Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Plant a Phobl Ifanc
The Children and Young People Committee

Dydd Iau, 13 Hydref 2011
Thursday, 13 October 2011

Cynnwys
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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Christine Chapman	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Jocelyn Davies	Plaid Cymru The Party of Wales
Suzy Davies	Ceidwadwyr Cymreig Welsh Conservatives
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Simon Thomas	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

David Davies	Gwasanaeth Deintyddol Cymunedol Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Abertawe Bro Morgannwg University Local Health Board Community Dental Service
Mary MacDonald	Uwch Swyddog Iechyd Cyhoeddus (Ysgolion Iach), BILl Hywel Dda Senior Public Health Officer (Healthy Schools), Hywel Dda LHB
Carol Maher	Ymarferydd Ysgolion Iach Bro Morgannwg, Iechyd Cyhoeddus Cymru Vale of Glamorgan Healthy Schools Practitioner, Public Health Wales
Paula Roberts	Ymarferydd Ysgolion Iach, Cyngor Sir Dinbych Healthy Schools Practitioner, Denbighshire County Council

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Claire Griffiths	Dirprwy Glerc Deputy Clerk
Sarah Hatherley	Gwasanaeth Ymchwil Research Service
Claire Morris	Clerc Clerk

Dechreuodd y cyfarfod am 9.15 a.m.
The meeting began at 9.15 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Christine Chapman:** Good morning and welcome to the Children and Young People Committee. I remind you that all mobile phones, BlackBerrys and pagers should be switched off. The National Assembly operates through the medium of the Welsh and English languages. Headsets are available for simultaneous translation, which is on channel 1, and sound amplification, which is on channel 0. As this is a formal public meeting, Members do not need to operate the microphones themselves. In the event of an emergency, an alarm will

sound and ushers will direct everyone to the nearest safe exit and assembly point.

[2] We have received a number of apologies this morning from Angela Burns and Lynne Neagle, and I understand that Keith Davies is sitting in on another committee.

9.16 a.m.

Ymchwiliad i Iechyd y Geg mewn Plant: Sesiwn Dystiolaeth
Inquiry into Children's Oral Health: Evidence Session

[3] **Christine Chapman:** We are taking evidence from Public Health Wales. This is the final oral evidence session for the committee's inquiry before we scrutinise the Minister for Health and Social Services on our findings. I welcome David Davies from Abertawe Bro Morgannwg University Local Health Board community dental service. Members will have read your paper; thank you for that. Are you happy to go straight into questions, or would you like to say a few words to start?

[4] **Mr Davies:** I would like to say a few words, if I may. It might help you to know a little bit about my background, my experiences and how I came to be here. My name is David Davies, as you know. I am Welsh; I was born in Llandovery and my family all come from the Carmarthen area. We moved to Swansea when I was three, where I have lived ever since, so I know the area pretty well. I received my secondary school education in Penlan Comprehensive School in Swansea and graduated in dentistry from Cardiff in 1978. After that, I gained experience in general practice, in the community dental service, in the hospital service, back into practice and then the community dental service again. Over the time that I have been in dentistry, I have developed interests in several areas, particularly special care dentistry, and my role now involves the provision of dental care for vulnerable people of all age groups—not just children, but adults as well. I have found my involvement with the Designed to Smile initiative really quite interesting, because, in my time in practice, I have always sought to try to understand why people need treatment and how we can best help them. Not all people are able to seek treatment for themselves, because of their particular vulnerability and various health inequalities, and I feel that this knowledge has helped me to be able to support the Designed to Smile initiative.

[5] **Christine Chapman:** We have a series of questions and we are very interested in your experience and perspectives on this, Mr Davies. I will start with the first question. As you know, the Designed to Smile programme was first introduced in 2008. It was extended across Wales in late 2009, early 2010. Do you have any anecdotal evidence to support the view that child dental health in your area is improving as a result of the programme?

[6] **Mr Davies:** I have spoken to a few people who visit schools and dental offices during school screenings and they have noticed an apparent improvement in the oral health of the children they have seen. A few of the Designed to Smile programme staff have commented that, when they go back and forth to schools to carry out supervised tooth brushing, they have noticed an improvement in the oral hygiene of the children that they see. A few of the children's teachers have commented that the children are much keener to clean their teeth these days. Formerly, with many of them, it was a relatively alien experience. Unfortunately, I know that it sounds incredible, but a lot of the vulnerable children that we see do not possess toothbrushes. Oral health is not a priority in their backgrounds. So, brushing teeth is a novel experience for many of them.

[7] **Jocelyn Davies:** A number of people have mentioned to us the issue of general anaesthetic because it is generally used to extract the teeth of young children. Would the number of cases where general anaesthetic has been used, overall, be a good indicator of how successful the programme is?

[8] **Mr Davies:** Yes, I think so. I have a particular interest in managing people who have some form of vulnerability, including disproportionate dental anxiety, which is a rather grand way of saying that they are scared stiff of having dental treatment. A lot of people are scared—young children in particular. Wherever possible, we try to manage them using conscious sedation techniques but, sometimes, the volume of treatment that a lot of young children need is too much. We have to resort to general anaesthesia. In Abertawe Bro Morgannwg University Health Board, we are currently seeing about 1,700 children a year having a general anaesthetic. One of the ways that I gauge the success of my conscious sedation programme is to see a fall in the number of people referred for general anaesthetics. So, likewise, if the Designed to Smile programme is effective, we will see a fall in the number of people being referred full stop.

[9] **Jocelyn Davies:** So, you would accept that that would be a good indicator of success and a robust measure. The number of general anaesthetics is an easy thing to count because there will be clear records of how many times a general anaesthetic has been administered. It is an easy thing to count, but does that necessarily mean that it is a good indicator of how successful the programme is?

[10] **Mr Davies:** It is an indicator. You have to be careful how you interpret it, because some dentists may plan for treatment differently to others, so, one dentist, for example, might plan for a patient to receive treatment under general anaesthesia where that treatment could have been provided using conscious sedation.

[11] **Jocelyn Davies:** It might be to do with the disposition of the individual, as you say, a fear of the dentist perhaps, rather than the need for a general anaesthetic.

[12] **Mr Davies:** It could be both. I think it would be a useful indicator, but I think that you would have to draw up a robust means of looking at these indicators first and decide what your criteria are going to be for measuring outcomes.

[13] **Aled Roberts:** Byddaf yn gofyn fy nghwestiwn yn Gymraeg.

Aled Roberts: I will ask my question in Welsh.

[14] **Mr Davies:** I used to be able to speak Welsh until I moved to Swansea. [*Laughter.*]

[15] **Aled Roberts:** We will have to get you back to the language.

[16] Yn eich barn chi ac yn eich ardal chi, a ydych yn credu bod Cynllun Gwên yn mynd i gael effaith sylweddol ar ddannedd plant yn yr ardaloedd mwyaf difreintiedig? Yr wyf yn cyfeirio'n benodol at bydredd dannedd a llwyddiant y cynllun.

In your opinion and in your area, do you believe that the Designed to Smile programme is going to have a significant impact on children's teeth in the most deprived areas? I am referring specifically to tooth decay and the success of the scheme.

[17] **Mr Davies:** Yes, I do. In my time working in Swansea, I have not seen any real fall in the level of decay in children's teeth and it has been rather depressing. Despite all my efforts, nothing much has happened. The Designed to Smile team that we have in Swansea is very committed. I cannot imagine a nicer, more conscientious bunch of people working with children. The anecdotal evidence that I have seen so far indicates that they are going to achieve that. In the past, we have had to refer children for treatment under general anaesthesia and, very often, the mother of the child will turn around and say, 'That's okay, I had my teeth out the same way'. Unless the Designed to Smile programme continues, it is inevitable that we are going to see an occasion where a child, a mother and a grandmother will all sit in the same room and say that they had their teeth out the same way.

[18] We are looking at vulnerable people who do not know any different. We must alter their lifestyle, basically, but we cannot do that from a clinical point of view. A dentist cannot do that. That can only happen by addressing oral health inequalities via a programme such as Designed to Smile. I am sure that Designed to Smile will do that.

