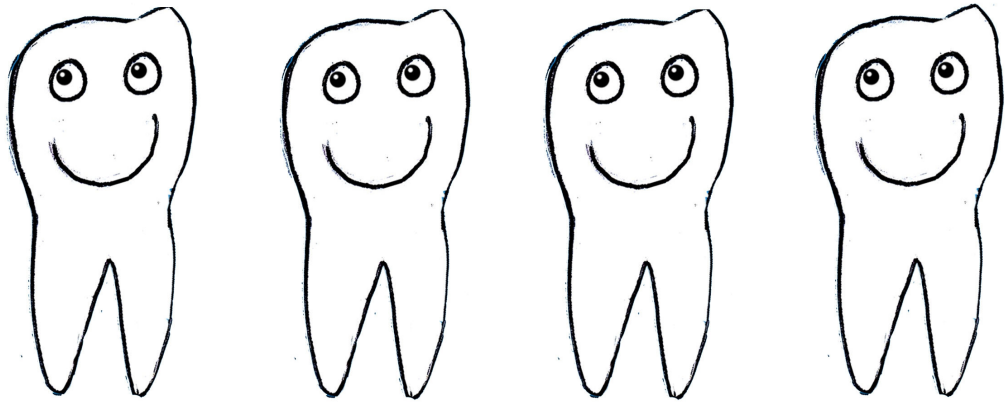
Children's Oral Health Task Group



A report of the Children's Oral Health Task Group

Overview & Scrutiny

The London Borough of Hammersmith & Fulham

July 2011

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Foreword

The Coalition's 'Our Programme for Government'[♣] document states that 'The Government believes that we need action to promote public health, and encourage behaviour change to help people live healthier lives. We need an ambitious strategy to prevent ill-health which harnesses innovative techniques to help people take responsibility for their own health'. '

Hammersmith and Fulham's aspiration to be 'The Borough of Opportunity' and local health objectives are entirely consistent with this approach. Specific aims include a reduction in health inequalities, giving people more control over their health and enabling health and well-being.

With this report we have an opportunity to improve an important area of public health, as part of a wider attempt to combat health inequalities in the borough. A key finding of the report is that our child oral health statistics mask an even worse situation amongst disadvantaged groups, which is why we have put forward a highly targeted set of proposals.

The direct cost of non-preventative dental treatments such as extractions for children in the borough is over £2,000,000 per year. There is therefore a compelling financial argument for change, in addition to the obvious social and moral arguments.

Our recommendations are both ambitious and innovative. They recognise that we must capture the attention and imagination of our community and call upon the support of varied professionals and stakeholders to achieve this. Above all, I hope that we can enable families to help themselves and in so doing create real and lasting change. There is already a lot of excellent work and many examples of best practice in the borough, and the many parents that I have met want to be assisted to do the right thing for their children.

I would like to thank the witnesses and professionals that have given their time to support this piece of work, many of whom are listed at the back of the report.

Councillor Marcus Ginn
Chairman of the Task Group

[♣] The Coalition: Our programme for government, Crown Copyright 2010

Membership of the Task Group

- Councillor Marcus Ginn – Chairman

- Councillor Caroline Needham - Vice-Chairman

- Councillor Peter Tobias

Aim and Objectives

The Aim and Objectives of the Task Group are:

Aim

To investigate the high incidence of tooth decay amongst the child population of the borough (0-19 years old), to identify possible reasons for this and identify ways in which Council services, working with partners, can contribute to the promotion of oral health in young people.

Objectives

- To review the oral health services available for children including new health service initiatives and the reasons for a high level of tooth decay amongst the child population of the borough (0-19 years old).
- To identify and consider the mechanisms available to improve oral health in the Borough.
- To identify best practice in children's oral health services nationally, regionally and locally, with particular reference to collaborative working between local authorities, PCTs and other community partners.
- To consider how Council services, along with partner agencies, can most effectively contribute to the promotion of oral health in young people, in particular, through schools and children's centres.

Executive Summary

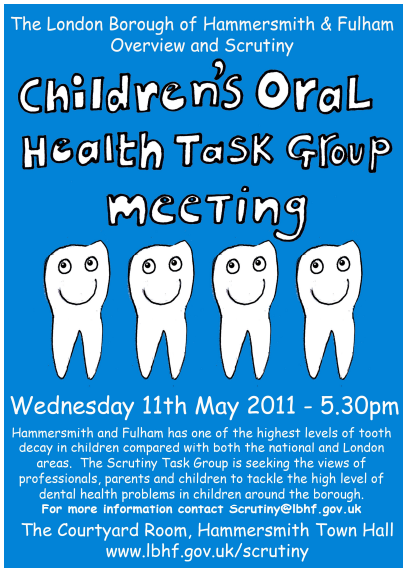
The Children's Oral Health Task Group was set up by Hammersmith and Fulham's Overview and Scrutiny Board (OSB) to examine this issue and to report back with findings and recommendations to the Council Cabinet, the PCT and other partner agencies on ways to reduce the numbers of young people being afflicted by what is, in most cases, an entirely preventable disease.

Following a proposal by the Education Select Committee and agreement by the OSB on 21st September 2010, the Task Group met for the first time on 12th January 2011.

> *"Poor dental health in children can influence oral health later on in adult life and influence a wide range of social and health issues. This is an important investigation to help tackle the problem of poor oral health in children and to look at ways in which the council and its community partners can work more closely to find solutions to improve peoples' quality of life"*
>
> *Cllr Marcus Ginn,*
> *Chairman of the Task Group*

The Task Group has collected evidence from a wide selection of stakeholders in the field, as well as written and documentary evidence and field research.

Witnesses and consultees to the inquiry have included H&F Cabinet Members Cllr Carlebach and Cllr Binmore, Barry Cockcroft – the Chief Dental Officer for England, The Borough Youth Forum, local parents and children, The British Dental Association, local community dental practitioners, private sector representatives including Colgate Palmolive, leading academics including Professor Aubrey Sheiham - University College London, local schools and Children's Centres, school nurses and health visitors, the Children's Trust Board and the NHS Inner North West London Primary Care Trust. During our inquiry we have received advice from Claire Robertson – Consultant in Dental Public Health at the North West London PCTs throughout.

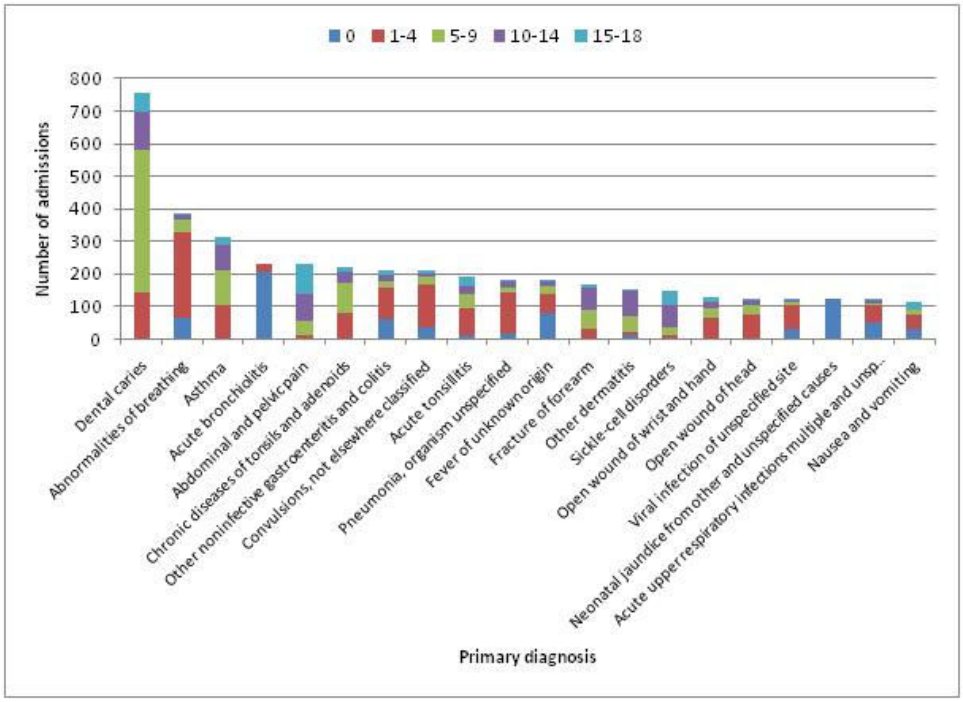


For a full list of witnesses to the inquiry please see Appendix One.

<u>The Cost of Decay</u>

Hammersmith and Fulham has the 3rd highest prevalence of child oral health problems in London. Poor oral health can blight an individual's life, with serious

social and economic implications. It can affect the way a person looks and feels, impair a child's concentration at school and necessitate time off school for dental repairs. Extractions can be traumatic, particularly for young people, and a pattern of poor oral health during childhood can impact upon later health, wellbeing and life chances. Dental caries is the top cause of admissions of children and young people to Chelsea and Westminster Hospital♥.



Top causes of hospital admissions to children aged 0 – 18 years, 2006/07 – 2008/09♥

During the inquiry we visited Chelsea and Westminster Hospital and interviewed staff in Paediatric Dentistry, including Kate Barnard, Consultant in Paediatric Dentistry. In addition to the social costs, dental health problems are expensive to the public purse. The table below shows the rate of admissions and interventions (mainly teeth extractions and fillings) for children from the borough at Chelsea and Westminster Hospital. The number is increasing.

NHS Hammersmith & Fulham Activity

2006/7 to 2010/11

Year	New Appts	Admissions	Conversion Rate
2006/2007	332	221	66.57%
2007/2008	328	276	84.15%
2008/2009	400	325	81.25%
2009/2010	413	331	80.15%
2010/2011	422	316	74.88%

Numbers of children admitted and treated for extractions and fillings at Chelsea and Westminster NHS Trust.

♥ *Source: NHS Secondary Uses Service*

The direct cost of these appointments and treatments at Chelsea and Westminster Hospital in 2010-2011 was £354,024 and practically all of these admissions were avoidable through prevention. This cost was in addition to the £1,700,000 cost of non-preventative Primary Care treatments, such as fillings and extractions, incurred during the same period. **The combined cost of these non-preventative treatments was therefore over £2,000,000, 25 times the projected 2012-13 cost of our recommendations.** Much of this spend could be avoided in future years if a higher priority is given to prevention work.

The Strategy

This report outlines 14 recommendations to the Council Cabinet, the NHS PCT and other local partners to improve children's oral health in the Borough. The overarching strategy is:

1. to improve children's oral health for all young people in the Borough (a whole population approach)
2. to target particular groups and communities where decay is more likely or more prevalent (a targeted approach), and
3. to bring together the work going on in different agencies

Within this there are 4 key strands:

i. **Getting the message across** – effectively communicating with children and families to change behaviour
ii. **Targeting & Outreach** – targeting resources and bringing services and advice in to communities
iii. **Dentists** – engaging dental practices in the campaign
iv. **Partnerships** – building even more effective partnerships among local professionals, communities and parents and children themselves.

