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Dental Public Health in Action

Oral Health Advice for Looked-After-Children: A pilot care pathway in Buckinghamshire, UK

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Introduction: Looked-After-Children (LAC) frequently are more likely to have untreated dental caries, periodontal diseases or dental trauma (McMahon *et al*., 2018). The COVID-19 pandemic reduced the availability of dental appointments, including for LAC. This initiative piloted the inclusion of a dental pathway into the existing LAC care pathway in Buckinghamshire. The key principle was providing oral health messaging around maintaining good oral health and preventing disease in these children by training those involved with their care. ***Methods***: A working group was convened, which included dental public health, clinical and training expertise. A care pathway was developed with resources drawn from existing programmes including mini Mouth Care Matters (mMCM). The care pathways were designed to identify children who needed care urgently due to pain or discomfort, signpost them to the relevant/most appropriate providers and provide oral health improvement advice for everyone. Local partners were engaged to ensure that the processes and training were appropriate. A pilot training session was then carried out for a range of staff engaged in the care of LAC within Buckinghamshire. ***Results***: The pilot dental pathway, launched in March 2022, initiative was welcomed by all stakeholders, including dental commissioners. The pilot training session received positive feedback from participants, with requests for more sessions. Training sessions were subsequently translated into video sessions, accessible when needed, for new staff or as refresher sessions. ***Conclusion***: There are opportunities to reduce future inequalities for these children by inculcating positive behaviours early in their care journey. This will reduce their need for care. Identifying and implementing the most appropriate initiatives requires collaboration and commitment from all stakeholders.

Keywords: *health promotion, oral health, oral health inequalities England, looked-after-children*

Initial impetus for action

On 25th March 2020, the COVID-19 pandemic led to complete dental practice closures for two and a half months (25th March - 8th June 2020) (OCDO, 2020b) on the advice of the Chief Dental Officer of England to reduce risk of transmission of the disease (OCDO, 2020a). This was followed by reduced dental capacity due to the implementation of more stringent infection control procedures. The result of all this was greatly increased waiting times for all patients, including vulnerable groups such as Looked-After-Children (LAC) (CQC, 2021).

With long delays in dental treatment, there was a risk that dental problems could worsen and/or new problems emerge, including acute conditions such as irreversible pulpitis that might cause pain (CQC, 2021). Dental commissioners were already trying to identify strategies to increase the availability of appointments, specifically for LAC. In the interim, the dental public health team were keen to explore opportunities to provide oral health improvement messages to help these vulnerable children improve their oral health and prevent existing problems from progressing. Whereas oral health advice is available to the wider public through various programmes, it is unclear how much of this reaches vulnerable groups such as LAC. This is an inequality that the dental public health team were keen to address, particularly when dental appointments were limited and waiting times lengthy.

In England, children are defined as LAC when the state becomes a "corporate parent", in place of their parent(s). After their 18th birthday they are considered young adults but continue to be eligible for assistance from a local authority. Under the Children Act 1989 (HMG, 1989), a child is legally defined as 'looked after' by a local authority if he or she:

- is provided with accommodation for a continuous period for more than 24 hours
- is subject to a care order
- is subject to a placement order

The health (including oral health) needs of LAC are likely to be more complex than those of the general population (Hurry *et al.*, 2023). However, robust information is currently limited due to a lack of suitable studies (McMahon *et al.*, 2018). The available contemporary information indicates that LAC are more likely to have untreated dental caries, periodontal diseases and untreated dental trauma (Clark *et al*., 2017). A study in Scotland found that LAC had double the rates of urgent treatment need, were half as likely to attend dental services regularly, and nearly twice as likely to have had teeth extracted under general anaesthesia than the general child population (McMahon *et al*., 2018). A study investigating a designated dental pathway for LAC found that oral health in this group was often characterised by poor oral hygiene, as well as prolonged use of both bottles and dummies (Williams *et al.*, 2014).