[19] **Jocelyn Davies:** I want to ask a question based on your huge experience. I do not just clean my teeth for the sake of my teeth, but because I could not stand not to have my teeth cleaned. Anyone who has stayed away overnight and forgotten a toothbrush will know that it is a horrible feeling. So, why would adults not clean their teeth? After all, it is not just about looking after your teeth, but because you feel more comfortable with clean teeth.

[20] **Mr Davies:** That has always puzzled me, but it is partly because people do not know any different. I can offer some personal evidence here by saying that my first experience of going to the dentist was to have several teeth out, and, by the time I was 10, I had lost quite a few baby teeth and four second teeth. That was not due to neglect on the part of my parents; it was just the way that we were brought up. We just did not know any different. I was never taught to clean my teeth until I started losing teeth and then something must have clicked. A lot of the people who I see come from a background of never being told to clean their teeth. So, that is why we have to go out to help those people via health improvement initiatives, such as Designed to Smile. It is about altering lifestyles.

[21] **Jocelyn Davies:** Is there also a feeling that a child is going to lose their baby teeth anyway, so there is no need to look after them because another lot will be coming along?

[22] **Mr Davies:** Yes. That is an unfortunate and erroneous view that ought to be corrected.

[23] **Aled Roberts:** Yn eich tystiolaeth, dywedwch fod angen mynd i'r afael ag anghenion plant difreintiedig mewn ardaloedd mwy cefnog. A yw'r cynllun hwn yn gwneud hynny?

Aled Roberts: In your evidence, you state that there is a need to address the needs of deprived children in more affluent areas. Does this scheme do that?

[24] **Mr Davies:** There is a misconception that because someone lives in a more affluent area, such as Sketty or the Mumbles in Swansea, they will have better teeth than people who live in less affluent areas. However, that is not the case. One possible weakness of the programme is that, because we are looking to go into designated deprived areas, we might be missing children in other areas who could benefit from our help, and that will grow as time passes. A lot of the schools are learning that the Designed to Smile programme is valuable and could help them, and we are therefore being approached to go into other areas as well as the designated areas that we have already been into. So, as time goes by, we will reach the other less deprived areas, where there are pockets of deprivation.

[25] **Aled Roberts:** Are you able to do that?

[26] **Mr Davies:** We try to build a degree of flexibility into our programme. We have targeted certain schools and our team never turns away a group that approaches us, whether that is a children's group or an ethnic minority group. So, we often seek to provide help and advice to other groups that approach us, and, as far as possible, we build that into our working programme and try to operate within our budget to do that.

[27] **Aled Roberts:** A yw hynny'n batrwm ar draws Cymru, ynteu eich bwrdd iechyd chi yn unig sy'n dilyn y polisi

Aled Roberts: Is that a pattern across the whole of Wales, or is it just your health board that is following that policy?

hwnnw?

[28] **Mr Davies:** I would hope that it is a pattern across Wales, but I cannot comment because I do not have any knowledge of that.

9.30 a.m.

[29] **Suzy Davies:** My question refers to something that you mentioned in your report regarding the promotional programme for six to 11-year-olds, but it is on the same point. You say that,

[30] ‘Teaching sessions have been provided not only to those schools and nurseries taking part in the tooth brushing part of the scheme but also for many others who are not involved, making a total of 140 settings participating in this programme.’

[31] Who are the people who are not involved? I am not quite sure what you mean by that. Are we talking about Designed to Smile or the community dental service?

[32] **Mr Davies:** It can be both. My service relies a lot on people who look after vulnerable people to provide care. For example, many of my patients are adults with learning disabilities who cannot speak for themselves and are highly dependent upon carers. I have to liaise with those carers in order to bring the patients into the clinic and to be able to communicate with them, to treat them and to ensure that they receive appropriate after-care. So, we look to work with all sorts of groups of people who support vulnerable people, and that includes children. As part of the Designed to Smile programme, we are very keen to develop working initiatives with all sorts of groups. So, if we are ever approached by a group, we always try to get involved because it could lead to all sorts of beneficial arrangements in the future.

[33] **Suzy Davies:** How do those other groups find out about you? The suggestion is that Designed to Smile seems to go through the obvious channels, such as schools and playgroups, so how do these people know about you?

[34] **Mr Davies:** The main way is through word of mouth. There has not been a huge amount of coverage in the popular press. It is largely through word of mouth and the good work of our team. They really are a very accessible team. They make themselves well known, they are very friendly and people talk to them.

[35] **Simon Thomas:** Mae’n glir o’ch tystiolaeth ysgrifenedig a’r hyn yr ydych wedi ei ddweud hyd yn hyn bod delio gydag iechyd y geg yn dibynnu ar ymyriadau cymdeithasol. Hoffwn droi hynny ar ei ben a gofyn ichi am fynediad at ddeintyddion mewn ardaloedd difreintiedig. Mae tystiolaeth lafar sy’n awgrymu ei bod yn anodd denu deintyddion i ardaloedd o’r fath. Er mwyn sicrhau bod Cynllun Gwên a’r holl gynlluniau yn gweithio yn iawn, mae’n rhaid cael deintyddion yn yr ardaloedd hynny yn ogystal â chynlluniau megis Cynllun Gwên. Mae’n rhaid sicrhau bod deintyddion ar gael ar stepen y drws i bobl yn yr ardaloedd mwyaf difreintiedig.

Simon Thomas: It is clear from your written evidence and from what you have said so far that dealing with oral health depends on social interventions. I would like to turn that on its head and ask you about access to dentists in deprived areas. There is anecdotal evidence that suggests that it is difficult to attract dentists to work in such areas. To ensure that Designed to Smile and all the other schemes are working properly, there must be dentists in those areas in addition to schemes such as Designed to Smile. It is vital to ensure that dentists are available on the doorsteps of people in the most deprived areas.

[36] **Mr Davies:** Yes, it would certainly be very helpful. The community dental service has a finite budget and we would like to be able to treat everybody, but, unfortunately, we cannot do that. Wherever possible, we seek to work with our colleagues in the general dental services in high street practices and accept patients from them. However, we also refer patients to them whenever we can. Many of our patients are vulnerable. For example, there may be a family in which there is a disabled child, but the other children may be perfectly normal. It is much more acceptable then if the whole family goes to a dentist. So, we like to build up working relationships with them.

[37] There are areas in Swansea and Neath and Port Talbot, such as the Afan valley, for example, where the availability of dental services is quite limited. We try to target our services there and, wherever possible, we work with general dental practitioners. We have a clinic in Cymmer, for example, where a general dental practitioner visits one day a week, and we try to work with them. However, very often, general dental practitioners may have contractual limitations in terms of the number of units of dental activity that they have available to take on new patients. So, it can be difficult for some people seeking treatment. Unfortunately, many of the vulnerable people we see have a habit of not going for dental treatment until they are in pain, by which time they find it more difficult to get seen. It is not always easy to arrange treatment for them then.

[38] **Simon Thomas:** You talked earlier about word of mouth being important to your service, but it is also true with regard to making a visit to the dentist a regular habit. There is obviously a culture of not going to the dentist in certain areas, or among certain groups of people. It would be useful for there to be a greater dental reach so that it could become more ingrained in a local culture that you do go to the dentist. Clearly, that must be one of the things we should be looking at.

[39] **Mr Davies:** Yes. Part of the Designed to Smile role—and, I think, a very important part—is raising awareness of the benefits of good oral health, but also of the role of the community dental service. It makes people aware that we exist. A lot of people do not know that. There is a great deal of confusion among the public about exactly what dentists do, what the hospital services do, what general practitioners do, what the community dental service does and how you get seen by a dentist. A lot of people just do not know. A big part of my role and that of my staff is not just providing treatment, but advising people how to get seen. I cannot see everybody. The community dental service goes out to see people. It meets teachers, children's parents and grandparents and child support groups. They do not just tell them about brushing teeth; they tell them about what we do and what numbers to ring if they are in pain and so on. Then, when we see them, we direct them towards general dental practitioners. The community dental service role is not just about treatment. There is a great deal of liaising in there. That is why the Designed to Smile initiative is so important—it gets out and about and raises contacts. It is all about networking, really.