Getting the Message Across

Recommendation 1: Keep Smiling – A Children's Oral Health Campaign and *Recommendation 2: Review of Health Information and Advice* aim to get the key messages across, particularly targeted at "hard to reach" and the most "at risk" communities, with a more joined up campaign and targeted events in community settings.

Targeting & Outreach

Recommendation 3: Targeted Fluoride Varnishing Programme and *Recommendation 5: Targeted Provision of Dental Health Packs* will take oral health interventions to at-risk groups at key times in their children's lives. One of the most effective forms of communication is word of mouth and *Recommendation 4: Community Champions, Health Advisors and Parent Volunteers* bolsters targeted community led initiatives to engage with parents and children directly and involve parents themselves.

Recommendations 6 and 7: Targeted Support for Children in Care and for Children with Special Needs recommend further targeted support for children who we recognise as particularly vulnerable and for whom the Council and PCT have special responsibilities.

Dentists

It goes without saying that local dental practices are key partners in delivering children's oral health and the Children's Oral Health Campaign. We urge as many local practices as possible to actively join in the campaign and help to engage more children and families, as well as make links with local schools, nurseries, children's centres, health centres and medical centres.

Recommendation 8: Child Friendly Dentists aims to build upon the pilot to increase access to children's dentistry and bring local dentists further into partnership with local communities. We would like to see as many dentists as possible sign up to being a 'Child Friendly Dentist'.

Partnerships

Building local partnerships is pivotal to making different strands of work combine to have a real impact upon children's oral health. Everyone in contact with children and young people can make a difference, including health visitors, after school and breakfast clubs and of course parents and young people themselves. The issue should also concern local retailers who sell sugary sweets and drinks and we urge everyone to get involved in this campaign.

We are asking commercial companies such as toothpaste brands to help sponsor the campaign and to offer the wealth of advice they have in getting the message across and engaging children and families.

Recommendation 12: 'Keep Smiling' Oral Health Campaign for Professionals - Using Professionals to Influence Behaviour aims to bring professional groups together in delivering the programme and to identify and provide for associated training needs. Children's oral health can be impacted upon even before birth and *Recommendation 11: Maternity and Early Years* is directed at health visitors and midwives involved in delivering advice to new parents.

We recognise that Schools and Children's Centres have a very important role to play, as they are centres for young people. We have recommended some key elements of the campaign for schools and children's centres in Recommendation 10 and several schools have already agreed to pilot the programme. We urge other schools, nurseries and children's centres to get involved, including secondary schools and especially schools in areas where there is the greatest socio-demographic challenge. We would like to see school councils involved too, as well as the Borough Youth Forum, which has played an active role in our inquiry already.

Water Fluoridation

We have also considered the options for water fluoridation, examined evidence in favour and against the proposition and interviewed representatives from Thames Water.

We have noted that there are a number of hurdles to introducing water fluoridation, starting with building a consensus amongst London boroughs, some out of London councils, the health authorities and the general public. Belying the seemingly straight forward case for fluoridation, there are in fact some fairly complex issues around public confidence in the long term medical effects of compounded exposure to fluoride and the rights of the individual in the face of state intervention (you cannot "opt out" of fluoridated tap water).

Despite this, we believe that there are substantial public health benefits to water fluoridation and negligible proven public health risks. We are therefore recommending that the political, financial and public health implications of water fluoridation are further investigated and that the Council seek to build a coalition to instigate possible public consultation. We envisage that this would begin with a debate at Council.

The Executive Response and Implementation

This report summarises the salient points in the investigation and presents recommendations to the H&F Cabinet, NHS and other local decision makers. The estimated budget implications for each recommendation are detailed at the end of this report.

It is anticipated that the agreed scrutiny report and recommendations will be presented to the Cabinet, NHS PCT and other decision makers, who will be invited to provide an Executive Response to the report and executive decisions for each recommendation.

It is also anticipated that the Executive Response and executive decisions will be presented to the Council's Education Select Committee, which will monitor the implementation of the agreed recommendations and outcomes for children and young people. It is requested that in conjunction with the Executive Response, that the implementing agencies provide a joint Action Plan which details for each agreed recommendation (executive decision): the agreed hypothecated budget and resources, an implementation timetable (including when it will happen and when it will be fully in place) and key measurable outputs.

With the work already undertaken through the Scrutiny Task Group to engage partners working with children and young people and the positive response we have received to this initiative; the Children's Oral Health Campaign has already begun. We hope that the Cabinet, the NHS PCT, local dental practices, schools, Children's Centres and other professions, local communities and parents and

children themselves will be willing to take this campaign forward. We commend these recommendations to you.

Summary of Recommendations

Getting the Message Across

Recommendation 1: Keep Smiling – A Children's Oral Health Campaign
It is recommended that the Council and the PCT initiate a local campaign to highlight the issue of children's oral health. The campaign should focus upon key issues including decay prevention, diet, teeth brushing and visiting the dentist and speak to parents and young people. It should be branded, have a name, a logo and a master set of key publicity messages. The campaign should include events such as an oral health events week in 2011, an annual Children's Oral Health Day and year round community events which are targeted at the borough's most high-risk areas.

Recommendation 2: Review of Health Information and Advice
It is recommended that the PCT review health information and advice to define key messages and to make sure that there is consistent advice from professionals across the spectrum of children's agencies. Particular attention should be paid to advice to professionals, the use of child-centred communication and the need to use community languages.

Targeting and Outreach

Recommendation 3: Targeted Fluoride Varnishing Programme
It is recommended that a targeted programme should be launched to provide fluoride varnishing for children aged 3–5 from the most at-risk groups in the borough. The programme should be delivered in schools, children's centres, community centres and supermarkets to maximise coverage of target geographical areas, as well as "drop in" fluoride varnishing sessions in dental practices.

Recommendation 4: Community Champions, Health Advisors and Parent Volunteers
It is recommended that the Community Champions and Health Advocate schemes be continued and enhanced to include targeted community led action to raise awareness of oral health, recruit parent volunteers from the local community and register children with local dentists.

Recommendation 5: Targeted Provision of Dental Health Packs (Fluoride Toothpaste, Toothbrushes and Baby Beakers)
It is recommended that fluoride toothpaste and toothbrushes be distributed regularly to targeted groups, through health visitors, Community Champions and events, and that free baby beakers be distributed at age 8 months to 1 year to at-risk groups to encourage the reduced use of feeding bottles containing sugary drinks.

Recommendation 6: Targeted Support for Children in Care
It is recommended that the following steps are taken to promote oral health amongst children in care:

i. Incorporate dental screening into mandatory 28 day health checks
ii. Sign-post H&F foster parents to Child Friendly Dentists
iii. Follow up and monitor the registration of all looked after children
iv. Encourage one H&F dentist to take the position of 'Looked After Children Champion' and to educate other dentists in the borough about the high level of sensitivity required for these children
v. Include Keep Smiling campaign in the 'Rocket Club' and other targeted points of contact
vi. Lobby the Government to make the disclosure of dental reports (for looked after children) free, as part of the NHS dental contract.
vii. Send a Brushing for Life Pack to all looked after children, sponsored by Colgate or another commercial partner
viii. Add oral health improvements to the 'Independent Reviewer's' agenda.

Recommendation 7: Targeted Support for Children with Special Needs
It is recommended that good practice is maintained including joint-working with schools and Chelsea & Westminster Hospital, and that Child Development Service contracts are amended to include oral health promotion.

Dentists

Recommendation 8: Child Friendly Dentists
That dentists who would like to be known as 'Child Friendly' display a logo and appear on a list which is distributed to professionals, stakeholders and parents. These H&F dentists should gain the necessary paediatric training from Chelsea & Westminster Hospital and be encouraged to open at 'child friendly' times such as on Saturday mornings. In return their services could be promoted to families in the Borough.

Partnerships

Recommendation 9: Commercial Partnerships
It is recommended that a commercial operator in the field of dental care products, such as Colgate or Glaxo Smith Klien, be approached to sponsor report recommendations including (1) Keep Smiling and (5) Targeted Provision of Dental Health Packs.

Recommendation 10: Chuck Sweets Off the Check-Out
It is recommended that supermarkets, high street shops and leisure centres be asked to play their part and to "chuck sweets off the checkout" as part of a local campaign to promote healthier diets.

Recommendation 11: Schools and Children's Centres
It is recommended that schools, nurseries and children's centres implement a range of the following measures:

i. Gain parental consent for dental inspections and fluoride varnishing
ii. Supervised tooth brushing
iii. The use of a chart for children to record teeth brushing at home
iv. The school nurse to provide oral health advice and sign-post at-risk families to dentists during the universal age 4-5 health check and at later dates
v. A fluoride varnishing programme
vi. A more proactive Healthy Food Policy, including the provision of healthy snacks (fruit, water, etc) as well as a prohibition on sugary products
vii. Making water available throughout the day
viii. Establish links with at least one dental practice and take school classes to the dentist or bring the dentist into school
ix. Inclusion of oral health care education in the school curriculum
x. Oral Health educational events for children and parents.

Recommendation 12: 'Keep Smiling' Oral Health Campaign for Professionals - Using Professionals to Influence Behaviour
It is recommended that GP medical practices improve their links with dentists and that other professionals who are able to pass on oral health advice be trained by the Oral Health Promotion team. Professional groups include:

- Teaching staff and learning mentors
- Social Workers
- School Nurses
- Health Visitors
- Youth Services
- Midwives
- Child-care workers and child-minders.

Service specifications for relevant professionals, including health visitors and school nurses, should be amended to include oral health actions.

Recommendation 13: Maternity and Early Years
It is recommended that health visitors and midwives be trained to provide oral health advice to new parents on the key stages of infant oral health development and health services, Key stages include a child's first tooth and registration from age from age 1 with a local dental practice, free NHS dental treatment for new and pregnant mothers and children and health advice on avoiding "teat bottles" and sugary liquids and foods.

Water Fluoridation

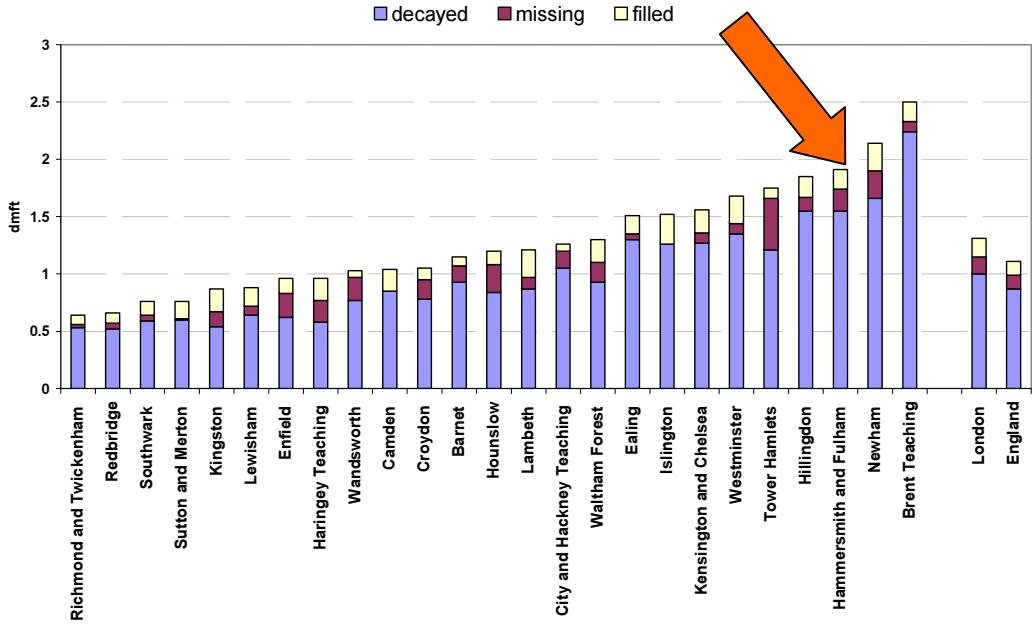
Recommendation 14: Further Consideration of Water Fluoridation
It is recommended that the Council considers the political, financial and public health implications of water fluoridation and seeks to build a coalition of councils

and health partners to instigate possible public consultation on the introduction of water fluoridation in the future.

