Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Iau, 29 Medi 2011
Thursday, 29 September 2011

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Inquiry into Children's Oral Health in Wales: Evidence Session

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

Huw Bennett	Iechyd Cyhoeddus Cymru Public Health Wales
Dr Shannu Bhatia	Cymdeithas Deintyddol Pediatrig Prydain British Society of Paediatric Dentistry
Dr Mechelle Collard	Cymdeithas Deintyddol Pediatrig Prydain British Society of Paediatric Dentistry
Lesley Griffiths	Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol Minister for Health and Social Services
Dr Tony Jewell	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
Dr Nigel Monaghan	Cymdeithas Prydain ar gyfer Astudio Deintyddiaeth Gymunedol British Association for the Study of Community Dentistry
Maria Morgan	Cymdeithas Prydain ar gyfer Astudio Deintyddiaeth Gymunedol British Association for the Study of Community Dentistry
Dr Heather Payne	Uwch Swyddog Meddygol, Iechyd Mamol a Phlant Senior Medical Officer, Maternal and Child Health

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

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

Dechreuodd y cyfarfod am 9.34 a.m.
The meeting began at 9.34 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Christine Chapman:** Welcome to the Children and Young People Committee. I remind Members to turn off mobile phones, BlackBerrys and pagers. The National Assembly for Wales operates through the media of Welsh and English. Headsets are available with simultaneous translation on channel 1 and sound amplification on channel 0. As this is a formal public meeting, I remind Members that you do not need to operate the microphones manually as they will come on automatically. In the event of an emergency, an alarm will sound and ushers will direct everyone to the nearest safe exit and assembly point. We have not received any apologies.
9.35 a.m.

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

[2] **Christine Chapman:** We will now move on to the next item on our agenda, which is our inquiry into children's oral health. Today, we will be taking evidence from Public Health Wales. This is the second oral evidence session for the committee's inquiry. I would like to welcome Huw Bennett from the dental public health team of Public Health Wales.

[3] We have read your paper, Mr Bennett; thank you for providing it. Are you happy for us to move straight on to Members' questions?

[4] **Mr Bennett:** Yes.

[5] **Christine Chapman:** I will ask the first question. The Designed to Smile programme was first introduced in 2008 and extended across Wales in late 2009 and early 2010. In terms of improved health outcomes, what contribution has the programme made to improving child dental health so far?

[6] **Mr Bennett:** It is probably too early in the life of the programme to definitively say that we have evidence to show improvement. A couple of years ago, a dental health survey was carried out on five-year-olds. However, the problem with it was that it was conducted under a different process of consent to previous surveys. I think that the British Dental Association gave evidence last week and explained that. With any programme like this, it would be four or even five years into the programme before an epidemiological survey could definitively show a significant improvement. A survey will be carried out very soon, although I think that that one may be too early. I think that I said in my evidence that we might carry out a survey on five-year-olds in 2013-14. Looking at the timetable for national surveys, it would be possible to conduct one in 2012-13. If we did do, I would be very hopeful that that survey would give us definitive evidence. The programme will have been running for a sufficient length of time by then and we will be able to make comparisons with the two previous programmes that were conducted under a similar form of consent.

[7] **Lynne Neagle:** The Designed to Smile programme is targeted at deprived communities, but some of those children are quite hard to reach. How satisfied are you that the programme is reaching the children for whom it is intended?

[8] **Mr Bennett:** It is a programme that targets Communities First areas and takes that kind of approach. It is conducted across seven community dental services, and its value lies in

the fact that it uses a lot of the local knowledge of community dental service staff. That helps to ensure that the locations that should be targeted are known and approached. I have some figures on this. If you look at three to five-year-olds and six to 11-year-olds in Community First areas, you will see that we have an estimated child population of about 66,000. We have already reached about 63,000 of those children. Tremendous progress has been made, particularly in the last 12 months, when that figure has risen by about 30,000. So, I am fairly confident that we are reaching those target populations.

[9] **Lynne Neagle:** I want to look at this from the other side as well. There are children who do not live in Communities First areas and who are at risk of dental decay. Are we doing anything to address the dental needs of those children?

[10] **Mr Bennett:** Even if you look back at the original guidance that underpinned the super-pilot schemes, you will see that there is a line in there stating that this programme is flexible. Within a particular area, if the local CDS knows that there are localities or institutions such as special needs education units for children that lie outside the defined borders of a target area, they can take the programme to them. That is the strength of it: it is not rigid and it can be flexible.

[11] **Jenny Rathbone:** In your evidence, you talk about getting children in these areas to use fluoride toothpaste, and say that your prevention work begins with parents-to-be. Could you talk us through how you are doing that? We have heard that a lot of families do not have a toothbrush.

[12] **Mr Bennett:** That is right. When the programme first started, we targeted three to five-year-olds and the six to 11-year-olds. However, as the Designed to Smile team was established, and as more funding was made available, all the Designed to Smile groups were encouraged to embrace those from birth to the age of three.

[13] I tend to be more strategic in all of this, but I have got more local operative knowledge of what happens in the Abertawe Bro Morgannwg University Local Health Board area, so I will use that as an example. During the past nine months, they have started to think about how they can reach children in the nought to three age group and their parents and grandparents, because these days, a lot of grandparents are involved in caring for young children. Some of the groups they have reached out to include breastfeeding support groups and various child minder groups, importantly linking in with the health visitor services. They have now made contact with 29 different organisations, or even child minders, and a large proportion of those have already started tooth-brushing programmes. The key is not only to introduce tooth brushing, but to change the habits within the family, too. Hopefully, all those messages will be taken home.

[14] The programme is at quite an exciting stage now, as it tries to take on the challenge of the nought to three age group. It is a little more difficult. You know where the school at the top of the hill or down in the valley is, but knowing where some of the children in the nought to three age group are in child minding services and so on takes a lot more effort.

[15] **Jenny Rathbone:** Are you working with midwives and health visitors on that?

[16] **Mr Bennett:** Yes. In mid and west Wales—in Powys Teaching Local Health Board, Abertawe Bro Morgannwg University Local Health Board and Hywel Dda Local Health Board—we have set up Designed to Smile steering groups. We have invited health visitors to those groups. We do not have any midwives in these groups as yet. In the Swansea area, we made an initial contact with midwives, but it was probably the wrong time because they were involved in other initiatives, but we will try to bring midwives and health visitors into this project.

[17] **Aled Roberts:** Following on from Jenny's point, we had evidence last week that midwives are involved in the programme in some areas but not in others. As this is a national initiative, it seems strange that connectivity is stronger in some areas than others.

[18] **Mr Bennett:** That probably goes back to the way that the programme was launched with two super pilots. In the two super pilot areas, the community dental services set up, almost, their own steering groups, and perhaps they were not as inclusive as they could have been at that stage. However, big efforts are being made. The steering groups that we have set up in mid and west Wales are being used as exemplars of how wider stakeholders should be brought in. In Gwent recently, they set up an oral health promotion steering group that is going to be chaired by the director of Public Health Wales. Having the director of the dental public health team involved will provide a wider overview of health promotion. Hopefully, that will bring other stakeholders in.

[19] There is something called the Designed to Smile national forum, which is chaired by the chief dental officer. In fact, next Monday, I am chairing a meeting on his behalf. This is one of the issues on that agenda. That forum gives us time to formally share all our best practices. We want consistency, but I do not think that you should devalue the local flexibility of the programme, which is a point that I have made. Equally, the ability to respond to local circumstances is a strength.

9.45 a.m.

[20] **Jenny Rathbone:** My last question is on how you are approaching the habit of people giving babies sugary drinks and fresh juice in bottles, as opposed to using beakers once the child is old enough to use them.

[21] **Mr Bennett:** Before the Designed to Smile programme, there was a lot of inconsistency in the advice being given. I am not an expert on baby cups—please do not go there—but there was inconsistency in the advice from stakeholders. Designed to Smile has allowed the teams to link with local health visitor services in any given area, and more consistent messages are now being given. If the Designed to Smile teams go in to a particular location, it is about more than just tooth brushing; it is backed up by dental education. On its own, dental education has generally been proven to be ineffective, but allied to things like tooth-brushing teams and so on, it can have an effect. So, the thing is to get that message consistent, first of all, and then to get it across more broadly.

[22] **Jocelyn Davies:** I just wanted to ask about public information films. They seemed to be on television all the time, once, but you do not really see them anymore—I think that tooth brushing was featured in one of those.

[23] **Mr Bennett:** I seem to recall a health promotion initiative in Pembrokeshire that did something like that with an overhead gantry—this was not to do with Designed to Smile, but it involved an element of oral health. Schools have these educational programmes running all the time, and there is some mileage in that. Were you thinking of national campaigns on television?

[24] **Jocelyn Davies:** Yes.

[25] **Mr Bennett:** That tends to cost money—that is the only thing.

[26] **Jocelyn Davies:** Is it effective?

[27] **Mr Bennett:** I think that it would be. If you look at oral health generally, and how it

has improved since 1973, it is probably because of the use of fluoride toothpaste, and if you look at the television advertising for fluoride toothpaste, there is no doubt that it has been really effective.

[28] **Christine Chapman:** We move on now to Angela Burns.

[29] **Angela Burns:** To be honest, Chair, I believe that Huw Bennett has fully answered my question.

[30] **Christine Chapman:** Fine. Suzy Davies is next.

[31] **Suzy Davies:** I just want to develop something that you said earlier about the two types of survey methodology. If the dental health surveys are focused on five-year-olds, surely that means that the effect on nought to three-year-olds and on three to five-year-olds are included in those surveys. Is that sufficient to measure what is happening to those age bands?

[32] **Mr Bennett:** I think that it would give us sufficient evidence, yes.

[33] **Christine Chapman:** The next question is from Julie Morgan.

[34] **Julie Morgan:** I want to move on to tooth extraction. You say in your evidence that some 8,000 or 9,000 children have tooth extraction under general anaesthetic. You say that this is totally unacceptable and that it could be prevented, which is obviously right. Do they all take place in hospital now? Fairly recently, I heard of situations where anaesthetic was being given in dental surgeries.

[35] **Mr Bennett:** No general anaesthetics are given in what you would describe as the family high street dentist. That finished a decade or so ago. Some general anaesthetics are still administered in a hospital environment, but a large number, especially in south Wales, are carried out in what are best described as independent units that are contracted to the NHS. There is the Parkway Clinic in Swansea and one in the Victoria area of Newport. They would account for a large amount of the child general anaesthetics that are administered in Wales. In north Wales, it tends to be done in a hospital, in a secondary care environment. In south Wales, you could class it, not as primary care, but as an intermediate type of care.