[40] **Aled Roberts:** Do you have a view on whether the profile of the community dental service is clear enough? My sons go to the community dental service, but my wife and I have our own dentist. I do not understand how that happened. I do not know whether there is an understanding among the general population about the role of the community dental service. One of your colleagues in an earlier evidence session was quite taken aback when I referred to the school dentist. However, that is what they are known as in our area. There is not a clear understanding. As Simon said, that may be even worse in areas where there is a lack of general dental practitioners, where they could fulfil a greater role.

[41] **Mr Davies:** That is a very good point. There is a general lack of knowledge about the role of the community dental service. I have tried very hard to address that since I have been the clinical services manager. I am only too keen to go to speak to various groups—community health council groups, support groups, you name it—to tell people about the role

of the community dental service. The community dental service evolved from the school dental service. However, we no longer just look after children. We also look after vulnerable people—vulnerable adults.

[42] My role, more specifically, clinically, is to provide special care dentistry for adults who cannot otherwise get care. That could be because they have just been admitted to hospital suffering, for example, from a stroke and have toothache. They could be a vulnerable homeless person in the community. We deal with all of these sorts of things. We developed teams within the CDS—care for adults, care for children, care during the transition. We have clinics with disability access features, such as hoists and wheelchair tipping platforms, and we use conscious sedation for people with involuntary muscle movement, such as Parkinson's disease and so on. Unfortunately, the public does not know about this and healthcare professionals do not know about it. I am concerned about that because the patients who need treatment do not get referred to the appropriate sites. It is something I would like to see addressed. The role of the community dental service needs to be made more widely known.

[43] **Christine Chapman:** We will have some questions from Julie Morgan now.

[44] **Julie Morgan:** I want to ask about the relationships with schools and how that is going. From your report, it seems that you have been very successful in targeting three to five-year-olds. I think that you exceeded your target in terms of the number of schools you worked with. How did you manage to get such a positive result?

[45] **Mr Davies:** We have a very good team. The team leader, Mandy Silva, has a lot of experience in the community dental service. She has a lot of background and experience in helping children and managing staff, and she has taken to heart the delivery of this service. I would also like to say also that we are giving her plenty of support, and we have a very good steering group in Abertawe Bro Morgannwg University Local Health Board that is helping her to do this. Ultimately, we have been lucky in recruiting a lot of very good members to the team. She has looked at the ways in which her team provides the various interventions in the schools, she carefully monitors the outcome, and, if there are any ways that they could be improved, she is constantly looking to do that. That is reflected in the success that she has experienced.

[46] **Julie Morgan:** With regard to the small number of negative responses that we have heard about, where headteachers have not co-operated, what reasons are behind that?

[47] **Mr Davies:** We have looked at that, and the main reasons are a fear of the unknown, and of integrating a possibly time-consuming activity into an already busy day. Those fears have largely been overcome—it is just a question of working a system out. For example, some schools might want children to brush at their desks, and others might want to take them individually to a bathroom area to clean their teeth and they just do not see how they can do it. When the Designed to Smile team goes in, it helps them to work that out. In some cases, that has meant providing funding for a sink or wash-hand basin in a particular area, to enable it to be used for brushing teeth. In most cases, that has resulted in any possible antagonism being overcome.

[48] On the problems that we have experienced, I think that five schools withdrew temporarily because of staffing problems—some of the staff were part-timers, and the schools had to withdraw from participation because they lost those part-timers temporarily. I am informed that they intend to come back into the scheme when the staff members are replaced.

[49] **Julie Morgan:** Are there any schools that are not using the scheme or not intending to use it?

[50] **Mr Davies:** None that I am aware of. At the moment, as the report mentions, I think that we have exceeded the target.

[51] **Julie Morgan:** It has been very successful.

[52] **Christine Chapman:** Before we move on, I have a couple of supplementary questions from Jocelyn and then Suzy Davies.

[53] **Jocelyn Davies:** Just on this point, do you think that some schools or some headteachers see this as just another thing that the school has to do? It would appear that cleaning your teeth is something that you should learn at home, rather than being part of education. Of course, Government cannot insist that parents do things at home. We have to give the children breakfast, there are after-school clubs—why do we not just bath the children and put them to bed at night as well? Do you think that there is something in that—that teachers might think, 'It is cleaning teeth now, when we are already expected to do all these other things for children, and parents ought to take some responsibility'?

[54] **Mr Davies:** That is a very valid point. This is an attitude that is not restricted to the Designed to Smile programme. Our community dental service, for example, will visit adult day care centres for people with learning disabilities, where the clients are dependent upon their carers. The carers do not clean their teeth or help them with that at all, and when we have suggested that perhaps they might do that, the answer is, 'No—they can do it themselves', but they cannot. The same sort of thing applies to schools. Perhaps because children are more manageable, and more easy to approach than a great big 20-stone autistic patient, and it is easier to brush a child's teeth, there is that attitude. That is where the Designed to Smile team work with them. In most cases, the team has managed to break that down. Sometimes, it has come across some staff who have a bit of an attitude, if you know what I mean, but the team tends to break it down.

[55] **Suzy Davies:** In your experience, do the schools that are a bit less than helpful, shall we say, tend to be in the areas that are the most difficult to reach in the first place—in the most deprived areas? If those schools provide free school breakfasts, as they tend to do in deprived areas, I do not understand why they are not taking up the opportunity straight after the school breakfast. It is part of a seamless day for them, is it not? It is not a case of, 'We've done that, now we've got a break and then we start school'; there are staff available at that stage, even if they are voluntary staff.

9.45 a.m.

[56] **Mr Davies:** I think that it is a question of altering working practices and habits, which sometimes takes time. I am sorry that I cannot be more precise than that. I am not aware of any particular areas—I do not think that it follows in that way. There are deprived areas where you have more helpful teachers and less deprived areas where teachers are less helpful—it does not seem to follow, I am afraid. I think it is really just a matter of habit. It is then a question of chipping away at it.

[57] **Suzy Davies:** Is the Designed to Smile team working with schools at the time of the free school breakfast, rather than at the beginning of the school day?

[58] **Mr Davies:** The team tries to adopt a holistic approach so that it fits in with schools' practices as much as possible.

[59] **Christine Chapman:** We have a question on programme expansion from Julie. I remind Members that we need to finish this part of the meeting at 10.00 a.m. because we will have other witnesses in, so we need to move on if we can.

[60] **Julie Morgan:** I was going to ask about the expansion of the scheme to nought to three-year-olds, because that has happened since the programme started. The question is linked to what we discussed earlier in that the British Dental Association told us that the community dental service has historically been unable to reach into playgroups and pre-school activities. Have you had any success in reaching nought to three-year-olds through playgroups, for example?

[61] **Mr Davies:** Prior to the Designed to Smile programme, we had two oral health promotion officers who approached and established links with schoolchildren of all age groups, but it was organised on a rather ad hoc basis—it was nothing like as well organised as the Designed to Smile programme. So, some ground work had been done already, and the Designed for Smile programme has built on that and established links with nursery groups, and it looks very favourable.

[62] **Julie Morgan:** And with playgroups?

[63] **Mr Davies:** Yes.

[64] **Jenny Rathbone:** I apologise for being late. I thought that your paper showed that the way that you are working in your area is excellent, so congratulations. I want to ask about the implications for the workload with regard to restorative work and the use of local anaesthetics on children, given that you will have fewer children with poor teeth, which is obviously a good thing. However, that has implications later down the road. Can you tell us about that?

[65] **Mr Davies:** I mentioned earlier that the Designed to Smile programme will hopefully result in less use of general anaesthesia and fewer extractions, but that does not mean that teeth will not need to be filled and restored. As teeth are retained, you also have complications such as orthodontic treatment needs and so forth. Children will still fall over and damage their teeth, and their teeth will need to be filled and repaired with crowns. The community dental service will still be faced with treating a lot of these children, which will mean that we will look at our current resources. If we find that there is an increased need for treatment, we will look to recruit into the service to provide the manpower to treat these cases.

[66] We already have teams building expertise in various areas of children's dentistry; we have a dental officer with a particular interest in orthodontics. I do not just treat adults—I treat children as well using conscious sedation, and I have interest in prosthodontics, which includes crowns, bridges and such things. Our children's team is led by a senior dental officer at the moment, and we hope to recruit a specialist in paediatric dentistry to the CDS in the near future, which will hopefully fulfil children's treatment needs.