For details of the budget and resource implications of these recommendations, please see Appendix Two.

Introduction

Hammersmith and Fulham has an unacceptably high level of tooth decay in children. The percentage of five year olds experiencing tooth decay was 44.5% in 2007-8 – higher than London (32.7%) and England (30.9%) and the 3rd highest rate of decayed, missing and filled teeth (dmft) in London for this age group♣ .

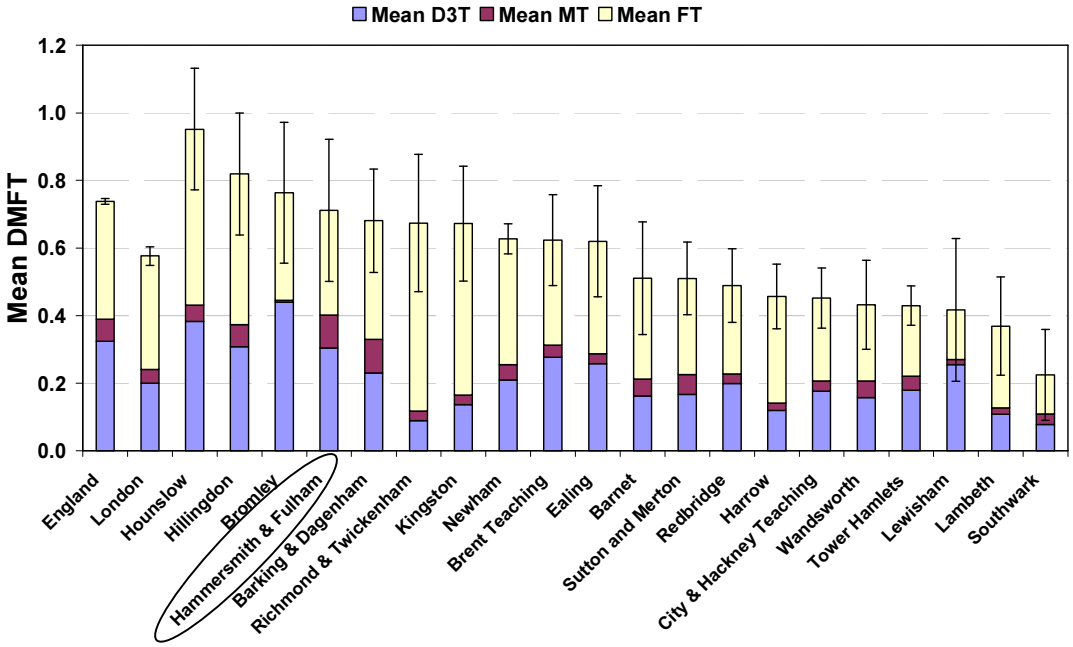


At an early stage in the research process we asked why H&F performs so badly on this measurement of child oral health. We advise a note of caution: these statistics are based upon 'sampling' research in each London borough, rather than 'universal screening'. Nevertheless, they are a useful indication of the scale of the problem in the borough, even if not an exact measurement.

Poor oral health is generally linked to socio-demographic factors including poverty, population transience and overcrowding, with which this inner-city borough must contend to a high degree. We perform better on many of these demographic measurements than on dmft amongst children however, which could suggest more subtle demographic influences, problems with local oral health services or in the sampling research. Regardless of the exact scale of the problem, there is agreement that children's oral health must be improved and the Task Group has focused upon how this can be achieved.

♣ *Source: British Association for the Study of Community Dentistry (BASCD) 2007-08*

Mean DMFT 12 years, London PCTs, London SHA & England BASCD Survey 2008-09



'Choosing Better Oral Health'♠ was published in 2005 by the Department of Health. In 2007, the Department of Health also published 'Delivering Better Oral Health'♣ which provided the evidence base for oral health promotion initiatives. The two documents provide a guide to PCTs in developing oral health improvement programmes.

There are two basic approaches to achieving health improvement, the 'targeted' or 'high-risk' approach and the 'population' approach. The 'population' approach is designed to reduce the level of risk in the whole population. The 'targeted' approach involves targeting preventive strategies at identified groups who are at high-risk of dental disease, for example, people living in areas of material and social deprivation, people who have learning disabilities and people in long term institutional care♦.

Evidence suggests that a combination of 'targeted' and 'population' approaches is likely to be most effective♥. We have taken account of both approaches in our inquiry, as reflected in the recommendations put forward in this report.

Tooth decay occurs throughout populations and is not confined to subgroups, although it is most severe in certain groups. Strategies limited to individuals 'at risk' would therefore fail to deal with the majority of new decay•.

♠ *Department of Health Choosing Better Oral Health. An oral Health plan for England. 2005*

♣ *Delivering Better Oral Health, Department of Health. 2007*

♦ *Choosing Better Oral Health, Department of Health 2007*

♥ *Strategies in the design of preventive programs. Fejerskov O. Adv Dent Res. 1995 Jul;9(2):82-8*

The pattern of children's oral health often appears in an uneven distribution across the population. Although the overall rate of tooth decay may not be high compared to some international comparisons, high incidents of tooth decay appear in specific population areas. Targeting allows us to use the finite resources we have to tackle the populations where there appear to be particular issues. Patterns of oral health decay, like other health issues, are often married to social deprivation or may follow particular ethnic communities and groups.

In targeting children's oral health intervention programmes it is also important to consider the different needs and character of different ages of children from birth to adulthood. In our inquiry we have considered children and young people across the age ranges up to nineteen. We recognised, however, that a focus for a lot of the intervention work is upon younger age groups, where prevention can have earlier impact and where positive habits can be encouraged that will last as a child gets older.

> *"When it comes to children's teeth, it's important to set good habits early, as studies have proved that tooth decay is relatively easy to prevent. Our aim is to raise awareness of the importance of dental care and the importance of starting good habits early"*
>
> *Navdeep Pooni - Oral Health Promoter, Central London Community Health Care NHS Trust*

During the inquiry we have considered community based programmes as these seem to be a common and effective approach in providing targeted intervention. Community-based prevention needs to address the particular needs of the local population. A strategy that is effective, cost-effective and appropriate at one time and place may not be in another.

Fluoride forms the basis for most community based caries prevention strategies as it has been shown to prevent decay[♠]. This can be delivered in a variety of ways including supervised tooth brushing programmes ('targeted' approach) and water fluoridation ('population' approach).

Oral health improvement programmes also work in partnership with generic health improvement initiatives to address common risk factors, such as smoking and diet to achieve maximum impact on people's health[♣]. 'Choosing Better Oral Health' identifies 6 key areas for action to achieve sustainable improvements in oral health:

• *The limitations of a 'high-risk' approach for the prevention of dental caries. Community Dent Oral Epidemiol. Batchelor P, Sheiham A. 2002 Aug;30(4):302-12*

♠ *Fluoride toothpastes for preventing dental caries in children and adolescents - Marinho VCC, Higgins JPT, Logan S, Sheiham A. Cochrane Database of Systematic Reviews 2003, Issue 1. Art. No.:CD002278. DOI: 10.1002/14651858.CD002278*

♣ *The common risk factor approach: a rational basis for promoting oral health - Sheiham A, Watt RG, Community Dent Oral Epidemiol. 2000 Dec;28(6):399-406.*

i. Increasing the use of Fluoride
ii. Improving diet and reducing sugar
iii. Encouraging preventive dental care
iv. Reducing smoking / sensible alcohol use
v. Increasing early detection of oral cancer
vi. Reducing dental injuries.

In children's oral health multi-agency partnerships are required to make intervention effective. We have considered a wide range of programmes in place and engaged with a spectrum of organisations and individuals involved in children's services. It is hoped that the momentum for further and enhanced partnerships between agencies and disciplines will have a visible impact upon the scourge of poor child oral health in our Borough.

1. Getting the Message Across

1.1 The biggest impact on reducing the number of children with oral health problems will come from changing the behaviour of children and families themselves. We need to communicate key messages on children's oral health care, especially to the population groups that we can estimate as being at high risk. Key messages are:

- ► brushing teeth properly twice a day with fluoride toothpaste
- ► minimising sugary foods and drinks and
- ► visiting a dentist regularly.

If we can get these messages heard and understood by the families and children most likely to develop oral health problems, we can make a real impact on the level of children's tooth decay and extractions in the Borough.

1.2 During the inquiry we heard evidence from Ray McAndrew - Associate Medical Director for NHS Dental Services and Clinical Director of the Community and Salaried Dental Service. Mr McAndrew is also Honorary Clinical Teacher at the University of Glasgow. His role includes clinical governance and advice to the Board on Clinical Strategy. Mr McAndrew has contributed to a number of Paediatric Oral Health Promotion initiatives which have helped to contribute to a 20% reduction in Dental caries in 5 year olds in Glasgow in the last 10 years , including the redesign of the Board`s Paediatric Dental Service and the Child Smile programme in Glasgow.

1.3 Mr McAndrew told us in evidence that Glasgow had recovered from the worst oral health in the UK and that there has been a 20% improvement in the last 10 years, through a series of government programmes and interventions such as the roll out of Oral Health Action Teams and the Child Smile programme.

1.4 The Child Smile programme in Scotland is very impressive but was also expensive. There are a lot of things within the programme that could be done that are not expensive. We were particularly impressed by the community action work for example.

1.5 For more about the Child Smile programme see www.child-smile.org.uk

> *"don't waste money on techniques on how to brush your teeth" – "keep it simple, keep it consistent, and keep it reliable"*
> *Ray McAndrew - Associate Medical Director for NHS Dental Services*

1.6 Mr McAndrew said we need to get the key messages across such as "Spit don't rinse" (maximising exposure of teeth enamel to fluoride toothpaste). He advised not to waste resources on techniques on how to brush your teeth but to keep the message simple, direct and consistent.

1.7 In summary:

- Leaflets don't work
- Change the environment to make it easier for people to have the right behaviour
- Invest in parents and parent peers – this is how most people receive advice on childcare.

