

7.2.1 Oral health (Children & young people) Brighton & Hove JSNA

Why is this issue important?

Tooth decay is the most common oral disease affecting children and young people (CYP) in England, yet it is largely preventable. While children's oral health has improved over the last 20 years, almost a quarter (24.7%) of five year olds still had tooth decay in 2015.¹

Poor oral health impacts upon children and families' wellbeing. It can lead to absence from school and the need for parents to take time off work to take children to the dentist. Oral health is an integral part of overall health; when children are not healthy it affects their ability to learn, thrive and develop. Good oral health can also contribute to school readiness.² Nationally dental extractions due to tooth decay are the top cause of hospital admissions for 5-9 year olds.²

Poor oral health may be indicative of dental neglect and wider safeguarding issues.² The risk factors for poor oral health include a frequent and high sugar diet, which is also common to diabetes and obesity. Topical fluoride such as in toothpastes, varnishes and mouth rinses helps to prevent tooth decay.²

Key outcomes

- **Tooth decay in children aged five (Public Health Outcomes Framework)**
- **Improving dental health: i. decaying teeth (Public Health Outcomes Framework and NHS Outcomes Framework) ii. Tooth extractions in Secondary Care for children under 10 (NHS Outcomes Framework - in development)**
- **Ensuring people have a positive experience of care – Patient experience of NHS Dental Services (NHS Outcomes Framework)**
- **Ensuring people have a positive experience of care - Improving access to NHS Dental Services (NHS Outcomes Framework)**

Impact in Brighton & Hove

The oral health of children in Brighton & Hove is measured through a series of nationally co-ordinated epidemiological surveys for three, five

and twelve year olds. The requirement of positive consent from parents for their children to be part of the survey means the findings should be treated with caution due to the possibility of bias (as well as the small sample size).

Definitions
Mean d₃mft – average number of obviously decayed, missing (due to decay) and filled teeth per child
% d₃mft>0 – percentage of children with decay experience
Care Index % - Proportion of teeth with decay that have been filled

Three year olds survey: The first national three year olds survey was conducted in 2012/2013 in nurseries (private and state), nursery classes attached to schools and playgroups. For the first time data was included on early childhood caries. This is an aggressive form of decay that affects upper incisors and can be rapid and extensive in attack. It is associated with long term bottle use with sugar-sweetened drinks, especially when given overnight or for long periods of the day.

In Brighton & Hove 15% of those examined had evidence of decay, compared to 12% in England and a higher proportion of three year olds had early childhood caries (Table 1).³

Table 1: NHS Dental Epidemiological Programme for England. 2012/13 Survey of 3 year old children, Brighton & Hove and England

	Brighton & Hove	England
3 year old population (2012)	2,966	665,744
Examined	69	53,814
%dmft>0	15%	12%
Mean d ₃ mft including incisors	0.45	0.36
% with early childhood caries	7%	4%

Source: Public Health England. Dental Public Health Intelligence Programme

Five year olds survey: The most recent data for five year old children is based on the 2014/15 survey.

¹ Public Health England. National Dental Epidemiology Programme for England: Oral health survey of five year old children. 2015

² Public Health England. Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities. June 2014

³ Public Health England. Dental Public Health Intelligence Programme. Available at <http://www.nwph.net/dentalhealth/> [Accessed 10/08/2016]

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Since the 2011/12 survey the proportion of five year old children in Brighton & Hove with decayed, missing or filled teeth has increased slightly from 12% to 18%, which is lower than the 25% for England. The proportion with decayed teeth that have been filled has increased from 19% to 22%, which is higher than the 12% for England (Table 2).³

Table 2: NHS Dental Epidemiological Programme for England for 2014/15, 2011/12 and 2007/08 Surveys of 5 year old children, Brighton & Hove

	2014/15	2011/12	2007/08 (positive consent not required)
Sample	2,965	2,808	2,407
Examined (% of sample examined)	170 (54%)	87 (55%)	192 (54%)
%d ₃ mft>0	18%	12%	21%
Mean d ₃ mft including incisors	0.4	0.3	0.5
Care Index	22%	19%	20%

Source: Public Health England. Dental Public Health Intelligence Programme

Twelve year olds survey: The most recent data for 12 year old children is from the 2008/09 survey.

Table 3. NHS Dental Epidemiological Programme for England for 2008/9 Survey of 12 year old children, Brighton & Hove

	England	Brighton & Hove
Sample	120,642	307
Examined	89,442 (74.1%)	234 (76%)
%dmft>0	34%	17%
Mean dmft	0.74	0.27
Care Index	47%	68%

Source: Public Health England. Dental Public Health Intelligence Programme

In Brighton & Hove, 17% of 12 year olds had decayed, missing or filled teeth in 2008/09, which is lower than 34% for England. The proportion of

children with decayed teeth that have been filled was higher than for England (Table 3).³

Tooth extractions in secondary care

In 2014/15, 296 children aged 19 and under in Brighton & Hove, were admitted to secondary care for dental extraction, of whom 183 (61.8%) had a primary diagnosis of dental caries.³ There is no trend data available for this measure.

