-2 years).

- In Inverclyde the proportion of children aged 0-2 years who are registered with a dentist is 58.3%.
- This compares to 48.1% for Scotland and 50.9% for NHS GG&C.

Although this figure is higher than Scotland and GG&C it remains lower than desired as this starts the oral health journey for a child.

4.4 Public Dental Health Service (PDS)

This service provides comprehensive dental care and oral health education to priority group patients, including those with special needs, adult and paediatric learning disabilities, medically compromised and all groups of children. Treatment is provided in clinics, schools and nurseries, care homes, outpatient daycentres, hospital units and domiciliary visits, prisons and undergraduate outreach clinics.

The following table illustrates the Location and services delivered by the PDS in Inverclyde –

Locations/Services	Paediatric Dentistry	Paediatric Special Care Dentistry	Paediatric Sedation Services	Adult Special Care Dentistry	Adult Special Care – Sedation Services	General Dental Services	Oral Hygiene Services	Domiciliary Care
Greenock Health Centre	√	√	√	√	√		√	√
Inverclyde Royal Hospital							√	
Greenock Prison						√	√*	

* A pilot hygiene therapy service is currently taking place in Greenock Prison.

4.5 **Dental Public Health**

The oral health of children in NHS GG&C has improved significantly over the last 20 years and this can be attributed to the implementation of the Childsmile programme.

Children in Inverclyde have generally demonstrated poorer oral health than the average for Scotland and the average for NHSGG&C, supported by data from the National Dental Inspection Programme (NDIP).

NDIP Data for Primary 1 (Detailed Inspections 2012/14) –

% of Primary 1, with no obvious decay experience		
	2012	2014
Scotland	67.0%	68.2%
NHSGGC	63.2%	65.3%
Inverclyde	59.7%	65.3%

Pr 1 Mean DMFT for Children With DMFT>0		
	2012	2014
Scotland	4.10	3.97
NHSGGC	4.38	4.10
Inverclyde	3.90	4.00

NDIP Data for Primary 7 (Detailed Inspections 2013/15) –

% of Primary 7, with no obvious decay experience		
	2013	2015
Scotland	72.8%	75.3%
NHSGGC	67.8%	72.5%
Inverclyde	66.4%	65.4%

Pr 7 Mean DMFT for Children With DMFT>0		
	2013	2015
Scotland	2.24	2.16
NHSGGC	2.33	2.27
Inverclyde	2.40	2.40

DMFT = number of decayed, missing or filled teeth

The proportion of children who do not have obvious dental decay is lower in Inverclyde than in GG&C and Scotland. The differences between Inverclyde and NHSGG&C for P1 children are not significant. However for P7 children, significantly fewer children in Inverclyde have no obvious dental decay when compared to NHS GG&C.

Where children have decay experience, the DMFT (number of decayed, missing or filled teeth) is higher in Inverclyde than the average for Scotland for P7 children. The DMFT figures for P1 children are comparable between Inverclyde and NHSGG&C and slighter better than the average for Scotland. Comparison of data between 2012 and 2015 suggests no significant improvement in oral health at a local level.

School level data for P1 and P7 Basic NDIP for Inverclyde (2014/15) is illustrated in the following summary tables, with totals and proportions is also displayed, together with corresponding summaries for the years 2012-2014 for comparison. The letter categories can be explained as –

Letter A : child should seek immediate dental care on account of severe decay or abscess
Letter B : child should seek dental care in the near future due to one or more of the following: presence of decay, a broken or damaged front tooth, poor oral hygiene or may require orthodontics
Letter C : no obvious decay experience but child should continue to see the family dentist on a regular basis

Basic NDIP Data P1 Schools Inverclyde 2015 (2012-2014 for comparison) –

Number of NDIP Schools	20	
Total number of P1's on Roll	770	
Total number of P1's not receiving NDIP	60	
Number (%) Children Inspected: Letter A	107	15.1%
Number (%) Children Inspected: Letter B	149	21.0%
Number (%) Children Inspected: Letter C	454	63.8%
Number (%) with Poor Oral Hygiene	98	13.8%

	2012		2013		2014	
Number of NDIP Schools	21		20		20	
Total number of P1's on Roll	788		806		807	
Total number of P1's not receiving NDIP	64		71		54	
Number (%) Children Inspected: Letter A	114	15.7%	103	14.0%	123	16.3%
Number (%) Children Inspected: Letter B	231	31.9%	184	25.0%	218	29.0%
Number (%) Children Inspected: Letter C	379	52.3%	448	61.0%	412	54.7%
Number (%) with Poor Oral Hygiene	156	21.5%	90	12.2%	164	21.8%