An Oral Health Campaign

1.8 To engage parents, children and all key stakeholders from the outset, we recommend an oral health campaign. The campaign should focus upon the prevention of tooth decay, healthier low sugar diets, oral care and visiting the dentist. The campaign needs to be effectively marketed and high profile. It should have a clear and popular appellation, a catchy strapline, a recognisable badge or logo and produce a master set of key publicity messages for use by all participating agencies. Key publicity messages and logos can be produced in targeted community languages but with exactly the same look and feel.

1.9 The campaign should be led by Hammersmith and Fulham Council and the PCT, but should involve as wide a range of community organisations as possible, including all local dental practices and particularly the Child Friendly Dentists, all local schools, nurseries and children's centres, health centres and GP medical practices, the Borough Youth Forum, commercial operators (eg Colgate) and local supermarkets and retailers.

Recommendation 1: Keep Smiling – A Children's Oral Health Campaign
It is recommended that the Council and the PCT initiate a local campaign to highlight the issue of children's oral health. The campaign should focus upon key issues including decay prevention, diet, teeth brushing and visiting the dentist and speak to parents and young people. It should be branded, have a name, a logo and a master set of key publicity messages. The campaign should include events such as an oral health events week in 2011, an annual Children's Oral Health Day and year round community events which are targeted at the borough's most high-risk areas.

1.10 Children's Oral Health Campaign events should be held in community centres, supermarkets, schools and imaginative locations to engage parents and promote children's oral health. Events could include dental varnishing, mass registration of children and families with dentists and the distribution of toothbrushes. A logo design competition should be run between H&F nurseries and schools, to engage children and raise awareness of oral health issues.

1.11 Key campaign messages could include: “Keep Smiling – Children are seen FREE at NHS Dentists”, “Keep Smiling – No sweets and fizzies”, with key messages appearing in key community languages with the same branding. **An expensive advertising campaign is not recommended, as evidence shows that it would not produce a significant return on investment.** Promotional materials should be used at existing contact points and made available to professionals. All health and social care professionals involved with children and young families need to be involved.

1.12 Improving children’s oral health is everyone’s business, and the campaign needs to identify the role played by all stakeholders including local dental practices, children’s centre staff, schools, social workers, health visitors, school nurses, ‘Looked After Children’ nurses, Community Champions, Health Advocates, GPs, the Borough Youth Forum and parents and children. Support should be sought from a commercial partner, such as Colgate, to help design and produce communications materials.

1.13 Invitations to participate in the campaign should be sent to all school governors and head teachers of local schools (including breakfast and after school clubs), local shops and supermarkets, children’s centres and nurseries, health centres and GP practices, dental practices and local libraries, community health champions, CITAS and the Borough Youth Forum. As a minimum, these stakeholders can participate by displaying linked oral health promotion material in waiting rooms, reception areas, and shop fronts. They should also be invited to host oral health promotion events such as oral health promotion days and dental varnishing sessions. All organisations should be invited to participate in oral health events such as Teeth Week.

1.14 Children’s oral health events should provide a focus for the Children’s Oral Health Campaign and a range of targeted events around the Borough to promote the key children’s oral health messages and register as many children with a local dentist as possible. Events should target ‘at-risk’ communities and groups, sponsored where possible by Colgate (or another commercial operator) and repeated where found to be effective.

Child Centred Communication

1.15 We need to get the message across to children themselves and different communications need to be used for children and young people at different ages, starting with nursery age children all the way up to adulthood. The right pictures and images can be effective if focused upon the age relevant audience and can cut across language barriers. During our inquiry we used interactive surveys for young children, including drawing picture boxes, which we found helped to engage and inform them about oral health, as well help us see their perspectives.

1.16 It is suggested that the Borough Youth Forum be invited to be involved in the development and review of Children's Oral Health publicity and campaign material. They helped us to develop some of the key messages and images in this report.

Health Messages

1.17 With the wide range of different health messages and different agencies involved in supporting and promoting children's health as they grow up, it is important that the key health information and advice is consistent and "joined up". For Children's Oral Health, this starts even before a child is born and when a mother is receiving support and advice from midwives and health visitors.

1.18 NHS dental treatment is free for pregnant women and so this is a good opportunity to encourage prospective mothers to register with a local dental practice, where she will hopefully later register her child. Children with parents who visit the dentist are much more likely to be taken to visit the dentist themselves. Health visitors can also take the opportunity re-enforce health advice on discouraging sugary drinks for babies and young children, especially in the "teat" bottles and beakers, providing teeth friendly drinking beakers as part of the promotion.

> ***"Posters showing the effects of poor dental hygiene stuck around the schools would probably have quite a profound affect on unsuspecting pupils"***
>
> *Josie Durley, aged 15*

1.19 'Delivering Better Oral Health in Dental Practices: Prevention Toolkit'[*] provides the evidence base for all dental public health messages and is the tool for training by the Oral Health Provider and following it will ensure messages are consistent.

1.20 There is an identified need for increased oral health promotion capacity to train the professionals delivering key oral health prevention messages; including teachers, children's centre staff, health visiting teams and staff in early year's settings. The possibility of "buying in" additional resources from other Boroughs also covered by the CLCH Provider should be investigated to increase capacity within existing budgets.

1.21 Personal Social and health Education (PSHE) oral health is part of the National Curriculum and there is a need to ensure schools and PSHE teachers have appropriate resources available in local schools.

1.22 Other routine advice given out through health centres, dentists, GPs, schools, nurseries and children's centres, the Children's Oral Health Campaign,

[*] Delivering Better Oral Health - An evidence-based toolkit for prevention 2nd Edition, DoH and British Association for the Study of Community Dentistry 2009.

Community Health Champions, the Brush for Life Packs, other healthy eating advice and health advice translated into community languages, all need to be consistent and clear. Examples where advice may need clarification include feeding from a beaker or bottle, clarity about registering and visiting a dentist from an early age and healthy eating.

Recommendation 2: Review of Health Information and Advice
It is recommended that the PCT review health information and advice to define key messages and to make sure that there is consistent advice from professionals across the spectrum of children's agencies. Particular attention should be paid to advice to professionals, the use of child-centred communication and the need to use community languages.

1.23 In getting the key messages across we need to make sure that we identify all of the main audiences and that we have relevant communication resources aimed at them. This includes parents and children generally, but we need to make sure that we target all sections of the population and particularly those groups that we can estimate as being of high risk or where there are barriers to communication which compromise their understanding of basic oral health guidance.

1.24 Particular regard should be given to the need for targeted communication to be in appropriate minority languages. During our inquiry we interviewed Malika Hamiddou from the Community Interpreting, Translation and Access Service (CITAS), who explained some of the issues for minority language speakers in accessing information and ways in which this can be overcome. Targeting and outreach is dealt with further in the next chapter.

1.25 For more information about CITAS see www.citas.org.uk

2. Targeting & Outreach

2.1 Statistical evidence indicates that children's oral health in Hammersmith and Fulham is amongst the worst in London. The more deprived members of our community will have the worst oral health. Resources should therefore be targeted at these groups♥. There is a well established correlation between areas of deprivation and a wide range of health issues, including oral health.

Fluoride Varnishing

2.2 Fluoride varnish is a golden gel containing a highly concentrated form of fluoride, which can be applied to children's teeth using a soft brush. The varnish sets quickly and has a pleasant taste and a fruity smell.

2.3 Fluoride varnish provides an effective prevention of decay in permanent teeth and health guidelines advise that it should be applied to the teeth at least twice-yearly for pre-school children assessed as being at increased risk of dental decay♣. There is a strong evidence base that fluoride varnishing improves child oral health.

2.4 There are several fluoride varnishing projects being carried out around the Borough, including the Old Oak Community Centre and the Normand Croft Early Years Centre. We are recommending a targeted programme of fluoride varnishing for children aged 3 –5 years, starting with children's centres, health centres, nurseries and schools in the most "high risk" community settings.

Recommendation 3: Targeted Fluoride Varnishing Programme
It is recommended that a targeted programme should be launched to provide fluoride varnishing for children aged 3–5 from the most at-risk groups in the borough. The programme should be delivered in schools, children's centres, community centres and supermarkets to maximise coverage of target geographical areas, as well as "drop in" fluoride varnishing sessions in dental practices.

2.5 Proxy measures such as obesity and child poverty should be used to decide which areas should be targeted. Appropriate targeting would be according to one of three variables as a proxy measure for high risk of poor oral health: deprivation, percentage of children receiving free school meals, and top quintile for obese and overweight children.

2.6 Fluoride varnishing should be an on-going program, as it is most effective if repeated twice annually. For any Fluoride varnish programme to be successful it should not be done in isolation. It requires an integrated approach with very

♥ London Strategic Health Authority and England BASCD Survey 2008-2009
♣ Scottish Intercollegiate Guidelines Network Guideline 83: Prevention and Management of Dental Decay in the Pre-School Child, 2005 SIGN 83 Guideline.

active community and school engagement to increase uptake alongside promotion of public health messages and sign posting to services for continuing care.

Community Champions

2.7 During the inquiry we interviewed Suzanne Iwai and Lornia Polis – Community Health Champions on the White City Estate, Sherherds Bush. The Community Health Champions (now known as "Community Champions") scheme has been running in Hammersmith and Fulham for the past 3 years, as a strategy to signpost health services, information and advice to targeted populations in community settings to improve access. The Community Champions are people living in the local community with direct links to people living locally, often able to break down cultural and language barriers to signposting local health services.

2.8 The key roles of the Community Champions are:
- ► Signposting local services
- ► Community networking events
- ► Helping to facilitate events and community activities
- ► Providing some training for health and well being e.g. stop smoking sessions.

2.9 Information days are held as part of the project, at which as many of the local service providers as possible attend. These include "fun" activities for children and families.

2.10 One of the areas currently using the Community Champions project is the White City Estate in Shepherds Bush. It was estimated that up to 30% of local residents on the White City Estate cannot read. The best way to campaign is often community awareness activities which could include community awareness events for children's oral health.

2.11 The Community Champions are engaged through Well London, which is a project aimed at building stronger local communities by getting people working together to improve their health and well-being. The Community Champions project is funded by Well London in partnership with the PCT (which funds the co-ordinator post to manage the volunteers) and the White City Residents Association which provides the office. We have also heard in evidence about Health Advocates, with a similar role of translating and building links with the community, being managed through CITAS, funded by the PCT.

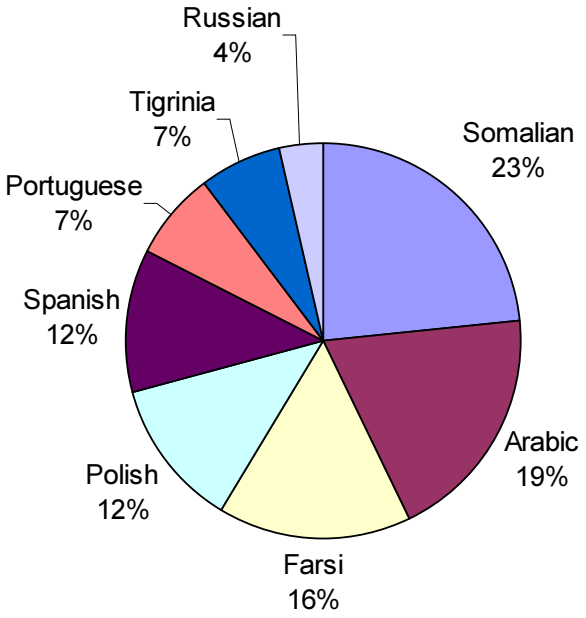
2.12 We recommend that the Community Champions and Health Advisors programmes be continued and enhanced to include community led action events to raise awareness of children's oral health and register children with local dentists. These could coincide with proposals for community children's oral health to promote oral health to children and families around the Borough. Ideally, a Community Champion should be recruited for all key language groups where there is an identified language barrier to understanding.