There has however, been a statistically significant increase in hospital admissions for all dental extractions⁴ for 5-9 year olds since 2012/13 (Figure 1). It has increased from 0.8% to 1% in 2014/15, but remained at 0.8% in England for this age group. The overall proportion of children being admitted to hospital between 2011/12 and 2014/15 has remained the same as England at 0.5%.

Brighton & Hove has a comparable percentage of children aged 0-19 years having dental extractions in hospital for decay as England (0.3%) and a higher proportion overall than its comparators except for Bristol and Blackpool. In the 5-9 age group, it is slightly higher than England (Brighton & Hove 0.8% and England 0.7%). It is higher than all its comparators, except Bristol (0.5%) and Blackpool (0.9%), in the 0-4 age group at 0.2%.³

Access: As at June 30th 2016, 60% of children aged 0-17 were seen as patients by dentists in the previous 12 months in Brighton & Hove.⁵ Out of 325 children in care in Brighton & Hove, 275 (85%) had their teeth checked in 2014.⁶

Where we are doing well

General Dental Practitioners have implemented Delivering Better Oral Health and are following the prescribed patient care pathways, including the application of fluoride varnish.

In 2014/15, Brighton & Hove had a higher percentage of fluoride varnish applications in its child courses of treatment than Portsmouth, East Sussex and Blackpool local authority comparators and had a similar percentage to Southampton and

⁴ Data with a primary diagnosis of dental caries is only available for 2014/15 but this will be the primary diagnosis for the majority of extractions.

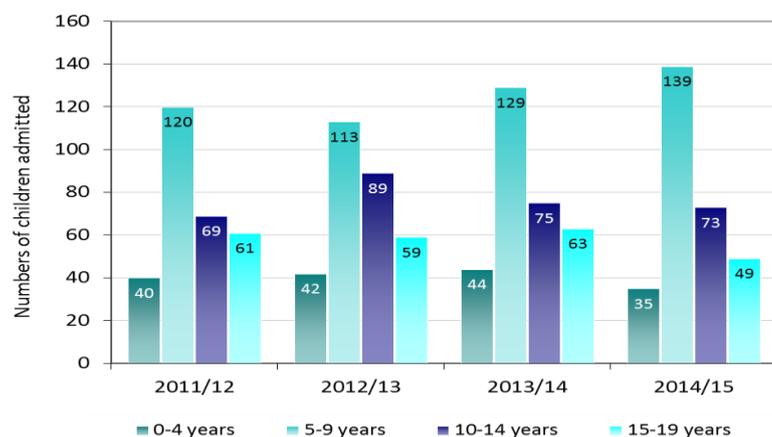
⁵ Health and Social Care Information Centre (HSCIC). NHS Dental Statistics. 2014/15. Available at <http://content.digital.nhs.uk/catalogue/PUB21701> [Accessed 27/10/2016]

⁶ Department for Education. Health care and development assessments of children who have been looked after continuously for at least 12 months. 2014.

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Bristol (Figure 2).⁵ In 2015-16, 37% of children in Brighton & Hove had courses of treatment that included fluoride varnish.⁷

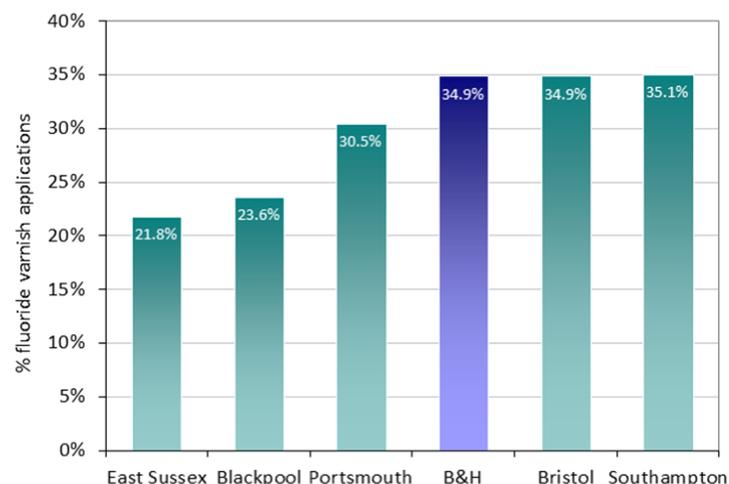
Figure 1: Children admitted to hospital for all dental extractions, by age band, Brighton & Hove, 2011/12 -2014/15



Source: Public Health England. Dental Public Health Intelligence Programme⁸

In 2015-16, 2.6% of child courses of treatment included fissure sealants in Brighton & Hove. This was a slightly higher proportion than local authority comparators in Bournemouth (1.9%), East Sussex (1.8%) and Bristol (2.0%), and similar to Portsmouth (2.7%) but lower than Blackpool (3.6%) and Southampton (3.4%).⁷

Figure 2: Percentage of child courses of treatment including fluoride varnish applications in Brighton & Hove compared to local authority comparators, 2014/15



Source: Health and Social Care Information Centre. NHS Dental Statistics 2014/15.