[36] **Julie Morgan:** Are there some children who do not need the general anaesthetic because they can cope with it? Do all children who have extractions need it?

[37] **Mr Bennett:** This is quite a complicated one, because there is a feeling that some of the children who have a general anaesthetic could probably be treated under sedation. There is a whole range of different forms of sedation, ranging from a little bit of gas and air, to using a drug or a combination of drugs. As you slide up that scale, you get to a point where some of the risks involved, particularly outside of a hospital environment, are equal to or, in some cases, maybe more than those for a general anaesthetic. So, we must be careful. I know that some health boards are rightly looking at whether they want to increase the number of cases in which sedation is used. However, off the top of my head, 10 per cent of those GA cases at most could be treated with the simpler forms of sedation. So, as we move towards more complex types of sedation, we must recognise that in some cases GA is probably the safer option.

[38] Public Health Wales is carrying out a piece of work for Abertawe Bro Morgannwg University Local Health Board, and we are retrospectively looking at the throughput of GAs at Morriston Hospital and at the intermediate setting in Parkway Clinic. We are trying to gather some more information, including how many cases could have been treated under

sedation, so that we can make some better-informed decisions. However, until something like Designed to Smile has had a chance to run for a little longer, one way or another, we will still have quite a demand for general anaesthetic.

[39] **Julie Morgan:** So, there is no evidence yet that Designed to Smile has reduced the number of general anaesthetics needed?

[40] **Mr Bennett:** It is all anecdotal. When you talk to dentists and people in Parkway, you will hear some evidence that there may be a slight reduction in the number of decayed teeth children have. Dentists are also telling us that they are noticing an improvement in the oral hygiene of the children who visit them. However, that is again anecdotal evidence. We will have to rely on the next child survey to give us the robust evidence.

[41] **Jocelyn Davies:** My question is about children who are in hospital. We know that some children spend long periods of time in hospital with chronic and severe conditions, so can you tell us little bit about your work in improving the oral health of those children in connection with the Designed to Smile programme?

[42] **Mr Bennett:** I mentioned in my paper that I recently had some discussions with a colleague in the National Leadership and Innovation Agency for Healthcare who has been involved with the fundamentals of care audit. In 2009, when it came out, there was something in it about the need to carry out oral health assessments for people in care in Wales, particularly those in longer-term care. We are now going to try to work with the fundamentals of care audit and try to instil a stronger emphasis on the need for oral assessments for people in longer-term care, including children. So, that is something that I reflected upon when I was putting together the evidence for the committee's inquiry. There is no reason why Designed to Smile could not be involved with that as well—we have recognised that, but we will have to think through how we are going to marry it all together.

[43] **Aled Roberts:** Yr ydym yn ymwybodol bod rhaglen Cynllun Gwên wedi arwain at fuddsoddiad sylweddol mewn offer, staff ac ati. Fodd bynnag, y cwestiwn a ofynnais yr wythnos diwethaf oedd: pa mor gynaliadwy yw'r gwasanaeth deintyddol cymunedol yn y tymor hir?

Aled Roberts: We are aware that the Designed to Smile programme has led to considerable investment in equipment, staff and so on. However, the question that I asked last week was: how sustainable is that community dental service in the long term?

[44] **Mr Bennett:** Over the last six or seven years, there have been a couple of reviews of the community dental service. They showed us that, in some parts of Wales, the community dental service is quite strong. The Cardiff and Vale community dental service may well be the largest example of that type of service in the UK—although they do not have community dental services in England now, because they call them something else, although they can offer a wide range of expertise and fulfil most of the requirements of the role of the community dental service as set out in the Welsh Government guidance.

[45] However, in other parts of Wales, particularly west Wales, the story is not as good. Historically, there has been disinvestment in the services. What saved the community dental service in the Hywel Dda Local Health Board area is the fact that the three smaller community dental services of Ceredigion, Carmarthenshire and Pembrokeshire came together by default because of the reorganisation, so it has more critical mass. What Designed to Smile has done for a service such as that in Hywel Dda LHB is to lift morale, because the funding that has come in recognises and values what it has tried to do. More tangibly, Hywel Dda LHB has purchased a mobile dental unit with the Designed to Smile money. It is a massive rural area and it did not previously have a mobile dental unit. It has also been able to employ the staff to form the Designed to Smile teams and to train up existing staff to contribute to the

programme. So, there is no doubt that it has been a big fillip to the CDSs in many ways. However, it is still a challenge and there is an inequity in the strength of community dental services across Wales, but we also have strong ones.

[46] **Aled Roberts:** Yr wyf eisiau aros gyda'r anghysondeb hwn ar draws Cymru a symud ymlaen at ba mor effeithiol yw partneriaethau ac integreiddio'r Cynllun Gwên gyda gwahanol strategaethau Llywodraeth Cymru. Yr wyf yn meddwl yn arbennig am y cynllun ysgolion iach. Pa fath o effaith mae'r anghysondeb hwn yn ei gael ar hybu iechyd?

Aled Roberts: I want to stay with that topic of inconsistency across Wales and to move on to the effectiveness of partnerships and integrating Designed to Smile with other Welsh Government initiatives. I am thinking in particular of the healthy schools scheme. What kind of effect is this inconsistency having on health promotion?

[47] **Mr Bennett:** In all the Designed to Smile areas, outreach efforts are being made with regard to the healthy schools initiatives. In mid and west Wales, we have healthy schools representatives on the steering groups. In Abertawe Bro Morgannwg University Local Health Board, we have set aside a considerable amount of funding to help some of the healthy schools initiatives, because I understand that their budgets have slightly suffered. So, we have been able to provide some funding for them to carry on some of their programmes. For example, they hold study days for teachers, but for teachers to attend, they have to come out of school and the schools have to bring in locum support. So, we have used some of the Designed to Smile money to help the schools to provide the back up so that teachers can attend healthy schools days. During those days, there is then a strong section on Designed to Smile. Those are examples of where we are trying to bring in those links. It is important. Although I lead the dental public health team, I have a specific responsibility for west Wales and, within the Designed to Smile steering groups that we have built up there, an important step has been ensuring that the chair of those groups is a specialist in general health promotion. So, almost by default, you are bringing in the wider health promotion picture.

10.00 a.m.

[48] However, not every Designed to Smile area is at the same point of development. In my paper, I said that it is probably true to say that all areas have gone past the implementation phase to the initial delivery phase. They have set up their teams, made their links, and they will now have capacity and time. This is going to be the strength of the programme into the future. It has to ensure that it continues to build up the links with healthy schools. I know there is a new initiative, similar to healthy schools, looking at pre-schools. I represented the Designed to Smile initiative on the Welsh Government's task and finish group that was developing that pre-school programme, to ensure that oral health is interlinked into its programmes and vice versa. It is a challenge, but in the long term it is going to be the strength of the programme. As I have said before, tooth brushing and getting the fluoride in contact with teeth is most important. However, we have to be more holistic. We have to pay attention to nutrition and so on.

[49] **Keith Davies:** Your team is supporting the Welsh Government in developing general dental service contracts. How do they fit in with the Designed to Smile initiative?

[50] **Mr Bennett:** There are two sorts of pilot schemes. One is a more general dental services pilot scheme. I think that there are about eight pilot schemes in Wales and about three or four of those are not the general dental service model but a child-preventative-type model. So, yes, we have all of this prevention work being delivered through the community dental service, but we felt that, if we had the opportunity to model a preventative type of approach in general dental practice, we should take that opportunity. So, this child preventative model of piloting takes the practice out of things called units of dental activity.

These units of dental activity are, at the moment, the way in which the general dental service contracts are delivered, monitored and linked to the payments system. However, children do not have to pay for treatment so, it was an opportunity to look at whether we could treat children outside of the units of dental activity system, with the emphasis not so much on treatment interventions, but on trying to look at a much more preventative approach.

[51] The Scottish NHS did a piece of work where it laid out some guidance on how you might treat children through such an approach. We have used that to underpin the programme. So, you are getting a preventative type approach to children visiting general practice but, additionally, those practices are linking with the local Designed to Smile teams. That is important so that you get a consistency of message and both teams can learn from each other. There are other benefits as well, because Designed to Smile sits in the community dental service. What we are also trying to develop are some cross-referral systems. The community dental service may have children who have had all their decay treated, are stabilised and, perhaps, would now be better treated within a general practice environment. So, they could be referred into the private practice. Vice versa, you could find children coming into a practice for whom the practice felt, for a number of reasons, that the community dental service might be better placed to provide treatment, as it probably has more time and expertise in treating children. So, that child could be referred across there. It is a consistent message. It is building up the preventative approach generally and trying to bring two services closer together.

[52] **Keith Davies:** You also say in your report that more needs to be done. So, what further action is needed?

[53] **Mr Bennett:** Do you mean across the board, and not just with the pilot schemes?

[54] **Keith Davies:** With the pilot schemes.

[55] **Mr Bennett:** We are only one year in to the pilot schemes, and we are starting to see the evidence coming through of how they are working. The contract that we have at the moment is a difficult one to work with, at all levels, whether you are the dentist or whether you are the patient. Certainly, it is a difficult job for the LHBs to manage it. I may have been alluding to that. Hopefully, out of these pilot schemes, we may get some ideas that, in the end, might lead to some better contractual arrangements.

[56] **Keith Davies:** I am from west Wales. You talked about the LHBs earlier and the three separate teams within the three counties of the old Dyfed; do they still operate independently?

[57] **Mr Bennett:** No, there were three community dental services teams and there is now one Designed to Smile team. It is one service, but, partly because of history and partly because of geography, it is difficult and work is still being done to bring the wider CDS teams together. Designed to Smile is helping that process of bringing everything together.

[58] **Christine Chapman:** Thank you, Mr Bennett, for your evidence. The transcript will be available in the next few days for you to look at. I thank you for coming in this morning, and we look forward to seeing you again in the future.

[59] The Minister is here. We were due to start that session at 10.15 a.m., but I suggest that we adjourn for two minutes. The Minister has to leave no later than 11.15 a.m., so we will adjourn for two minutes while she comes in.

Gohiriwyd y cyfarfod rhwng 10.06 a.m. a 10.12 a.m.
The meeting adjourned between 10.06 a.m. and 10.12 a.m.

Craffu ar Waith y Gweinidog: Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Ministerial Scrutiny Session: The Minister for Health and Social Services

[60] **Christine Chapman:** I welcome Lesley Griffiths, the Minister for Health and Social Services, Dr Tony Jewell, the Chief Medical Officer for Wales, and Dr Heather Payne, Senior Medical Officer, Maternal and Child Health. Welcome to you all. I invite the Minister to make some introductory remarks before Members ask questions.