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Placing children in foster care, whilst removing the immediate threat to the child, has long lasting effects in terms of psychosocial, and health outcomes (Muirhead *et al*., 2017). The oral health inequalities outlined above add to these existing inequalities. One study found that LAC were 12% less likely to attend a dentist, compared to the general population (McMahon *et al.*, 2018). Post COVID-19, the long wait for dental appointments without any dental advice or support increases the risk that a child's oral health could deteriorate. This inequality is undesirable both for the child and the health system, particularly with the drive to ensure equity of access to healthcare and health outcomes for everyone.

LAC receive initial health assessments by a dedicated team when they are taken into care but there is no oral health improvement advice provided until they are examined by a dentist. Incorporating oral health information into this initial assessment would achieve a more holistic approach to the overall health and wellbeing of the children. It would involve training medical staff to conduct a basic mouth check and provide oral health information. This integration of oral health into the pathway using the staff already engaged in that pathway is based on the Making Every Contact Count (MECC) model (Nelson *et al*., 2013). MECC advocates training patient or public facing staff to use opportunities during routine contacts with the people they support to support, encourage and enable people to consider healthy behaviour changes such as stopping smoking.

We describe an initiative to incorporate dental checks on entry to care. The dental checks would be conducted by training the staff making the initial health assessments. They would also be given oral health improvement information to pass on to the children and their carers.

Solution suggested

As mentioned above, increased access to dental services for these children was being addressed by dental commissioning colleagues. The aim of this initiative was to consider the oral health of LAC from the time they were taken into care so that those in pain or distress could be identified for immediate dental care and all LAC could be given information about caring for their mouths.

Objectives:

1. Develop a dental component integrated into the existing initial health assessment for LAC.
2. Train and empower members of safeguarding teams to provide oral health advice and to be able to recognise any urgent dental problems for signposting to the appropriate service.
3. Develop resources to support the training and delivery of the dental component.

A multi-disciplinary approach was taken to develop the initiative. The Dental Public Health team had discussions with dental commissioners, Health Education England (Thames Valley & Wessex) and the Thames Valley Special Care/Paediatric Dentistry Managed Clinical Network (MCN). The MCN identified a specialist in paediatric dentistry (EV) to provide clinical expertise. An adult patient representative who had previously contributed to hospital care pathways volunteered to contribute his experience.

Mouth Care Matters (MCM) is a national initiative to support the oral care of hospital in-patients and care home residents. Mini Mouth Care Matters (mMCM) was subsequently developed for hospitalised children. The programme involves training non-dental staff to look into children's mouths and check for any urgent problems, whilst recognising that the children would still need a professional dental examination. On the advice of the specialist clinician, we used mMCM as the basis for this initiative.

LAC have a health check upon entry into the system. Subsequent health checks must be carried out at least every six months for children under five years of age and every year for those aged over five years (Department for Education and Department of Health, 2015). The mouth is not checked nor is any oral health advice given, as the child is referred for a statutory dental examination, treatment and advice. This became an issue when dental appointment capacity was reduced. Integrating an oral health component within the health check would help to identify and direct the limited care available to LAC who were most in need of urgent dental attention (those experiencing pain or distress). All children and foster carers would also be given information on keeping the mouth healthy, specifically around diet and oral hygiene using the information drawn from Delivering Better Oral Health, a national evidence-based resource (OHID, 2021).

A protocol was developed with three possible pathway options (Figure 1). Children in pain, would be referred urgently to the general dental service (GDS) or community dental service (CDS) depending on which service criteria they meet, for management of the dental issue and to relieve pain. Children would be referred to A&E if no other option was available. Those with obvious decay, but no pain would be referred to a general dental practitioner (GDP) for the next available appointment, whilst highlighting that treatment was needed to avert the need for urgent care. Finally, if all seemed well from the basic mouth check, they would be referred to a GDP for the next available appointment. It was anticipated that more appointments, which specifically prioritised these children, would be available through the dental commissioning processes which were underway.

