Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Iau, 3 Tachwedd 2011
Thursday, 3 November 2011

Cynnwys
Contents

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

Angela Burns	Ceidwadwyr Cymreig Welsh Conservatives
Christine Chapman	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Jocelyn Davies	Plaid Cymru The Party of Wales
Keith Davies	Llafur Labour
Suzy Davies	Ceidwadwyr Cymreig Welsh Conservatives
Julie Morgan	Llafur Labour
Lynne Neagle	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

Yr Athro/Professor Ivor Chestnutt	Athro ac Ymgynghorydd Anrhydeddus Iechyd Deintyddol Cyhoeddus, Prifysgol Caerdydd Professor and Honorary Consultant in Dental Public Health, Cardiff University
Lesley Griffiths	Aelod Cynulliad (Llafur), Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol Assembly Member (Labour), Minister for Health and Social Services
Andrew Powell-Chandler	Pennaeth Polisi Deintyddol, Llywodraeth Cymru Head of Dental Policy, Welsh Government

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

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

Dechreuodd y cyfarfod am 10.13 a.m.
The meeting began at 10.13 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Christine Chapman:** Good morning, everyone, and welcome to this meeting of the Children and Young People Committee. We have no apologies today.

10.13 a.m.

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

[2] **Christine Chapman:** The first item on today's agenda is our inquiry into children's oral health. We are taking evidence from the Minister for Health and Social Services, Lesley Griffiths, to whom I extend a warm welcome. I will also introduce and welcome the other witnesses who have joined us this morning. We have Professor Ivor Chestnutt, who is an honorary consultant in dental public health at Cardiff University, and Andrew Powell-Chandler, who is the head of dental policy in the Welsh Government.

[3] The Members have received your paper, Minister. Thank you for submitting it. I understand that you are happy for us to go straight into questions.

[4] **The Minister for Health and Social Services (Lesley Griffiths):** Yes, no problem.

[5] **Christine Chapman:** I will ask the first question. We are looking at the effectiveness of the Welsh Government's Designed to Smile programme. We have taken a lot of evidence over the last few weeks, and we are still trying to find out more about this. In your paper, you state that

[6] 'the successes of *Designed to Smile* are already clear'.

[7] What evidence do you have to support this view?

10.15 a.m.

[8] **Lesley Griffiths:** The success of the scheme is the level of participation that we have across Wales. The consent rate for parents allowing children to take part in the scheme in schools is currently at 94 per cent, while 92 per cent of headteachers in the pilot areas felt that the scheme was a positive experience for the school. I stated in the paper that it was too early to talk about clinical outcomes, because the scheme has not been running long enough to find out how successful it is from that angle. However, a similar scheme has been running in Scotland since the late 1990s and there has been a definite improvement in the dental health of children in Scotland and a decrease in dental decay. I think that it is a very successful scheme.

[9] **Jocelyn Davies:** I am sure that you have been keeping an eye on the transcripts of this inquiry. The evidence from all of the professionals is that it is too early to tell how successful the scheme is. The scheme is designed to improve oral health, yet you are claiming that it is successful because more people are participating. Surely, if the scheme is not producing the outcomes that you want, the participation rate can hardly be an accolade.

[10] **Lesley Griffiths:** One would hope that the participation levels will be accompanied by a decrease in dental decay, which is what we want. One of the things that we wanted to do was to get more fluoride onto teeth. That has been a success; because of the participation levels, we are getting fluoride onto young children's teeth. That is how I would weigh up

success in that regard. It is too soon to tell how successful the clinical outcomes will be.

[11] **Suzy Davies:** Minister, you mention in your paper that over 61,000 children are brushing their teeth daily in schools and nurseries across Wales. That brushing is supervised, is it not? In the same set of statistics, you mention that just under 138,000 home tooth-brushing packs are sent out to children, but that brushing is not supervised. Are you able to give us any evidence as to whether those packs are being used at home?

[12] **Lesley Griffiths:** It is difficult to say, because we are obviously not present in 137,999 homes. I remember visiting one of the schools in the pilot areas as a constituency Assembly Member in 2008-09. I was told by the headteacher that some of the children in the class had never seen a toothbrush. It is hard to assess how the packs will be used at home.

[13] **Suzy Davies:** Do you have any plans to try to find a way of getting at least some information, because there is an obvious cost implication in providing those packs and we would like to know whether they are effective?

[14] **Professor Chestnutt:** As part of the overall assessment, work is being done to look at the parents' attitudes to the programme. One of the benefits is the socialisation into regular tooth brushing that you would expect to result, and from some qualitative research that has been done we know that parents are reporting that the children come home wanting to brush their teeth. The uptake of brushing at home will be one of the objectives of the programme. Provision of the packs will hopefully help with that.

[15] **Suzy Davies:** When will you be able to give us some idea of whether that parental interest manifests itself in regular brushing?

[16] **Professor Chestnutt:** That is part of the ongoing evaluation. There will be a further report later this year on the parental aspects.

[17] **Keith Davies:** Yn atodiad A i'ch papur, yr ydych yn sôn am y rhai sydd wedi cymryd rhan yn y cynllun. Yr wyf yn gweld bod yr ystadegau yn amrywio o gyfradd cyfranogiad o 75.8 y cant yn ardal Bwrdd Iechyd Lleol Hywel Dda i 94.9 y cant yn ardal Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg. Pam nad yw cymaint o bobl mewn ardal benodol yn mabwysiadu neu'n manteisio ar y cynllun?

Keith Davies: In annex A to your paper, you refer to those who have taken part in the scheme. I note that the statistics vary from a participation rate of 75.8 per cent in the area covered by Hywel Dda Local Health Board to 94.9 per cent in that of Abertawe Bro Morgannwg University Local Health Board. Why are so many people in one specific area not adopting or taking advantage of the scheme?

10.20 a.m.

[18] **Lesley Griffiths:** When we rolled out the enhanced scheme, pilot areas were much better placed to take it forward. It has taken a little time for community dental services in other parts of Wales to get fully up and running, particularly in Pembrokeshire, Ceredigion and Powys. They were also not part of the fissure sealant programme that we ran. Now, we are in a position where all community dental services across Wales are delivering the programme. I hope that as the programme beds in, we will see a higher uptake across the country.

[19] **Keith Davies:** Dewis y byrddau lleol yw hi yn y pendraw felly. Ai dewis Penfro, Powys a Cheredigion yn unigol ydyw?

