Children and Young People Committee
Inquiry into Children's Oral Health

Evidence from Dr Hugh Bennett

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Committee Clerk
Children and Young People Committee
National Assembly for Wales
Cardiff Bay
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Dear Sir/Madam

Designed to Smile Inquiry

This is a personal response to the Committee.

I am a Consultant in Dental Public Health employed by Public Health Wales, and I will also be coordinating and forwarding a response on behalf of Public Health Wales.

I go back a long way with Designed to Smile, right back to the original concept. In my previous position as Deputy Chief Dental Officer for Wales, it was my responsibility in 2007 to report to the then Minister for Health and Social Services, Edwina Hart, the results of the latest five-year olds dental health survey for Wales. These showed that the dental health of five-year olds in Wales was the poorest in Great Britain.

The Minister asked for plans to be submitted on how this appalling state of child dental health in Wales could be addressed. At the time, you will recall that there was a coalition Government in Wales, and water fluoridation was not on the agenda of the coalition. Therefore, any national plan to improve child dental health could not include that public health measure.

Although improvement in socio-economic status, nutrition and diet will contribute to better oral health in the long run, the most efficient and

effective method is to, "get more teeth in contact with fluoride". Therefore, the Minister was presented with plans for an oral health improvement programme that became known as Designed to Smile (D2S).

The Minister accepted that if D2S was to be effective it had to be an adequately funded and sustainable programme, everyone had to be in it for the long haul.

In 2008 the programme was launched in two pilot areas. It is important to point out that this was not to pilot the preventive interventions being used (because the evidence base is strong and well established), rather it was for testing the efficiency of delivery through NHS and Community Dental Service (CDS) structures.

The pilot was carried out in two 'super pilot' areas, one in an area of south Wales and another covering north Wales. Another reason for piloting into just two areas was that it concentrated the funding that was initially made available so that the chances of delivering to telling effect were increased. Consequently, as you know, further funding became available in 2009 and the programme expanded across Wales.

It is too early in the programme's development to assess how effective it has been in reducing dental decay for our children.

There is a 5-year old dental epidemiology survey being carried out this year 2011/12, but this will be too soon to demonstrate benefits. It will be the survey in 2014/15 that will confirm whether our 5-year old child population has significantly benefited.

One effect of the high prevalence of tooth decay in our young children is the large number of children who receive a general anaesthetic (GA) for tooth extraction, in the order of 8000/9000 annually. This is unacceptable for what is an almost totally preventable disease. It is a risk to child health and wellbeing that would not be tolerated in other diseases.

The Committee has asked whether the D2S programme has been integrated into the wider local and national initiatives such as Flying Start and Healthy Schools etc. Firstly, I think the Committee should recognise the immense task that LHBs and the CDS were set in launching and extending this programme against extremely tight deadlines.

However, in all LHB areas we are now moving away from the implementation phase and the opportunities to engage with other local and national initiatives become more feasible. Indeed, there are already good examples of integration and partnership working that I am sure will be highlighted in many other responses that you receive

In 2008 The Welsh Assembly Government made a commitment to develop the role of the CDS in Wales as set out in *Ministerial Letter EH/ML/014/08: Dental Services for Vulnerable People and the Role of the Community Dental Service*.

As a demonstration of this commitment, the CDS was given prime responsibility for delivering D2S. This has resulted in a considerable investment in terms of general resources, staff and equipment into the CDS, and most importantly has had a positive effect on morale of the service.

The adverse effects of tooth decay on the health and wellbeing of children, the 'knock on' effects to them and their families and the wider community, both educationally and economically are considerable. Too often in the past poor oral dental health has been low down political and health agendas. Too often, childhood tooth decay and its symptoms have been trivialised.

The decision of the Welsh Government in 2008/09 to implement D2S was the first time in Wales for a properly funded concerted national effort to be made to address a problem that had been allowed to fester for too long.

The Committee is asked to note the phase at which Designed to Smile is now positioned. Although all implementation phases are completed, different Health Boards are moving to different timescales, but all are now into the roll-out and sustainable delivery phases of their local programmes.

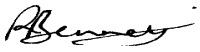
The programme needs continued support to deliver its long term potential.

Scotland has put great effort into preventing tooth decay in children, notably through its Childsmile programme, (a programme not dissimilar to D2S). Scotland has been rewarded with significant improvements in the dental health of its children, confirming that a sustained national oral health improvement programme can deliver significant improvement in a nation's oral health.

Regardless of levels of access to dental treatment services, we will never improve the poor oral health of our child population to amongst the best in the UK unless we also sustain a population based preventive approach.

Thank you for the opportunity to contribute to your Inquiry.

Yours sincerely



Dr. Hugh Bennett