All three categories should have a dental care plan incorporated into their healthcare plan that would be transferrable between local authority areas, using a common format. This was to support all the children to develop good oral health behaviours and prevent new disease or worsening of existing problems. The idea was that the information was accessible to all those involved in the care of that child, including foster carers, social workers and the wider medical team. The training was designed to empower those involved in the care of LAC to impart suitable oral health preventative advice.

Training was developed to help foster carers, safeguarding nurses, health visitors and others involved with the assessment and/ or care of LAC. The training included information on healthy mouths and identifying major issues which are causing pain and/or distress. Oral health advice on eating a healthy diet and toothbrushing with a fluoride toothpaste was also provided to encourage health behaviours early in the child's care journey.

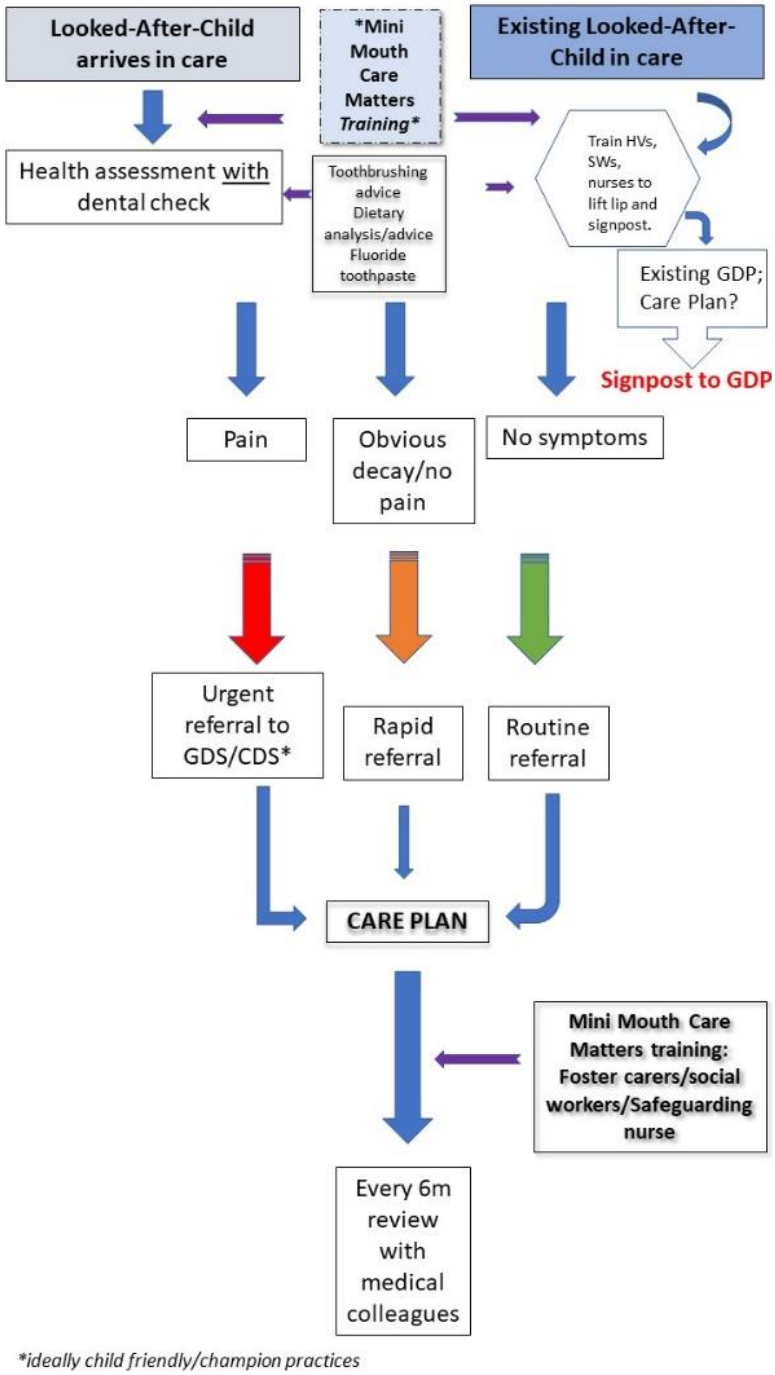

***Figure 1**. The LAC pilot pathway in Buckinghamshire.*

Existing resources from mMCM were modified to suit our pilot led by specialist clinical advice and support from those working in the field of paediatric dentistry. DBOH was used as a supplementary resource to ensure that all information was based on contemporaneous evidence. This obviated the need to develop bespoke resources and, instead, maximising the use of existing resources.

Stakeholder engagement gauged support for the inclusion of a dental component and identified training needs. Stakeholders included the Designated Nurse for safeguarding children and LAC, CCG, Lead nurse for LAC (Buckinghamshire), Family Nurse Supervisor, Head of safeguarding nurses, HEE, operations manager at Buckinghamshire Children's Services and a lay patient representative. Training needs were identified and used to develop a pilot training session.

The draft protocol was presented at the Thames Valley Local Dental Network (LDN), followed by a discussion with the Thames Valley Special Care/Paediatric Dentistry MCN. Subsequent updates were provided at both groups to ensure that local clinicians and commissioners continued to be engaged with the work.

Actual outcome

The training was delivered online in February 2022 by the authors, to pilot the slides and resources for feedback. The training consisted of a series of slides showing the most common dental conditions as well as simple tips on how to identify them (Figure 2). Based upon mMCM resources, any dental findings were to be recorded on a special proforma (Figure 3) that was highlighted in the presentation.