Keith Davies: So, it is up to the local health boards ultimately. Is it a matter for Pembrokeshire, Powys and Ceredigion to decide upon individually?

[20] **Lesley Griffiths:** Yes, and then it is for schools to take it up.

[21] **Julie Morgan:** Going back to the previous questions about parental involvement, a similar scheme was done in Scotland and, therefore, do we have any evidence from the Scottish experience about how involved parents have become and how successful it has been in the home?

[22] **Professor Chestnutt:** Yes. Some work has been done in Scotland by the University of Dundee where they have looked at the impact of the programme and how that has been received by the parents.

[23] **Julie Morgan:** Do we know what the results are?

[24] **Professor Chestnutt:** Parents are appreciative of this type of scheme. That is reflected in the high consent rates.

[25] **Julie Morgan:** Do we have any evidence that they are brushing their teeth at home?

[26] **Professor Chestnutt:** I am not sure if quantifiable data on the degree to which the programme has resulted in an increase of brushing at home is available, because they are not recording how often they brush their teeth at home. However, it is probably reflected in the clinical outcomes of the programme that brushing in school needs to be supplemented by brushing at home to achieve the kind of clinical outcomes that are expected to be achieved in Scotland.

[27] **Aled Roberts:** Hoffwn ragor o eglurhad ynglŷn â'r pwynt a wnaed gan Keith. Os ydy hyn yn gynllun cenedlaethol, a ydych yn dweud bod hawl gan fyrddau iechyd lleol i ddewis pa rannau o'r cynllun y maent am ymwneud â nhw, neu a ydych yn dweud bod pob bwrdd iechyd yn gweithredu'r cynllun cyfan?

Aled Roberts: I would like further clarification on the point that Keith made. If this is a national scheme, are you then saying that local health boards have the right to choose which parts of the scheme they want to get involved in, or are you saying that all local health boards are implementing the entire plan?

[28] **Lesley Griffiths:** All local health boards can implement the entire plan. It is up to the schools. The chief dental officer wrote to the headteacher of every infant school, nursery and special school in Wales in November 2010 to raise awareness of, and publicise, the effectiveness of the programme, following the pilot areas and then the roll-out. The letter also included information for eligible schools that were yet to participate on how they could become involved and the contact details for an article that went into bulletins to every school, so that every school was aware of it.

[29] **Mr Powell-Chandler:** It also reflects the staggered and staged start of the programme. The two pilot areas in central south Wales and north Wales are well placed to start the expanded scheme. Other community dental services that are delivering the programme were not in quite the same position. So, they were starting from a lower base. On participation in those areas—the Minister mentioned Ceredigion and Powys in particular—it is not that they were slow off the mark, they just had a bit further to go. The national scheme is going to be deliverable in the same way throughout Wales.

[30] **Christine Chapman:** Before I bring Jocelyn Davies in, one of the concerns that I had was about how positive the schools were because at the end of the day it is up to the school. I wonder whether there is a role for local authorities in trying to persuade them to adopt that partnership approach.

[31] **Lesley Griffiths:** The fact that 92 per cent of headteachers in the pilot areas felt that it was a positive experience, and were willing to participate, shows that schools are positive about the scheme. The 92 per cent figure is a good rate. I think that about 90 schools across Wales did not participate and there were a variety of reasons for that. It was only one school that did not give a reason for it. The uptake is good. We could look at local authorities, but 92 per cent probably means that we are hitting our target.

[32] **Jocelyn Davies:** You might find that the schools that have been reluctant in the past might come on board when they see the success of the scheme and that it is not going to take up much of their resources. Minister, you cannot be expected to be responsible for home brushing. [*Laughter.*] There are hundreds of thousands of homes, so, to be fair, I do not think that you could be responsible for that. However, I would be very interested to see whether you have any robust monitoring of that, because it is going to be difficult.

[33] My question is about the brushes. We are told that you should replace your toothbrush frequently, so I am curious about the replacement brushes for home brushing. Could you expand on that?

[34] **Professor Chestnutt:** Brushes are replaced at three-monthly intervals, which is in line with recommendations. So, they are replenished every three months, but should there be a need to replace a brush sooner, for example, if a child has been overenthusiastic and the toothbrush bristles get lost or if the brush has been dropped on the floor or whatever, then they are replaced.

[35] **Jocelyn Davies:** I know that all sorts of things can happen with children's toothbrushes. Do they have to bring the other one back? Would you be able to tell whether it had been used?

[36] **Professor Chestnutt:** They get to take home the ones in school. So, they take their own toothbrush home, in addition to the home packs.

[37] **Aled Roberts:** Cawsom dystiolaeth bod rhai o'r swyddogion cyllid o fewn y byrddau iechyd lleol wedi bod yn amharod iawn i ryddhau arian yn y cyfnod gwreiddiol. Pa gamau ydych chi'n eu cymryd i sicrhau bod yr arian sy'n cael ei anfon allan gan y Llywodraeth i'r byrddau iechyd yn cael ei neilltuo i'r pwrpas hwn? Pa fath o fonitro ydych chi'n ei wneud o ran gwariant blynyddol y byrddau iechyd lleol ar y cynllun hwn?

Aled Roberts: We received evidence that some of the funding officers within health boards were reluctant to release funds during the initial phase. What steps are you taking to ensure that the money that is sent out from the Government to the health boards is being ring-fenced for this purpose? What kind of monitoring work are you doing with regard to the annual expenditure of the local health boards on this scheme?

[38] **Christine Chapman:** Do any Members have their Blackberrys or phones on, because something is affecting the translation feed? Please remember to turn them all off. Thank you. Minister?

[39] **Lesley Griffiths:** The funding is ring-fenced and monitored through the health boards' annual accounts process. External independent evaluation is also done by Cardiff University.

[40] **Lynne Neagle:** Some of my questions with regard to the roll-out of the community dental service have been covered. However, I am still unclear about one thing. You have said that the intention is for this to be a universal service, and you have highlighted where good

progress is being made in the pilot areas. Therefore, to what extent are you able to provide data that demonstrate that this is being effectively rolled out everywhere? Also, how is that monitored at a Welsh Government level?

