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Dental Public Health in Action

Dental Public Health in Action: Putting oral health on the local public health agenda

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Oral health is a key public health issue across England. In Wakefield in the north of England, local data suggested the oral health of local children was significantly worse than the national average. This paper describes the work undertaken by Wakefield Council to strategically address this issue. A structured process was adopted. Key lessons include; having senior ownership from the Director of Public Health, partnership working across all key stakeholders, utilising dental public health expertise from Public Health England and the use of extensive engagement with stakeholders. Through this work, oral health is now identified with greater importance in Wakefield as a public health issue. Actions are now strategically co-ordinated across stakeholders to improve oral health in local children.

Key words: *dental public health, oral health, public health, needs assessment and strategy*

Initial impetus for action

Significant changes in commissioning responsibilities regarding oral health occurred in 2013 in England following the UK Coalition Government's Health and Social Care Act 2012 (UK Government, 2013). NHS England became responsible for commissioning all NHS dental services. Dental public health specialist support and advice is now provided by an executive agency of the Department of Health; Public Health England (PHE). Oral health improvement and prevention functions became the responsibility of public health departments within local authorities (HM Government, 2012).

Since these reforms a number of key guidance documents have been published to support local authorities to discharge their commissioning responsibilities (Local Government Association, 2014; National Institute for Health and Social Care Excellence, 2014; Public Health England, 2014a; Public Health England, 2014b). Themes within this guidance include using evidence to inform decisions, evaluating existing oral health improvement programmes, using oral health needs assessments (OHNA) to understand their population, incorporating oral health within all children and young people's services and collaborating with partner organisations including NHS England, PHE and clinical commissioning groups.

Over the last forty years there have been significant improvements in oral health in the UK with improved use of fluoride toothpaste, however many people still suffer the pain and discomfort of oral diseases which are largely preventable and remain a major public health problem.

Nationally, children's oral health has improved over the last 20 years. However, recent local average for Wakefield show that tooth decay in five year olds is not reducing in line with regional and national trends (Figure 1; Public Health England, 2015). The proportion of five-year-olds in Wakefield with decay experience (36.5%; 95% confidence interval (CI) 29.7% - 43.4%) was significantly higher than both the England (24.7%; 95% CI 24.5% - 25.0%) and regional average (28.5%: 95% CI 27.7% - 29.3%). Despite significant reductions in the prevalence of tooth decay in 5 year olds between 2007/08 and 2014/15 nationally and regionally, there was no change in Wakefield.

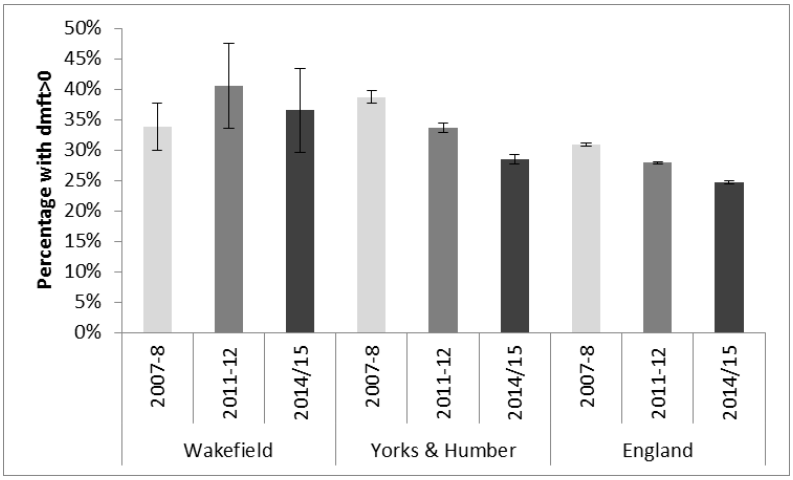

Figure 1. Prevalence of tooth decay experience in five-year-olds, 2007-08 to 2014-15
Source: Public Health England (2015).

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Moreover, inequalities continue across West Yorkshire; with 5 year old children in the most deprived quintile having a mean decayed, missing or filled teeth (dmft) score over four times higher than those in the least deprived in 2010/11 (Public Health England, 2015).

In April 2013, Wakefield Council became aware of these outcomes and that the Wakefield PCT Oral Health Strategy had expired. In light of the Council's statutory responsibilities, the Director of Public Health (DPH) and local councillors agreed that the oral health needs assessment should be refreshed to support the development of a strategic action plan to address local oral health and support commissioning. This paper outlines how Wakefield Council exercised these new dental public health responsibilities. The partnership approach that underpinned the work is described.

Solutions suggested

In order to prioritise oral health, the following key actions were identified by the Council: complete an assessment to help identify local oral health needs: review the commissioned local oral health improvement programmes and; develop the Council's oral health action plan.

