Health, Social Care and Sport Committee one-day inquiry on dentistry in Wales: Evidence from the Royal College of Paediatrics and Child Health (RCPCH), August 2018

About the RCPCH

The Royal College of Paediatrics and Child Health (RCPCH) is responsible for training and examining paediatricians, setting professional standards and informing research and policy. RCPCH has over 18,000 members in the UK and internationally with over 500 in Wales. We work to transform child health through knowledge, research and expertise, to improve the health and wellbeing of infants, children and young people across the world.

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Dentistry and child health

Good oral health is essential for children's overall health and wellbeing. In our State of Child Health (SOCH) report of 2017, we set out the evidence around children's oral health across the UK, comparing data between nations where possible[1].

Despite tooth decay being almost entirely preventable, tooth decay is the most common single reason why children aged five to nine require admission to hospital. Multiple tooth extractions can also result in the need for a child to go under general anaesthetic[2].

Poor oral health can have a major impact on a child's physical health and their quality of life, including:

- Pain
- Infections
- Altered sleep and eating patterns
- School absence
- Need for dental extraction (with the potential for subsequent dental problems later in life)

In addition, children's dental and oral health can be a strong indicator of general health and wellbeing and can be a way of detecting issues from poor diet and risk of obesity to neglect.

[1] Royal College of Paediatrics and Child Health (2017). *State of Child Health* p. 46 – 48 Available at: https://www.rcpch.ac.uk/sites/default/files/2018-05/state_of_child_health_2017report_updated_29.05.18.pdf

[2] For evidence on the need for anaesthetic in England (we are not aware of Wales data), see Faculty of Dental Surgery (2015). *The state of children's oral health in England*. Available at: https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/report-childrens-oral-health/

A Healthier Wales[3] sets out the Welsh Government's vision for health services in the future. A key component of this plan, which we welcome, is the need for investment in prevention to support people to stay well. It also sets out the case for services to work together as a single system.

It is essential that children and young people's health is considered as a whole, with oral health a vital component and that paediatric and community dentistry services operate accordingly. With this in mind, we take this opportunity to highlight issues of concern to paediatricians in Wales and urge the Committee to consider its inquiry in the broader context of child health.

Reduction in consumption of high-sugar foods, particularly drinks is key. National actions to reduce sugar in children's food should be accompanied by conversations with children and parents about reducing and replacing high-sugar foods and drinks.

Children's oral and dental health in Wales and the UK

Since the early 1990s there has been an increase in the proportion of 5-year-olds with no obvious tooth decay across all four nations. At the time of publishing SOCH, the comparable data available suggested that tooth decay was a particular problem for Welsh children, compared with the rest of the UK: the proportion of 5-year-old children with no obvious tooth decay in 2013 was 69% in England, 68% in Scotland, 60% in Northern Ireland and 59% in Wales. Improved oral health since 2003 was most noticeable in Scotland (23% increase) and Northern Ireland (21%)[4].

Data published by the Welsh Government since then suggest that progress is being made. In June of this year, Welsh Government announced that "the Welsh Oral Health Information Unit report… shows that the percentage of children experiencing obvious tooth decay has dropped significantly from 45% in 2004/05 to 30% in 2016/17"[5] (note that the sources used for SOCH data were the Children's Dental Health Survey for England, Northern Ireland and Wales and the National Dental Inspection Programme for Scotland). This suggests that the Designed to Smile programme is having a positive impact. However, for an almost entirely preventable condition, we believe that 30% remains alarmingly high and that in line with the principles set out in A Healthier Wales, further action is required to prevent children from experiencing tooth decay.

Access to dentists

We understand that research carried out by the British Dental Association (but not yet published) shows that only 28% of dental practices are currently accepting children and young people as new NHS patients in meaningful terms. Even within that 28%, many patients will wait weeks or months for an appointment.

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[3] Welsh Government (2018). *A Healthier Wales: our Plan for Health and Social Care.* Available at: https://gov.wales/topics/health/publications/healthier-wales/?lang=en

[4] RCPCH, 2017, p46

[5] Welsh Government (2018). *Health Secretary welcomes reduction in child tooth decay*. Available at: https://gov.wales/newsroom/health-and-social-services/2018/59732995/?lang=en

There are worrying socio-economic inequalities leading to health inequalities: in SOCH, we reported that 5-year-olds living in the most deprived areas of England, Northern Ireland and Wales were at least three times more likely to experience severe tooth decay than their peers living in the most affluent areas[6]. All children should therefore have timely access to dental services.

Paediatrics and dental health

Currently, there are few formal networks between dentists and paediatricians, so when paediatricians treat patients who would benefit from routine dental services, paediatricians can do little more than advise them or their parents to seek a dentist in their area and provide a phone number. However, those children and families will then be in the same situation as any other family looking for an NHS dentist. There is not usually a formal referral pathway.

Feedback from paediatricians suggests that there is inconsistency around referral pathways for children who require more specialist services. Our conversations with the BDA suggest that fewer practices which offer specialist services for children with, for example, neurodevelopmental disorders, mental health problems or learning difficulties, are accepting new NHS patients. One member has told us that for these groups, he has found it easier to successfully refer to the appropriate service. It may therefore be that referral via a paediatrician is sometimes a route into services which may otherwise be difficult to access. However, another member reports to us that it has never been clear to her as a community paediatric registrar what her referral routes are and that she has "come across families who have children with additional needs and accessing specialist paediatric dentists is difficult for them… I have written letters before to community dentistry but hear nothing back".

A final issue to consider is that children's oral health can be an indicator of neglect. Dental neglect can be considered a form of child abuse through neglect. Paediatricians and dentists do work together on this: one of our members told us that she had recently delivered level 2 child protection training to undergraduate dental students about this link and how dentists can work closely with their local child protection teams and paediatricians. However, there is evidence that better links between paediatricians and dentists would be beneficial. An article (co-authored by Dr David Tuthill, RCPCH Officer for Wales) in the British Dental Journal highlights that "dentists require specific training to identify concerning child protection injuries" and proposes that "multidisciplinary training with dentists and paediatricians would be of benefit when considering child protection issues". The paper found that "there remains a worrying lack of knowledge about thresholds for action [on child protection issues] among dentists. Doctors and nurses have minimal training in, or knowledge of, dental health in children, thus precluding appropriate onward referrals"[7].

The issues around referral pathways and training for dentists and paediatrician therefore warrant further consideration.

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[6] RCPCH 2017, p47

[7] Olive, Tuthill, Hingston, Chadwick and Maguire (2016). Do you see what I see? Identification of child protection concerns by hospital staff and general dental practitioners. *British Dental Journal*, Volume 220. Available at: https://www.nature.com/articles/sj.bdj.2016.331

Recommendations

Ongoing development, implementation and evaluation of national oral health programmes for children and young people, building on Designed to Smile.

All children should receive their first check-up as soon as their first teeth come through and have timely access to dental services for preventative advice and early diagnosis, with targeted access for vulnerable groups.

Children need timely access to both primary and specialist dental care to reduce the likelihood of serious complications following early tooth decay.

Good oral hygiene and reduced sugar consumption, coupled with access to timely primary dental care, are important for reducing tooth decay in children.

We would like Welsh Government to explore the option of fluoridation of public water supplies across Wales, particularly in areas where there is a high prevalence of tooth decay.

NHS Wales, Welsh Government and Health Education and Improvement Wales (HEIW) should ensure that all health care professionals, including dentists, can make every contact count by having conversations with their patients (whatever their age) about reducing and replacing high-sugar foods and drinks.