[61] **The Minister for Health and Social Services (Lesley Griffiths):** Thank you for inviting me to discuss the very broad subject of children's health. We all agree that healthy and well-educated children and young people contribute to the security, economic growth and civil stability of nations, and they are absolutely an investment for our future. Underpinning all of our policies for children and young people will be a focus on the rights of the child to the best possible health, in accordance with the United Nations Convention on the Rights of the Child and the Rights of Children and Young Persons (Wales) Measure 2011.

[62] An effective and high-quality preventive programme in childhood is the foundation of a healthy society. The programme tries to ensure that our children have the best start possible, and trying to prevent future health problems begins before birth, in early pregnancy. An integrated programme from pregnancy to adulthood is essential. I also want to increase the promotion of healthy lifestyles before, during, and after pregnancy, and for maternity care, in this sense, to extend beyond the health service into schools, social services and the third sector. You will be aware that, last week, I launched the strategic vision for maternity services in Wales, and, while talking to people at the launch, it became apparent that pregnancy is often a time when a woman and her partner make very positive lifestyle choices. We need to build on that. We already have a maternity service that we can be proud of, but, as with everything, there are improvements that could be made. That was the reason for the strategic vision. The strategy sets out to the national health service my expectations in terms of delivering safe, sustainable and high-quality maternity services and improving the quality of care for women and their babies during pregnancy and childbirth.

[63] In addition to giving our youngest children the very best start, we will invest to double the Flying Start programme in the course of this Government. This programme is based on overwhelming evidence that children from disadvantaged backgrounds will benefit hugely from an increased investment in their early years with regard to health and education, both in the short and longer term.

[64] Giving children and young people a good start in life with regard to their long-term health and wellbeing is one theme of 'Our Healthy Future', the Welsh Government's public health strategic framework, which takes us to 2020. This is also a fundamental component in 'Fairer Health Outcomes for All', which is about reducing inequities through a health strategic action plan. There is also a raft of other public health initiatives relating to children and young people that are designed to tackle screening, immunisation, healthy eating, obesity, smoking, sexual health and wellbeing and healthy schools.

10.15 a.m.

[65] Underpinning all of this is the national service framework for children and young people and maternity services, which seeks to ensure that services are designed to meet the needs of children and young people and their families.

[66] Since we published the NSF in 2005—it is a 10-year document, which takes us to 2015—much has been achieved. It is a document of which we can be very proud. We are now

looking at how we can build on it to develop a more outcome-focused approach to setting out the quality of care that we want for our children in terms of the services that they need, which include health services.

[67] Safeguarding and protecting our children and vulnerable people is vital, and it is a key priority for me and Gwenda Thomas, the Deputy Minister. We will continue to put effective arrangements in place that support key agencies within social services, the health service and other services to ensure that they deliver on their statutory responsibilities to protect the most vulnerable citizens of Wales.

[68] In conclusion, we need to ensure that we have a skilled and flexible workforce, local leadership and an infrastructure that is capable of innovating and adapting to the changing needs of children and young people and their families. That must include strategic monitoring, evaluation and quality improvement by the Welsh Government, the Welsh NHS, and all bodies involved in the care and provision of services to children and young people.

[69] **Christine Chapman:** Thank you very much for those introductory remarks, Minister. I will start off with the first question. By the end of 2011-12 each local health board must deliver against the targets relating to child health inequalities and child poverty. How confident are you that local health boards will achieve these targets in protecting and improving the health of children in their areas?

[70] **Lesley Griffiths:** Every local health board has the local public health strategic frameworks, which emphasise the importance of improving the health of children and young people. Each LHB is represented on the children and young people partnerships, so the plans that they already have include the actions and priorities of LHBs in relation to children and young people in their area.

[71] There is also the document '2011 Children and Young People's Wellbeing Monitor for Wales', which presents data on a range of wellbeing indicators. It is very much based on evidence and the voices of children and young people, and it is structured around the United Nations Convention on the Rights of the Child. The indicators have very specific themes. Dr Payne may say more about this, but the wellbeing monitor for Wales was produced by social services, and the NSF was produced by the health services. I think that there has been a lack of joining up of those two documents, which I think that Dr Payne is going to look at to ensure that local health boards are able to achieve their targets.

[72] One of the main things that local health boards must ensure is the implementation of the immunisation programme. I have looked at the figures for immunisation, and you can see that the uptake exceeds 95 per cent at the age of one year. The uptake for the MMR vaccine at two years of age is about 91 per cent. As we go on, we need to ensure that the targets for immunisation are reached.

[73] **Christine Chapman:** We will come on to immunisation, so we will talk about that later. However, thanks for that. Angela Burns wants to ask some questions about Flying Start.

[74] **Angela Burns:** Good morning, Minister. You state that you intend to double the number of placements for Flying Start and roll it out in more parts of Wales. It is an initiative that has an awful lot of support from all of us, but I would like to ask you a few questions on this. We have heard in previous sessions that health visitors already have an incredibly big workload going into the Flying Start programme—I think that, on average, they have about 110 individuals on each of their books, and that does not count the families who have other children that are not technically in the Flying Start programme, but who get wrapped up into that whole level of care. Do you think that that number is too high? When you roll out the programme, will you also double the number of health visitors? Will you expect health

visitors to do more, or will you look to dilute some of the effort that they have to put in so that they can spend more time with slightly fewer children and not have such a big load?

[75] **Lesley Griffiths:** The evidence that we have shows that it is probably about the same. It would be great to have more. We are going to double the number of health visitors. We are also going to put funding into buildings. Flying Start was launched in 2006-07, based on evidence that shows that the most effective intervention that we can make is at an early stage. The scheme puts money into childcare so that parents are able to go out and work. We know that work leads to a better home and health. The scheme is aimed at our most deprived areas, the Communities First areas. One of our commitments is to double Flying Start, and we are now looking at where we need to intervene with the extra funding. Is 110 the right number? From talking to health visitors, I know that it would be good if we could reduce it, but we have to see how we can do that. As we work through this manifesto commitment, we will be extending the core elements of the programme over time to cover about 36,000 children. I have been told that ordinary caseloads are much higher than 110 children, but we will continue to cap the number at 110 as we roll out the programme.

[76] **Angela Burns:** Flying Start is obviously a comprehensive programme that takes in education and helping chaotic families to schedule their lives in a more positive way. However, what are the health outcomes that you would hope to achieve by increasing the provision throughout Wales?

[77] **Lesley Griffiths:** By having an early intervention—we know that that is the time when health problems can start—and because the health visitors are working so closely with families who are deprived or are, as you say, chaotic, it is then easier for the health visitor to build a relationship to help parents know where to go for help for any health problems that come along. The immunisation programme is important to ensure that children do not miss the dates for immunisation. The breast feeding initiative is also important. I have been heartened by the increase in breast feeding rates. I want to spend some time on continuation of breast feeding, because we see a definite drop-off in it. That is where health visitors have an important role to play in getting in early enough. Breast feeding for a certain time ensures a focus on the health of the child.

[78] **Simon Thomas:** Mae'r pwyllgor wedi clywed am y gwerthusiad o raglen Dechrau'n Deg sy'n mynd i ddigwydd yn ystod y tymor hwn. Yr ydym yn mynd i edrych ar y rhaglen ar ôl gweld canlyniadau'r gwerthusiad hwnnw. Yr ydych newydd ddweud, Weinidog, bod tystiolaeth yn bwysig yn y broses hon. A oes unrhyw beth yn y dystiolaeth sy'n awgrymu bod angen newid agweddau ar raglen Dechrau'n Deg? A fyddech yn agored i newid y cynllun yn ogystal â dyblu'r cynllun? A ydych yn ystyried y posibilrwydd y bydd rhai pethau efallai wedi gweithio'n well nag eraill?

Simon Thomas: The committee has heard about the evaluation of the Flying Start programme that will take place during this term. We will be looking at the programme after seeing the results of that evaluation. You have just said, Minister, that evidence is important in this process. Is there anything in the evidence that suggests that there is a need to change aspects of the Flying Start programme? Would you be open to changing the programme as well as doubling it? Have you considered the possibility that some things may have worked better than others?

[79] **Lesley Griffiths:** At the moment, a lot of the evidence is unaudited. Once we have that evaluation and look at the evidence, if something is not working, we would definitely have a look at it with the Deputy Minister. Flying Start is one of our flagship policies, and if it is not working, we need to know. However, I do not think that it is the case that it is not working; it is. I know that it has been of huge benefit to many families in my area.

[80] **Suzy Davies:** For clarification, you have just said that you will double the number of

health visitors; is that only in the Flying Start areas—albeit these extended areas—or are you talking about doubling them across the board?

[81] **Lesley Griffiths:** I am talking about the areas covered by the Flying Start programme.

[82] **Jenny Rathbone:** Following up on that, could you tell us about your strategy for doubling the number of Flying Start health visitors? How is that going to be done without undermining the general health-visiting service? Is it that there are a lot of English health visitors who are going to be surplus to requirements? How are we going to double the number of health visitors?

[83] **Lesley Griffiths:** The strategy is being worked out now. Obviously, we will be looking to take on a large number of extra health visitors, so that has had to be looked at within the workforce programme. Officials are working on that as we speak. We will be taking it to Cabinet very soon and the Deputy Minister, as I said, is working very closely with her officials at the moment to ensure that we have enough health visitors to undertake this major Government commitment.

[84] **Dr Jewell:** We have had a quick look at this, and some of the health visitor training is conducted over two years. We are increasing the numbers who do the training in one year and we are looking at return-to-nursing options for people who may have been health visitors in the past, who would like to return to work, in order to try to improve the marketplace. In England, the use of health visitors is expanding and we realise that the market is, therefore, quite competitive, so we are adjusting our workforce planning by having one-year courses instead of two-year courses and increasing the number of students to try to meet the need.

[85] **Lesley Griffiths:** Workforce programming is very important because we need to ensure that we have the numbers that we need. We are very confident that we will achieve those numbers.

[86] **Christine Chapman:** I would like to move on to maternity services now. Julie Morgan will ask some questions on this subject.

[87] **Julie Morgan:** I was very pleased to be at the Heath hospital maternity unit when you launched the maternity strategy, Minister. It was a very interesting visit. A few issues have come up as a result of those proposals, one of which relates to the number of midwives. Could you make some comments about the number of midwives available for this strategy?