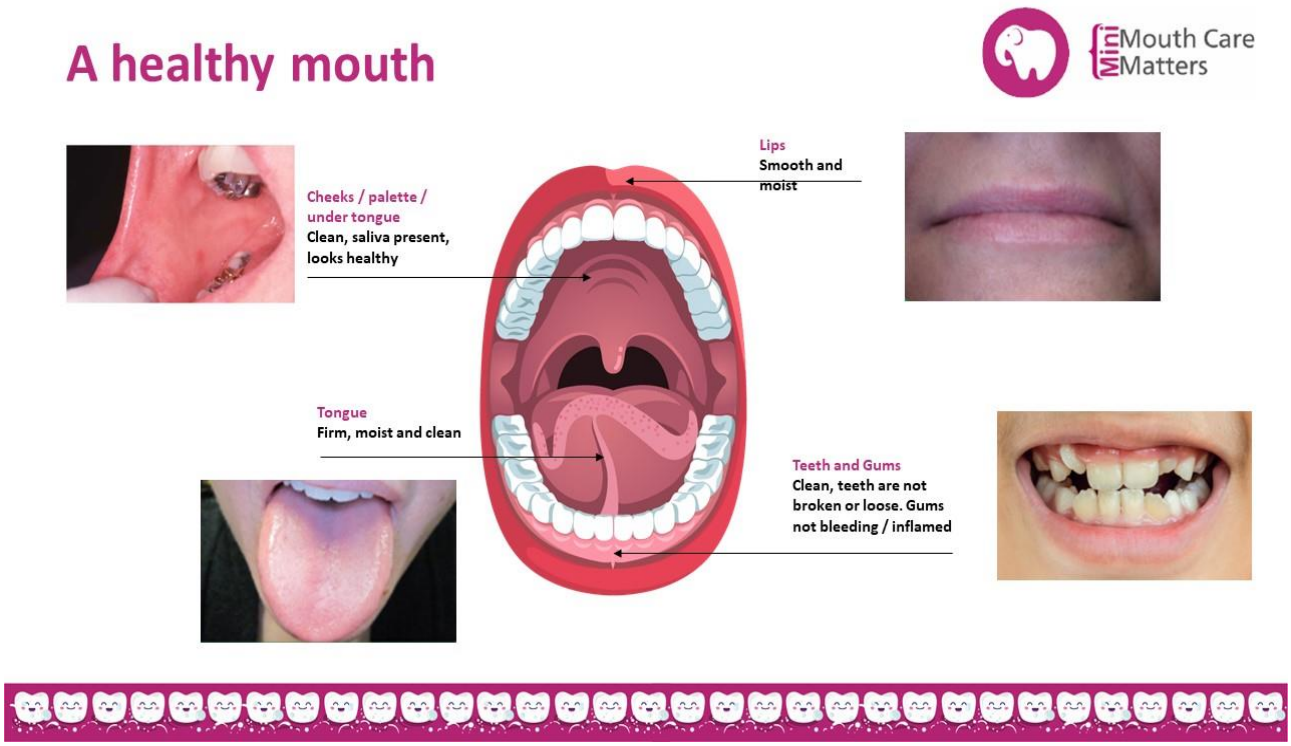

***Figure 2**. Excerpt from the Lifting The Lip training for safeguarding nurses, foster carers and health visitors.*

There were 31 attendees at the pilot training session, including safeguarding nurses, social workers, foster parents and health visitors. The training was evaluated using a Microsoft Forms questionnaire. Feedback from participants confirmed that it had been delivered at an appropriate level and met their expectations. There were requests to repeat the training for other colleagues also involved in the care of LAC.

Subsequently, HEE took over leadership of the programme and more training was delivered across Buckinghamshire in collaboration with local specialist clinicians. The training was recorded and is available online for training new staff and as a reference document. The resources developed for this programme, including links to other information on mouth care, have been collated and are also available online to local services.

Future implications and learning

This was a good example of cross-organisational working, with contributions from NHSE dental public health, HEE and the Thames Valley Special Care MCN as well as a patient representative. Collaboration facilitated development of an initiative appropriate for LAC, as well as those engaged with their care. With the difficulties of accessing dental care, local safeguarding teams were keen for more opportunities to support these vulnerable children. This provided a receptive environment to pilot this initiative with everyone focused on the same goal.

Continued support will be needed to keep their skills updated and maintain their confidence in supporting oral health. It may be that ongoing access to clinical dental advice may be needed in future and the question is how to incorporate and resource this for the longer-term. Training will need to be integrated into existing development sessions to make them sustainable and remain integral to ongoing health assessments.

The intention is for the programme to be developed and expanded across Thames Valley and, eventually, the Southeast Region, with modifications to suit local systems. Work has already started in other areas, flexing the model to suit local LAC health assessment processes with leadership from local clinicians. Some of the experience from this pilot is informing that expansion. For example, including information on assessing the priority of a dental visit in the context of all the changes occurring in the child's life at that point and whether the child is emotionally "ready" for a dental visit and able to cooperate with dental assessment and treatment. There are plans to evaluate the programmes and build-in a system of ongoing monitoring to assess whether this initiative is sustainable, identify aspects to be improved and whether, and how, it is contributing to the health of the children.

Conclusion

This initiative was designed to train and empower health professionals involved with the care of LAC to provide initial mouth checks as well as oral health advice. Integrating an oral health component into the initial health assessment means that oral health is considered as part of overall health, at the start of the child's care journey.

It is still important for LAC to receive full dental examinations and treatment in a timely manner, and the simple mouth checks described here cannot replace that. There are strategies in place to increase the capacity within primary dental care, but these are taking time to develop. In the interim, advice and support will help LAC, like everyone else in the population, encourage an awareness of the importance of achieving good oral health and develop the right knowledge and skills to maintain their oral health into adulthood.