Basic NDIP Data P7 Schools Inverclyde 2015 (2012-2014 for comparison) –

Number of NDIP Schools	20	
Total number of P7's on Roll	736	
Total number of P7's not receiving NDIP	52	
Number (%) Children Inspected: Letter A	23	3.4%
Number (%) Children Inspected: Letter B	471	68.9%
Number (%) Children Inspected: Letter C	190	27.8%
Number (%) with Poor Oral Hygiene	301	44.0%
Number (%) Letter B - Ortho Only	40	5.8%

	2012		2013		2014	
Number of NDIP Schools	21		20		20	
Total number of P7's on Roll	811		698		754	
Total number of P7's not receiving NDIP	65		64		62	
Number (%) Children Inspected: Letter A	18	2.4%	16	2.5%	20	2.9%
Number (%) Children Inspected: Letter B	582	78.0%	436	68.8%	488	70.5%
Number (%) Children Inspected: Letter C	146	19.6%	182	28.7%	184	26.6%
Number (%) with Poor Oral Hygiene	380	50.9%	243	38.3%	312	45.1%
Number (%) Letter B - Ortho Only	35	4.7%	49	7.7%	52	7.5%

The extraction of teeth is an end-point for dental decay experience. For young children this procedure is usually performed under general anaesthetic – a traumatic experience presenting a risk to children, loss of school time, plus work time for parents/guardians and resource intensive for NHSGG&C.

4.6 Oral Health Improvement - Childsmile

Childsmile is the National Dental Programme to improve the oral health of Scottish children. The programme has three main components –

- Childsmile Practice
- Childsmile Core Toothbrushing Programme
- Childsmile Fluoride Varnish Programme.

4.7 Childsmile Practice provides the important link is established between Health Visitors (HSCP's Children & Families) and the Oral Health Directorates Dental Health Support Workers (DHSW) and dental practices. Assistance is provided in locating and visiting a dentist for new parents.

4.8 Childsmile Core Toothbrushing programme, delivered by both the Health Improvement & Inequalities Team and Children & Families was established within the Inverclyde area in 2006. There are currently 20 Inverclyde mainstream schools taking part in the programme, which is in addition to the 100% (n=30) of all pre-5 establishments. Any non-participating schools are contacted on a regular basis to review interest in participation and offered support to implement Childsmile.

The following table highlights the Inverclyde establishments participating in tooth-brushing for the period 2015/2016, by SIMD area –

SIMD	Nurseries	Playgroups	Primary Schools	Special Education Establishments	Overall Total Brushing
1	5	0	3	0	8
2	9	0	6	0	15
3	3	0	4	0	7
4	7	0	5	0	12
5	6	0	2	0	8
Total	30	0	20	0	50

4.9 **Childsmile Fluoride Varnish Programme**

Currently 1 modern apprentice DHSW, from the Oral Health Directorate is assisting with the collection of Fluoride Varnish consent forms in order to increase the number of children accessing Fluoride Varnish. It is usual practice for fluoride varnish to be applied twice yearly in some establishments where there is a high level of children from SIMD 1 and 2.

Below is a summary of the total number of fluoride varnishes applied in the nursery and school programme during 2015/2016.

Please note the information below was extracted from Childsmile HIC site on 23rd May – additional activity may be added until end of June 2016

Class Type	Targeted Children	Children with validated consents		Children receiving at least one FVA			Children receiving two or more FVA's		
	T	V	% of T	n	% of T	% of V	n	% of T	% of V
nursery	573	435	75.9%	366	63.9%	84.1%	190	33.2%	43.7%
p1	331	272	82.2%	254	76.7%	93.4%	176	53.2%	64.7%
p2	343	321	93.6%	303	88.3%	94.4%	269	78.4%	83.8%
p3	335	315	94.0%	303	90.4%	96.2%	264	78.8%	83.8%
p4	330	304	92.1%	286	86.7%	94.1%	252	76.4%	82.9%
p5	51	5	9.8%	1	2.0%	20.0%	1	2.0%	20.0%

4.10 **Caring for Smiles**

Caring for Smiles is Scotland's national oral health promotion, training and support programme, which aims to improve the oral health of older people, particularly those living in care homes.

The programme contains information, which is adaptable to all adults, particularly those who are dependent or vulnerable. The table below provides data on the number of Care Home involved in the programme in Inverclyde.