[88] **Lesley Griffiths:** It was a very good launch. We launched the document in a midwife-led unit at the University Hospital of Wales, as Julie said. We have had an increase of 11.5 per cent in the number of midwives since 1999. Workforce development is again extremely important in ensuring that we have enough midwives for our services. Since 2007, the number of training places has increased from 90, through 95 and 110 to 123 in 2010. This year, we will have 102 midwife training places. There is a drop this year because we have had that steady increase that means that we now have so many more midwives in place. The strategy outlines the vision, and I expect local health boards to ensure that the maternity services that they provide reflect that strategy and are orchestrated by it. We have the Birthrate Plus levels and that is how we decide how many midwives should be trained per year. I know that the Royal College of Midwives said that we did not have enough, but it had stated the previous week that Wales, Scotland and Northern Ireland had enough and that it was England that had seen a significant drop in the number of midwives. I was very surprised, therefore, that the organisation said what it said the following week, just as we launched the strategy.

[89] **Christine Chapman:** Have you gone back to the Royal College of Midwives and sought clarification on its remarks?

[90] **Lesley Griffiths:** Yes, we have. The statements that it made were poles apart, were they not? It went from one stance to another, which was very surprising. Therefore, we have asked for some clarification on that.

[91] **Julie Morgan:** Have you had that yet?

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

[93] **Christine Chapman:** Could you send us a note on that when you receive a response?

[94] **Lesley Griffiths:** Yes, we will send you a note.

[95] **Julie Morgan:** Does your plan for midwives take into account the rising birth rate?

[96] **Lesley Griffiths:** Yes, it does. As I said, from a numbers perspective, it is so important that we have workforce development in place. In looking at the figures, as I said, there has been an increase of 11 per cent in the number of midwives since 1999, and we have to ensure that we constantly update that.

[97] **Christine Chapman:** I believe that Aled Roberts wants to come in on this.

[98] **Aled Roberts:** A oes problemau mewn rhai ardaloedd? Cynhaliwyd cyfarfod yng ngogledd Cymru, a derbyniodd rheolwyr Bwrdd Iechyd Lleol Betsi Cadwaladr bod angen 16 o fydwragedd ychwanegol ar y bwrdd iechyd i gyrraedd y safon a bennwyd gan Birthrate Plus. Yr oeddent yn dweud bod problemau ariannol yn golygu nad oedd yn bosibl iddynt recriwtio yn ôl y gofyn.

Aled Roberts: Are there problems in some areas? A meeting was held in north Wales, and managers at the Betsi Cadwaladr Local Health Board accepted that the health board needed 16 additional midwives to meet the standard set by Birthrate Plus. They said that because of funding problems it was not possible for them to recruit according to demand.

10.30 a.m.

[99] **Lesley Griffiths:** It is for local health boards to ensure that they have the workforce that they need to deliver the plans that they have decided upon for their local population. We give all the LHBs massive budgets, and they have to ensure that they have all the skills in place and all the staff that they need to provide those services.

[100] **Julie Morgan:** You say in the evidence that you want children to be delivered as close to their homes as possible and in an integrated, safe and sustainable health system. Could you tell us what that will mean in practice? I am particularly interested in your plan to increase the number of babies that are born at home. Could you give us an indication on that?

[101] **Lesley Griffiths:** Maternity services have to be high-quality, safe and effective. If a mother chooses to have a baby at home, we have to ensure that that facility is available. Powys has very good home birth numbers. We have initiatives in place to promote home births. The unit we visited at the University Hospital of Wales had at least two birthing pools, so they are there if mum wants that. It is right that mums can choose to attend a midwife-led unit or a consultant-led unit; those facilities and services must be available to them. We have several initiatives to encourage home births.

[102] I am sorry, but what was your other question?

[103] **Julie Morgan:** I was asking about the general implications for the service.

[104] **Lesley Griffiths:** Services may have to be reorganised and changed; that is what local health boards have to do now. They have to look at the strategic vision and ensure that their services are aligned with it.

[105] **Julie Morgan:** Do you agree that we should be treating pregnancy and birth as a natural thing, not an illness?

[106] **Lesley Griffiths:** Absolutely. We need to ensure that this is where public health, health promotion and preventive healthcare come in. Many women, and their partners, make positive lifestyle choices. However, we need to try to encourage people to make those choices before pregnancy and to stop smoking, for example. Since my appointment, I have been shocked to learn that one in four women smoke during pregnancy. We must do more to educate women on that, as well as on obesity. I met a midwife—I mentioned this in the debate last week—at the midwife-led unit who was a community midwife for normality. I asked her what was meant by 'normality'. She works with people who have epilepsy or diabetes. If you have epilepsy, you can get very tired—there is a reason why it is called 'labour', it is very hard—and if you get very tired, the chances that you will have to have a caesarean, instead of the normal delivery that you wanted, are increased. There is a lot to do with education, preventive medicine and health promotion to ensure that we get those messages out to women.

[107] **Christine Chapman:** Suzy Davies has a final question, and then we will move on to another area.

[108] **Suzy Davies:** It was a lengthy question; I could defer it and send you a written question, if that would be acceptable to you.

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

[110] **Christine Chapman:** Moving on to the next set of questions, Lynne Neagle has a question on neonatal care.

[111] **Lynne Neagle:** Neonatal care has been a long-standing concern in the Assembly, as you will know. Concerns have been expressed about neonatal care by Assembly Members and by the Children's Commissioner for Wales regularly. Your paper highlights the action that has been taken to implement the improvement that we want to see in staffing and so on. However, we know that good intentions at Government level are not always matched by delivery on the ground. You refer in your evidence to the all-Wales action plan and note that individual LHBs are developing action plans to take this agenda forward. What steps are you taking to monitor that?

[112] **Lesley Griffiths:** You are right that steps are being taken. It is for local health boards to ensure that they fund the most effective neonatal services possible. To support them, we gave an additional £2 million in 2009-10. That was used to establish the all-Wales neonatal clinical network and a lead clinician was appointed to drive forward the service improvements that are needed. As you say, it is an issue that has been raised by many Assembly Members over the years. A baseline review of capacity and compliance with the all-Wales service standards has taken place, and an all-Wales action plan has been put into place. As you say, local health boards are now developing their local action plans.

[113] On 14 July, I launched a new dedicated neonatal ambulance equipped to transfer sick and premature babies across south Wales. We hope that, in the very near future, when the

services are there, we will be able to provide one in north Wales as well.

[114] **Lynne Neagle:** You referred to the baseline review, so is it your intention to monitor this on an ongoing basis to check that these standards are being implemented locally?

[115] **Lesley Griffiths:** Yes. I will bring Dr Payne in on this.

[116] **Dr Payne:** Again, the important thing here is the structure of the all-Wales neonatal network. That is the professional body that uses the standards, which are UK-wide and benchmarked against the best in Europe, to see which areas need improvement and where there may be concerns, and that co-operates with national audits. That is the basic structure. There have been some difficulties in recruiting to posts that are being funded. That is a Wales-wide problem in a number of areas of medicine. However, I have spoken to Dr Mark Drayton, the leader of the neonatal network, and he is a top-quality clinician on whom I know we can rely to take those things forward.

[117] **Aled Roberts:** Could you provide us with evidence on where those recruitment problems exist? It is important to understand the reasons for any difficulties and what may be a patchy roll-out.

[118] **Dr Payne:** We certainly could.

[119] **Lesley Griffiths:** It is not just a Wales-wide issue; it is a UK-wide issue, and that is why you cannot have the services spread too thinly. The local health boards need to ensure that those services are safe and that is really important.

[120] **Christine Chapman:** Could we have a brief report on the Wales picture to show where the difficulties are?

[121] **Lesley Griffiths:** Do you mean the difficulties with recruitment?

[122] **Christine Chapman:** Yes.

[123] **Lesley Griffiths:** Yes, you may have a report on that.

[124] **Christine Chapman:** That would be helpful; thank you. I will move on to the issue of child and adolescent mental health services and Keith Davies has a question on this.

[125] **Keith Davies:** Lesley, as you and I know from discussions with the representatives of charities, they are concerned about the staffing for mental health services for children in Wales. They do not think that the staffing complement is sufficient. Are you satisfied that you can deliver the national strategy for Wales?

[126] **Lesley Griffiths:** We have made huge improvements. When I was elected back in 2007, it was a real issue in north Wales and I think that we have made huge improvements. There has been significant investment in the service. In answer to your question, yes, we are ensuring that a sufficient workforce is in place. However, as well as tier 2 and 3, we are also looking at tier 1 skills and including teachers, for example, because early intervention is so important in relation to child and adolescent mental health services. So, we are ensuring that other people's skills are also brought into that service to get the early intervention that we need to support the service. We have just announced, from 2011-12 to 2013-14, an extra £1.4 million to expand the service to look at addressing learning disabilities and emotional health and wellbeing because, again, the two often go hand in hand.

[127] **Christine Chapman:** Is any work being done on depression among young people,

which may not be as severe as what is being alluded to here, but which nonetheless seems quite prevalent at the moment?

[128] **Lesley Griffiths:** It is monitored within the service at a very high level. I do not know whether Dr Jewell wants to add anything.

[129] **Dr Jewell:** It is difficult to differentiate between clinical diagnosis of depression and children with emotional problems. The Minister mentioned the school counselling service that has been introduced, which is very helpful for children in the normal event of going to school in that they get counselling support before it turns into an illness. Depression would normally involve a clinical diagnosis, but we all know that a lot of emotional things can happen before you get to that stage. So, earlier interventions, which the Minister mentioned, and the use of things such as school counselling, are really important.

[130] **Lesley Griffiths:** We also have schemes such as the Meic advocacy service, and we have also done a lot a work on eating disorders, which can lead to mental health issues. So, there are several initiatives to support.

[131] **Suzy Davies:** In 'A Strategic Vision for Maternity Services in Wales', which you announced last week, there was reference to the facility being made available for expectant mothers to access the mental health system—they would be signposted to a specific mental health nurse if they needed the service. Do the services that you are talking about here include the capacity to ensure that pregnant women get access to a mental health professional if they need one, or is that just an aspiration?

[132] **Lesley Griffiths:** It is a completely different service—we are talking about the child and adolescent mental health service.

[133] **Suzy Davies:** My point is that we regrettably still have a high level of teenage pregnancy, particularly in the deprived areas that we have been talking about in this committee. Is that being considered specifically?

[134] **Lesley Griffiths:** Are you referring to teenage pregnant women?

[135] **Suzy Davies:** Yes; I am sorry, I should have said that.

[136] **Lesley Griffiths:** Teenage pregnant women would be able to access this service.

[137] **Suzy Davies:** So, there is a crossover.

