SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 19 July 2017

PRESENT: Councillors Pat Midgley (Chair), Sue Alston (Deputy Chair), Pauline Andrews, Steve Ayris, David Barker, Lewis Dagnall, Mike Drabble, Adam Hurst, Dianne Hurst, Talib Hussain, Douglas Johnson, Richard Shaw and Garry Weatherall

Non-Council Members (Healthwatch Sheffield):-

Margaret Kilner and Clive Skelton

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1. APOLOGIES FOR ABSENCE

1.1 An apology for absence was received from Councillor Tony Downing.

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. PUBLIC QUESTIONS AND PETITIONS

4.1 There were no questions raised or petitions submitted by members of the public.

5. ORAL AND DENTAL HEALTH IN SHEFFIELD

5.1 The Committee received a joint report of the Director of Public Health, Public Health England, University of Sheffield and NHS England, which provided information on the oral and dental health of children and adults in Sheffield from both a public health and NHS services angle.

5.2 The report was introduced by Greg Fell (Director of Public Health, Sheffield City Council) and supported by a presentation which was given jointly by Dr Sarah Robertson (Consultant in Dental Public Health, Public Health England), Dr Zoe Marshman (Reader/Honorary Consultant in Dental Public Health, University of Sheffield) and Emma Wilson (Head of Co-Commissioning (Yorkshire and Humber), NHS England). Also in attendance for this item were Sarah Hipkiss (Contract Manager, NHS England), Prof. Barry Gibson (Head of Dental Public Health Unit, University of Sheffield), Joanne Charlesworth (Oral Health Promotion Manager, Sheffield Teaching Hospitals), Mel McCart (General Dental Practitioner), Debbie

Hanson (Health Improvement Principal, Sheffield City Council) and Helen Lomas (Assistant Service Manager, Sheffield City Council).

5.3 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- It was accepted that oral health improvement programmes had to be developed and implemented through involving the local community.

- Health visitors provided tooth brushing packs at 12 month checks to all children, and to targeted 2 year olds in the most socially deprived areas. Oral health promotion by health visitors had been underpinned by research with parents into how they could be better supported to improve their care of their children's teeth.

- The Community Dental Service (CDS) (six city-wide clinics and three clinics within special schools), cared for children who could not be treated in the general dental services. Patients were referred to the CDS by general dental practitioners and other professionals. Such patients included children with physical or learning difficulties or medical conditions, children who were looked after or on the at risk register, children with extensive untreated tooth decay who were particularly anxious or uncooperative, adults with complex needs who had a proven difficulty in accessing or accepting care in the general dental services, including adults with moderate and severe learning and physical difficulties or mental health problems and severe dental anxiety, adults with medical conditions who needed additional dental care and housebound and homeless people. Monthly clinical sessions were provided at Sheffield Cathedral at the Archer Project for homeless people. Care was also provided at the Charles Clifford Dental Hospital and the Royal Hallamshire Hospital. Jordanthorpe clinic provided cognitive behavioural therapy for anxious/phobic adult dental patients, a sedation service and a service to Aldine house, a secure centre for Children. CDS was currently under procurement. It was planned that by October 2018, there would be a new CDS service covering the whole of South Yorkshire.

- The budget for commissioning dental services for Yorkshire and the Humber had now been brought together and it was important to commission services which were right for the population. Urgent dental care and general access to general dental practices was currently under review and redesign by NHS England.

- Many people did not wish to access regular routine dental care, opting to attend urgent dental care services only when in pain. This may be due to anxiety, phobia, lifestyle and cultural issues. The '111' and urgent dental care services in Yorkshire and Humber were currently under review and redesign by NHS England.

- Three dental practices in Sheffield were trialling the new NHS dental contract prototypes, with the aim of changing the focus of dental service provision from the delivery of treatment to a more preventive approach. The idea was to

promote a shared responsibility to improve and maintain patients' oral health.

- There were three NHS dental charge bands which were based on the level of treatment required. These were set out in detail in the report.

- Dentists worked under general dental service or personal dental service contracts and were contracted to provide an agreed annual number of Units of Dental Activity (UDAs). They received UDAs dependent on the band of treatment provided. The diagram in the report showed the UDAs commissioned per population in Sheffield by Ward in 2012/13, with the darker areas indicating a higher level of funding. More UDAs were commissioned on the east side of the city than the west, reflecting those wards which experienced greater social deprivation and also higher levels of tooth decay. Improving access to dental care did not necessarily equate with improvements in oral health. Improving oral health and reducing oral health inequalities required community-based oral health promotion programmes and a more prevention-focused dental service.

- NHS England was aware that some people accessed dental services on a regular basis whereas others did not have a regular dentist. It should be noted that there were also high 'did not attend' rates. The figures on access presented in the paper only applied to NHS dentists and not those operating privately. Access figures in Sheffield were relatively good, but some people only accessed services when they were in pain.

- A request had been received from one school asking for an ice cream van not to be positioned at the school entrance and officers were considering an appropriate response.

- There was a clear link between poor dental health and deprivation. Children living in the most deprived areas of the City had average tooth decay levels that were four times higher than those living in the least deprived areas.

- Both dental health and oral health were important, with consideration being given to the health of the teeth and the mouth more generally. Poor diets, tobacco and alcohol were all significant risk factors for poor oral health and also the risk factors for a number of other chronic diseases.