Recommendation 4: Community Champions, Health Advisors and Parent Volunteers
It is recommended that the Community Champions and Health Advocate schemes be continued and enhanced to include targeted community led action to raise awareness of oral health, recruit parent volunteers from the local community and register children with local dentists.

2.13 Community Champions should be assisted to organise 'Motivational Interviewing' of parents and 'Small Group Discussions', both of which have proven oral health benefits. This work will particularly benefit 'hard to reach' immigrant groups including the Somali, Arabic, Farsi and Polish speaking populations. A list of dentists conversant in community languages should be compiled and Brushing for Life packs be made available in all key languages. Community Champions should also recruit a list of Parent Volunteers' to assist them.

2.14 To provide an estimate of the main minority language needs in Hammersmith and Fulham, CITAS have provided us with the numbers of translation requests through them for 2010. These are:

Somalian	754
Arabic	616
Farsi	513
Polish	390
Spanish	378
Portuguese	228
Tigrinia	216
Russian	118



More accurate data for Children's translation needs may be available from schools.

2.14 The aim of involving the Community Champions is part of the strategy to target high risk populations. Pockets of high deprivation tend to correspond with cultural and language barriers to information and access and a higher risk of poor health.

2.15 As part of the strategy to break down cultural and language barriers to local health services, we are also recommending that a list of dentists conversant in community languages should be compiled and that Brushing For Life packs be made available in all key languages.

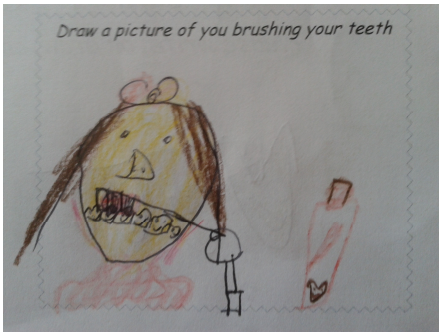
Community Children's Oral Health Events

2.16 One way to target communities that may be "high risk" is to hold community focused health promotion days. In evidence we have heard that talking to people directly and where possible and appropriate, in their own community language or dialect is the most effective way of getting key messages across. It is also another opportunity to provide children's oral health promotion packs to targeted families.

2.17 We are recommending that oral health awareness events be run as assertive, targeted outreach community based programmes in identified communities, including the White City estate, Edward Woods, Fulham Court, Gibbs Green; to target areas with high levels of children with dmft or not registered with a dental practice, to provide an assertive public education programme and to register children and families with local dental practices.

2.18 During the inquiry we interviewed Kelly Nizzer – Senior Contracts Manager for Dental, Pharmacy and Ophthalmic Services at NHS North West London. She told us said it was important to make a link with where the most at risk communities are (eg most deprived communities). She explained that the community projects on dental care they ran in Hounslow had taken health advice and dental varnishing to community settings including Asda supermarket, where an oral health promoter would approach parents in store. More than 280 children had received fluoride varnish in this way. Parents also received a voucher and a list of all the dental practices in the area. Dental nurses are still stationed at Asda in Hounslow.

Children's Oral Health Promotion Packs



2.19 There are a small number of families where children do not even possess a toothbrush and toothpaste, either for reasons of poverty, ignorance or neglect. These children are amongst the most at risk of oral health problems, and in such cases we believe that it is a cost effective solution to provide toothbrushes and toothpaste directly. This is also a direct and clear message to parents and children that children's oral health is important.

2.20 Health visitors are currently distributing Brushing for Life packs to families and children at one and two and a half years of age when children have their developmental reviews. Brushing for Life is a Government initiative to reduce the inequalities in children's oral health in the most disadvantaged areas of the country. The scheme provides children in areas with highest levels of dental decay a free pack of fluoride toothpaste and a toothbrush - supported by advice

on oral hygiene. Future funding for these packs and training needs to be identified.

2.21 The distribution could take place via health visitors assigned to visit new parents, who should be able to communicate the key messages on oral health care directly. An assessment of translation and communication needs should be undertaken prior to the visit, so that appropriate translation materials are available at the time. Written material used in conjunction with visits should include visually clear key messages on oral hygiene, where to find local dental practices, Child Friendly Dentists and that children are seen free at NHS dentists.

Recommendation 5: Targeted Provision of Dental Health Packs (Fluoride Toothpaste, Toothbrushes and Baby Beakers)
It is recommended that fluoride toothpaste and toothbrushes be distributed regularly to targeted groups, through health visitors, Community Champions and events, and that free baby beakers be distributed at age 8 months to 1 year to at-risk groups to encourage the reduced use of feeding bottles containing sugary drinks.

2.22 Colgate (or another commercial partner) should be encouraged to fund this recommendation.

2.23 We have heard in evidence that baby beakers and bottles with teats can contribute to early tooth decay, especially where babies suckle on the beaker for long periods of time and where they are being given sugary drinks. Health advice is to encourage parents to use teat-less baby feeders and to discourage sugary drinks. In order to encourage this and to re-enforce this message we believe it is cost effective to provide free teat-less baby cups to parents with babies between 8 months to 1 year of age, targeted to high risk groups.

Children in Care

2.24 Children in care are a group of young people for whom the council has particular responsibility as Corporate Parent. In particular the Council must make sure that they do not fall off the radar of health services. During our investigation, we heard from Lin Graham-Ray, a Nurse Consultant for Looked after Children for the London Borough of Hammersmith & Fulham. She was able to highlight some of the issues for looked after children in accessing health services.

2.25 One of the problems is that most looked after children for which Hammersmith and Fulham Council is responsible are resident outside of the Borough, which can make co-ordination and communication more challenging. Another is that current regulations allow dentists to charge prohibitively high fees for copies of the children and young people's dental records, which could be used to monitor their oral health.

Recommendation 6: Targeted Support for Children in Care
It is recommended that the following steps are taken to promote oral health amongst children in care:

i. Incorporate dental screening into mandatory 28 day health checks
ii. Sign-post H&F foster parents to Child Friendly Dentists
iii. Follow up and monitor the registration of all looked after children
iv. Encourage one H&F dentist to take the position of 'Looked After Children Champion' and to educate other dentists in the borough about the high level of sensitivity required for these children
v. Hold Keep Smiling campaign events in the 'Rocket Club' and other targeted points of contact
vi. Lobby the Government to make the disclosure of dental reports (for looked after children) free, as part of the NHS

Children With Special Needs

2.26 Children's with special needs or "disabled" children are one group that are at risk of oral health problems and during the inquiry the good practice of joint working between Chelsea and Westminster NHS Trust and schools has been noted.

2.27 Special efforts should to be made to target early prevention advice and support to these children.

Recommendation 7: Targeted Support for Children with Special Needs
It is recommended that good practice is maintained including joint-working with schools and Chelsea & Westminster hospital, and that Child Development Service contracts are amended to include oral health promotion.

3. Dentists

Kids are seen FREE at NHS dentists

3.1 One of the key ways in which we can improve the dental health of children is to encourage them to visit the dentist regularly. Children can start visiting the dentist from 1 year old. Forging the habit of visiting the dentist from an early age ensures that a child's oral health development is regularly inspected, introduces children to the concept of visiting the dentist and breaks down dental phobias.

3.2 During our inquiry we interviewed Henrik Overgaard-Nielson – Chairman of the Ealing, Hammersmith and Hounslow Local Dental Committee and we were also able to visit his practice "NHS Dentist" in Fulham. We have heard in evidence that Hammersmith and Fulham has enough capacity in terms of the number of dental practices operating, but not all dentists are reaching the child population. Hammersmith and Fulham has 45 NHS dental practices including community dental practices[♦].

> *"Children need to get used to attend their local dental practice so both children and their parents are aware of how to look after their teeth throughout their lives. It is the involvement of the local high street dentists that will change the oral health of the population of Hammersmith and Fulham"*
>
> *Henrik Overgaard-Nielsen –*
> *Chairman of the Ealing, Hammersmith and Hounslow Local Dental Committee*

3.3 Attendance at dental practices is influenced by a wide variety of factors including information about dental services, parents' perceptions of dentists and their own fears and worries and a lack of appreciation of the importance of dental care for children.

3.4 As with oral health generally, there are links between accessing dentists and to economic deprivation, as well as linguistic and cultural barriers. We have heard in evidence that people from more deprived socio-economic groups, from BME communities or living in more deprived areas tend to be less likely to attend dentists, especially for prevention, than people who are more affluent, or white, or who live in a less deprived area. (Currently, social and ethnicity data collected by dental practices is incomplete and therefore we are unable to draw any more definite conclusions about "high risk" sections of the population).

3.5 Some parents may still be worried about the cost of treatment, if they do not understand that children are seen free at NHS dentists. They may be reluctant to take their children if they do not attend a dentist themselves and some only seek healthcare when there is a problem and not for prevention. We need to get the message across that in oral health "prevention is better than cure" so that children are not only seen by a dentist when there is a problem.

♦ NHS Choices – www.nhs.uk

“I go to the dentist because my teeth hurt, to get my teeth cleaned or taken out”

Teenager from the H&F Borough Youth Forum

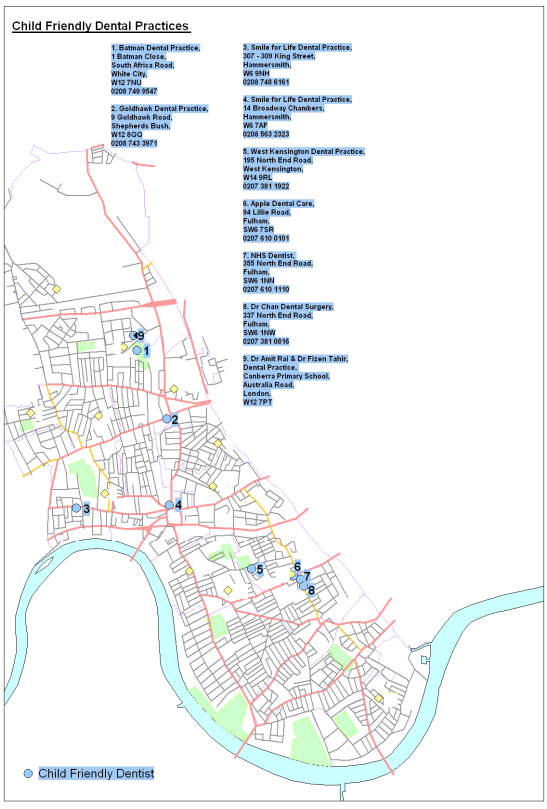
3.6 We need to encourage more children and families to register with a dentist and more importantly, to visit a dentist regularly. This is a key part of the preventative strategy to encourage every child to receive a regular dental screening and to highlight any dental problems at an early stage. To achieve this, we need to improve the awareness of free NHS dental services for children, improve the awareness of the importance of children visiting a dentist regularly, make dental practices more attractive and accessible to children and families and to do all of this whilst targeting those children who are least likely to be registered or visiting a dentist and most likely to suffer from oral health problems.