HSCP	Number of Care Homes	Number participating in CFS Training	Number participating in CFS Monitoring	Total number of Residents	Number registered & seen by a dentist within last 12 months	% of resident seen & registered with a dentist within last 12 months
Inverclyde	18	18	18	632	446	71%

Between 1st April 2015 and 31st March 2016 a total of 44 staff have been trained and the Oral Health Directorate undertakes on a monthly basis checks of the baseline audit and updates the dental registration figures.

5.0 Summary of Report Recommendations

There is a comprehensive list of recommendations from the Oral Health Directorate and can be themed with the aim of improving oral health outcomes for the local area, with a focus in the following areas –

- Build on and develop the good working practices and partnership working with the HSCP;
- Seek to improve targeting more vulnerable, or deprived children;
- There needs to be a focus on increasing the number of children registered and participating in the oral health service, particularly very young children aged 0-2 years;
- The need to engage with NHS dental practices to improve the uptake and delivery of Childsmile Practice;
- The Dental Public Health team should continue to monitor national and local data intelligence on oral health outcomes and engage with pertinent community planning partners in priority setting and strategic planning;
- Identify areas and/or populations where increased focus is needed to tackle inequalities and poorer oral health;
- Aim to improve links with NHS dental practices and provide support and training for Childsmile;
- Continue to work with pertinent community planning partners to improve the uptake and delivery of Childsmile Core and the Fluoride Varnish programme.

5.1 In response to the above recommendations, the HSCP should consider the future effectiveness of delivering oral health services on behalf of the Oral Health Directorate. This would be with a view to reviewing the current provision undertaken by both the Health Improvement & Inequalities Team (HIIT) and those in Children & Families with a view to a more cohesive and joined up approach. Consideration needs to be cognisant of the forthcoming HIIT redesign, largely due to efficiency savings required and for this team to now work more strategically.

It is recommended that a service improvement process is created that will identify –

- Scope and Deliverables
- Benefits, Costs and Risks

- Governance, Organisation and Reporting
- Project Plan
- Reflect any proposed organisational change processes in following the NHSGGC Workforce Change Policy and Procedure, which should ensure the minimum of disruption to individuals and services through this process.

6.0 IMPLICATIONS

FINANCE

There are no financial implications from this report.

6.1 **Financial Implications**:

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Vehement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Vehement From (If Applicable)	Other Comments

LEGAL

6.2 There are no legal implications from this report

HUMAN RESOURCES

6.3 There are no legal implications from this report

EQUALITIES

6.4 Has an Equality Impact Assessment been carried out?

	YES.
X	NO – An Equality Impact Assessment will be undertaken by a working group that will oversee the proposals outlined in 4.12.

6.5.1 How does this report address our Equality Outcomes?

Given the report was published by the Oral Health Directorate, this section is not applicable, however, due consideration will be given to all Equality Outcomes following any service redesign, if applicable.

6.5 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

There are no clinical or care governance implications at this time.

6.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

a) **People are able to look after and improve their own health and wellbeing and live in good health for longer.**

The ethos of enabling more people to support individuals at different levels of need should facilitate earlier intervention and more effective supported self-management.

b) **People are able to look after and improve their own health and wellbeing and live in good health for longer.**

There is evidence to suggest that some of this outcome is achieved and future developments, contained in the above recommendations, will build upon these.

c) **People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**

Not directly reflected in this report.

d) **People who use health and social care services have positive experiences of those services, and have their dignity respected.**

Continuing delivering on the core functions and areas for improvement should contribute to the delivery of effective services that are positively regarded by service users.

e) **Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**

Not directly reflected in this strategy.

f) **Health and social care services contribute to reducing health inequalities.**

Continuing delivering on the core functions and areas for improvement should contribute to this outcome.

g) **People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.**

Not directly reflected in this report.

h) **People using health and social care services are safe from harm.**

Not directly reflected in this report.

i) **People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**

Sustaining and improving a multiagency partnership approach with a focus on continuous improvement and learning from practice should contribute to this outcome.

j) **Resources are used effectively in the provision of Health and Social Care.**

Not specific to the Oral Health Directorate report but for the proposal in a service

review, it is anticipated that these are driven by a need to use resources more effectively.

7.0 CONSULTATION

7.1 The report was produced by the Oral Health Directorate, based on data and clinical outcomes, rather than consultation.

8.0 LIST OF BACKGROUND PAPERS

8.1 http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/data-tables.asp?id=1677#1677