⁷ NHS Digital. NHS Dental Statistics 2015-16. <http://content.digital.nhs.uk/catalogue/PUB21701>

⁸Data is for all dental extractions, not just those due to caries, but this will be the majority diagnosis.

The specification for the 0-19 years Public Health Community Nursing Service includes a requirement for dental care to be included as part of the 2- 2½ years review and for access to dental care to be included in the Reception Years health assessment questionnaire.

Actions to reduce the impact of dental decay in children are being implemented in the city as part of the oral health promotion programme and Public Health Schools Programme. This targets tooth brushing at children's centres, special schools, and early years settings; breakfast clubs and child health clinics. It also provides awareness training for the wider workforce and works with the Public Health Schools Programme to promote oral health.

Local inequalities

Children living in deprived communities have poorer oral health than those living in more affluent communities. They are more likely to eat diets that are high in fat, sugar and salt, contributing to higher rates of dental caries and obesity, as well as Type 2 diabetes, heart disease and cancer.²

Whilst children in poverty live all across the city, there are concentrations of families living in poverty in East Brighton (36%) and Moulsecoomb and Bevendean wards (37%). Child poverty is also more common among Black and Minority Ethnic groups, Gypsies and Travellers and families with disabilities.⁹

Predicted future need

The population of 0-17 year olds in Brighton & Hove was 51,249 in 2015.¹⁰ This is projected to increase to 52,595 by 2020 and 53,980 by 2025.¹¹

⁹ Brighton & Hove City Council and NHS Brighton and Hove. Look inequality. Annual Report of the Director of Public Health. Brighton & Hove. 2014-15. Available at: <http://www.bhconnected.org.uk/content/reports> [Accessed 10/08/2016]

¹⁰ Office for National Statistics. 2015 Mid-Year Population Estimates by age and gender. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalescotlandandnorthernireland>

¹¹ Office for National Statistics. 2014 based sub national population projections. Available at: http://web.ons.gov.uk/ons/data/dataset-finder/-/q/datasetDetails/Social/2014SNPP?p_auth=7tbmmAyZ&p_p_auth=d2A76clv&p_p_lifecycle=1&FOFlow1_WAR_FOFLOW1portlet_dataset=Back&FOFlow1_WAR_FOFLOW1portlet_dataset=Back&FOFlow1_WAR_FOFLOW1portlet_dataset=Back

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An unhealthy diet including the consumption of sugary food and drink contribute to both obesity and poor oral health. If obesity continues to increase this is likely to have an impact on the oral health of the population.

What we don't know

Due to the need for positive consent to oral health surveys for children and the small sample sizes, we do not have a comprehensive picture of the prevalence of dental caries in five and twelve year olds.

There is no up-to-date local data describing health inequalities in the oral health of children.

There is a lack of stakeholder, public and patient consultation data.

Key evidence and policy

Key interventions for improving oral health in children: make fluoride available; healthy eating; tooth brushing schemes in nurseries and primary schools in areas at high risk; oral health promotion incorporated into all children and young people's services, including early years; whole school approach; universal and targeted interventions; oral health promotion training for frontline workers; sugar free medication.

These are outlined in:

- Local authorities improving oral health: commissioning better oral health for children and young people²
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CB_OHMaindocumentJUNE2014.pdf
- NICE guidance 55¹²
<https://www.nice.org.uk/guidance/ph55/resources/oral-health-local-authorities-and-partners-1996420085701>
- and Delivering Better Oral Health: an evidence-based toolkit for prevention.¹³
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CB_OHMaindocumentJUNE2014.pdf

[em/uploads/attachment_data/file/367563/DB_OHv32014OCTMainDocument_3.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367563/DB_OHv32014OCTMainDocument_3.pdf)

Recommended future local priorities

1. Continue oral health promotion work (including the delivery of tooth brushing and fluoride interventions) with children in a range of settings.
2. Develop the capacity of children and young people's frontline workers to deliver oral health promotion
3. Continue to develop joint work between the healthy eating/sugar reduction and oral health agendas for children and young people
4. Continue to monitor the outcomes of national epidemiological surveys, and take appropriate follow-up action.

Key links to other sections

- Oral health (Adults and older people)
- Child healthy weight
- Education
- Child Poverty

Last updated

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[Accessed 10/08/2016]

¹² NICE. Oral health: approaches for local authorities and their partners to improve the oral health of their communities; NICE Public Health Guidance 55. October 2014.

¹³ Public Health England. Delivering Better Oral Health: an evidence-based toolkit for prevention. June 2014.