[67] **Jenny Rathbone:** So, you have buy-in by the health board, despite the financial pressures.

[68] **Mr Davies:** At the moment, we do not have any significant referral-to-treatment waiting times. We have the capacity to manage the children. If we were to find that we had a treatment need and we were looking to fill that, I would start pressurising my managers for extra funding.

[69] **Suzy Davies:** My question is in the same area. You have given us a level of detail there. I was interested to hear that you thought that one of the main advantages of Designed to Smile is that it acts as a gateway for people to come to the CDS and start using services. So, there is obviously an increased pressure on those services now, and you still have the

restorative and orthodontic elements that Jenny was talking about. Are you coping with that workload at the moment? Also, can you give us some information about how to draw in the kind of vulnerable children that you were talking about? Can you give a little bit more detail on that and the overall impact on the CDS and paediatric dentistry? Is it all coming in a big surge?

[70] **Mr Davies:** We monitor our activities carefully. In the past, we had to rely on a rather complicated paper system, but we have recently introduced an electronic patient management and appointments system, whereby we can collect data and reports much more carefully and thoroughly. Therefore, we can monitor all our referrals carefully and the types of patients that we are seeing. I have produced a clear service specification and referral acceptance criteria for the CDS to be sure that we receive only appropriate referrals, so I can see exactly what we are receiving. We liaise with all the various dental specialties within the health board and we refer patients where appropriate. There is some evidence to suggest that, since the Designed to Smile programme started, we have seen an increase in the number of vulnerable people and children referred to the CDS. It is early days yet, but there is some evidence that the numbers of people that we have seen has increased.

[71] **Suzy Davies:** Are you confident that you are reaching long-stay hospital children or children with particular disabilities? You touched on it earlier, to be fair.

[72] **Mr Davies:** I am not sure that we are receiving all of them. As I mentioned with vulnerable adults, a lot of people do not realise the CDS's role, and I am afraid that that still applies to children. With all due respect to medical colleagues, they are not always aware of the importance of oral health. For example, there are clinics for percutaneous endoscopic gastrostomy-fed children in ABM health board, but not all of the medical professionals there are aware of the need to refer these vulnerable children to the CDS. Certainly, there is work to be done to raise the role of the CDS in children's groups, as well as adult groups. This is the CDS's role and this is something that we try to do.

[73] **Christine Chapman:** I will ask a few questions to finish. We have very much valued your responses today, Mr Davies. Based on the evidence of progress so far, what action could be taken to deliver a stronger and more cost-effective programme? Also, in your evidence, you urge the committee to support the sustainability of Designed to Smile with appropriate levels of funding, so that the efforts of the past few years in setting the foundations are not wasted. Could you tell us more about your concerns in this respect?

[74] **Mr Davies:** I think that we are managing our budget well at the moment. We are very cost-conscious within our department, to ensure that resources are used appropriately and that all our patients are being seen and offered treatment. This is also reflected within the Designed to Smile team. We also have a very good steering group. The chair is an excellent housekeeper who watches the books carefully and will not let me spend a penny more than I am allowed to. I am happy with the budgetary arrangements at the moment, and as long as the current level of funding continues, I think that we will be able to continue to provide the level of service that we do at the moment.

[75] **Christine Chapman:** Are you happy that you are doing as much as you can on this? Are there any lessons to be learnt for the future?

[76] **Jenny Rathbone:** How are you going to share your good practice with the other health boards?

[77] **Mr Davies:** I am happy with what we are doing and I hope that you are, too. To share working practices is a question of getting together with the other community dental services and talking to them, and perhaps letting them know that there is nothing to be worried about:

we are all here to achieve a common goal. I would be happy to meet up with anybody who wanted to see what we are doing and to show them around. They can visit the schools when the Designed to Smile teams are going out. They can visit me in the clinics—I would be happy to do that.

[78] **Christine Chapman:** On that note, thank you on behalf of all the Members. We have all appreciated your responses today and your perspective. Thank you for coming along and sharing that with us, Mr Davies. We will send you the transcript of today's meeting and, if you are happy with it, it will be published.

[79] **Mr Davies:** I was pleased to be invited here to give you an insight into what we do, and from a practical point of view. Thank you for giving me the opportunity to speak.

[80] **Christine Chapman:** We have enjoyed it. Thank you.

[81] We will now adjourn for about 10 minutes.

Gohiriwyd y cyfarfod rhwng 9.57 a.m. a 10.06 a.m.
The meeting adjourned between 9.57 a.m. and 10.06 a.m.

Ymchwiliad i Iechyd y Geg mewn Plant: Sesiwn Dystiolaeth
Inquiry into Children's Oral Health: Evidence Session

[82] **Christine Chapman:** Welcome back to the Children and Young People Committee. I welcome Paula Roberts, Mary MacDonald and Carol Maher from the healthy schools network. Thank you very much, all of you, for coming. Members have read your paper. Would you like to introduce yourselves first of all, for the record, and then, if you are happy, we will go straight into questioning.

[83] **Ms Maher:** Good morning. I am Carol Maher. I am the healthy schools co-ordinator for the Vale of Glamorgan, so I have had a comparatively short trip this morning. I do not know what else you would like to know.

[84] **Christine Chapman:** That is fine.

[85] **Ms MacDonald:** I am Mary MacDonald. I am based in Pembrokeshire, but today I am representing Carmarthen, Ceredigion, Neath Port Talbot, Powys and Swansea.

[86] **Jenny Rathbone:** A small area, then.

[87] **Ms MacDonald:** It is, rather. [*Laughter.*]

[88] **Ms Roberts:** I am Paula Roberts. I look after the healthy schools scheme in Denbighshire in north Wales, so I had a nice journey this morning. I am representing my colleagues from the six counties of north Wales.

[89] **Christine Chapman:** We appreciate your coming in this morning. I will begin with a fairly general question about the healthy school scheme. Could you provide us with more detail about the scheme and the role of healthy schools co-ordinators nationally and locally throughout Wales?

[90] **Ms MacDonald:** The healthy schools scheme was set up in 1999, following the European network of healthy schools. After a successful pilot scheme, it was established in three areas and then rolled out in all 22 authorities. We have a healthy schools co-ordinator in

each authority, based either in health or in education. So, there is a dual partnership working throughout Wales between health and education. Some work with support, depending on the size and the number of schools. I think that 95 per cent of schools in Wales are now part of the healthy schools scheme, and 70 per cent have passed phase 1. So, it is not just that they are part of the scheme; they are all actively involved and working through the phases.

[91] There are five phases, which lead to the national quality award for excellence. That is to represent between nine and 11 years of working on the scheme. The evidence is that it takes nine to 11 years to establish a health behaviour change. So, it works more as a system. The quality award is given when health is embedded into the life and the processes of the school, so that health has been established in education.

[92] **Aled Roberts:** Hwyrach y dylwn wybod hyn, ond ai'r awdurdodau lleol neu'r byrddau iechyd sy'n cyflogi'r cydgysylltwyr?

Aled Roberts: Perhaps I should know this, but are the co-ordinators employed by the health boards or the local authorities?

[93] **Ms Roberts:** Mae'n amrywio ym mhob sir. Mewn rhai siroedd, mae'r cydlynwyr lleol wedi eu sefydlu yn yr adran addysg neu yn yr adran iechyd cyhoeddus. Felly, mae partneriaeth yn bodoli ym mhob sir. Mae pwyllgor llywio ym mhob sir hefyd i reoli'r cynllun yn lleol, ac mae gwahanol bartneriaid ar bob pwyllgor. Fodd bynnag, o ran rheoli'r cyd-lwynwyr yn lleol, mae cytundeb gwahanol ym mhob sir.

Ms Roberts: It varies in every county. In some counties, the co-ordinators are established either in the education department or in the public health department. So, there is a partnership in place in every county. There is also a steering committee in every county to manage the scheme locally, and there are various partners on each committee. However, in terms of managing the co-ordinators locally, the contracts are different in every county.

[94] **Aled Roberts:** Pa mor ddiogel yw'r cytundebau hynny o ystyried y toriadau?