[138] **Lesley Griffiths:** Yes, for teenage mums.

[139] **Jocelyn Davies:** I have a general question. An issue that has been raised with us frequently and for many years is that this is a service that charities continue to be concerned about. Why is it so difficult to make rapid progress in an area where there is consensus that it is a high priority?

[140] **Lesley Griffiths:** I think that we have made huge progress, certainly in north Wales, where the service has been completely transformed.

[141] **Dr Payne:** Are you talking about mental health generally?

[142] **Jocelyn Davies:** I am talking about this particular area—child and adolescent mental health services.

[143] **Dr Payne:** As the Minister mentioned, four tiers have been developed in CAMHS in a strategy called 'Everybody's Business', because it is everybody's job to reach out to people who may be suffering from mental-health-related problems, which is most of us at some time in our life's course, particularly young people. The best use of resources in focusing as much as possible on early intervention at tier 1 is being addressed by the national expert reference group and a delivery assurance group that is working on the workforce strategy and on monitoring the high-level indicators—depression, the early onset of psychosis, eating disorders and suicide in young people. All those things are being looked at in terms of auditing professional staff levels and mapping the best distribution of competencies and skills, so that they are delivered as close to home as possible, at the right time and as early as possible, to prevent the need for a higher level use of CAMHS. That is part of the remit of the groups that are working at the moment.

[144] **Jocelyn Davies:** It does not explain why the charities are still raising concerns, does it? I am sure that they are well aware of everything that you have just told us.

[145] **Lesley Griffiths:** An independent report published last month showed that there is better and quicker access to services and that we have more specialist staff. However, improvements can always be made.

10.45 a.m.

[146] **Aled Roberts:** Fel un a fu'n aelod o bartneriaeth plant a phobl ifanc am bum mlynedd, yr wyf yn cytuno bod y sefyllfa wedi gwella ond yr wyf yn parhau i deimlo nad yw'r sefyllfa yn foddhaol. Yr wythnos hon, clywais am un achos yn Wrecsam lle yr oedd merch 16 oed wedi cael ei chymryd i'r uned ddamweiniau yn Ysbyty Maelor Wrecsam nos Sadwrn diwethaf oherwydd ei bod wedi ceisio lladd ei hun. Mae hi wedi cael apwyntiad gyda'r gwasanaeth ymhen mis. Yr wyf yn cytuno gyda Keith; efallai fod gwelliant wedi bod, ond nid wyf yn teimlo y dylem ni, fel Cynulliad, dderbyn y sefyllfa hon fel un sy'n foddhaol.

Aled Roberts: As someone who was a member of a children and young people's partnership for five years, I agree that the situation has improved but I continue to feel that the situation is unsatisfactory. This week, I heard about one case in Wrexham where a 16-year-old girl was taken to the accident and emergency unit at Wrexham Maelor Hospital last Saturday night because she had tried to commit suicide. She has been given an appointment with the service a month from now. I agree with Keith; there might have been an improvement, but I do not feel that we, as an Assembly, should accept the situation as being satisfactory.

[147] **Lesley Griffiths:** I agree. I cannot comment on an individual case, but it is for the local health board to ensure that appointments and staff are available. I suggest that you take the case up with the chief executive of Betsi Cadwaladr University Local Health Board.

[148] **Jenny Rathbone:** Perhaps I should have asked this question when we discussed maternity services, but I wish to turn to the impact of postnatal depression on the wellbeing of children, because it is an important issue. Could you tell us how we screen for postnatal and antenatal depression? Are we providing that front-line listening service to prevent people having to be referred for secondary care?

[149] **Lesley Griffiths:** We have the Edinburgh screening process. Health visitors obviously have a huge role to play, and one of the reasons for Flying Start and the doubling of its funding is to ensure that health visitors can pick up on postnatal depression in some of our most deprived areas. Postnatal depression is not confined to deprived areas—it is a wide-ranging illness—but we are carrying out that screening.

[150] **Jenny Rathbone:** Are all health visitors trained to undertake that screening and offer

counselling or listening services?

[151] **Dr Payne:** The Edinburgh postnatal depression scale is a standard scale. It is a screening tool, and all health visitors are trained to identify when they might need to apply it. It is not necessarily used for every woman, but if there is any indicator that there is prolonged low mood, it would certainly be used. As a screening tool, it then identifies a need for referral to other services.

[152] **Lynne Neagle:** I do not expect an answer to this question now, but with postnatal depression there is sometimes a need for the woman to be hospitalised. What is the situation in Wales regarding mother and baby beds? Could we have a note on that, Chair?

[153] **Lesley Griffiths:** We can send a note with that information.

[154] **Christine Chapman:** I remind Members that we have a lot of ground to cover, as the Minister has to leave no later than 11.15 a.m., so please keep your questions as succinct as possible. We now move on to discuss safeguarding children.

[155] **Jenny Rathbone:** Can you update us on how you are responding to the Mansel Aylward report on the interface of health workers with the safeguarding agenda?

[156] **Lesley Griffiths:** I have accepted all 19 of the report's recommendations and implementation has already started. All recommendations relating directly to NHS Wales are in train and will be implemented by April of next year. The two recommendations that contain additional aspects reliant on statutory guidance or integrated planning structures will be implemented by 2013.

[157] **Jenny Rathbone:** I have a specific question on how we are safeguarding children from female genital mutilation. This problem is quite specific to places like Cardiff and is probably not so prevalent in other parts of Wales. How well can health professionals support other people who may be able to spot when a child is about to have their clitoris removed, on the misunderstanding that this will—

[158] **Dr Jewell:** A chief medical officer's update is probably going out as we speak, and will go to all doctors in Wales. The update contains a section on female genital mutilation, which expresses to professionals their responsibility if they have wind of people taking daughters abroad, because that is what usually happens, during the school holidays, and their responsibility to report that rather than simply to ignore it. It is also their responsibility to let officials here know about any interventions that have been done in this country in respect of practices that are against the law. That is going out to all doctors in Wales now.

[159] **Jocelyn Davies:** Across the UK, it is estimated that there are about 26,000 girls at risk. I was looking at figures recently relating to the numbers of affected girls who go on to have babies and who, therefore, come into contact with the health service. When they have babies, it can be seen that they have been mutilated. The relevant figure for Wales is rising, Minister. The latest figure that I could find was for 2004, which was 130 girls, concentrated in the cities. That figure is rising. Those girls need enhanced intervention services if we can prevent this from happening. When women who have been mutilated have babies, there is an opportunity to intervene, so that this practice is not passed on through the generations. I am not aware of a single prosecution for this. I know that it is illegal, but there seem to be no prosecutions. There are opportunities for the health service in Wales, which will have contact with these women from time to time. We should bear in mind that some of these women were not born here and did not come under our jurisdiction. However, some of them may have been born here and they are certainly having babies here now. Minister, I would be very pleased if you could look at this issue, in the context of your sexual health strategy—

[160] **Simon Thomas:** It also involves Flying Start.

[161] **Jocelyn Davies:** Yes and Flying Start. I know that this relates to a small number of people, but it is a very significant issue for them.

[162] **Jenny Rathbone:** My interest is in how we transfer the expertise of health professionals—midwives and GPs—to ensure that other people who work with children, such as teaching assistants and teachers, are aware of what they need to look out for.

[163] **Dr Jewell:** Heather, would you like to say something about training?

[164] **Dr Payne:** This is touched on in a lot of multi-professional child protection training. To reiterate the point, it is illegal to perform this in this country and to allow the removal of a person to another country for that purpose. That is stated very clearly in the all-Wales safeguarding procedures. We expect all professionals, volunteers and anyone else in contact with children to undertake the universal training. There is a reference to this in the all-Wales child protection procedures.

[165] **Christine Chapman:** We need to move on. Would the committee be happy to have a note from the Minister on this?

[166] **Lesley Griffiths:** I would like to say something. I think that Jocelyn has raised a really important point. There is a consultant obstetrician in Cardiff, whom Jenny might know, who works with the minority ethnic community and who performs remedial surgery. It is quite surprising that, to Jocelyn's knowledge, there have been no prosecutions.

[167] **Jocelyn Davies:** I am not aware of any, but you might be able to prepare a note on that.

[168] **Lesley Griffiths:** I think that that is definitely worth looking at, so we will provide a note on it.

[169] **Aled Roberts:** Mae gennyf gwestiwn ynglŷn â syndrom Down. Ar hyn o bryd, mae ysbytai Cymru yn cynnig profion gwaed i sgrinio ar gyfer syndrom Down. Mae gan Loegr gyfundrefn wahanol, lle defnyddir sgan mesur tryleuder y gwegil i gynnal profion ar gyfer syndrom Down ac ar gyfer namau ar y galon. A oes gennych unrhyw gynlluniau i gyflwyno profion o'r fath yng Nghymru?

Aled Roberts: I have a question relating to Down's me. At present, Welsh hospitals offer blood tests to screen for Down's syndrome. England has a different system, where nuchal translucency scans are used to conduct tests for Down's syndrome and cardiac defects. Do you have any plans to introduce such tests in Wales?

[170] **Lesley Griffiths:** Yes. I believe that my predecessor introduced these in March. We had some recommendations from the UK national screening committee, and the former Minister for Health and Social Services requested that health boards and Public Health Wales introduced combined screening for Down's syndrome within existing resources, to include NT screening.

[171] **Aled Roberts:** A yw'r profion yn weithredol erbyn hyn?

[172] **Aled Roberts:** Are the tests operational yet?

[173]

[174] The policy may have been introduced—

[175] **Dr Jewell:** It is a plan.

[176] **Aled Roberts:** Is there a timescale for that?

[177] **Dr Jewell:** I have two things to say about this. In February 2011, the quadruple test came in, which, as you rightly say, is a blood test. That improved the uptake to 75 per cent. Then, as the Minister said, this new guidance came from the national screening committee in March, about introducing the nuchal translucency test, or NT test. This requires the training of staff and an introduction in a planned way, so a group met and it planned for implementation from June next year, having trained all the staff, introduced the monitoring and so on. It is important to get this right because the risk with Down's syndrome screening is that the diagnostic test procedure can cause miscarriages, so you have to be absolutely sure that you are right. We are making sure that the staff are trained properly, the quality is assured, and we have the information systems in place. It is under way.

[178] **Lesley Griffiths:** I should also say that cardiac defects are not screened for, but again, if a raised NT is found, that would be looked at.

[179] **Christine Chapman:** We will move on now. I remind you that you do not need to touch the microphones because they come on automatically. The next question is from Julie Morgan.

[180] **Julie Morgan:** Your evidence mentions the newborn blood spot screening, and you have had phase 1, is that right?