These actions were planned within a partnership-working approach between the Council, PHE and other key stakeholders. Central to this approach was the establishment of an Oral Health Advisory Group (OHAG) for Wakefield.

Actual Outcome

Initial engagement between the Yorkshire and Humber PHE Centre dental public health team and the Director of Public Health was pivotal and benefitted from the continuation of key personnel on both sides, despite the recent NHS reforms. The Council assigned a senior public health staff member to lead on oral health, to work closely with a named PHE DPH consultant. This resulted in the consultant becoming an integral member of the Council's public health team. It was also agreed that a Specialty Registrar in Public Health would be assigned to the project to develop DPH experience; an area from which not all public health trainees benefit.

Although the Council's Health and Wellbeing Strategy 2013-2016 (Wakefield Health and Wellbeing Board, 2013) did not prioritise oral health, there was an opportunity to raise its profile and its contribution to the general health and well-being for people locally.

Completing the local OHNA

In line with the NICE guidance (2014), the approach to completing the OHNA (see Fig. 2) used a 10 step model (Chestnutt et al., 2013).

Step 1 - The first agreed action was to establish an OHAG to provide expert advice to support the Council's oral health responsibilities. The PHE consultant drafted terms of reference. Membership included representatives of the council's public health and children's services, NHS England, PHE, local dental committee, community dental service, secondary dental care providers and patients and public via HealthWatch.

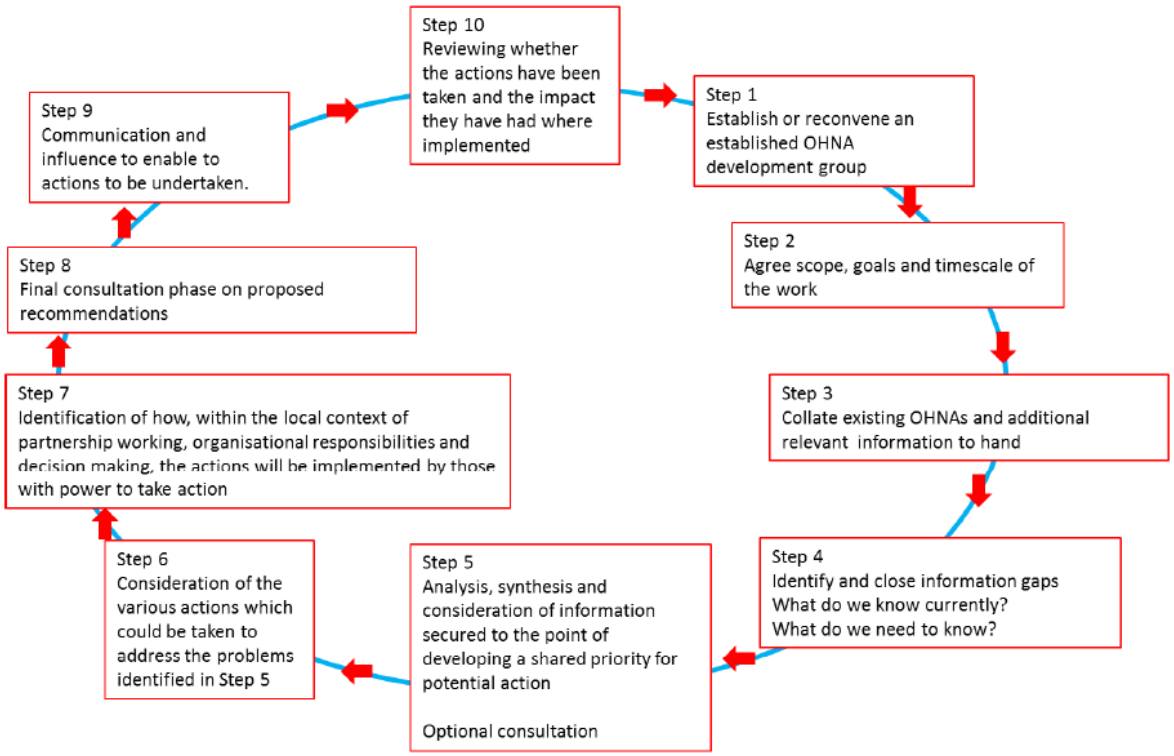

Figure 2. The 10 Step Approach for an Oral Health Needs Assessment

Step 2- The OHAG agreed a project plan to support the local OHNA and the scope, goals and realistic timescale were agreed by the OHAG, with ultimate approval sought from the Director of Public Health.

Step 3 - Information requirements were identified and existing information was collated from a variety of sources including national guidance, a previous oral health strategy and national and local public health and dental datasets.

Step 4 – After collation and synthesis, it was evident that local dental data were limited for vulnerable groups. OHAG members agreed to prioritise additional surveys of key groups identified in the Health and Wellbeing Strategy: older adults, pre-school children, people with mental health problems and residents of care/nursing homes.

