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Dental Public Health in Action

Maintaining a survey programme during structural change

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To be effective dental public health practitioners often have to work in partnership with other agencies and use their skills of persuasion to bring about positive influences to improve oral health. This paper reports an instance where these competencies were successfully applied to bring about synergistic results.

Key words: *health surveys, questionnaires, epidemiologic methods, schools, refusal to participate*

Impetus for action

In recent years, Primary Care Trust (PCT) dental epidemiological teams in England have increasingly faced new challenges in delivery of the National Health Service Dental Epidemiological Programme (NHS DEP). Often the annual surveys involve local fieldwork teams going into schools to collect data. Access to schools is therefore crucial for the programme's success. Dental teams have reported that this access to schools is becoming increasingly challenging.

School Challenges

In the years before 2000 all schools in the North of Tyne area were willing to participate in the epidemiology programme. Since that year, there have been a small number of schools not participating and the epidemiological teams have had to be far more persuasive in recruiting others. There are several reasons for this. The main issue being that schools in England are now driven by targets and league tables so any intrusion into the school timetable is seen as loss of valuable teaching time. Schools are also being approached from an increasing number of groups seeking access to children. Sometimes this is to provide education for matters such as safety but there are also other health surveys or programmes taking place such as programmes aimed at reducing obesity. Dental teams face competition in trying to persuade schools to give up valuable teaching time.

Working relationships

In the early years of the surveys local dental teams had usually built up very good working relationships with their schools via activities such as school dental screening and oral health improvement programmes. In recent years screening is usually restricted to schools for children with special needs and, similarly, oral health improvement programmes are often limited to a targeted few.

With reduced contact it is much more difficult for the dental epidemiology fieldwork teams to "cold call" schools and gain their co-operation with the oral health surveys. Dental teams need to have excellent communication skills to negotiate the obstacles presented by the current climate.

Data Protection

This is another issue of concern to schools and staff may be reluctant to share essential information about pupils, despite information sharing agreements being in place between health and education agencies. Most organisations are equipped to ensure adequate data sharing and protection. Although compliance with the NHS process of good information governance, as outlined by Caldicott guidance (Department of Health, 2010), ensures good practice, this can be quite onerous and particularly time consuming.

Structural Changes

Teams also faced challenges of structural change occurring as a result of NHS reforms and local authority restructuring. There was uncertainty whether the working relationships with partner organisations would continue or not.

In summary, the issues regarding changes in working relationships, safeguarding and information governance mean that the dental epidemiology fieldwork teams can experience barriers which impact on the successful completion of NHS DEP school-based surveys.

Suggested solutions

It was obvious that the PCT dental epidemiology fieldwork teams needed greater support so that they could approach schools with the confidence that the programme was seen as worthwhile, not just for the dental community, but for the wider health and local community.

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Local education authorities have responsibilities for all state schools and it has been customary to approach the directors of children's services or their equivalent to gain their support for the dental surveys. Experience has shown that some directors of children's services do not see oral health as a priority issue amongst their many responsibilities.

Following NHS reform the responsibility for improving public health in England will transfer, in 2013, from NHS primary care trusts to local government authorities. Directors of Public Health (DsPH) will be responsible for improving health, undertaking health needs assessments, co-ordinating local efforts to protect the public health and wellbeing and ensure health services promote population health effectively. Local Authorities will also be responsible for measuring levels of general and oral health. It appeared to the team reporting here to be an opportune time to gain support for the dental epidemiology programme among DsPH as partnership working is being built up in local authorities. DsPH will be working even more closely with directors of children's services in the future and so are in a good position to champion the importance of the NHS DEP and ask for the support of directors of children's services as well as other groups which sit within the local authority.

Recent Public Health Outcomes Framework indicators (Department of Health, 2012) now include the oral health of five-year-olds and are important to local authorities. It was considered that this should be highlighted so that oral health had a higher priority on the public health agenda. This was particularly so for the North of Tyne area where the levels of caries were a cause for concern which needs to be addressed.

Action

In the North of Tyne cluster of PCTs, there are three local authorities each with a director of public health. In the absence of a Consultant in Dental Public Health (CDPH) the NHS DEP Regional Coordinator contacted each of the DsPH directly by telephone and arranged a face to face meeting. At these meetings the coordinator explained the reasons for, and the value of, the NHS DEP, as well as the methods used and barriers experienced. Connections between oral health and general health were described, along with the value of measures of caries among 5 year olds as an indicator of the success of general health improvement initiatives for young children.