Aled Roberts: How secure are those contracts given the cuts?

[95] **Ms Roberts:** Mae'n dibynnu ar y cyllid a'r grantiau yr ydym yn eu cael. Ar hyn o bryd, mae'r cyllid wedi ei gadarnhau tan y flwyddyn nesaf, ac efallai tan 2014.

Ms Roberts: It depends on what funding and grants we get. At the moment, funding is confirmed until next year, and possibly until 2014.

[96] **Julie Morgan:** You say that most areas have positive partnerships between Designed to Smile and the healthy schools scheme. However, you say that there is inconsistency across Wales. Will you expand on that and explain why?

[97] **Ms Maher:** There is a bit of inconsistency. A lot of it is down to the different localities and how they work with individual Designed to Smile staff, and how proactive they are in establishing partnerships with healthy schools schemes. As well as representing the Vale of Glamorgan, I represent south-east Wales and the majority of the feedback is positive. A lot of it is down to personalities. Mary, do you want to say anything else?

[98] **Ms MacDonald:** It is down to the established partnerships that already exist. Speaking personally, in Pembrokeshire, we are fortunate that we work with a wide range of partners and that we work with them successfully. There has always been a good link between the director of education and the bosses in public health. We are used to partnership working and that was a strength for the Designed to Smile team because, when it came in, it could hit the ground running; it had an established network of agencies and partnerships that were used to working together, so it could just slot in. Any new initiative that comes in could just slot in easily to that way of working, if it is already established. In other areas where it is not so established, you have to set up the partnerships and the face-to-face meetings. Perhaps they

were not given the time to do that initially; they had a short time span in which to spend an awful lot of money and get going quickly. If they had been given more time, they could have set up the partnerships more effectively.

[99] **Julie Morgan:** So, Pembrokeshire is fine, but some areas in south-east Wales are not so fine.

[100] **Ms Maher:** I would say that the majority of areas in south-east Wales are working well. The Gwent area has taken a little longer to establish the partnerships, but that is now moving forward as well. Representatives from Gwent now sit on the Designed to Smile local steering group; that has happened quite recently.

[101] **Julie Morgan:** So, that is to do with time and developing the partnerships rather than any real problems.

[102] **Ms Maher:** Yes. None of the areas have gone backwards; they have all moved forward.

[103] **Julie Morgan:** What about the north?

[104] **Ms Roberts:** It is similar in north Wales. Denbighshire was part of the original pilot projects, so obviously things were more well-established there. Our working relationships were set up in the early stages when the Designed to Smile team was set up and approached us to develop that partnership and discuss the schools and the settings that it wanted to work with in our area. Other parts of north Wales were not part of the initial pilot, so perhaps their relationships are not as strong as ours because we are perhaps a little more embedded. So, that is where the discrepancy in the relationships lies in our area.

[105] **Christine Chapman:** I now have follow-up questions from Jenny and Aled. Sorry; had you finished, Julie?

[106] **Julie Morgan:** I was just saying that the key issue is the link between health and education generally. Is that the case? It seems to be such an important issue in so many areas.

[107] **Ms Maher:** Again, that varies. The healthy schools co-ordinator is based in education. Obviously, it is much easier to form stronger links where we are based in Public Health Wales. Again, it takes a little longer to establish relationships, but I think that they are all pretty positive.

[108] **Ms MacDonald:** With Designed to Smile, they struggled a little bit because it is not part of the curriculum; it is an extra for schools. In healthy schools, we try to incorporate everything that we do as a process and ensure that it is throughout the curriculum and throughout personal and social education. If a school has to do away with something, the first things to go are those that are not part of the curriculum. Later on, we will probably talk about time constraints and staffing, but a lot of the issue is that the Designed to Smile programme does not have as much importance in a school because it is not part of the curriculum. Then, it is down to time constraints and good will.

[109] **Jenny Rathbone:** In Cardiff, we have had a particular problem in secondary schools where they continue to sell junk food in the vending machines as a way of subsidising the school meal service. I put that down to lack of political leadership. Will you tell us about your opportunities to help to inform the political leadership of local authorities? This is an important initiative that brings education and health together, and ensures that people are working together in the interest of all children. As cuts are made, it is important that the political leadership understands what you are doing.

10.15 a.m.

[110] **Ms MacDonald:** I will come in on that one. In Pembrokeshire, we led on the healthy vending pilot scheme with Joe Harvey, who you will know from his work on food and health in Wales; he was on the English committee and then came to help us in Wales. It is a bit of a 'prove it' situation. Due to the fact that secondary school catering is a business in most areas, including Cardiff, the catering has to be run as a business and show a profit. Primary school meals are subsidised, but secondary school meals are not. It has to be run as a business and they think that they are dependent on the vending machines. There is a big fear that they are going to lose money; it is a leadership thing.

[111] In Pembrokeshire, we were fortunate to have the director of education's support for the vending scheme. He supported healthy vending and 'Appetite for Life'. The 'Appetite for Life' guidelines note that healthy vending should be in place by 2012, but, it is not legislation quite yet; the Healthy Eating in Schools (Wales) Measure 2009 has just come through, which will also help. However, it depends on the leadership commitment and the 'prove it' element; they have to prove that they will not lose money. They have to be brave to make the decision to take the unhealthy foods, which are profitable, out of vending machines and come up with alternatives. It is a bit like a drip feed. We are working in partnership, but we do need legislation to support us as well. All of our secondary schools are compliant with 'Appetite for Life' and much to their surprise, and mine, I must say, they have not lost money.

[112] You need the headteacher's support; the catering side does not answer to the headteacher in secondary schools—only through a service level agreement—but they need the headteacher's support to keep the children on site. Most secondary schools have an on-site policy, but it is often not followed because the catering facilities are not able to cater for 1,200 children, which is the average number. They might have been able to cater fast food in a 1970s-style restaurant where the children were herded through, but now that we are asking them to cook food and for the children to sit down to eat, they do not have the capacity to do that. Funding is needed for schools to put in extra service provision and deal with queuing systems and so on. The two have to work in balance. So, yes; it is an opportunity, but we need support for the wider issues. We have got around it by finding funding through 'Appetite for Life' to put extra service provisions in place in addition to the usual serving points, but it is still a problem. In most schools, if you keep all of the children on site, they do not have the capacity to feed them all in the restricted lunchtime that they get.

[113] **Ms Maher:** Pembrokeshire is a flagship area for healthy schools. Not all secondary schools in Wales are 'Appetite for Life' compliant; a lot of them find it very difficult. As you say, a lot of it is down to whether headteachers want to take part, and the cost involved. Making local Assembly Members aware of the problems in schools would help. We are fortunate that our local Assembly Member is very involved with what goes on. It is a difficult area.

[114] **Aled Roberts:** To pick up on the variation, it is frustrating to hear that there is good practice here and there, but that there are other instances where things are not as good. What is the situation regarding a national overview to identify where there are obstacles or where practice is perhaps not as advanced as it could be? Is it all down to how long the scheme has been in place, or have you identified political or managerial resistance, or even resistance within schools?

[115] **Christine Chapman:** It would not be fair to ask our witnesses to talk about political leadership, but perhaps you could mention the experiences that you have had in schools. That might have put you in an unfair position.

[116] **Aled Roberts:** I am more concerned with the national overview and identifying where people need a bit more support, and whether that happens.

[117] **Ms MacDonald:** We are fortunate in Wales to have the system—is this about Designed to Smile or healthy schools?

[118] **Aled Roberts:** It is about healthy schools, but applying that process in other areas.

[119] **Ms MacDonald:** As I said, we are fortunate in Wales to have the system that we have. We have someone in the Welsh Government who does not only top-down work, but bottom-up work as well, which is great. She takes on everything that we do in our local area and gives us the flexibility to take on national issues as well. So, we get national training and meetings regularly. We have a robust national network of healthy schools.