[41] **Lesley Griffiths:** As you say, I said eariler that the community dental service has a stronger presence in some areas than in others. An objective of the previous One Wales Government was to build up the community dental service, and the Designed to Smile scheme has really enabled community dental services to enhance their role and expand. So, following the roll-out, additional resources and equipment have been provided and, as a direct result of the programme, several new members of staff have been employed, and the figures are as follows: 33 in south-east Wales, 18 in north Wales and the new areas—Aneurin Bevan Local Health Board, Hywel Dda Local Health Board, Abertawe Bro Morgannwg University Local Health Board and Powys Teaching Local Health Board—have 30 new members of staff. So, that is 81 new members of staff across Wales. It is ultimately a matter for the local health boards to determine the appropriate level of CDS across their areas. I will pass over to Andrew with regard to monitoring.

[42] **Mr Powell-Chandler:** The evaluation is part and parcel of the agreement that we have with Cardiff University, and Professor Chestnutt might be able to add a bit more to that. The first stage of the monitoring has been for the pilot areas and the next stage of monitoring, which is due probably this month or next month, will cover the first full year of the roll-out. So, you will see from that that the evaluation data will give the information on every LHB and how they have taken up the scheme in their areas. However, at the moment, the first reported evaluation was for the pilot areas.

[43] **Lynne Neagle:** Could that evaluation be shared with the committee?

[44] **Lesley Griffiths:** Yes.

10.30 a.m.

[45] **Professor Chestnutt:** The evaluation is in two parts. The first part is the process monitoring, which provides the statistical returns and is monitored closely in terms of the number of children and participating schools and so on. That informs the data presented. The second part is the more formal evaluation. There are three elements: the views of the staff who participate in the programme, the views of the headteachers, and the views of parents and children. We can then triangulate what they say in an independent survey conducted by the university, as opposed to returns from CDS staff only. Those are the three elements of the evaluation that was commissioned for the programme when it was initiated.

[46] **Lynne Neagle:** Are you confident that the evaluation will give us a comprehensive picture of service delivery across Wales?

[47] **Professor Chestnutt:** Yes.

[48] **Aled Roberts:** Do we have figures for the numbers or percentage of children in local health board areas that receive services from, or are registered with, community dental services, outside the scheme?

[49] **Mr Powell-Chandler:** We have data on the number of children who regularly see a dentist as part of the general dental service. There are also separate data for the community dental service, as it also has a traditional role in seeing some additional children. The data are available.

[50] **Aled Roberts:** Could the data be made available to us?

[51] **Lesley Griffiths:** Yes.

[52] **Christine Chapman:** We would like to see that.

[53] **Jocelyn Davies:** In your paper you say that you are developing a national oral health plan, which is to be welcomed. It will have a particular focus on disease that is persistently high, and you mentioned children under five years age. However, some of the evidence that we have received about children who spend long periods of time in hospital with severe and chronic health conditions notes that oral disease among that group can be persistently high as carers do not consider it their responsibility to clean teeth. You have mentioned children under five, but could you expand on other groups? You say that the plan's delivery will be integrated with Designed to Smile; how will that work?

[54] **Lesley Griffiths:** When I came into post in May, I found out that we did not have an oral health strategy for Wales. That was something that I was keen to pursue. It is currently being drafted and officials are looking at it. I do not have any details at the moment, but I hope to have a draft by February. Any recommendations made by committee will be considered and included in that plan. There will also be wide consultation on the plan. It would be good to get the views of the people who you have just referred to. What you said about children in hospital or children with chronic conditions is interesting. It surprised me to learn that oral health, like the eyes, can tell a lot about a person's body. I read an article not long after coming into post that said that if you have gum disease, it can lead to infertility in some people, although that is very unusual. When I raised it with the Chief Medical Officer for Wales, he said that gum disease can reflect people's lifestyles and it can cause other diseases. There are difficulties with children with chronic conditions in getting carers to brush their teeth, but they could also have problems with their gums and oral health because of their chronic conditions. That is something that we need to look at.

[55] **Lynne Neagle:** Is the dental contract doing enough to encourage dentists to do preventive work with children? Are there any plans to strengthen those contractual arrangements?

[56] **Mr Powell-Chandler:** There is probably room for improvement. We had a review of the dental contract a couple of years ago. Part of the work that came from that is that we are now running pilot schemes. Four pilot schemes based around Designed to Smile are running in Wales and four are running an alternative pilot scheme, which started in April. We are starting to get data from them and it rewards prevention and quality. It removes the current system of remunerating dentists. In very simple terms, they are given a number of patients—children and babies—to care for, with regard to everything that they require on prevention and so on.

[57] **Julie Morgan:** What are the financial arrangements for that?

[58] **Mr Powell-Chandler:** All dentists will have a contract with the local health board, so they would carry on with that contract. With regard to the pilot scheme element of that, we have said that, while they are in the pilot scheme, they do not need to worry about it. So, if, for some reason, they started to see fewer children but were spending more time with them, that would be fine; they will carry on getting the same amount of money. Each dentist already has a contract, and that is what would stay in place. However, within that contract, they are working differently.

[59] **Angela Burns:** Thank you very much for your paper. I want to talk about whether Designed to Smile is addressing the needs of all groups of children and young people. In order to do that, I want to spend a few minutes trying to flesh out some of the statistics. You

say that 50 per cent of all five-year-olds in Wales have experienced tooth decay. Then you go on to say that you are aiming to improve the dental health of five to 12-year-olds in the most deprived fifth of the population to the level presently found in the middle fifth. Do you have any numbers we can attribute to these fifths? This is a fifth of the 50 per cent with tooth decay.

[60] **Professor Chestnutt:** These are targets that were set as part of the child poverty reduction scheme and the mechanism of addressing inequalities by bringing the level of the worst fifth to the middle fifth, as you say. We have the figures for those. We can provide those figures. The issue has been changed slightly by, as you have heard previously, changes in the arrangements for the collection of the epidemiological data. So, it has been necessary to re-base the baseline for the targets and then reset the targets. We can make the figures that those data relate to available to you. It comes down to the numbers of teeth affected by decay, either by being decayed by having been extracted or filled. So, we set those targets in terms of the number of decayed, missing and filled teeth in children resident in the most deprived areas. We hope that, by 2020, that will have reduced to the level of the middle quintile of deprivation. I appreciate that that is a somewhat technical answer. However, we have those figures and we have readjusted them for the changes in the epidemiological programme.