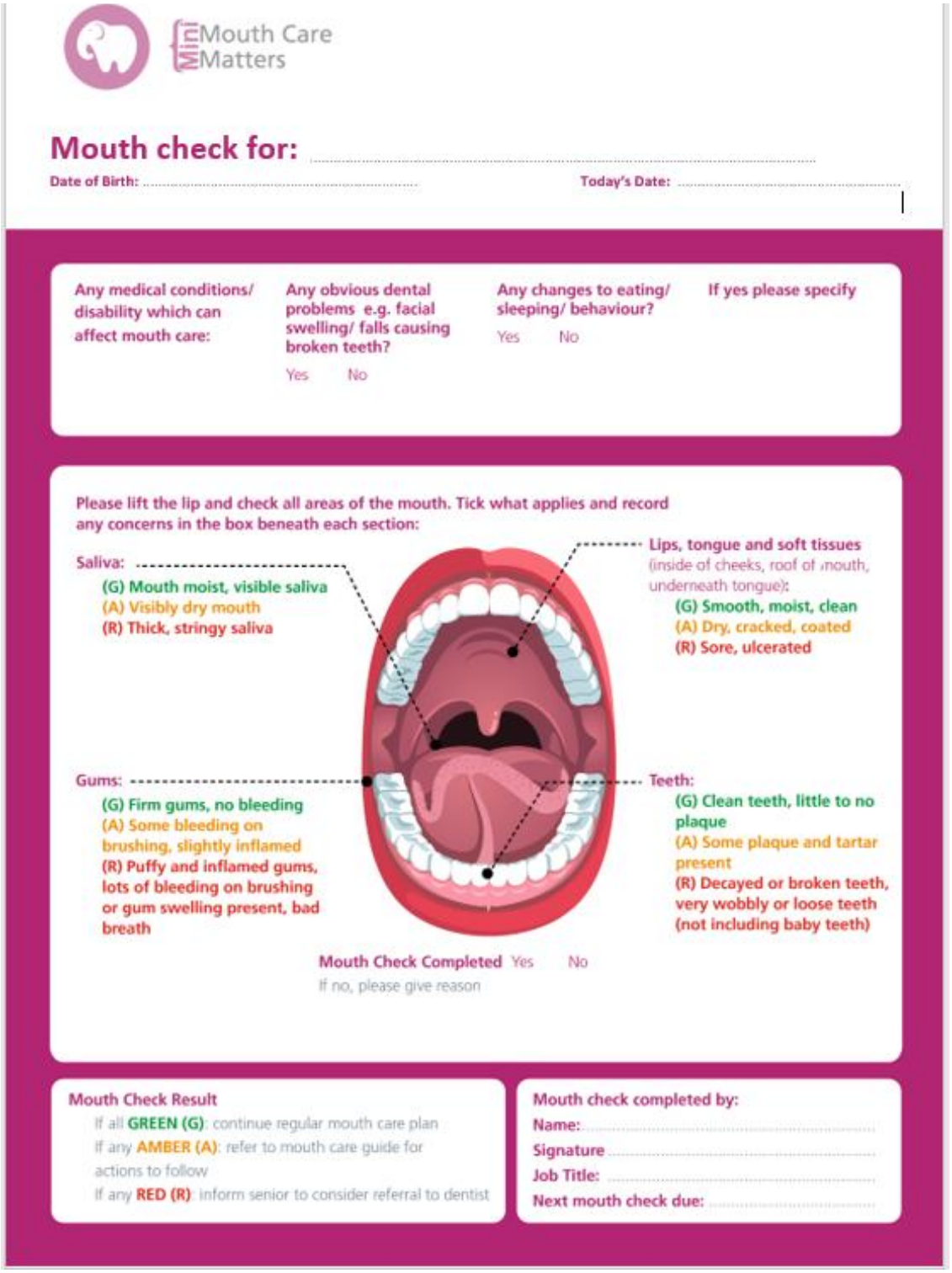

Figure 3. *Proforma for use in oral health checks.*

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