[120] Having said that, there were inconsistencies. We undertook a review about two or three years ago with the Cardiff Institute of Society, Health and Ethics, which came up with inconsistencies between the different regions. A phase 5 school in Pembrokeshire that has been in the scheme for 10 years may be completely different to a phase 5 school that has been in the scheme for 10 years in Cardiff or Swansea, depending on how they were led, as you said, or on how the scheme was implemented. That is where the national quality award came from. It is a benchmark. If you have a national quality award after nine or 11 years' involvement, which is phase 6 and pretty much the end of it, you are a health-promoting school with that benchmark of quality that is consistent across Wales. A school in Cardiff with a national quality award would be of the same standard as one in Pembrokeshire or one in Denbighshire. So, that is where the inconsistencies were found and put right.

[121] As for Designed to Smile, it has not got there yet. It is early days, but they need to think about consistency across Wales in terms of how to benchmark it, how it is implemented and driven, and the standards.

[122] **Jocelyn Davies:** We would see Designed to Smile as part of the healthy schools agenda. You mentioned earlier that Designed to Smile is not part of the curriculum and so it is seen, by some schools, as an add-on. So, it is a separate dental programme and perhaps not part of the healthy schools scheme. To what extent do you think that that is happening? We know from previous evidence and from your paper that there is some negativity from some schools. I suppose that that comes from the headteachers, the staff, the governing bodies and so on of those schools. How easy will it be for us to slot in the Designed to Smile programme? I am asking that as if I will be doing it. [*Laughter.*] However, how do we collectively, as a nation, mainstream Designed to Smile and slot it in as part of healthy schools?

[123] **Ms Maher:** At the moment, it is not part of healthy schools. We do not manage Designed to Smile, but we work with it as partners.

[124] **Jocelyn Davies:** Yes, but in terms of what you do, if people reduce the amount of sugar that they eat and are more aware of what they are putting in their mouths, that will have an effect on oral health.

[125] **Ms MacDonald:** We address the common risk factors that you are talking about within healthy schools, with nutrition, exercise and fitness. However, at the moment, it is seen as being separate in schools. That is what I meant: if it became part of the curriculum, it could be incorporated a lot more. Headteachers and teachers see it as just a topical fluoride application programme and they then ask, 'Why aren't we going for water fluoridation and why do we have to do that?'

[126] **Jocelyn Davies:** What they mean is, 'Why doesn't somebody else do it?'.

[127] **Ms MacDonald:** A little bit. They do not see it as their responsibility to brush teeth. It is like the wraparound care argument with breakfast clubs.

[128] **Ms Maher:** Teachers have a demanding workload and, although I fully support Designed to Smile, I can appreciate that some teachers find it difficult to fit it into the school day. As Mary said, if it was considered part of the curriculum for educating about oral healthcare, it would be a lot easier for teachers to do it, because at the moment it is seen as an extra and, in my experience, the teachers in key stage 1 and in the foundation phase do not have so much of a problem with it—although, actually, that is where it is, is it not? It is the smaller schools perhaps that do not have so much of a problem as the bigger schools in my area.

[129] **Ms MacDonald:** We can incorporate into our scheme the monitoring and assessment process because we go into schools twice a year and we assess standards at least once a year or once every two years. So, we can incorporate it into that and monitor it in that way, but only at that visit because we do not have the capacity to see how their tooth-brushing programmes have been implemented, but it can be part of our monitoring system, because, as I say, we have that system. In some areas that is more developed than others; some have put it into their indicators and outcomes and some have trained up Designed to Smile staff so that they can help with assessments and they have more of an understanding of the whole wide breadth of health. With dental health, it is very difficult not to work in a silo; it is very difficult to work openly, because staff are very clinically based initially, so they are very focused. That is good in one sense. With partnership working, working with public health and the healthy schools programme have enabled, in a lot of areas, opening them up very much to those common risk factors, which are dietary, as you say.

[130] **Christine Chapman:** Okay, thank you very much. I have some supplementary questions from Aled Roberts and Simon Thomas.

[131] **Aled Roberts:** Picking up on that then, are you saying that it is a local decision as to whether monitoring of Designed to Smile is included in the healthy schools programme? Am I right?

[132] **Ms Maher:** It is included in the national quality award as one of the indicators for good practice that schools are participating in Designed to Smile, and, as from January next year, all schools that are being assessed for their national quality award will be expected to participate in Designed to Smile if they have been offered the opportunity.

[133] **Ms Macdonald:** They have their own very robust monitoring and assessment systems. That is not in question, but it is about trying to bring the two together, and, to the extent of how many questions you ask at your assessment visit about Designed to Smile, it is probably down to individuals and to the area they are focusing on for health.

[134] **Ms Roberts:** In terms of the Designed to Smile team, I know that, in our area, the educators or the Designed to Smile team work with the school to set up the initiative in a way that will best suit the school, so it is not too overwhelming in the first instance and can be phased in, works with their school day, and works with parents to get them on board. They also have a team of educators who go in and do work with the pupils, so perhaps that links in more with the curriculum, but they also then do their own monitoring visits, as Mary just said; they revisit the school to check that the school is sticking to the procedures—that teeth are being brushed for two minutes on a daily basis—so they are monitoring within their own teams as well.

[135] **Christine Chapman:** Thank you very much. I want to move on now to Julie Morgan's question on the healthy pre-schools scheme.

[136] **Julie Morgan:** Can you say a little bit about the link between Designed to Smile and the healthy pre-schools scheme? What is the connection between the two schemes, and could it be made more effective?

[137] **Ms Maher:** Most areas have very strong links with Designed to Smile as far as the healthy pre-schools scheme is concerned. In many areas, one of the criteria is that you participate in Designed to Smile. In every area, there is a steering group for the healthy pre-schools scheme and a member of the Designed to Smile team will sit on that steering group.

[138] **Ms MacDonald:** We have a healthy school network and now a healthy, sustainable pre-schools scheme across Wales, and because it is held in quite high regard in most areas—all areas have the healthy schools schemes, and now the pre-schools scheme—that enables us to exert pressure, as it were—'encouragement' is a much better word—for them to join the scheme and say, 'If you want to be part of our healthy pre-schools scheme then you need to be involved in Designed to Smile'. So, it is an actively encouraging way of getting them involved and it works well.

10.30 a.m.

[139] **Julie Morgan:** So, is that fairly extensive among pre-school organisations?

[140] **Ms MacDonald:** Again, fortunately, in Pembrokeshire, we ran a whole scheme under the inequalities funding a few years ago, where we looked at nutrition and oral health together in the under-fives. There was a lot of pioneering work that went into the pre-school scheme. Then we brought it into the Pembrokeshire healthy schools scheme, again successfully. It was then adapted and rolled out across Wales two years ago. It is very extensive in Pembrokeshire and our local area. Again, because of the prestige and the importance the healthy schools scheme has, and the fact it is held in high regard by headteachers, education and health experts, it has taken off. We have learned from the healthy schools scheme and, when the pre-school scheme came, it was extensive and there were good partnerships across the area. It was much easier in the under-fives.

[141] **Ms Maher:** That is true across Wales.

[142] **Ms Roberts:** The pre-school scheme has only recently been brought in, within the last 12 months. It was piloted in two areas and now it is being rolled out to other areas. So, a lot of counties are in the process of setting up their steering groups and Designed to Smile is a key part of those groups.

[143] **Jocelyn Davies:** So, it is early days yet?

[144] **Ms Roberts:** Yes.

[145] **Suzy Davies:** I appreciate that the pre-school scheme is still in its early days. I am pleased to hear that there is a good crossover already between Designed to Smile and that scheme. However, the Designed to Smile programme is targeted primarily at areas that are deprived for various reasons, whereas the pre-school scheme is universal, is it not? Are there going to be areas where Designed to Smile is not available to be paired up with the healthy pre-schools scheme? If so, are we going to run into the situation that you have identified in the paper that we received, where schools that do not participate in Designed to Smile are excluded from going for the healthy pre-school award? You do not have equal catchment areas, have you?

[146] **Ms Roberts:** With our healthy pre-schools scheme we are prioritising the deprived areas, so that coincides with the Designed to Smile settings. That is how our local steering group has decided to take things forward. I suspect that other areas may work in the same way, because they are working in partnership with initiatives such as Flying Start and Communities First as well. In terms of not being able to go forward for the healthy pre-school award if they are not taking part in Designed to Smile, I think I am right in saying that the criterion is participation if you have been invited to be part of Designed to Smile, so if you are invited and decline, you would not be able to go forward for the pre-school or healthy schools award. It works in that way. Schools that are not in deprived areas have approached us because they want to be part of Designed to Smile. I presume that applies to the whole of Wales. Those schools would make a case to the Designed to Smile team and if their percentage of free school meals and things such as that was high they would be considered for engagement in the scheme, but that would not always happen.