[61] **Angela Burns:** My concern is that, because the programme is, at the moment, designed for a particular cohort of children, we are missing some. I would like to understand how many of the 50 per cent of children with rotten teeth are being missed because they are not in that cohort. Are we saying that we are not reaching 10 per cent, which we could deem as inacceptable? Or are we saying that, in our drive to get to the worst, we are missing 40 per cent or 35 per cent, which we may think is not acceptable? One of my concerns is that, whenever there is any sort of cut-off point, there is quite usually a big rump of people just the other side of the line who tend to have almost the same issues, but, being just the other side of the line, they are not included. I was trying to get an understanding of that.

[62] **Lesley Griffiths:** It is a very targeted programme, but I think that we can provide those figures.

[63] **Professor Chestnutt:** The issue is that, even in the most affluent areas—in the most affluent fifth—about 20 per cent of children will have suffered tooth decay. In the most deprived area, somewhere between 60 and 70 per cent of children will have tooth decay. Obviously, we have to target the programme in those areas where a greater proportion of children have experienced tooth decay. The programme is targeted based on Communities First areas and our knowledge from the local epidemiology. If there is a school in a pocket of deprivation within a more affluent area there is a degree of flexibility to allow it to be targeted outside the original list of schools set up. However, obviously, in addressing rural health inequalities, we have got to devote resources to the areas of greatest need.

[64] **Angela Burns:** Yes, and I understand that. To explain where I am coming from, you state that, in the longer term, you aim to develop and expand the programme to cover the whole of Wales. One of the things we are learning through this inquiry is how incredibly important good teeth are to your long-term health future. Therefore, this is what I am trying to understand: if, Minister, of the 50 per cent—because that is a high figure—you come back to us to say that we are reaching 20 per cent of them well but that we do not have the funds or resources for the rest of them, it gives us a good picture of what we need to bring forward to extend this programme throughout Wales. If you tell us that the picture is more urgent than perhaps we think, then we can lobby, and help you to lobby, for the money that is needed to get this programme into every single school in Wales, so that it reaches every child, because the benefit 20 years down the road will be enormous for our society and culture.

[65] **Lesley Griffiths:** As Professor Chestnutt said, even in the most affluent areas, 20 per

cent of children have difficulties. There are no plans to have this scheme extended to every child across Wales. We do not have the resources to do that.

[66] **Mr Powell-Chandler:** There is also an issue with the level of decay. If you have 50 per cent with some decay, that would include people with only slight decay. When you get towards the more deprived communities, rather than having people with one filling, you might find that they have four, five, six, seven or eight—or missing teeth.

[67] **Lesley Griffiths:** Is that what you are trying to get at?

[68] **Angela Burns:** It is, exactly.

[69] **Professor Chestnutt:** There are two measures of decay—there is the percentage of the population that is affected, but then there is the severity of the disease. You could have one decayed tooth, and that would place you in the 50 per cent who have decay, but the further down the socioeconomic scale you go, the more decayed teeth you will have. If you leave out those who do not have any decay, the mean number of decayed teeth is about four and a half, whereas if you look at the national picture, it is somewhere around two. The mean is diluted by those who do not have any decay, and that is why we target the programme, because not only do these children have more decay, but they have more severe decay.

[70] **Angela Burns:** That is what we wanted to try to get a handle on—these statistics can say all sorts of things.

[71] **Julie Morgan:** On the same sort of question, in the constituency I represent, I do not think that we have any schools involved in this. It is generally regarded as a more affluent area. I feel very concerned about the issues that Angela has been raising about how you reach the children in these areas who need help. I know that you have to target it, but if you have a school outside the most deprived areas, how do you get that school to take part in the scheme?

[72] **Lesley Griffiths:** There is local flexibility—the community dental service can go into a school and assist the school.

[73] **Mr Powell-Chandler:** One of the great benefits of this is that it is being delivered by local community dental services, and they have that local knowledge. So, if you are saying that there is a school that might be borderline, or might not be in a Communities First area, but they know that it serves an area of high-ish deprivation, then they have the ability to go into that school and start Designed to Smile there. Obviously, resource is an issue, but it is happening, and some community dental services are doing that. Some local health boards have added resources to the ring-fenced Designed to Smile money, because they want further schools included in the scheme. It is possible.

[74] **Lesley Griffiths:** I mentioned before that this scheme has really enabled community dental services to expand and enhance their service. A little while ago it was seen as a bit of a cinderella service, but it has really come on because of this scheme, even in areas where it was not rolled out.

[75] **Aled Roberts:** On that theme, it would be interesting from our point of view to have a breakdown by local health board area showing how many schools outside the targeted areas have been included. I am someone who believes in local decision-making as far as it can work, but although this is a national scheme, if there is one local health board area where no schools outside the targeted areas have been included, we might want to understand the decision-making process that that local health board has gone through. It might be that, in other areas, 40 schools have been added to the scheme because the local health board put the moneys in. I am not saying that we could not or should not be challenging that decision; it is

just to understand it. There is a danger that we will have a postcode lottery again.

10.45 a.m.

[76] **Lesley Griffiths:** We can send you a note on that.

[77] **Lynne Neagle:** I heard your answer to Julie, but you could have an incredibly prosperous school in Cardiff North, and there could be one child in a class who has problems with his or her teeth. I am not convinced that such children will have any access to services, based on what we have heard. Is there any way of picking up that child such children if they are not being taken to the dentist?

[78] **Mr Powell-Chandler:** If they are not accessing services, then that is difficult, because you cannot force somebody to go to the dentist. Community dental services do have a traditional role in picking up some of those harder-to-reach groups, but if you are talking about an individual in one school, it is very difficult for any scheme to target them on a one-off basis.

[79] **Lynne Neagle:** So, when this becomes a universal service, which you say it will, it will effectively pick up such children. The community dental services will be engaging with all schools and that should pick up the pupils who may be falling through the net.

[80] **Mr Powell-Chandler:** There will be a universal service delivered across Wales and in the same way, but still targeted at schools. So, yes, if there were one child at a school in an affluent area that was not part of the programme, we would have to consider how else that child could be picked up. It would not necessarily come under this scheme; it would be through other, traditional roles that the community dental service has. One of the messages is that, in terms of the national health plan that the Minister has talked about, pupils are required to look after their own health. It is about getting those messages over as well, and trying to encourage people to access the services that are there for them.