[181] **Lesley Griffiths:** Yes, that has been completed.

[182] **Julie Morgan:** Could you tell us how that went and whether there has been progress?

[183] **Lesley Griffiths:** Yes. The original plan was set out back in 2009, to introduce the MCADD and the sickle cell test. As you say, there has been a phased approach, with phase 1 having been completed. Ongoing at the moment is phase 2, which is the preparatory phase, which identifies existing activity and performs the training requirements—they analyse that and review the protocols. Then, from 2012-13, we will manage the implementation of tests and the roll-out across Wales, because obviously we need to make sure that we have the necessary equipment and training in place for the staff.

[184] **Julie Morgan:** So, it is going as expected, is it?

[185] **Lesley Griffiths:** Yes; it is going as expected.

[186] **Julie Morgan:** Do you anticipate that it will be implemented on time?

[187] **Lesley Griffiths:** Yes. We need to procure the equipment as well, which will probably take a few months, before we can implement the programme. However, everything is absolutely on course.

[188] **Christine Chapman:** The next question is on immunisation, which you mentioned earlier, Minister.

[189] **Lynne Neagle:** You referred to the progress that had been made with one-year-olds. I know that there has been progress with the uptake of the MMR vaccination, but the figure is still down on the 95 per cent that is needed and slips further at the pre-school booster stage. I know that there have been information campaigns in the past. What action is the Government taking to get that up to the rate that it should be at? The scares around the MMR vaccine have all been completely discredited.

[190] **Lesley Griffiths:** We now have a named school nurse for every secondary school in Wales, which was one of the One Wales Government commitments; I think that we have something like 227 school nurses now. It has been proven that there is a much higher uptake when immunisation programmes are done in school. One thing that is worth looking at is that we currently have immunisation in year 10, but we might move that to year 9 because there is evidence that the younger the teenager, the better the uptake. That is something that we are looking at in relation to teenagers. Obviously we now have the human papilloma virus vaccine as well, and the uptake of that was 87 per cent, with the second dose at 85 per cent and the third at 74 per cent. There is obviously some work that needs to be done around that. Perhaps we should be looking at having more immunisation done by the school. It has to be done with partners such as general practitioners.

[191] **Lynne Neagle:** On the MMR vaccination, are you taking any specific steps to boost uptake?

[192] **Lesley Griffiths:** We are having a leaflet distributed at the moment. It has been redesigned, and we are having it distributed now.

11.00 a.m.

[193] **Dr Payne:** People must make their own choices about these sorts of important outcomes and the whole point of Flying Start and those sorts of initiatives is to support people to help them get over false beliefs and unrealistic concerns about dangers and to point them in the right direction. So, all of those things will feed into antenatal health messages. They are consistent and coherent and push towards these outcome measures.

[194] **Simon Thomas:** Sylwais o'ch tystiolaeth fod gennym darged o 95 y cant ar gyfer brechu plant yn gyffredinol, ond mai'r targed ar gyfer brechu merched yn eu harddegau yn erbyn feirws papiloma yw 90 y cant—ac nid ydym yn cyrraedd y targed hwnnw hyd yn oed. Pam fod gwahaniaeth rhwng y ddau darged a pham nad ydym yn anelu at darged o 95 y cant ar gyfer brechu merched yn eu harddegau yn erbyn feirws papiloma gan ei fod wedi'i brofi yn effeithiol?

Simon Thomas: I noticed in your evidence that we have a target of 95 per cent for the general immunisation of children, but that the target for the immunisation of teenage girls against the papilloma virus is 90 per cent—and we are not even reaching that target. Why is there that difference between those two targets and why are we not aiming for a 95 per cent target for the immunisation of teenage girls against the papilloma virus, given that its effectiveness has been proven?

[195] **Lesley Griffiths:** The target was set at 90 per cent, but I am looking at all targets to do with immunisation. Health visitors advise new mums about immunisation and perhaps we need to target more mums and teenage girls, because they will have their own views. As a mum of a teenage girl, I certainly know that they have their views.

[196] **Simon Thomas:** I also know that as the father of one. [*Laughter.*]

[197] **Lesley Griffiths:** Exactly. In fact, I remember having a conversation with her about immunisation. So, again, perhaps school nurses could be used more than they have previously. We need to look at the target because there is that 5 per cent difference; it is something that we will be looking at.

[198] **Christine Chapman:** The next questions are on healthy eating and Jenny Rathbone has the first one.

[199] **Jenny Rathbone:** We have already covered excellent improvements in breastfeeding rates. I have two specific questions. First, I have read about the amount of salt in manufactured baby food. It is incredible that these manufacturing companies are putting salt in food that is poisoning babies. That is obviously a UK-wide issue, but have you had any conversations with these companies on this issue? Secondly, how effective has the MEND—Mind, Exercise, Nutrition…Do It!—programme been in working with children and young people who are at a serious level of obesity?

[200] **Lesley Griffiths:** No, I have not had any conversations with manufacturers about salt, but I do not know whether my officials have. Do you want to pick that one up?

[201] **Dr Jewell:** The UK Government takes the lead on that because the regulations usually come from the European Community. However, the Scientific Advisory Committee on Nutrition has stated that we should lower the amount of salt in all foods, in tinned and processed foods, and particularly in baby foods. So, we will follow that up, and I can assure you that there is a concerted action on reducing the amount of salt in processed food, including baby food.

[202] **Lesley Griffiths:** Health visitors also have a role to play, as does Flying Start, in educating new mums about food. As Dr Jewell said, the UK Government is leading on this, but perhaps we should make stronger representations to it about the levels of salt in food.

[203] The MEND project has been rolled out across Wales and 795 children have benefited. Also, the evaluation of the programme has demonstrated that it is not just the child who has undergone the programme that benefits from it. There is a need for sensitive handling by health visitors and school nurses, for example, who may need to have discussions with parents about their children being overweight, because not all parents recognise that in their own children. The evaluation has shown that the physical activity level of a child that has undergone the programme is higher after it and that there are lifestyle changes, not just for that specific child, but also for their siblings and their parents.

[204] **Jenny Rathbone:** May we be sent the evaluation in due course because it sounds very interesting?

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

[206] **Christine Chapman:** We will move on to a specific question on smoking from Simon Thomas—I know that you mentioned something briefly, but this is quite specific.

[207] **Simon Thomas:** Yn gyntaf, dilynaf gwestiwn Jenny cyn symud at y cwestiwn ar ysmygu. Yn benodol, a ydych yn trafod o fewn y Llywodraeth, efallai gyda'r Gweinidog Addysg a Sgiliau, y ffordd y mae cwmnïau bwyd cyflym yn dechrau newid y ffordd y maent yn gwerthu i blant drwy gysylltu eu hunain â chwaraeon? Er enghraifft, mae McDonalds yn gysylltiedig â chwaraeon ysgol a phethau felly. Yr wyf yn pryderu am hyn am ei fod yn ffordd o fynd o gwmpas y rheolau ynglŷn â braster a halen mewn bwyd. A ydych yn cael trafodaethau o fewn i'r Llywodraeth ynglŷn â hyn? Soniasoch am drafod gyda San Steffan, sydd yn iawn, ond mae hwn ar stepen ein drws.

Simon Thomas: First, I will follow on from Jenny's question before moving on to the question on smoking. Specifically, are you discussing within the Government, perhaps with the Minister for Education and Skills, the way that fast food companies are starting to change the way that they sell to children by linking themselves to sports? For example, McDonalds is doing schools sports and so on. I am concerned about this, as it is a way of getting around the rules in relation to fat and salt in food. Are you having discussions within the Government on this issue? You talked about discussions with Westminster, which is fine, but this is on our doorstep.

[208] **Lesley Griffiths:** I have had discussions with the Minister for education about the healthy schools initiative and trying to spread that out across Wales. I had heard about the McDonalds matter, and that is concerning, because it then becomes much more attractive to children.

[209] **Simon Thomas:** Diolch am hynny ac mae'n siŵr y byddwn yn gwylio hynny yn ofalus fel pwyllgor. Yn benodol ynglŷn ag ysmygu, yr ydych yn dweud yn eich tystiolaeth a chlywsom gan y Prif Weinidog am y bwriad, o bosibl, i ddeddfu yn erbyn ysmygu mewn ceir pan fo plant yn bresennol. Fodd bynnag, yn gyntaf, yr ydych yn mynd i aros am dair blynedd a gweld beth sy'n digwydd i'r lefel o ysmygu. Os yw ysmygu mewn ceir ac ysmygu ail law yn beryglus i blant, pam nad ydych yn gweithredu yn gynt? Os ydych yn teimlo bod modd gostwng y nifer sy'n ysmygu heb gyflwyno deddf, sut yn y byd yr ydych yn mynd i fesur faint o ysmygu mewn ceir y mae oedolion yn ei wneud gyda phlant yn bresennol ac felly mesur bod gostyngiad wedi bod?

Simon Thomas: Thank you for that, and I am sure that we will watch that carefully as committee. Specifically in relation to smoking, you say in your evidence and we heard from the First Minister about the possible intention to legislate against smoking in cars when children are present. However, you are first going to wait for three years to see what happens to the rates of smoking. If smoking in cars and second-hand smoke are dangerous for children, why are you not acting sooner? If you feel that there is a means of lowering the rate of smoking without introducing legislation, how in the world will you measure how many adults smoke in cars when children are present and, therefore, measure whether there has been a reduction?

[210] **Lesley Griffiths:** You are quite right; the intention is to hold a public health education campaign over the next three years. It is an important campaign, because—Dr Jewell has spent more time talking about it—where it has happened, namely Australia, there has been a significant drop in health difficulties. Some provinces of Canada have banned it completely and there has been a drop there. The First Minister announced that we would have a three-year campaign before we move to legislate. If we do not have significant drops, we will have to legislate, but the public health message was that we should try to do it by campaigning first. We need to do a lot more on smoking. I think that we were the first place to introduce a ban on smoking in public places and we need to make it more difficult for people to smoke. I am really anti-smoking, and when you see the figures for lung cancer—90 per cent of lung cancers are caused by smoking—you realise how much more we need to do. I will hand over to Dr Jewell to talk about the public health campaign.