[147] **Jocelyn Davies:** Turning to the membership of the steering committee, is it automatic that somebody from the Designed to Smile team is on the regional steering groups you mentioned? You mentioned earlier that it is only recently that somebody from the Designed to Smile team was on a steering group in Gwent.

[148] **Ms Maher:** I am not from Gwent, so I am just feeding back the information sent to me.

[149] **Jocelyn Davies:** So, it is not automatic?

[150] **Ms Maher:** It is not automatic, but I think all areas have included a representative from Designed to Smile on their steering group.

[151] **Jocelyn Davies:** Do you see membership of that steering group as an important factor in integrating the two and trying to smooth out some of these inconsistencies?

[152] **Ms Maher:** Yes, definitely. The steering groups have responsibility for progressing the healthy schools scheme and the healthy pre-schools scheme. They are also a good forum for information-sharing.

[153] **Suzy Davies:** To go back to the issue of the barriers to Designed to Smile, you have already mentioned that some schools do not treat it as a priority because there are other pressures from the curriculum and so on. Have you had any experience of problems getting consent from parents? If so, is that about a lack of engagement or is it about a proactive objection to their children taking part in Designed to Smile?

[154] **Ms Roberts:** I met with my Designed to Smile colleague before coming so I know that, in our area, there has been 100 per cent uptake from the parents who have been approached in the settings they are working in. Occasionally, parents may ask questions, but they have the educators there to go into schools and talk to people if needed.

[155] **Suzy Davies:** Congratulations.

[156] **Ms Roberts:** I do not know whether I can say the same for elsewhere, and I cannot take the congratulations because I do not lead on Designed to Smile. I do not know whether it is the same for other areas.

[157] **Aled Roberts:** We are very compliant in north Wales. [*Laughter*.]

[158] **Ms Maher:** In the Vale, the majority of schools have wanted to participate, and there

have not been many problems with parents. There have been a few, and the main issues parents have brought up are that they do not like the idea of someone else teaching their child how to brush their teeth and the possible problem of cross-infection, which does not arise. Once the Designed to Smile co-coordinators explain that to the parents, their fears are allayed.

[159] **Suzy Davies:** So they are engaged parents who have concerns rather than parents who just are not interested.

[160] **Ms Maher:** That is right. It is not that the parents are not interested—they have thought about it and have concerns.

[161] **Jocelyn Davies:** So they are concerned about whether their child is going to have their own toothbrush and want to know that no other child is going to use that toothbrush.

[162] **Ms Maher:** That is right, yes.

[163] **Jocelyn Davies:** Of course, I can understand that.

[164] **Ms Maher:** Obviously, they have their own toothbrushes.

[165] **Jocelyn Davies:** It was not the case that there was total refusal, with parents saying, 'You are not putting anything in my child's mouth'?

[166] **Ms Maher:** No.

[167] **Christine Chapman:** Before I bring Simon Thomas in, could you clarify the issue about the consent forms? Earlier witnesses spoke about this issue, which came up in my constituency some time back.

[168] **Ms Maher:** That is done through the Designed to Smile co-ordinator. I do not personally get involved in that. Do you?

[169] **Ms Roberts:** No, but I am aware through friends who are parents that, when tooth brushing takes place in schools, an information pack and a consent form are sent home. I think that has to be done annually rather than just once.

[170] **Christine Chapman:** These are practical issues, really, are they not?

[171] **Ms Roberts:** Yes.

[172] **Simon Thomas:** Do you have any evidence of particular obstacles or different attitudes within different cultural groups in Wales? Is the idea of someone else brushing your children's teeth particularly problematic for groups from particular ethnic backgrounds? Have you had any feedback on that?

[173] **Ms Maher:** We have not had any such feedback in south-east Wales. No co-ordinators have commented on that aspect.

[174] **Simon Thomas:** Good. I just wanted to ensure that that was not an issue.

[175] **Jenny Rathbone:** To pick up on this theme, we have heard evidence from other people that some parents do not embrace the Designed to Smile initiative in the sense that we brush the child's teeth in school—brilliant—but, when the toothbrush and toothpaste go home, the good habits that may have been promoted in school are not picked up at home. With regard to how we integrate Designed to Smile and mainstream it in our healthy schools

and healthy eating advice, can we also promote the importance of brushing your teeth in secondary schools, when pupils are more able to go out and buy a toothbrush, which they cannot do in primary school? We all agree on what we are trying to do with Designed to Smile, but how do we integrate that with our wider initiatives on healthy schools and healthy eating?

[176] **Ms MacDonald:** The most important initiative is the one on healthy eating. Not eating well is the most common cause of dental decay, rather than hygiene, although hygiene is important. In secondary school in particular, you can get them on body image, and you can sell it to them that way—fresh breath and appearance. The most important factor is healthy eating. This is seen as a topical fluoride application more than a hygiene habit-forming thing. I have to say that diet is the most important. The application of fluoride is the biggest advance that we have made in the last 30 years—putting fluoride into toothpaste. That is how Designed to Smile came about—topical fluoride application. The hygiene issue is something that we have in personal and social education anyway, to a certain degree, within the schools. As for getting it into secondary education, as I say, we have to sell it on what it can do for your appearance, and we need even more education at that point on diet, because as you say, this is the age at which they get money in their pockets, and unfortunately they are more likely to go and buy Mars bars than tooth brushes.

[177] **Ms Maher:** We could get the dieticians involved—perhaps the community dietician who works with the healthy schools scheme. They go into schools to do health promotion. I am not quite sure how we would do this. We have dieticians on the steering groups, so they obviously meet with the Designed to Smile co-ordinators through those groups. That would be a good link. It happens in most areas already. If the dieticians, when they go into schools—they are obviously focusing on healthy eating—bring dental hygiene into that, and the effect of healthy eating on dental erosion, that would be a good way of doing it.

[178] **Jenny Rathbone:** You have given us some excellent examples of how we can mainstream Designed to Smile into the healthy schools agenda. I do not think that we have touched on the role of the school nurse; how pivotal is that?

[179] **Ms Maher:** Until now, it has been quite pivotal. I understand that the role of the school nurse is changing and there will be less health promotion time available to the school nurse, so that could be a problem.

[180] **Ms MacDonald:** It depends on the area. We are fortunate that we have always had school nurses in our schools, delivering health promotion.

[181] **Ms Maher:** We have, up until this term.

[182] **Ms MacDonald:** Yes, they are responsible for inoculations. There was a question in one area about whether school nurses could help with consent and dietary advice, which they tend to do—they do health questionnaires anyway, so they tend to give out dietary advice there. As for how involved they have been with Designed to Smile, they are part of the same steering groups, so they are not duplicating work, and they are aware of what is going on, but I am not sure whether that would fall into their remit, as such, because they are pretty much at full capacity anyway with the work that they do, being based in a secondary school, and responsible for the primary feeders. In the context of healthy schools, school nurses are absolutely the most important people that we work with. They always have been. As for Designed to Smile, I am not quite sure about the role.

[183] **Christine Chapman:** We need to clarify the point that you made about the school nurse. I know that a few people wanted to ask about that, so it might be quicker if we write to the Minister, because there are some inconsistencies here.

[184] **Aled Roberts:** Could we also establish whether the changes are dependent upon the locality?

[185] **Ms Maher:** In south-east Wales, and particularly in the Vale, we have always had very good working relationships with the school nurses. They do a lot of health promotion in our schools, but I have been told that there is a change because of the change in workload. I know that, with some of the things that they do—immunisations, safeguarding and child protection, and care planning with the children—their workload is increasing. They will also be doing drop-ins with children as part of their workload in our area, which would be an opportunity to promote oral health.

[186] **Christine Chapman:** We will seek clarification. Thanks for bringing that up. Given the time, I will now move on to Simon on child poverty targets.

10.45 a.m.