Once the connections with general health were made explicit and the outcome indicator highlighted the DsPH were keen to support the surveys and suggestions were made to increase the utility of them. This made sense when costs are of high importance and opportunities to collect valid population-level data are few. It had already been determined that the dental survey in 2011/12 would involve all schools, rather than a standard sample, as robust information at a local level was required for planning purposes. The last full population survey was carried out in 2003/04 and there was a clear need to update information for small areas within PCT geographic boundaries.

All three DsPH were keen to maximise each public health opportunity and ensure resources are used to gain full potential. So a population-wide survey where parents are giving consent was seen as a good opportunity to collect more information than the standard clinical data set. There was some discussion on what local information could be collected that would be most valuable. Within Newcastle, a fluoridated city, there has been a marked rise in the number of immigrant families with young children who would be surveyed but not have benefitted from the local fluoridated water. Hence, one of the additional questions was agreed to be about lifelong residency in the city. Linked with the issue of fluoridated water, the local lifestyle data had recently flagged up that many children did not drink tap water. So although living in a fluoridated area, they would not receive the full benefit of this. It was therefore agreed that the second additional question should be about tap water consumption.

There was much debate about the use of a third question. It was finally decided that this was a good opportunity to collect some information about breastfeeding as the current data set for breastfeeding has some limitations and it was a good opportunity to ask all parents of five year olds about their history of breastfeeding.

There was also discussion between the DsPH to ensure that the information collected could be triangulated with other routinely collected information to maximise potential use of the data.

Reflecting the support of the local DsPH, letters were developed with their logos and signatures, etc. which were appropriate to each of the local authorities and the various stakeholders. These had an impact upon schools previously reluctant to co-operate. The DsPH were able to suggest other people within their local authorities who could help support the dental teams in gaining the information required e.g. heads of children's services or health professionals. It was found that simply knowing the names and roles of staff in the local authority helped the fieldwork teams to communicate effectively. Having the explicit support of the head of children's services for the surveys certainly appeared to be important to school staff, but also knowing the names of the local authority staff who liaise with school staff for data collection was especially helpful. This meant that many fewer schools declined to co-operate than was previously the case. Among the co-operating schools there were fewer who had concerns about sharing information.

Awareness of the survey among DsPH will mean that greater use will be made of the dental data collected and analyses will be undertaken with the data arising from the three questions being asked during the dental survey. Other non-tangible benefits are anticipated from the new partnership working, to the benefit of local children's health.

Challenges

Time is precious for people in leadership roles such as DsPH and oral health, unlike those conditions with high mortality and morbidity rates, can be perceived as low priority. Engaging DsPH to discuss the issues of dental surveys can therefore be challenging. Hence it was important to ensure the initial contact was made by someone with sufficient status who was known to ,

and respected by, the directors. A suitable person may be the CDPH, NHS DEP Regional Coordinator, local epidemiology lead or senior clinical director depending on the local organisation.

During the transition of public health responsibilities, as described above, it is likely that losing the knowledge of who is responsible for what and able to influence will increase so the DsPH may be an even more important connection.

Some of the schools still did not wish to participate despite the efforts described above. However, another letter sent to head teachers from the DPH and director of children's services clarifying the expectation of compliance solved this in most cases.

Learning Points

It is clear that DsPH are keen to have good robust data regarding their populations and they soon appreciate the implications of oral health being linked with nutrition and wellbeing. They are particularly concerned about how their populations are faring compared to their statistical neighbours and NHS DEP data provide these comparison.

There is an impetus to have more joined up and partnership working so that the most can be gained for any activity carried out. It is important that dental epidemiology teamsand their work in collecting oral health data is carried out in partnership with public health and local authority colleagues. Improved outcomes can result from working in this manner, whilst also raising the profile of oral health.

If handled carefully the solutions to problems can produce a far better outcome than was originally envisaged.

The challenges of the dental epidemiology programme in schools exemplifies the need for dental health professionals to have competencies in communication, information gathering and, in particular, use their skills and knowledge to persuade and influence their partners in the local authority.

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