Child Friendly Dentists

3.7 One way to encourage more children and families to register and visit the dentist is by making dental practices more child friendly. This can include making the whole experience of visiting the dentist more attractive to children, such as by training dentists and dental nurses and other staff (including reception staff) on working with children, making the waiting room more child focused and by making access points easier to navigate with pushchairs and young children.

3.8 The Child Friendly Dentist scheme was designed as a quality initiative to support practices through training, chairside mentoring from the consultant in children’s dentistry at the Chelsea and Westminster NHS Trust and audit. NHS Hammersmith and Fulham has trained special child-friendly dentists as part of a local pilot to improve access by providing more “child friendly” dentists to choose from.

3.9 Ten local dentists, based in seven practices across the Borough have been given additional training and undergone extra security checks. As well as check-ups and treatment they can give parents and children advice on brushing, flossing and which foods and drinks to avoid. From 1st April 2011 the scheme was aligned to the similar scheme in Kensington and Chelsea and further work is going on to develop links with children’s centres and schools, although the life of the pilot has now officially expired.



3.10 We have found the child friendly dentist pilot to be generally a good scheme and one which provides extra choice to children and families in a way that directly focuses on encouraging children and families to visit the dentist. We do believe however that the scheme could be further enhanced in some simple and low cost ways to make dentists even more child focused places and by promoting child friendly dentists more effectively to children and families.

3.11 We are recommending that the Child Friendly Dentist pilot be built upon by expanding the number of local dental practices who wish to become 'Child Friendly', by promoting the child friendly dentists more actively in places where children and families will notice and by asking dentists who have previously been, or in future would like to be known as 'Child Friendly' to provide clearly displayed "Child Friendly Dentist" logos and other promotional material in their window and anywhere else they advertise their services to the public.

Recommendation 8: Child Friendly Dentists
That dentists who would like to be known as 'Child Friendly' display a logo and appear on a list which is distributed to professionals, stakeholders and parents. These H&F dentists should gain the necessary paediatric training from Chelsea & Westminster Hospital and be encouraged to open at 'child friendly' times such as on Saturday mornings. In return their services could be promoted to families in the Borough.

3.12 The list of participating dental practices should be published and made available through children's centres, schools, nurseries, public libraries and other venues where parents and young children congregate, as well as through Community Champions and oral health events. A Child Friendly Dentist logo should be advertised by participating dental practices by display in their windows and on published materials.

Zara, aged 7 and a half

3.13 We believe a Child Friendly Dentist:

- Is an attractive and child centred place for children to come
- Has staff trained to deal with children
- Provides fun and educational things to do for children in the waiting room
- Opens after school and at weekends
- Displays the Child Friendly Dentist logo to let people know it's a Child Friendly Dentist.

3.14 Annual top up training and on going chairside mentoring should be provided to dental practices.

> ***"the opening times were during work/school hours when it should be opened later and/or weekends"***
> *Chikira Smith Richards aged 16*

3.15 A snap-shot survey was conducted during the inquiry by the Oral health Promotion Service of 29 local dental practices. Of the 29 practices surveyed, 16 were open on Saturdays and of these only 6 see children by appointment (for NHS treatment). These are:

- Batman Dental Practice, 1 Batman Close White City Estate, Shepherds Bush
- The Care Dental Practice, 118-120 Hammersmith Road, Hammersmith
- Fulham Dental Centre, 377 North End Road, Fulham
- Goldhawk Dental Practice, 9 Goldhawk Road, Shepherds Bush
- Ghauri Dental Practice, 1 Wormholt Road, Shepherds Bush
- NHS Dentist, 355 North End Road, Fulham.♥

10 of them were open on Saturdays for private patients only. All NHS dentists must be available to treat children as part of their NHS contract.

"Letters, emails or texts should be sent to young people reminding them to go to the dentist and explaining why going to the dentist is so important"

Julia Simons aged 15

♥ Oral Health Promotion Service, Central London Community Health Care NHS Trust - www.clch.nhs.uk

4. Partnerships

4.1 Central to the effectiveness of all of the projects and good work being carried out by the wide variety of different agencies and sectors involved in improving children's oral health is effective partnerships and co-ordination. As part of our evidence gathering we have made site visits to important examples of multi-agency collaboration around the Borough, such as the dental screening and fluoride varnishing project being run by the Normand Croft Early Years Centre and NHS Dentist in Fulham.

4.2 We would like to see even closer collaboration between the different agencies involved in a concerted effort to tackle children's oral health problems, building on the instances of best practice collaboration around the borough and with particular focus on identifying and targeting children and families most at risk.

Parents, Children and Young People

4.3 Parents and children are key partners in this themselves and engaging and involving parents and families will be key to getting the message across and changing the behaviours that will really impact on children's oral health. During our inquiry we engaged with parents and children at visits to local children's centres and health centres, including the Canberra Centre for Health, the Normand Croft School and children's centre and the White City Health Centre. It is important that parents and children themselves are engaged and involved in the children's oral health campaign.

4.4 During the inquiry we interviewed a focus group of young people from the Borough Youth Forum (BYF). They then held the same focus groups with young people from their school councils. Representatives from the BYF also attended our Children's Oral Health Forum. The BYF is a 'voice' for young people in Hammersmith and Fulham. They plan community based projects and initiatives, develop different methods to obtain and present the views of young people to decision makers, and they work with the Council and health services to give their opinion on policies, activities and services in the borough.

4.5 They told us that communications about dentists needed to be focused more on the youth populations and that more could be done to target where young people are, like schools and other places young people congregate. It is important also not to forget about the older children and teenagers, as most programmes focus on young children. Schools could use school newsletters to remind parents to make dental checks for their children during half term and school holidays.

Commercial Partnerships

4.6 We would also like to see the commercial sector involved, both suppliers of preventative care like Colgate toothpaste and local retailers. Kensington and Chelsea have partnered with Glaxo Smith Kline in a similar targeted campaign.

During the scrutiny inquiry we have interviewed representatives from Colgate, which may be able to assist in oral health promotion campaigns, both with resources and a wealth of expertise from the commercial sector.

Recommendation 9: Commercial Partnerships
It is recommended that a commercial operator in the field of dental care products, such as Colgate or Glaxo Smith Klien, be approached to sponsor report recommendations including (1) Keep Smiling and (5) Targeted Provision of Dental Health Packs.

4.7 In approaching a commercial operator for sponsorship and support we need to submit them with a project proposal detailing the assistance we will request from them.

Chuck Sweets Off the Checkout

Chuck Sweets Off the Checkout 2011
Facebook page

4.8 In 1992 a campaign called "Chuck Sweets off the Checkout!" was launched to campaign for supermarkets to voluntarily remove sweets and fizzy drinks from their checkouts and queue lines, as evidence suggested that this is deliberately aimed at encouraging impulse buying of high sugar snacks and drinks, especially to children•.

4.9 At the end of a shopping trip, children often nag their parents for the sweets, chocolates, crisps and soft drinks displayed at the checkout. Such tempting displays are deliberately placed where customers are a 'captive market' as they queue up to pay, activating pester power and increasing sales of snack products.

4.10 The campaign was run by Lona Lidington, a community dietician based in South West London. It was supported by the National Oral Health Promotion Group and also received funding from the Department of Health.

4.11 We agree with the principles of the campaign, that with big corporate business comes big corporate responsibility to the local community and we are asking the main supermarkets, as well as other local retailers, to remove the temptation to impulse buy by removing sweets and fizzy drinks from their check-outs and queues. We would like to see the Council and the PCT lead a local campaign to ask local retailers to play their part in reducing oral health decay, as well as the other related problems of child obesity and increased risk of diabetes, by reducing the amount of sugary snacks children consume.

• The Food Magasine, published by the Food Commission 2011 - www.foodmagazine.org.uk/articles/chuck_snacks_off_checkout

Recommendation 10: Chuck Sweets Off the Check-Out
It is recommended that supermarkets, high street shops and leisure centres be asked to play their part and to "chuck sweets off the checkout" as part of a local campaign to promote healthier diets.

4.12 This should include a written invitation to participate from the Cabinet Member and a public petition, which asks supermarkets and other high street retailers to join the local campaign by making sure sweets and fizzy drinks are removed to another part of the shop to discourage impulse buying of sugary snacks.

Sugar Free Education

4.13 During the inquiry we addressed at meeting of the Hammersmith and Fulham Head Teachers Forum, to talk and listen to head teachers from around the borough. We have also interviewed Jan Gouldstone – Senior Advisor Personal and Sexual Health Education (PSHE) and Citizenship / Healthy School Programme Co-ordinator. We have noted the widespread good practice and progress towards healthy schools and healthy diets in Hammersmith and Fulham schools. All schools have adopted school food policies and in most cases this includes the discouragement of sugary drinks and snacks in the canteen and at break times. Some schools seem to go further than others, especially in terms of enforcement of the policy, to include an effective ban on sugary drinks and snacks at pre-school breakfast clubs, in packed lunches and at after-school clubs.

4.14 We would like to see an effective ban on sugary drinks and snacks throughout the school period, including breakfast clubs and after-school clubs, where healthy alternatives could be readily available and encouraged. We would like to encourage schools, nurseries and children's centres sign up to Guidance issued by the Local Education Authority and the PCT.

4.15 Where possible we would like to encourage Healthy Tuck Shops to be established in schools where pupils can purchase healthy food and drinks to make sure alternatives are available and to discourage purchase of unhealthy alternatives from local retailers or from being brought in.

The School Dentist

4.16 If children do not come to the dentist we need to bring the dentist (or other health professionals) to the children, with more assertive outreach to make sure that every child receives some kind of oral health check to flag up oral health problems and make referrals and to encourage more children to be registered and to visit the dentist.

"Target schools, i.e. do projects on bad teeth and include sessions in either science or PSHE" *Chikira Smith Richards, aged 16*

4.17 There is already work underway to promote oral health and dental services in some children's centres, health centres and schools and we would like to see this good practice expanded to provide more oral health screening, fluoride varnishing and referrals to local dentists in these community based settings. This includes making links between local dental practices and children's centres, nurseries and schools and bringing the local dental practice and oral health promoters physically into these settings.

4.18 We believe that all schools should establish links with at least one dental practice and that wherever possible programmed Oral Health Days should take place in each school at least once a year. Where it is not possible for a local dental practice to make school visits then either the Community Dental Service could be requested to visit the school or arrangements made with local dental practices to arrange school trips to the dentist.

Brushing Teeth

4.19 NHS advice is for people to brush their teeth twice a day at least two minutes in the morning and last thing at night before going to bed[♠]. When we have a situation where some children are not brushing their teeth at all, it could help if children had the opportunity to brush their teeth at school, nursery and children's centre. In fact, cleaning teeth should be part of a child's health, hygiene and grooming routine.