[81] **Professor Chestnutt:** There is, of course, the traditional role of community dental services in terms of school screening, which is outside the Designed to Smile programme. As part of the programme, parents would be alerted to the state of their child's oral health and whether the child needs treatment. So, the scenario that you describe would be governed by that provision of school screening.

[82] **Christine Chapman:** I want to move on to the subject of fluoridation in a few minutes, but before that, I have a few other questions first. We will see how the time goes, but I know that Members are particularly concerned about that subject. Julie, do you want to ask your question about tooth extraction?

[83] **Julie Morgan:** Yes, it is about the anaesthetics. We have been quite surprised by some of the evidence that we been given about general anaesthetic being used on children for dental work—that is, that it happens so often. Clearly, we would hope to see a decrease in that with the progress made under the Designed to Smile programme. Have you seen any evidence yet of a decrease in the number of children having a general anaesthetic?

[84] **Lesley Griffiths:** The data for extractions under general anaesthetic are a useful indicator, but it is very hard to know exactly how many take place, because it can take place in a variety of settings. It is therefore quite difficult to get robust numbers for that. Public Health Wales is undertaking an exercise at the moment to analyse the available data on the number of general anaesthetics administered in Wales. Currently, the figure is estimated to be between 8,000 and 9,000 a year. However, as I said, it is very difficult to get the figure, because there are private dentists who will do that and the community dental services perform

extractions in that way as well.

[85] **Julie Morgan:** So, it is not all done in hospital.

[86] **Lesley Griffiths:** No, absolutely not. You have hospitals, private clinics, NHS clinics and the community dental services, so it is difficult to get the number.

[87] **Mr Powell-Chandler:** In north Wales, the community dental services do a lot of work under general anaesthesia, whereas in south Wales, there is a mixture involving secondary care. Local health boards will have a contract with a dental provider to undertake work under general anaesthetic. With regard to your question, it is probably too early to tell if there is a reduction in the number of general anaesthetics administered, but it is one of the things that we are going to look at. It will be a useful additional indicator, along with the study of the rest of it.

[88] **Julie Morgan:** Is it something that you will be monitoring?

[89] **Mr Powell-Chandler:** Yes, it is something that we are going to do. So, while it is probably too early to tell, there is some anecdotal evidence coming from some of the pilot areas that dentists are saying that oral health seems to be better, in the sense that children are cleaning their teeth more regularly and so on, but there is no concrete evidence as yet.

[90] **Lesley Griffiths:** There has definitely been a decrease in Scotland, which has run a similar scheme for at least 10 years before us.

[91] **Jenny Rathbone:** I had always assumed that general anaesthesia took place in a hospital setting. Do we have robust protocols in place where general anaesthesia is done in a community dental setting?

[92] **Mr Powell-Chandler:** There are such protocols in place; community dental settings are registered as private hospitals, because that is what they are. There are very strict protocols in place, and that has changed over the years. You used to get dentists providing general anaesthetic, but no dentist does it now in a high street practice, for example.

[93] **Simon Thomas:** We have assumed that the figures given in evidence in previous committees were non-caveated, but from what you have just said there seems to be some—I will not say doubt—room for difference around the figures. Although I appreciate that this takes place in different settings, would it not be useful for the Government to make it a reportable target, with any general anaesthesia used with a young person in a dental setting reported in the usual way? To have a firm figure for this and to monitor it over 10 years in Wales would be extremely useful.

[94] **Lesley Griffiths:** I have asked officials to look at it within the strategy.

[95] **Jocelyn Davies:** In the evidence that we have received, the witnesses named the places where general anaesthesia is carried out. There were not dozens of them—it was a small number. I accept that some of those are private clinics, but they are probably being paid for by the NHS. The impression that we have been given from previous witnesses is that this figure can easily be counted, is accurate and would be a very good measure of whether the programme was successful. So, perhaps we just need to look at the way in which the data are collected.

[96] **Lesley Griffiths:** I agree, and, as I said, it is something that I have asked officials to look at within the scheme. You are absolutely right. General anaesthesia is very safe, but there is an element of risk. It is something that we would want to see a big drop in, especially

among children, within the success of this scheme.

[97] **Jocelyn Davies:** Some of us are old enough to remember that dentists used to do it.

[98] **Lesley Griffiths:** Yes, indeed, with a gas mask.

[99] **Suzy Davies:** I am very pleased to hear that the programme has been rolled out for those from birth to the age of three, but we recognise that there are much more difficult to reach groups. Are you satisfied that this programme will reach the number of children between birth and the age of three that you hope?

[100] **Lesley Griffiths:** There is still a little way to go—we still need to make some progress in engaging those from birth to the age of three. With them, you only need a smear of toothpaste, because they swallow it much more than older children. So, I think that we will see greater success there. We have the stage implementation, which has meant that, in areas where we had the pilot scheme, the community dental service has been able to take it forward much more. So, a bit more progress needs to be made, but we are getting there.

[101] **Suzy Davies:** Specifically on how this is being delivered to those from birth to the age of three, there is obviously greater emphasis on the use of health visitors and social services professionals. As you say, the budget for Designed to Smile is ring-fenced, but will the money for additional work by health visitors, and, more specifically, for social service workers, come from that budget, or will the extra work that social service professionals need to undertake come from the social services budget?

[102] **Mr Powell-Chandler:** The community dental service has been provided with additional resources. The original pilot scheme was started as a tooth-brushing scheme for three to five-year-olds. It has been expanded, so it now includes nought to three year olds, but it still falls on the community dental service to deliver that, working with its partners.

[103] **Lesley Griffiths:** The £3.7 million that is ring fenced is—

[104] **Suzy Davies:** I appreciate that, but it seems to be leaking in to social services to cover—

[105] **Lesley Griffiths:** No, extra money can come out of the CDS.

[106] **Jocelyn Davies:** I am curious as to whether any work is done during pregnancy. You need not start only when the child is born. Generally, the mother is in contact with health services during the nine months leading up to the birth. Is there anything there about the brushing of teeth? I know that babies generally are not born with teeth, but could some education be provided at that point?