[187] **Simon Thomas:** Mae targedau ynglŷn â thlodi plant yn gyffredinol, ac mae targedau penodol ynglŷn ag iechyd y geg yn y targedau tlodi plant. A yw'r cydgysylltwyr ysgolion iach yn ymwybodol o'r targedau hyn ac yn ei weld fel rhan o'u gwaith i helpu'r Llywodraeth gwrdd â'r targedau hyn?

Simon Thomas: There are general child poverty targets, and specific targets for oral health are included in the child poverty targets. Are the healthy schools co-ordinators aware of these targets and do they consider it part of their work to help the Government to meet these targets?

[188] **Ms MacDonald:** The healthy schools scheme is slightly separate in its ambitions, as we take a whole-population approach. Targeting works to a degree, but there are always pockets of inequalities, even in the most affluent areas. I am always conscious that, by concentrating on deprived areas, you are still missing deprived people. Rurality is also a huge deprivation factor in its own way. So, we are aware of poverty in the healthy schools scheme, and we have certain things that help with that—the cooking bus is a great example. If you take a whole-population approach in a health promotion setting, you will not miss anyone, which is possibly better; it reduces the inequalities a little more. You can sometimes widen the equalities gap by using targets.

[189] **Simon Thomas:** You have mentioned a couple of times that Designed to Smile is about topical application of fluoride, and—

[190] **Ms MacDonald:** That is how it is seen.

[191] **Simon Thomas:** Yes, that is how it is seen from a health point of view, but it is not necessarily seen as a hygiene habit-forming programme. You have also just mentioned an all-Wales scheme. Would it not be better to have fluoridated milk or water in schools?

[192] **Ms MacDonald:** That is one of the questions that came up.

[193] **Simon Thomas:** Would that not meet the same requirements as Designed to Smile?

[194] **Ms Maher:** Part of the programme addresses educating children, which you would not get through direct fluoridation.

[195] **Simon Thomas:** When you say 'educating children', do you mean in terms of oral health?

[196] **Ms Maher:** Yes, education about oral health and the necessity to brush teeth, when to

do it and how to do it. It is not solely about fluoridation; it is also about educating children and parents about the importance of dental hygiene.

[197] **Jocelyn Davies:** How many times do you need to be educated about how important it is to brush your teeth?

[198] **Ms MacDonald:** Over the years, oral health education has proven to be totally ineffective. [*Laughter.*] The most effective measure was putting fluoride in toothpaste. It is very much a first aid thing in dental health; it is very difficult to get into a deprived area to try to say how important it is for children to attend check-ups every six months, because, if the child does not have toothache it is not an issue for the parents. They live very much day to day. As with all health promotion, if you try to tell a 12-year-old that if they keep eating the same diet, they will have toothache when they are older, they will say that it is not worth living when you are old and that they just want to live for today. We live in a society that is about instant gratification and people wanting something now. So, oral health education is difficult. It must happen hand in hand with topical fluoride application, which is where Designed to Smile is different—it is not just about people going into schools to talk about oral health education; they are putting something with it, which is the difference. So, let us look at the decay/missing/filled figures in five years' time to see whether it has made a difference. However, I have picked up on your point about whether we would be better if we were to engage the headteacher and teaching staff, but that is a question that we would pose to you more than the other way round. It has been questioned.

[199] **Christine Chapman:** We have only five minutes left of the meeting, and I know that a few Members want to come in.

[200] **Suzy Davies:** The Designed to Smile programme was introduced in 2008 and extended across Wales in late 2009 and 2010. In terms of improved health outcomes, do you have any anecdotal evidence yet to support the view that dental health is improving? I stress 'anecdotal' evidence, obviously.

[201] **Ms MacDonald:** I think that it is far too early for the demographic figures to come out yet. The survey of five-year-olds will be undertaken next.

[202] **Ms Roberts:** The data come out every five years.

[203] **Suzy Davies:** What about anecdotal evidence, as that is what I stressed?

[204] **Ms MacDonald:** No, there is none, because of the speed at which it was set up. With hindsight, we can see that it might have been beneficial to have done a baseline survey as a quick fix. However, once again, we are talking about epidemiology and they did not have the time to do that, unfortunately.

[205] **Suzy Davies:** If you do not have any anecdotal evidence regarding the outcomes, have you noticed any changes in attitude to oral hygiene among parents and children?

[206] **Ms Maher:** I understand what you are asking: are children brushing their teeth more?

[207] **Suzy Davies:** Yes. I hate to use the word 'mainstream', which has come up a few times, but are children and their parents more accommodating of the idea of brushing teeth? Once again, this would be anecdotal evidence, as I cannot push you on proper evidence, I know.

[208] **Ms Maher:** I have not heard anything like that.

[209] **Ms Roberts:** We are not in schools on a day-to-day basis, so it is hard to pick up on such feedback. I know that the Designed to Smile team has been monitoring things locally and has local data, but I could not quote any of that to you.

[210] **Suzy Davies:** That is absolutely fine; thanks.

[211] **Ms MacDonald:** It would be interesting to ask the general dental professionals whether they have seen a drop in the decay rate.

[212] **Suzy Davies:** That is why I had two separate questions. The first was about whether you could tell from looking at people's teeth whether there has been an improvement. The next question was more about the attitudes of parents and children. However, I understand that you are not in schools very often. That is absolutely fine; thanks.

[213] **Christine Chapman:** The final question will be asked by Simon.

[214] **Simon Thomas:** I would like to follow up on the earlier point about establishing an all-Wales Designed to Smile programme. You have possibly suggested what an all-Wales fluoride application programme could look like, but what about oral health being part of the curriculum? Would it make a difference if it was part of the curriculum?

[215] **Ms MacDonald:** You would get consistency.

[216] **Ms Maher:** It would if you believe that education helps in addition to fluoride.

[217] **Simon Thomas:** You suggested five minutes or so ago that public health education does not work anyway.

[218] **Ms MacDonald:** It does not work in isolation. Research has proven it to be ineffective in isolation. As you said, if it was part of the curriculum or part of a planned programme where there is preparation and follow-up and it is not just a one-off, it might be successful.

[219] **Christine Chapman:** Jenny has a follow-up question.

[220] **Jenny Rathbone:** We could learn from the anti-smoking campaign, perhaps. The Ffaith programme has used rugby players to promote the anti-smoking message. Is this something that we could be doing? Would it be possible to send out the message that having missing teeth is not good for your attractiveness to the opposite sex, for example?

[221] **Simon Thomas:** Have you seen rugby players' teeth? [*Laughter.*]

[222] **Jenny Rathbone:** Are you also thinking about peer promotion through school councils and so on?

[223] **Ms Maher:** I have already seen adverts that show an attractive woman with a tooth missing. That would probably appeal to teenagers, if you were trying to get the message home that way.

[224] **Ms MacDonald:** There was a programme called iSmile, which was available through iPads and through all of the new technology that children understand. That was around for a while and was quite successful. I think that it is still out there somewhere. It used rugby players to highlight gumshields and dental trauma. It also used a dating scenario to highlight appearance.

[225] **Jocelyn Davies:** Primary schoolchildren have teeth missing anyway, so they are used to looking at one another without teeth. They lose their baby teeth and go through a number of years when they have teeth missing, so they are used to seeing that. However, some of the things that you mentioned earlier about body image and how you are perceived by other people can be quite a powerful message to encourage children to keep their mouths clean, not just because they want to keep their teeth, as we discussed earlier.

[226] **Christine Chapman:** I thank the three of you for attending today. We have thoroughly enjoyed the session. A transcript of this meeting will be sent to you for you to look at before we publish it. Thank you for attending our meeting today.

[227] **Ms MacDonald:** Thank you for giving us the opportunity.

[228] **Christine Chapman:** The next meeting will be on Wednesday 19 October. We will be scrutinising the Minister for Education and Skills, the Deputy Minister for Skills, the Minister for Health and Social Services and the Deputy Minister for Children and Social Services. So, four Ministers will be coming to next week's meeting. We will be scrutinising them on the Welsh Government 2012-13 draft budget proposals.

Daeth y cyfarfod i ben am 10.55 a.m.
The meeting ended at 10.55 a.m.