Step 5 – Oral health priorities emerged in an iterative process as the OHNA was drafted. Of particular assistance were the surveys with vulnerable groups. Regular OHAG meetings provided opportunities to share new data and themes so that priorities could be agreed with members.

Steps 6 & 7 - The priorities were translated into recommendations by the OHAG. Great efforts were made to ensure wide stakeholder representation on the OHAG. Allocating ownership for the identified actions was relatively straightforward.

Step 8 - The report was shared with stakeholders whose comments informed the final report. The consultation included engagement with dental professionals through their local committee, council directorate management groups (including public health, adults and children's directorates), the Health and Wellbeing Board (H&WbB) and the Health Overview and Scrutiny Committee.

Step 9 & 10 - The OHAG continues to meet regularly. Its function has progressed to focus on monitoring the delivery of the action plan, which is still being developed and consulted upon. As oral health forms some of the indicators within the Public Health and NHS Outcomes Frameworks (Department of Health, 2012, 2013), it will be monitored through this route. It is anticipated that the Wakefield Health and Wellbeing Board will explicitly prioritise oral health in its upcoming H&WB strategy for the first time.

The 2016-18 Wakefield oral health action plan has now been developed from the OHNA, overseen by the OHAG. This action plan takes the recommendations from the OHNA and identifies the tangible actions to meet these priority local areas with an identified organisation having lead responsibility. Implementation of the action plan is overseen by the OHAG, which reports to the Children and Young Peoples' Health and Resilience Board at the Council.

Challenges addressed

The OHAG has helped address the fragmentation of oral health commissioning since the 2013 reforms. It is anticipated that this approach will ensure collaboration to support NHS England in their local commissioning responsibilities and ensure that oral health is integrated across the Council and other commissioned services.

Having a named local DPH consultant has contributed significantly to the work on oral health through the public health team. They provide a first point of contact for specialist support and advice, and enable sharing of good practice to influence local decisions. The benefits of expertise regarding water fluoridation from the national DPH PHE team working with local PHE colleagues has been welcome. Engagement to date has ensured that the OHNA report has been disseminated widely to help councillors and Council officers understand the complex oral health needs of the population and the key actions needed for improvement.

Dental professionals were recognised as key stakeholders from the outset. Regular engagement with the Local Dental Committee facilitates discussion. In turn, the Council and PHE update and broaden discussions to ensure further collaboration with local dental professionals.

Future implications

Work to date has highlighted the need to work with the HWB so that members are fully engaged with the Council's dental public health responsibilities, OHNA recommendations and draft oral health action plan. An essential requirement will be the monitoring and evaluation of this plan. The OHAG will focus on areas of work aligned to the plan and develop links with the GP-led Multispecialty Community Provider Vanguard, which has identified oral health as a priority. The OHAG is currently scoping the inclusion of oral health within the new model to inform greater partnership working across health, education and social care.

The outcomes of the review of the oral health promotion service will inform future commissioning intentions, including the choice of available evidence-based programmes to tackle poor oral health locally. The OHNA also provides local evidence to identify population groups with particular oral health needs.

The OHAG is expecting to recommend greater focus on vulnerable adults within commissioners existing funding. Future PHE guidance to support the Council's commissioning for vulnerable adults may support this. Now that oral health is a local priority, the 0-19 Healthy Child Programme, which includes health visiting and school nursing services, will be expected to contribute to the oral health improvement agenda.

Learning points

Progress has been underpinned by a strong partnership between the Council and PHE. The OHAG ensures stakeholders can influence decision making, co-ordinate the work and take joint responsibility for oral health improvements.

The full support of the Director of Public Health was essential in establishing and driving forward this project. Their central role on the HWB is also valuable in influencing the strategy and engagement with other senior stakeholders.

Early and consistent recognition of specialist DPH expertise from the national and local teams within PHE has been crucial. This process cannot be done by organisations working in isolation. The sharing of evidence of best practice was of particular benefit.

The valued role that the public health team have within the Council, translating evidence into action, has included managing the DPH responsibilities within the Council's structure and processes. This has enabled a shared understanding across all stakeholders, regarding oral health issues.

Extensive efforts to engage with stakeholders throughout the process paid off in developing and maintaining this work. Formal and informal routes were exploited to maintain dialogue and ensure the process is now bearing much promise in improving oral health and reducing oral health inequalities.

Conclusion

Wakefield Council's efforts to implement and progress its dental public health responsibilities has been informed by recently published guidance and underpinned by strengthened and co-ordinated partnership working. Oral health is now a priority, with local work benefiting from specialist dental public health support. The Council have a major role in championing oral health, resulting in strategic leadership for this important area of public health.

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