[211] **Dr Jewell:** Rest assured that we are not sitting on our hands. We are preparing the legislation, which will take some time. For the introduction of smoke-free workplaces and so on, there was a lot of preliminary work leading up to that, working with employers and the public, explaining why. So, such a campaign is helpful in terms of the way that you make changes: it is not just about legislation, but creating a climate and explaining to people why you are doing it. We commissioned an Omnimas survey in September to provide a baseline assessment of public attitudes to this that we can use again. We will do two more to provide evidence that there either has or has not been a change in people's attitudes. Enforcement was hardly used at all with smoke-free workplaces, restaurants and pubs, because the campaign was systematic in explaining it and preparing people for it before the legislation. I see it very much in that way. We are not sitting on our hands; we are preparing legislation because the evidence from Canada is that it made a difference for people to know that it was just around the corner. However, we are not wasting time, because we are getting the baseline data and making the case.

[212] **Simon Thomas:** To be clear, while the public information campaign is going on, you will be preparing legislation, perhaps to be put on the backburner. When can we expect the

‘Fag out on every trip’ campaigns to start? [*Laughter.*]

[213] **Lesley Griffiths:** We are preparing legislation now to work in parallel with the campaign. So, it will be in three years, but we will be able to evaluate it constantly. Did you ask about policing it?

[214] **Simon Thomas:** Yes, I did. I asked about how it is measured, but I think that Dr Jewell has answered that question.

[215] **Jocelyn Davies:** I just want to make the point that, in relation to smoking in public places, the message was not, ‘If you do not stop smoking in the pub, we will ban it’; it was ‘We are going to ban it’. The campaign that led up to it was to get public opinion on the side of the ban. However, you say in your paper that you will introduce legislation only if levels of smoking do not fall. It would be more honest to say that you are going to ban it, but that it will take you three years to get there.

[216] **Lesley Griffiths:** You might be right there. However, it takes a while to get that legislation in place. We also need to do more to educate young children so that they do not start smoking in the first place. There is a very good scheme that is run in primary schools, which is called Smokebugs, and there is also the ASSIST programme, namely A Stop Smoking in Schools Trial. All of these are very important. I think that Mauritius has banned smoking in cars completely. It does not matter who is in the car, it is banned completely. We need to look at all of the places across the world that have done this and see what we can learn.

[217] **Christine Chapman:** It would be good to get some clarity.

[218] **Jocelyn Davies:** May I make a point Chair? There is no point saying to a smoker that, if you do not stop smoking in your car, we are going to ban you from doing so. Either you ban it, or you do not. If it takes three years to get public opinion on your side, then it will take three years. If you are going to ban it, then you are going to ban it.

[219] **Lesley Griffiths:** Well, we are having a public campaign first to try to reduce it, and we will then see. However, as Dr Jewell has said, we are not just sitting back; we are looking at getting the legislation in place. If we wait three years and we do not see the big improvement we want, it would take longer again to start preparing the legislation.

[220] **Christine Chapman:** A couple of Members want to ask questions on this point, as it is a very relevant topic. There are quite a few questions, and I am aware that time is short. Simon and Julie, would you like to ask your questions, and we will then move on to another question?

[221] **Simon Thomas:** Mae dadl bod ysmygu mewn ceir yn anghyfreithlon yn barod oherwydd nid oes gennych reolaeth dros y car os ydych yn tanio sigarét a’i ysmygu. Pa drafodaethau ydych yn eu cynnal gyda’r heddlu i edrych ar y mater hwn? Byddai rhywun hefyd yn torri’r gyfraith pe byddent yn taflu stwmp allan drwy’r ffenest.

Simon Thomas: There is an argument that smoking in cars is already illegal, because you are not in control of the car if you are lighting and smoking a cigarette. What discussions are you having with the police to look at this issue? Someone would also be breaking the law if they were to throw a fag-end out of the window.

[222] **Christine Chapman:** I will take Julie Morgan’s question as well.

[223] **Julie Morgan:** I was not sure, Minister, whether you had responded to the question of how you would know whether smoking in cars while children are in them had gone down.

How would you measure that?

[224] **Dr Jewell:** That is one of the things that we are currently looking at. We do not have a way to measure that at the moment. We are doing a survey of people's attitudes to it and are looking at what scientific approach we could take to get a spot check at a given time of smoking in cars. We do not have that at the moment, other than survey data.

[225] **Lesley Griffiths:** I will answer Simon's question, Chair. I met a representative of the Association of Chief Police Officers yesterday—one of the chief constables—and this was mentioned. I presume that you were referring to the driver. Obviously, it is not only drivers who smoke in cars, but passengers as well, and children are normally sat in the back of the car, which is where the smoke goes. However, you are right with regard to your point about their not being in control. It is like drivers using mobile phones. The situation is the same and the police will have to look at that.

[226] **Jocelyn Davies:** Would we then say that someone is not allowed to tell their children off when they are driving because they might not be paying attention to the road? It could get ridiculous. If this is a public health initiative, then you should just stick to that and not say that if someone is smoking then they are not in control of the car.

[227] **Lesley Griffiths:** No, but what Simon is saying is right, and that point has been raised with me. The Police Federation of England and Wales has raised with me the question of how the police will police the ban on smoking in cars.

[228] **Christine Chapman:** There are many practical issues to be looked at.

[229] There are some further questions, but I am keeping to time because you have to leave as you have another appointment, Minister. So, if you are content for me to do so, I will send the other questions that we wanted to ask, because the questions were very broad this morning. Thank you, Minister, and thank you, Dr Jewell and Dr Payne, for attending this morning. I am sure that we will be seeing you in the near future.

Gohiriwyd y cyfarfod rhwng 11.15 a.m. a 11.26 a.m.
The meeting adjourned between 11.15 a.m. and 11.26 a.m.

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

[230] **Christine Chapman:** Welcome back. I welcome to our meeting Dr Mechelle Collard and Dr Shannu Bhatia from the British Society of Paediatric Dentistry. As you know, we are doing an inquiry into children's oral health. Thank you very much for attending. The Members here have read your paper, so are you happy to go straight to questions?

[231] **Dr Collard:** Yes, that is fine.

[232] **Christine Chapman:** With regard to prevention and access, how effective has the Welsh Government's strategy for improving child dental health in Wales been? What further action is needed?

[233] **Dr Collard:** It is sometimes difficult for us to quantify how well things are going and how good the preventive strategies, such as Designed to Smile, are. That is one of the hardest things to quantify. I do not know how aware you are of the child health surveys. Community dentists go into schools to look at children's teeth. One of the biggest problems with those is that, until 2006, it was almost a policy of negative consent. If the parents did not say anything,

the children's teeth got checked. More recently, that has been turned into a system of positive consent, which is difficult because, obviously, some of the parents whose children have the worst teeth may be the ones who do not give consent for their children's teeth to be looked at. That makes it difficult for us to determine from those sorts of surveys whether child health is improving. One of the ways to assess whether the preventive strategies are working and children's health improving is by our general anaesthetic extraction numbers. That might be one of the few ways to monitor whether child health is improving, because a large number of our children seem to end up going down that route.

[234] **Christine Chapman:** Thank you very much. Some Members may ask questions in Welsh. If they do, channel 1 on the headsets will give you the translation.

[235] **Angela Burns:** On the basis of your answer to the Chair, am I to assume that you are unable to say whether the Designed to Smile programme is effective in the areas of most deprivation, which is obviously where it is targeted?

[236] **Dr Collard:** I do not think I can give you any figures to say where it has worked and where it has not. For one thing, I think it is too soon. There is also a difficulty with collecting data. I can speak only from personal experience. I work as a consultant in the dental hospital in Cardiff and in Morriston Hospital in Swansea, and I can tell you that there is a difference between the parents who come in. For example, we talk about the sort of toothpaste their children are using. Some parents will not necessarily move children up to an adult toothpaste when they get to the age of about six, which is what we would recommend, because they say that the children do not like the minty taste, for example. We try to tell them the level of fluoride concentration that is best for their child's teeth. The parents whose children are in these programmes in school, with the Designed to Smile team, are the ones who know exactly what toothpaste they are using in school, and are much more aware of fluoride contents, for example. So, although I cannot give you the percentage of children that it has affected, anecdotally, from working as a paediatric dentist, I can definitely see the families that are influenced by it.

11.30 a.m.

[237] **Angela Burns:** Could I ask a quick question or two? Do small children get fillings, or would you just pull out teeth that are rotten because you know that new ones will come through?

[238] **Dr Bhatia:** We do fill them. Just to go back to Designed to Smile, it operates according to evidence-based guidelines, so although we do not have the exact numbers regarding prevention, in due course, when the next survey has been carried out, I am confident that we will see an improvement in oral health for children in Wales. Designed to Smile is based on evidence of what works.

[239] **Angela Burns:** A completely different question: we have talked to other people about fluoridisation of water, and it would obviously be quite a difficult thing to do, but an awful lot of schools not only give children milk at break time, but also enable them to have small amounts of water. I am thinking of nursery schools and early years. My children perpetually have a flask of water on their desk and they are encouraged to drink it. As fluoridation is one way to help teeth, would there be any mileage in our looking at the possibility of bringing in fluoridated water for children to drink during the school day? Would that be helpful to their dental health?

[240] **Dr Bhatia:** It has been shown to help in other European countries. I think that Switzerland had salt fluoridation, and certain other countries have fluoridated milk. It has worked in other countries in Europe.

[241] **Angela Burns:** Can they fluoridate milk?

[242] **Dr Bhatia:** Yes, and bread and water—it does help, especially bearing in mind that this is not a hot country, so a lot of children do not drink a lot of water, though they should. Again, that also comes down to parents who are motivated to get the fluoridated water for their children. If they are motivated parents, then the child's dental health will already be better.

[243] **Angela Burns:** What I am thinking, of course, is that the schools themselves could do this, because an awful lot of children go to school with a distinctive water bottle that is theirs, and they go to the tap and fill it up—it is all part of learning responsibility—and if, instead of filling it from a normal tap, they fill it from a vat of fluoridated water, it might help the oral health of all.

[244] **Dr Bhatia:** It is a very good idea. We would have to calculate the dosage of fluoride, though, to the amount of water that they will be drinking.

[245] **Jocelyn Davies:** We have heard evidence that too much fluoride is not good for the look of the teeth later on, and I know that this issue has been controversial in the past. I wondered what your view would be. We had a lot of evidence that some people have a very low tolerance of fluoride.

[246] **Dr Collard:** In all the time that I have worked in south Wales—and I have worked in other places as well—I have never seen a patient with fluorosis. Sometimes, the people who are most at risk of fluorosis are the children whose parents are dentists and healthcare professionals, who give them fluoride supplements as well as high-fluoride toothpaste. All the current advice is that a smear of toothpaste is enough, especially with the under threes, because we know that they will swallow it. So, we have to be careful with fluoride, but it has such huge benefits for dental health, and we know that, in Wales, we have the worst teeth in the UK for five-year-olds, so it is undoubtedly something that we should be looking at.