> *"Supervised tooth brushing programs in childcare settings have achieved up to 40 percent reduction in tooth decay*
>
> *Evidence based oral health promotion, Dept. of Health, Australia*

It is suggested that schools, nurseries and children's centres could run teeth brushing demonstrations where children complete their own personal record chart at home and bring it into school as part of the 'Keep Smiling' programme.

Piloting the Way

4.20 We would like to see more opportunities for dental health professionals to carry out dental health screenings and fluoride varnishing in children's centres and schools and other child and family settings, especially in targeted "high risk" and relatively deprived areas of the Borough.

> ***"I think the dentist visiting my school is convenient/quick. … I think that awareness of this should be raised and everyone should take part in how it works"***
>
> *Heanguen Chi, aged 16*

4.21 To lead the way on this, we have asked schools and children's centres to volunteer to pilot as centres for integrated oral health action, which could include

[♠] www.nhs.uk/Livewell/dentalhealth/Pages/Teethcleaningguide.aspx

participation in the Children's Oral Health Campaign, fluoride varnishing projects, bringing school classes to the dentist or vice versa, forging links with local dental practitioners and the availability of teeth cleaning facilities. Schools including Randolph Beresford, Bentworth, St Stephens and The Oratory have already agreed to 'pilot' the programme. Other schools and children's centres, particularly within more deprived areas of the borough, should be encouraged to join in. Pilot programmes should be tailored to the local needs of schools.

Recommendation 11: Schools and Children's Centres
It is recommended that schools, nurseries and children's centres implement a range of the following measures:

i. gain parental consent for dental inspections and fluoride varnishing
ii. supervised tooth brushing
iii. the use of a chart for children to record teeth brushing at home
iv. the school nurse to provide oral health advice and sign-post at-risk families to dentists during the universal age 4-5 health check and at later dates
v. a fluoride varnishing programme
vi. a more proactive Healthy Food Policy, including the provision of healthy snacks (fruit, water, etc) as well as a prohibition on sugary products
vii. making water available throughout the day
viii. establish links with at least one dental practice and take school classes to the dentist or bring the dentist into school
ix. inclusion of oral health care education in the school curriculum
x. oral Health educational events for children and parents.

GPs and Medical Centres

4.22 Integrated health services help patients navigate the appropriate pathways through the NHS health care system, improving information and choice and identifying potential health concerns at an early stage. Although General Medical Practitioners (GPs) often do an excellent job in informing and referring patients with general health concerns, there is often no link between GPs and medical centres and dental practitioners. This could result in unnecessary gaps in patient referral to a dentist and there may be occasions where a GP may easily highlight potential concerns and refer a patient to a dentist, or ask if a child is registered with a dentist as part of all round family health advice.

4.23 GP waiting rooms could also do more to inform patients about local dentists and improve awareness of the importance of children's oral care, as one of the key community settings where people find out about local health services.

Recommendation 12: 'Keep Smiling' Oral Health Campaign for Professionals - Using Professionals to Influence Behaviour
It is recommended that GP medical practices improve their links with dentists and that other professionals who are able to pass on oral health advice be trained by the Oral Health Promotion team.
Professional groups include:

- Teaching staff and learning mentors
- Social Workers
- School Nurses
- Health Visitors
- Youth Services
- Midwives
- Child-care workers and child-minders.

Service specifications for relevant professionals, including health visitors and school nurses, should be amended to include oral health actions.

4.24 During the inquiry we addressed a meeting of the School Nurses Forum to engage with school nurses in the children's oral health agenda and to listen to their ideas. We believe that school nurses can play an important role in educating children about oral health and signposting services. The Chairman of the Task Group will write to the Chairman of the GP Consortia, requesting an opportunity to address a meeting to present the findings of this inquiry and to broach the subject of inter-agency health linkages.

4.25 Existing 'Oral Health Promotion' capacity can be used to train the above list of professionals.

Maternity and Early Years

4.26 The Personal Child Health Record or "Red Book" is a guide issued to new mothers on the key stages of infant growth, development and health services. At the moment, oral health development and dental services are apparently missing from the current edition. Yet we believe that this stage is an important early opportunity to highlight children's dental health.

> *"Good oral health is important in preschool children. Evidence shows that poor dental health can have a serious impact on health and wellbeing"*
>
> *Navdeep Pooni - Oral Health Promoter, Central London Community Health Care NHS Trust*

Recommendation 13: Maternity and Early Years
It is recommended that health visitors and midwives be trained to provide oral health advice to new parents on the key stages of infant oral health development and health services, Key stages include a child's first tooth and registration from age from age 1 with a local dental practice, free NHS dental treatment for new and pregnant mothers and children and health advice on avoiding "teat bottles" and sugary liquids and foods.

> *Home visits using primary health workers who integrate oral health promotion into their general work may be as effective as employing specialised oral health promoters*

Evidence based oral health promotion, Dept of Health,

Service Specifications and Monitoring

4.27 It is important to make sure that the strategies and programmes we are rolling out are making a difference on the ground and to make sure that the programmes are being effectively integrated within the mainstream service provisions across all partner agencies involved. We suggest that within the service specifications for commissioned children's services there are elements for school nurses, health visitors and oral health and that that there are specific mechanisms for monitoring these.

5. Water Fluoridation

> *"Community water fluoridation is safe and cost-effective and should be introduced and maintained wherever it is socially acceptable and feasible"*
>
> *World Health Organisation Expert Committee on Oral Health Status and Fluoride Use, Fluorides and Oral Health*[♣].

5.1 Applying fluoride to teeth can help prevent tooth decay. Fluoride protects the teeth by inhibiting the demineralisation of teeth enamel, which causes tooth decay caused by the action of bacteria in the mouth producing corrosive organic acids and thus helps to protect against tooth decay and the development of tooth cavities.

5.2 There are many ways in which fluoride is used to provide protection for teeth, principally by the application of fluoride toothpaste, which is common in most high street brands of toothpaste. Dentists and dental health nurses can also apply fluoride through fluoride varnishing. Another method sometimes used to apply fluoride is through water fluoridation.

5.3 During the inquiry we interviewed representatives from Thames Water to discuss the pros and cons and feasibility of water fluoridation in London.

What is Water Fluoridation?

5.4 Water fluoridation is the controlled addition of fluoride to a public water supply, which is used in some parts of the UK and some countries to reduce tooth decay. Fluoridation does not affect the appearance, taste or smell of drinking water. Fluoridated water operates on tooth surfaces: in the mouth it creates low levels of fluoride in saliva, which reduces the rate at which tooth enamel demineralises and increases the rate at which it remineralises in the early stages of the development of tooth cavities.

5.5 There is a great deal of evidence that water fluoridation prevents cavities in both children and adults[♦] with some studies estimating an 18–40% reduction in cavities when water fluoridation is used by children who already have access to toothpaste and other sources of fluoride Centres for Disease Control and Prevention[♥].

♣ *WHO Technical Report Series No. 846.* Geneva: World Health Organisation 1994

♦ Parnell C, Whelton H, O'Mullane D. Water fluoridation 2009

♥ - Recommendations for using fluoride to prevent and control dental caries in the United States 2007

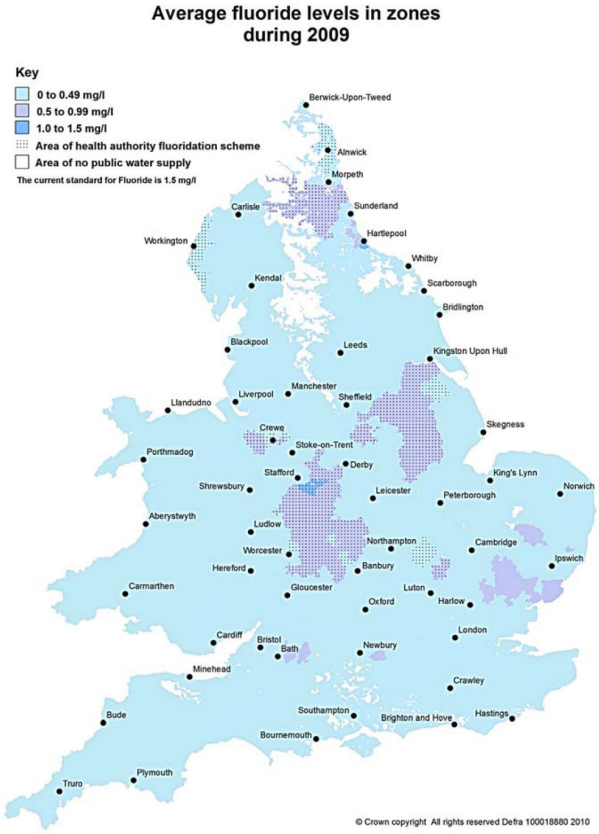
The Case for Water Fluoridation

5.6 One way of measuring the effectiveness of water fluoridation is to compare the rate of tooth decay in areas that have fluoridated water to unfluoridated areas. Comparing Manchester and Birmingham, which have similar levels of deprivation, gives one indication of the effectiveness of water fluoridation on reducing tooth decay. In one study, Birmingham, which is fluoridated, had a 0.98 dmft rate compared with 2.47 dmft in non-fluoridated Manchester[♠].

5.7 In the NHS Dental Survey of twelve year olds in 2008-09, the average dmft for 12 year olds in the Heart of Birmingham PCT was just 0.61. Five year olds in Manchester have the second highest dmft in the country. Fluoridated Sandwell near Birmingham has lower than the national average and five year olds from the Heart of Birmingham had higher than national rates of dmft, but were below those from Manchester[•].

5.8 The diagram below shows the areas of England with water fluoridation and water fluoridation levels.

Figure Source: DEFRA



♠ British Fluoridation Society - *One in a million:. The facts about water fluoridation*. 2nd edition

• Source: NHS Dental Epidemiology Survey, from evidence submitted by Inner North West London PCTs

The Case Against

5.9 There is no clear evidence of significant adverse effects of water fluoridation on public health. Over consumption of fluoride has been shown to cause a condition know as “dental fluorosis” in some cases, which can alter the appearance of developing teeth, but this condition is usually mild and not usually considered to be an aesthetic or public-health concern.

5.10 There are however significant concerns raised by those who deem water fluoridation treatment as “mass medication”, over the diminution of individual choice in favour of the state ascribed public health benefits to the wider population. This is, however, not an issue unique to water fluoridation, as water companies already have to treat water supplies in various ways in response to intermittent public health issues and maintaining the quality of the water supply.

The Costs

5.11 Water fluoridation is a public health measure to improve dental health and at present it is paid for entirely by the National Health Service; locally, the health authority is billed by the water company for the entire cost of fluoridating supplies. Current changes in legislation may, however, involve local authorities becoming responsible for some of the costs of fluoridation.

Governance

5.12 Under current legislation, Strategic Health Authorities (SHAs) have the duty to initiate the move to water fluoridation with public and stakeholder consultation. The Health and Social Care Bill currently passing through Parliament is expected to abolish SHAs and introduce new arrangements for instigating and consulting on possible water fluoridation of an area.