[107] **Professor Chestnutt:** There has traditionally been a focus on prenatal and postnatal classes. The experience is that, at that stage in the life course, mothers have other things on their minds. So, while it is important to raise oral health during pregnancy, it is when the teeth come through—usually when the baby is about six months old—that attention is focused on teeth, tooth-brushing and diet. As you heard previously, there is benefit in health education, but what you can achieve with that in terms of tooth decay is limited. This is about the emphasis of the scheme as it is operated. Through Flying Start and Sure Start, we have had packs being distributed via health visitors in the past. Designed to Smile provides a more systematic mechanism of ensuring that the teeth get into contact with fluoride.

[108] **Aled Roberts:** I would like to develop Suzy's point regarding health visitors for those from birth to the age of three. Presumably, health visitors would not be employed by the

CDS. In terms of transparency of budgeting, do we have any evidence regarding the numbers of health visitors who have been engaged within each local health board to focus on those from birth to the age of three?

[109] **Mr Powell-Chandler:** I wonder whether that would be included in the evaluation.

[110] **Professor Chestnutt:** I am not sure whether those data have been collected.

[111] **Lesley Griffiths:** We would have to send a note on that.

[112] **Aled Roberts:** From our point of view, it would be interesting if some local health boards were using health visitors, while others were not. We have an issue regarding the transparency of health budgets within local health boards. Some finance directors might be saying, 'Yes, we have had this extra money, but—'

[113] **Professor Chestnutt:** I do not think that they would run it off as being directly involved in the delivery of the programme.

[114] **Aled Roberts:** No, but on the point that Suzy was making, accepting that the health visitors were not directly employed, it is all very well to say, 'Yes, we are giving you this extra money and you can use it for health visitors'. On the other hand, if you are just pushing the burden onto health visitors or social services staff—

[115] **Lesley Griffiths:** Who are you saying is giving them this extra money? Is it the LHBs?

[116] **Aled Roberts:** You said that there was money—more than £3 million—that had been sent out to the LHBs.

[117] **Lesley Griffiths:** That is ring fenced for this programme.

[118] **Aled Roberts:** Yes, but if you are saying that there is a responsibility on health visitors to pick up issues relating to those from birth to the age of three, we are interested in establishing how that works within each LHB area. There may be some areas where they are saying, 'Yes, we will give this added resource to health visitors so that they can carry out additional work'. However, there may be others where no money is being pushed through and where we might find that, to all intents and purposes, health visitors are not as active as they are in other local health boards.

[119] **Christine Chapman:** Could we have a note on that?

[120] **Lesley Griffiths:** Yes.

[121] **Christine Chapman:** Thank you. I think that that would be useful, for clarification.

[122] **Lynne Neagle:** I wish to address wider public health issues. I understand why we are placing a lot of emphasis on brushing, and Professor Chestnutt has talked about some of the challenges relating to public health, but there are some fairly simple things that parents can do, such as not putting sweet drinks in a bottle and using free-flowing caps. This does not mean that they are never going to give their child a sweet again, but it might lead to the modifying of behaviour. Are those kinds of simple messages being incorporated into this oral health strategy?

[123] **Lesley Griffiths:** Absolutely. There is a big public health message here, and it will definitely be included in the strategy.

[124] **Mr Powell-Chandler:** Yes, and it is already part and parcel of the work done by community dental services in respect of the healthy schools scheme and so on. This is about ensuring that there is a consistent message. So, whatever the relevant people are saying about Designed to Smile is the same as what they would be saying about healthy schools, and vice-versa.

[125] **Jocelyn Davies:** This will sound like a really basic question, but is Designed to Smile about cleaning teeth or is it about getting fluoride onto the tooth? Three or four times this morning, you have said that it is about getting fluoride onto the tooth.

[126] **Lesley Griffiths:** It is both.

[127] **Jocelyn Davies:** Okay, so it is not all about getting fluoride onto the tooth. It is also about having clean teeth.

11.00 a.m.

[128] **Lesley Griffiths:** It is a preventative programme that a child will, hopefully, adopt for life.

[129] **Jocelyn Davies:** When I cleaned my teeth this morning, getting fluoride onto my teeth was not foremost in my mind.

[130] **Lesley Griffiths:** The programme is about finding ways of getting fluoride onto the teeth. You probably have fluoride toothpaste. We need to ensure that children have that toothpaste to get fluoride onto the teeth. It is a preventative programme that is about teaching good habits and how to brush teeth, which children will hopefully take with them through life.

[131] **Jocelyn Davies:** I noticed that all of you, in giving your evidence, have mentioned this issue of getting fluoride onto to the tooth; that is all. It is a bit of a distraction.

[132] **Jenny Rathbone:** I am interested in the whole issue of fluoridation. We have heard from lots of expert witnesses that Designed to Smile is a proxy for getting fluoride onto the teeth through toothpaste. In your paper, you mention the absence of fluoridated water supplies. What serious consideration has been given to fluoridating water?

[133] **Lesley Griffiths:** I have no current plans to fluoridate water supplies in Wales. We have to acknowledge that the scientific evidence supports the case for water fluoridation as having significant health benefits. However, there are no plans to do so at the moment. If there ever were, there would have to be a wide consultation, because I am very sensitive that a lot of groups fundamentally oppose it. I can see that Lynne agrees with them. [*Laughter*.]

[134] **Jenny Rathbone:** I am aware that people shout loudly, but you are a new Minister, and I would like to know whether your department has ever given serious consideration to this important public health issue.

[135] **Lesley Griffiths:** Yes, it has. In 2005, when Dr Brian Gibbons was the Minister for health, a huge amount of work was done on this issue. However, I have no plans to introduce fluoridation of the water supply.

[136] **Jenny Rathbone:** Are the outcomes of the deliberation and evaluation by Brian Gibbons in the public domain?

[137] **Mr Powell-Chandler:** I think that, at the time, they were looking at the legislation on

fluoridation. Legislation had been brought in in England that allowed fluoridation of water supplies; they had changed the legislation. The Minister at the time was looking at the application of the legislation, and whether it should be enacted in Wales. Issues of fluoridation go back much further, of course.

[138] **Jenny Rathbone:** We all have memories of those issues. However, there is some desire to revisit this issue. It would be pointless to start from scratch, so it is possible for you to give us the evidence and the evaluation that were given to the previous Minister in 2005?

[139] **Mr Powell-Chandler:** I would have thought so. I was not party to that evaluation, so I do not know what form that takes, but there is certainly a lot of evidence on fluoridation of water.

[140] **Jenny Rathbone:** It is a no-brainer. None of the expert witnesses have ever indicated that there is anything other than huge public health benefits in fluoridating water. It is important that the department of health tells us why it has not pursued this clear path.