- In relation to safeguarding, dental decay could be an indicator of wider neglect and it was important for practitioners to be aware of these issues. Dentists should know what to do in these circumstances and, if they were seriously concerned, should follow the local safeguarding policy. Safeguarding processes at the Dental Hospital were considered to be very good.

- Dentists were well trained in safeguarding and this was included as part of the Care Quality Commission (CQC) inspections, which set a high level of expectation.

- The return on investment figures in the report had been taken from Public Health England.

- The Sheffield City Council budget for oral health improvement was £120,000.

- The use of fluoride varnish came under the Band 1 activity.

- It might be worthwhile for headteachers to consider what was on sale in school shops in terms of sugar content.

- There had been significant investment in Sheffield in the provision of hearing loops in all practices and there were some courses on sign language available to practitioners. Interpreters, funded by NHS England, were available and these could be used for either language or signing.

- The cost of tooth brushing clubs was approximately £1.29 per year per child and the School of Clinical Dentistry was presently evaluating the tooth brushing programme for Sheffield City Council.

- The application of fluoride varnish should be offered under the dentist's contract free of charge to all children aged 3-16 years at least twice a year, and to children younger than 3 if they were at high risk of tooth decay.

- The use of school dentists had been discontinued as school dental screening had been found to be not effective.

- The Charles Clifford Hospital served the region for specialist care and also provided treatment by undergraduates.

- Patients needed to be referred to the Charles Clifford Hospital and analysis had shown that some patients could have been seen in a primary care setting e.g. for some minor oral surgery procedures.

- There were no data available on the link between accessing a dentist and detecting oral cancer, but dentists were the right people to detect oral cancer, as it formed part of the routine check-up procedure. However, some work had been undertaken in South Yorkshire on the late presentation of oral cancer.

- It was acknowledged that costs might be a prohibiting factor for some in deprived areas, but all NHS dental care was free for children.

- The effect of sports drinks on dental health should also be considered.

- The targets set for oral health improvement were fairly challenging and were set as a commissioner to a provider.

- Work was being undertaken with the voluntary sector, nurseries and schools to set up tooth brushing clubs and there was a focus on health visitors and

early years' settings to integrate oral health into their work. One way of increasing the uptake of tooth brushing clubs would be to put this on the early years' curriculum.

- It was important for people to attend their dentist regularly, however there is no longer 'registration' of patients. Registration would be included in the new NHS dental contract prototypes for dental services.

- The reason why dental practices stopped taking on new patients was generally due to lack of capacity and the need to allocate each patient sufficient time to provide quality care. Each practice had a webpage on the NHS Choices website and people could use this to check if any particular practice was taking new patients at any one time. However, there were issues with these pages not being kept up to date by practices.

- The impact of HPV (Human Papilloma Virus) immunisation on mouth cancers would not be known for decades, as this was a new development and mouth cancers did not usually occur until people were in their 40's.

- Whilst the use of tobacco linked strongly with mouth cancer, no real research had been undertaken on vaping and oral cancer specifically, as this was a relatively new development.

- Local people were engaged in the process of the provision of dental services through Healthwatch and the NHS England workstreams and Local Dental Networks, and consideration was being given to including a patient and carer on the CDS procurement group.

- 'Universal proportionalism' was applied to oral health recommending population-wide oral health initiatives to improve oral health overall, whilst investing additional resources in targeted initiatives in more deprived areas, to help reduce inequalities. To reduce the steepness of the social gradient in health, actions needed to be universal, but with a scale and intensity which was proportionate to the level of disadvantage. It was not possible to predict who would get tooth decay and it was felt that this approach gave everybody a chance to improve their oral health and also supported the more disadvantaged.

- Discussions were taking place on extending the distribution of tooth brushing packs to food banks if additional resources were available.

- Dentists purchased their own dental materials, including fluoride varnish, with the money they were paid by NHS England for providing dental services. Application of fluoride varnish had been subject to two audits in Barnsley, and this seemed to help raise awareness amongst practitioners of the need to apply fluoride varnish to all 3-16 year olds. A similar audit could be undertaken in Sheffield to raise awareness amongst Sheffield's dentists. The referral criteria for paediatric dentistry at the Charles Clifford Dental Hospital required children to have been previously treated with fluoride varnish.

5.4 RESOLVED: That the Committee:-

(a) thanks those attending for their contribution to the meeting;

(b) notes the contents of the report and presentation and the responses to questions; and

(c) requests that the Policy and Improvement Officer arranges a meeting of the Committee as a Working Group to identify priorities for progressing the oral health improvement agenda and areas where further information was required, with any recommendations from the Working Group to be brought to the September meeting of the Committee for consideration.

6. MINUTES OF PREVIOUS MEETINGS

6.1 The minutes of the meetings of the Committee held on 15th March, 12th April, and 17th May, 2017, were each approved as a correct record.

7. DRAFT WORK PROGRAMME 2017/18

7.1 The Committee received a report of the Policy and Improvement Officer which set out the Committee's Draft Work Programme for 2017/18.

7.2 RESOLVED: That the Committee approves the contents of the Draft Work Programme 2017/18 report.

8. DATE OF NEXT MEETING

8.1 It was noted that the next meeting of the Committee would be held on Wednesday, 20th September 2017, at 5.00 pm, in the Town Hall.