5.13 It is most likely that the new arrangements will require local authorities to initiate moves towards water fluoridation in their area. Thames Water supplies and treats water to most of London, including Hammersmith and Fulham and to areas outside of Greater London. It is not possible to introduce water fluoridation in one area of Thames Water supply and treatment without affecting the levels of fluoride in adjoining areas.

The Next Steps

5.14 Because the supply of water in the Thames Water area will affect several local authority areas both within and outside of Greater London, this is likely to require the consent of nearly all London boroughs, neighbouring local authorities and possibly the Greater London Authority. A widespread public consultation and feasibility study would also be required. So even if a wide consensus is built to introduce water fluoridation in the Thames Water area, it is not likely to happen any time soon.

5.15 From our preliminary inquiry into water fluoridation we have found that there is a great deal of evidence to suggest that, as one part of the overall strategy, it could make a significant contribution to protecting children's teeth against decay. We are therefore recommending that the Council considers in more detail the political, financial and public health implications of water fluoridation and upon the basis of this, seeks to build a coalition, firstly with Westminster, Kensington and Chelsea and then London wide.

Recommendation 14: Further Consideration of Water Fluoridation
It is recommended that the Council considers the political, financial and public health implications of water fluoridation and seeks to build a coalition of councils and health partners to instigate possible public consultation on the introduction of water fluoridation in the future.

5.16 It is suggested that this issue be debated at a meeting of the full Council in 2011.

6. Implementation and Evaluation

6.1 It is requested that, should agreement be gained for implementation of the Task Group's recommendations, mechanisms are put in place to monitor implementation of the agreed recommendations and resulting outcomes. Implementation of the report's recommendations should be monitored on a regular basis and from an early stage. Outcomes will take longer to become clear, and it is therefore suggested that these are measured over a longer time-frame.

Implementation of the Task Group's recommendations

6.2 It is requested that H&F Council and the PCT produce a joint 'Action Plan' detailing how and when the agreed recommendations will be implemented. The Action Plan should detail, for each agreed recommendation (executive decision): the agreed hypothecated budget and resources, an implementation timetable (including when it will happen and when it will be fully in place) and key measurable outputs.

6.3 It is requested that a brief progress report on implementation be made to the Task Group Chairman on a quarterly basis for (a minimum of) twelve months, to assess the success of the role-out of these proposals against the Action Plan. At the end of this time (after 12 months) it is requested that a review of implementation is undertaken at a meeting of the Education Select Committee and their findings reported to the Overview and Scrutiny Board and to Cabinet.

Outcomes: the impact of reforms upon child oral health in H&F

6.4 The best way of measuring improvements would be to carry out a borough-wide screening programme for dmft in 2011, followed by later screenings. This would be hugely expensive to deliver however, and the Task Group considers practical prevention actions to be a more cost effective use of limited budget. This is especially the case given that proxy measures including obesity and poverty can be used to effectively target at-risk population areas.

6.5 Progress can therefore be assessed in the following ways:

a. The number of H&F admissions to C&W hospital for paediatric dental care — *year-on-year*

b. The number of paediatric 'non-prevention' treatments carried out in H&F NHS dental surgeries — *year-on-year*

c. Levels of dmft amongst H&F children when next sample measured on a London-wide basis. — *vs 2007/8*

Appendix One

Witnesses

The following people and groups were interviewed during the scrutiny inquiry:

Hammersmith and Fulham Council	
Councillor Helen Binmore - Cabinet Members for Childrens Services	Hammersmith and Fulham Council
Councillor Joe Carlebach – Cabinet Member for Community Care	Hammersmith and Fulham Council
Councillor Donald Johnson - Chairman of the Education Select Committee	Hammersmith and Fulham Council
Andrew Christie – Director of Children's Services, London Borough of Hammersmith and Fulham	Hammersmith and Fulham Council
Carole Bell, Assistant director, Commissioning, Performance & Partnerships,	Hammersmith and Fulham Council
Jan Goulstone - Senior adviser PSHE and citizenship / Healthy School Programme coordinator, School Improvement and Standards, Children's Services Department, London Borough of Hammersmith & Fulham	Hammersmith and Fulham Council
	The Children's Trust Board, Hammersmith & Fulham
The Department of Health	
Barry Cockcroft - Chief Dental Officer for England	The Department of Health
The Borough Youth Forum - Hammersmith and Fulham	
Brenda Whinnett - Children & Young People's Officer	Hammersmith and Fulham Council
Josie Durley (aged 15) – Borough Youth Forum Representative	The Borough Youth Forum
Fred Gill (aged 15) – Borough Youth Forum Representative	The Borough Youth Forum
Julia Simons (aged15) – Borough Youth Forum Representative	The Borough Youth Forum
Mustafa Hussein (aged 16) – Borough Youth Forum Representative	The Borough Youth Forum
Chikira Smith Richards (aged 16) – Borough Youth Forum Representative	The Borough Youth Forum
National Health Service (NHS)	
Claire Robertson - Consultant in Dental Public Health	North West London Primary Care Trusts
Marie Trueman Children's Commissioning Manager	Inner North West London Primary Care Trusts

Julia Mason - Children's Commissioning Manager	North West & North Central London Westminster PCT
Christine Mead - Self Care Development Manager	Hammersmith & Fulham PCT
Navdeep Pooni - Oral Health Promoter Hammersmith and Fulham	Inner North West London Primary Care Trusts
Jennifer Allan - General Manager, Paediatrics	Chelsea and Westminster NHS Trust
Kate Barnard - Consultant in Paediatric Dentistry	Chelsea and Westminster NHS Trust
Helen Byrne - Interim Divisional Director of Operations	Chelsea and Westminster NHS Trust
Victoria Wilson - Senior Dental Nurse	Chelsea and Westminster NHS Trust
Huda Yusef - Specialist Registrar Dental Public Health	Inner North West London Primary Care Trusts
Kelly Nizzer - Senior Contracts Manager Dental, Pharmacy and Ophthalmic Services	NHS North West London

Community and Voluntary Organisations

Malika Hamiddou – the Community Interpreting	Translation and Access Service (CITAS)
Suzanne Iwai – Community Health Champion (White City)	
Saumu Lwembe - Stakeholder Development Officer (manages health champions and health trainers) Koss Mohammed White City Volunteer Coordinator Lornia Polius – Community Health Champion (White City)	Well London

Commercial Sector

Colgate (Colgate Palmolive UK Ltd)	
Rhona Wilkie (Colgate Professional Relations Manager)	Colgate Palmolive UK Ltd
Anousheh Alavi (Colgate Scientific Affairs Manager UK & Ireland) - Colgate Palmolive UK Ltd	Colgate Palmolive UK Ltd
Elizabeth Sale Local & Regional Government Liaison Manager	Thames Water
Steve White - Drinking Water Strategy Manager.	Thames Water

Dentists

Henrik Overgaard-Nielsen – Chairman of the Ealing, Hammersmith and Hounslow Local Dental Committee	NHS Dentist, Fulham.
Dr Denis Chan – H&F dentist	

National Dental Associations

Paul Ashley	British Society of Paediatric Dentistry

Schools

Michele Barrett – Head Teacher - Vanessa Nursery School

Marie Thomas – school nurse	School Nurses Forum
	The Head Teachers' Forum – Hammersmith and Fulham
	The School Nurses Forum – Hammersmith and Fulham

Health Visitors

Angela Ainslie –
health visitor

Pamela Tynan –
health visitor manager (White City)

Accademics

Professor Aubrey Sheiham	Dept of Epidemiology and Public Health at University College London (UCL)

National and International Best Practice

Child Smiles

Ray McAndrews	Glasgow PCT

Site Visits

School visits
the Old Oak Children's Centre
Normand Croft School and Children's Centre
The British Dental Association

Appendix Two

Budget Implications

a) Direct Costs Associated with the Existing Problem

Before looking at the details of proposed resources for intervention, we should consider the existing costs of the problems we have; all of which are in principal, entirely avoidable through intervention and education.

The table below outlines some of the main direct financial costs to the NHS for teeth extractions and fillings in hospital and at dental practices.

	Cost			
Problem	**10-11**		**Cost Detail**	**Budget Holder**
C&W Hospital 'New Appointments & Admissions' for H&F patients (2010/11)	£354,024		Outpatient Appointment (New or Follow-Up) £156. Daycase Admission £912 C&W take circa 95% of H&F paediatric admissions [CR]	PCT
Primary Care treatments (non-prevention, including extractions) in H&F [2010-11]	£1,700,000		Request from business services authority. No of extractions and their cost. CR to find.	PCT. Delegated to NW Lon Primary Care Team, on behalf of H&F
	£2,054,024			

b) Costs Associated with Proposals [Excluding Utilisation of Existing - Budgeted For - Resources)

	Cost			
Proposal	**11-12**	**12-13**	**Cost Detail**	**Budget Holder**
Getting the Message Across				
Keep Smiling	£3,000	£3,000	Design and printing costs. Colgate happy to contribute.	Public Health / Commercial Sponsor.
Review of Oral Health Information and Advice	£0	£0		
Targeting & Outreach				
Targeted Fluoride Varnishing Programme	n/a	£50,000	2 applications of FV for 5,000 children	PCT
Community Champions and Health Advocates	£0	£10,000	Additional CC's and HA's. Oral health training for both groups.	Public Health.
Targeted Provision of Dental Health Packs	£1,000	£3,000	11-12 beakers to be provided and paid for by the council or Public Health. Subsequent provision of all to be sponsored by corporate partner. Business case to be made to PCT for ongoing BFL pack budget.	Council / Commercial Sponsor / PCT
Targeted Support for Children in Care	£0	£0	BFL packs provided by corporate partner.	
Targeted Support for Children with Special Needs	£0	£0		
Dentists				
Child Friendly Dentists	£0	£0	C&W training already within budget if taken in dentist's own time.	
Partnerships				
Commercial Partnerships	£0	£0	Will provide funds	Commercial partner

Chuck Sweets Off the Check-Out	£0	£0		
Schools and children's centres	£0	£0	Costs budgeted for in other proposals	
Keep smiling - for professionals	£0	£10,000	Training from Oral Health Promoter. Use budgeted Oral Health Promotion capacity in 11-12 and make business case to PCT for expanded program in 12-13.	Public Health
Maternity and Early Years	£0	£0		
Service Specifications	£0	£0		
Water Fluoridation				
Further Consideration of Water Fluoridation	£0	£0		
Programme Manager				
Program Manager	£0	£0	From existing capacity within Children's Services. Support from PCT and ongoing 'scrutiny' function.	Council

TOTAL COSTS	**£4,000**	**£76,000**
Proposed costs as % of current direct costs of poor oral health	1%	4%

	BUDGET	
BUDGET HOLDER	**11-12**	**12-13**
PCT / Public Health	£3,000	£76,000
Council	£1,000	£0
Commercial Partner	£0	N/A
Other	£0	£0
Totals	£4,000	£76,000

Acknowledgements

Thank you to everyone who has given up their time to support this Scrutiny Task Group, including Claire Robertson of North West London PCTs, Carole Bell of Hammersmith and Fulham Council and the young people at the Borough Youth Forum. Thank you to everyone who has participated by speaking to us at our numerous visits around the Borough and filled in our questionnaires.

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