[141] **Mr Powell-Chandler:** I am sure that the department and the wider Welsh Government can provide you with information on what the position is and what would be required to introduce a fluoridated water scheme.

[142] **Jenny Rathbone:** It is the Welsh Minister that we wish to hear from.

[143] **Lesley Griffiths:** I will undertake to look at the issue. When that information was given to Dr Gibbons in 2005, it was decided that the Welsh Assembly Government, as it was at the time, would follow a basket of preventative oral health measures rather than adopt water fluoridation as the dental public health policy measure in Wales. I do not have the reasons for that decision, but I can provide a note on it.

[144] **Jenny Rathbone:** Have you seriously considered fluoridating the water that is available to children in schools as a way of targeting the group that we are considering?

[145] **Lesley Griffiths:** I have not considered the issue in the six months that I have been in post. The clinical evidence is that the amount of water that a child would drink at school would not be of that big a benefit.

[146] **Professor Chestnutt:** The Minister has answered the question. Prior to the implementation of Designed to Smile, all of the evidence base on the various vehicles for delivering fluoride as a means of preventing decay was reassessed through the Cochrane library systematic reviews of up-to-date world-wide literature. Fluoride toothpaste and fluoride varnish were found to be the most effective ways. If you gave children fluoride in water fountains at school, they would not drink enough and the fluoride would not be present at a sufficient concentration to have any clinical benefit.

[147] **Jenny Rathbone:** Okay, so the cost versus the benefit that would occur in any case has not been considered, has it?

[148] **Professor Chestnutt:** If something is not going to be clinically effective, it cannot really be cost-effective.

[149] **Jocelyn Davies:** I suppose that you would also have to have a different water supply for those children who want to opt out. Are there any possible health side-effects to having fluoride in the water? What is your view on the ethics of mass medication? What is your personal approach to that? I know that you say you have no plans to go ahead with this, but do you have any ethical issues on this? You might perhaps send us a note on the health side-

effects of fluoride in water.

[150] **Lesley Griffiths:** The one side-effect that comes to mind is that people say you can get dental fluorosis; too much fluoride could lead to children having marks on their teeth. I am sensitive to the fact that lots of people would feel that it is mass medication. I remember having a discussion in my constituency office on this; it was split down the middle, half for and half against. So, you would have to have a massive public consultation if you were going to take that forward.

[151] **Professor Chestnutt:** The evidence is clear, in spite of the claims that might be made by those opposed to water fluoridation. A review commissioned by the Department of Health, and undertaken by the University of York, found that there were no adverse effects on general health of having fluoride in the water at the level that would be required as an oral health prevention measure.

[152] **Jocelyn Davies:** It occurs to me that if you had a large public consultation, you would have people objecting, but the people who you are trying to help are children in the most deprived communities. I do not think that they will be responding to your consultation. They would not have a voice in this.

[153] **Lesley Griffiths:** That is why this scheme is so important.

[154] **Christine Chapman:** If you can supply us with information on what has been done by the Welsh Government that would be useful.

[155] **Lesley Griffiths:** Okay, Chair.

[156] **Christine Chapman:** Jenny Rathbone has a final question.

[157] **Jenny Rathbone:** My question is about the gathering of statistics, and the fact that some of the expert witnesses expressed concern that it is not possible to compare historic figures with current figures, because it is now a requirement to have positive acceptance from parents for their children to be examined. Is there any possibility of having a different approach, whereby the parents who do not wish their children to have their teeth looked at could opt out, that is, they would have to positively opt out, so that schools would not have to chase parents over pieces of paper that go home and never come back? It has serious implications for the quality of the data.

[158] **Mr Powell-Chandler:** It seems unlikely that the consent arrangements are going to change. It was the legal advice that the way it is done is the way it needs to be done. There was a loss of trend data, but the 2007-08 data gathering was the first time that data were gathered since the change. So, we have that now as the baseline, which is what we use for the evaluation of Designed to Smile. The changes came about long enough ago that we have the 2007-08 data. So, that coincides nicely with the start of Designed to Smile. So, we have that to build on now. Future surveys will be undertaken in the same way, so you will have the figures to compare it against.

[159] **Lesley Griffiths:** The change in consensus complicates the target setting and evaluation.

[160] **Jenny Rathbone:** I just think that there is one particular group that is a cause for concern, which is parents who do not wish it to be known that their children's teeth are rotting and who will therefore withhold consent. Those are the children who most need access to Designed to Smile. However, because of the legal constraints, there is nothing that can be done about that, is there?

[161] **Lesley Griffiths:** No.

[162] **Simon Thomas:** It seems to me that you have three approaches to children's oral health: Designed to Smile, access to community dental services, and the general high street dentist. We have looked at Designed to Smile in detail, and we have heard positive information about improvements to what you call a cinderella service coming forward because of that programme. The bit that is still missing is the high street dentist. We know anecdotally, as representatives, that many of our constituents do not have access to high street dentists, or do not choose to take up access—they simply do not go to the dentist, particularly in certain areas. For the long-term sustainability of what you are trying to achieve with Designed to Smile and your proposed oral health strategy, do we need to change the way that our high-street dentists work?

[163] **Lesley Griffiths:** No. There are now many more dentists providing NHS treatment than at any other time. The latest workforce data that we have, up until March of this year, show that there are now 1,349 dentists with NHS activity recorded. So, no, it is not something that we need to look at too closely.

[164] **Simon Thomas:** Yes, but you have four pilot programmes looking at alternative ways of dentists working.

[165] **Lesley Griffiths:** Yes.

[166] **Simon Thomas:** What I am trying to get at is where we will be in 10 years' time, really. I am not sure that they are actually delivering the sort of preventative action that you are talking about. Your overarching strategy for the NHS puts a great emphasis on prevention, but I am not convinced that they are fit for that.

[167] **Mr Powell-Chandler:** About two thirds of children see their dentist regularly. Some more will be seen by the community dental service and others will be picked up by Designed to Smile. However, there is that other element who are not taking themselves to the dentist.

[168] **Simon Thomas:** That still leaves around a quarter, does it not?

[169] **Mr Powell-Chandler:** Yes. We are looking at the contract with regard to what it does, and one of the points that you mentioned is that there is some criticism that it is still a treadmill and that dentists do not have enough time with each patient, whether they are children or adults. So, the pilot scheme is telling them to look at the individual and spend as long as they need with that person, without needing to worry about remuneration. That is what the pilot scheme is doing. We need to run that pilot scheme to see what effect that has on—

[170] **Simon Thomas:** How long will that pilot programme last?

[171] **Mr Powell-Chandler:** We have said two years, and it started in April. We need to let it run its course so that we can see what it has done with regard to the improvements in the oral health of individuals, the number of people being able to access the service, patient charges and all sorts of other things. So, yes, we are aware of that and looking at it.

[172] **Christine Chapman:** Time is moving on; we will have to finish shortly. We have Julie Morgan, Aled Roberts and Lynne Neagle next. Are there any other Members who want to ask some final questions? I see that there is no-one else.

[173] **Julie Morgan:** The issue that has come up throughout all of the evidence is the fact

that, at five years of age, the oral health of children in Wales is comparatively pretty bad, but is not true later on, at the age of 11 or 12. Is there an explanation for that? Why is it that, later on, we are not in such a bad state in this country?

[174] **Professor Chestnutt:** I observed that discussion in your previous committee meeting. The issue relates to some data that were presented by the British Dental Association that looked at 12-year-olds and the suggestion was that there was a difference between oral health in Wales and Sweden. However, that is not the case. If you look at the data, you will see that Wales is at about 1 and Sweden is at 1.1. There are areas in eastern Europe where there are still high levels of decay in permanent teeth. In Wales, we have not seen the decline that we have seen in permanent teeth in deciduous teeth. If you go back 30 years, you will see that the average 15-year-old in Wales had nine decayed teeth; now it is about one. So, we have had this improvement in the permanent dentition that has not been mirrored in the deciduous dentition. The reasons for that are probably quite complex. I am not sure whether it is fully understood why we still have this burden—it is related to socioeconomic status—and why we have not had the same reduction for deciduous dentition as we have had for permanent dentition.

11.15 a.m.

[175] **Julie Morgan:** It is fascinating, because we want to make all this effort with Designed to Smile so that children do not have to undergo general anaesthetic and so on, but later on it appears—

[176] **Professor Chestnutt:** There is evidence that, in trying to predict the risk of tooth decay for teenagers and adults, one of the best predictors of risk is decay in the deciduous or baby teeth. That is why it is important. Going back to the question of whether it is just tooth decay, the Designed to Smile focus is on tooth decay, because that is the oral disease that affects children, but gum disease becomes a problem as you get older. This programme will, hopefully, initiate socialised tooth brushing. We have been concentrating on fluoride, but gum disease is as important. You have referred to the epidemiological evidence of a link between poor gum health and general health and vice versa. It is about getting in at an early stage and socialising the key element in maintaining good oral health, which is tooth brushing in combination with dentist attendance and diet.

[177] **Julie Morgan:** So, we do not really have an explanation.

[178] **Professor Chestnutt:** No. I do not have an explanation with regard to deciduous teeth.

[179] **Christine Chapman:** I think that all of us are puzzled by it. Aled Roberts is next.

[180] **Aled Roberts:** I recognise the increase in NHS dentistry, but am still not able, as a parent, to understand access to those services. I still cannot get my head around that. My two children have always gone to the community dental service system, although I still do not understand how they got involved with it. My wife would probably say that I never take an interest anyway, but I have never seen any results of school screening. That may be because they are going to the dentist regularly and there is no problem. However, I have not heard anything on that, even as a chair of governors. Can you explain whether school screening involves all schools, whether it involves children of particular ages, and what the referral process is? I am in the same camp as Simon, in that I am not convinced that we are not just seeing the development of a piecemeal service, where certain parents will go to CDS, certain parents will go to their high street dentist, and certain parents will not go anywhere. We are worried that it is the parents who will not go anywhere are the ones who have the biggest problems. I worry whether we have a national approach to drive this preventive agenda, or

whether we are stuck with a mix-and-match service, which you referred to as a cinderella service, which is improving, but the main drivers are still the private high street dentists, and people may still think that there are difficulties in accessing them.

[181] **Christine Chapman:** I will bring in Lynne Neagle before you answer, because I think that her question is on the same point.

[182] **Lynne Neagle:** The big concern that I have, and what I was driving at with the question about Cardiff North, is that while I support targeting, and have always argued in favour of targeting the most deprived areas, I also think that all children should have access to some form of dental care. We have heard that 20 per cent of kids are not taken to the dentist. That is not the children's choice. What are we doing about that 20 per cent? Professor Chestnutt referred to screening when I asked about Cardiff North, but when I asked about screening in a previous committee meeting, we were told that it was like a sample approach. It is not enough to say that there are 20 per cent who are not seeing a dentist; we need to do something about it.

[183] **Professor Chestnutt:** Perhaps I can clarify the difference between the sampling, which relates to the data that are collected for epidemiological purposes to measure the amount of decay that is in the population, and screening, which is a different process. Both are carried out by the community dental service, but screening is a different process whereby, rather than going in and undertaking a detailed examination and recording the condition of each and every tooth, the children are screened to identify whether they have a need for treatment. That is then communicated back to the parents. One issue is then the uptake of treatment by parents, and I appreciate that how screening operates across Wales might differ, depending on the approach of different community dental services. However, the sample applies only to the epidemiological survey; the screening is, again, targeted at the schools in greatest need, I would suspect.

[184] **Lynne Neagle:** So, not all children are screened, basically.

[185] **Professor Chestnutt:** I suspect that that would be the case.

[186] **Aled Roberts:** Could we have evidence on that? If you are saying that there are different approaches in different parts of Wales, it is important that we have an understanding of how many children are being covered by school screening. I am still not totally comfortable with a situation where, if you live in one part of Wales you could have a brilliant service, but, if you live in another, it could be a cinderella service.

[187] **Lesley Griffiths:** We will have to send you a note on that.

[188] **Christine Chapman:** Are all Members happy with that? I see that you are. Thank you for attending today—it has been a good session, which will help with our inquiry into oral health.

[189] Before I close the meeting, I advise Members that the next meeting will be held next week, on Wednesday 9 November, when we will begin taking evidence for our inquiry into the implementation of the Learning and Skills (Wales) Measure 2009. The meeting is now closed.

Daeth y cyfarfod i ben am 11.21 a.m.
The meeting ended at 11.21 a.m.