[247] **Keith Davies:** What about children who are not part of, or are not targeted by, Designed to Smile? Will their rates of dental decay improve, or stay as they are? It is a small percentage that is involved, from what we have been told—it is just the deprived areas. I do not know what the percentage of children in Wales who are in the scheme is. It is probably less than 10 per cent.

[248] **Dr Collard:** No, it is much higher now. You can go to their website, which I did yesterday in order to refresh my memory. I am only aware of what is going on in south Wales, but Designed to Smile started in north Wales, and even areas like Powys have a huge number of schools on board. It has spread out quite far. The schools that do not have Designed to Smile are the schools that knew from the child health surveys that their children had good oral health. We measure everything in DMFT—I do not know if anyone has talked to you about that. We count the number of decayed, missing and filled teeth

[249] So, it has not been introduced in the schools where the average number of decayed, missing and filled teeth among pupils was very low, because those schools are seen to have children that have better than average teeth. Therefore, in terms of the children with good teeth, we do not have to worry about them so much, but I am sure that there are children in those schools from deprived areas with bad teeth, and I agree that it would be good for this kind of scheme to go to all those schools.

[250] Decay rates are shocking in Wales, and the number of children having general anaesthetics for extractions is disgraceful. It is absolutely shocking. We have almost failed

with the adult population—we are not getting anywhere with it. Every day in Wales children come in and we say to the parents that their child needs a general anaesthetic and to have 12 teeth out and rather than these parents looking shocked, horrified and appalled, they turn around and say, 'It's fine, I'll sign the consent form; I did this last year for my other son'. It has become acceptable to have a general anaesthetic to have your baby or adult teeth out.

[251] So, we have failed with the adults—we are not winning with them. The only way that we will get anywhere is with the children themselves. The British Society of Paediatric Dentistry is a UK-wide group, and we would be 100 per cent behind projects such as this, because we know that a lot of children get tooth decay between the ages of two and three, at nursery school age. If we do not take prevention measures until those children are aged seven, eight, nine or 10, it is almost too late, because they start getting adult teeth at the age of six. So, these early years are really important, and, if we cannot educate the parents, we need to start educating the children.

[252] **Christine Chapman:** It is obviously an unacceptable situation, but is it getting worse or is it levelling out?

[253] **Dr Collard:** I cannot give you the exact figures, but I think that we are carrying out more general aesthetic procedures, and I think that that is for a number of reasons. It goes back to the question about whether or not dentists fill teeth. This is not an indictment of general dental practitioners—I have worked in practice and my husband is an NHS GDP—but their contract does not necessarily encourage them to fill baby teeth. As a result, we see a lot of dentists who practice what can be termed as 'supervised neglect', where the children come in, their teeth are not causing them any pain, the children may not be massively co-operative, and so the small holes in their baby teeth are left. As a result, when the child does get pain, they get referred to us to have teeth out and it is a big deal. The trouble is that by the time that they get referred to us—sometimes having been on a waiting list for a few months—holes that were small and could have been filled have become so large that it exposes the nerve of the tooth, the child has an abscess and the only treatment is to extract. So, I think that we are failing as a profession to treat tooth decay early. I am not saying that that is necessarily due to financial considerations—there are some very good GDPs out there who are doing a great job and who do fillings. However, there are a number who do not fill deciduous teeth. The problem then is that when we see children, we have to take out a lot of teeth.

[254] **Christine Chapman:** Angela is next, then Aled.

[255] **Angela Burns:** I just have some information for the committee. I met the head honchos of Cardiff University's School of Dentistry a few weeks ago, and they said it is not just that 50 per cent of all Welsh children have shocking teeth, but that 20 per cent of affluent children have the same problem. I just want to ensure that we do not think that it is only a problem for deprived kids, because it is not—it is a problem throughout Wales. It is much more of a problem in deprived areas—

[256] **Keith Davies:** The trouble is that 'Designed to Smile' is targeted at deprived areas.

[257] **Angela Burns:** Absolutely, so we have this cohort that is left behind, whose teeth will consequently carry on getting worse.

[258] **Dr Bhatia:** If we can expand 'Designed to Smile' to other, affluent areas, that would be to be highly recommended.

[259] **Aled Roberts:** Dyma'r ail ddarn o dystiolaeth i ni ei gael y bore yma fod problem gyda chytundeb deintyddion. A

Aled Roberts: This is the second piece of evidence that we have received this morning that there is a problem with dental contracts.

fyddai'n bosibl i ni gael tystiolaeth ar yr hyn yr ydych chi'n credu sydd o'i le ar y cytundeb presennol? Mae'n iawn i ni gael strategaeth ynglŷn â phlant ifanc ond, os oes problem elfennol gyda'r cytundebau, mae'n rhaid inni fynd i'r afael gyda'r rheini hefyd.

Would it be possible for us to have evidence on what you believe to be wrong with the current contract? It is all very well for us to have a strategy for young people but, if there is a fundamental problem with the contracts, we must also get to grips with those.

[260] **Dr Collard:** I agree. There are several reasons why local dentists do not treat children. In the area where we live, in Cardiff, there is easy access to a dental hospital. As a result, there is an easy route to get children treated elsewhere. So that is one factor. Also, the difficulty with dentistry and the contracts that we have is that, if you work in a practice, you get paid for what you do, but you do not get paid for getting a five-year-old to come in three times, sit in the chair, and get used to things so that they are ready to accept dental treatment. That is a problem. In contrast, when children can go to community centre services and the hospital dental service, because we are salaried, we can spend time with that child. Also, we have the advantage of having undergraduate students, so we can book three appointments for a child without any treatment being done. That way, the child becomes co-operative and that is why we have very good success rates in treating children in dental hospitals, but not necessarily in general practice. I would not say that I am qualified to say any more than that about general dental practice, as I have not worked in general dental practice for a number of years, but I undoubtedly think that it is something that needs to be looked at.

[261] **Simon Thomas:** Dilynaf hynny drwy ddweud i ni gael tystiolaeth yn gynharach y bore yma ynglŷn â'r cytundebau hyn ac ambell i raglen beilot a oedd yn edrych ar atal pydredd ac yn rhoi pwyslais ar hynny, yn hytrach na thalu fesul triniaeth. A oes gennych unrhyw dystiolaeth neu farn ar y rhaglenni peilot a'r posibiliad eu bod nhw'n mynd i newid y diwylliant hwn?

Simon Thomas: I will follow that by saying that we received evidence earlier this morning in relation to these contracts and some pilot projects that were looking at preventing decay and put an emphasis on that, rather than payment per treatment. Do you have any evidence or opinion about these pilot projects and the possibility that they are going to change this culture?

[262] **Dr Collard:** There is a big nationwide project being carried out at the moment. As far as I am aware, it has only just started and it will be a number of years before we get any evidence from that. However, there is a professor in the dental hospital who has been very involved in organising that pilot scheme. You are right; we know that if we get decay that is only in the outer surface—the enamel of your tooth—we can arrest it. You cannot make it go away, but you can make it stop and not get any worse. So, as a result, children or adults do not necessarily get symptoms. We know that, if we catch decay early, we can do that, so there is definitely scope for that. This study is being done in a number of centres, looking at general dental practitioners treating patients, and, from what I am aware of the scheme, some of them are going to apply topical fluoride to fluoride on the tooth so they can arrest decay and get the parents to change the diet, and others are going to go ahead and fill the teeth. So, there is work being done on that. The difficulty with that is that, quite often, especially in, for example, the more specialist services such as ours, we do not see those children until it is too late.

[263] **Dr Bhatia:** Prevention and treatment have to go side by side, so you are treating the children who already have holes in their teeth, but you are also emphasising prevention, so that other teeth do not get holes in them. So, they have to go side by side. Of course, sometimes, GDPs cannot provide as much of their time, and that is where we perhaps need more specialist paediatric dentists in Wales to carry out this work.

[264] **Jenny Rathbone:** Focusing on the perverse incentives in dental contracts, I feel that we have been around this block many times. I can remember previously that we were

incentivising dentists to fill teeth that did not need filling, so I wondered what your view is, given that you are both senior practitioners, on having salaried dentists rather than private practitioners with incentives to do x or y.

[265] **Dr Collard:** I think there is an argument for it. As you were saying, it is a difficult balancing act. If you pay people to do certain things, then you are completely right, there is an incentive to do more than is strictly necessary. From a paediatric dentist point of view, my feeling would be that we have such geographical inequality in terms of specialists and consultants in paediatric dentistry that the difficulty is that, if you want to set up salaried services, then, especially with regard to such things as the community service, which can do great work, they need to have specialists to oversee the work that is being done. At the moment—I was trying to work it out before we came in—we have about eight or nine specialists in paediatric dentistry in Wales. Of those, two or three of them are not currently working in paediatric dentistry—one is an orthodontist as well—and they are all in the south-east. We have one in Merthyr, one in north Wales and there is nowhere further away than that. So, I am finding, particularly working in Morriston Hospital, that there are children in west Wales—and when I say west Wales, I mean anywhere west of Bridgend—that do not have access to specialist services. It is a very difficult one. The salaried services are where things could be improved, because, as you say, there is no incentive then to do unnecessary work, but every incentive to acclimatise children and get them used to having treatment, but we are incredibly short of anyone to oversee and manage those services. I do not think that you need a specialist everywhere, but, for treatment planning, you need a specialist to at least oversee what is happening. We are woefully short of those kinds of personnel, unfortunately.

11.45 a.m.

[266] **Keith Davies:** Yn eich papur, yr ydych yn sôn bod diffyg arbenigwyr. Yr wyf yn byw yn y gorllewin ac yr wyf yn clywed yn aml gan rieni a phlant sydd eisiau gweld orthodeintydd. Os ydych am weld orthodeintydd, mae'n cymryd misoedd, ac yn y pen draw rhaid ichi fynd i Dreforys. Wrth gwrs, os ydynt yn fodlon talu, gallant gael apwyntiad yr wythnos ganlynol. Beth allwn ni ei wneud am hyn? A oes diffyg orthodeintyddion hefyd?

Keith Davies: In your paper, you mention a lack of specialists. I live in west Wales and I often hear from parents and children who want to see an orthodontist. If you want to see an orthodontist, it takes months, and eventually you have to go to Morriston. Of course, if they are willing to pay, they can get an appointment the following week. What can we do about this? Is there also a lack of orthodontists?

[267] **Dr Collard:** I work closely with the orthodontists in Morriston Hospital, so I am well aware of those difficulties. One of the biggest problems in west Wales is that there was a consultant orthodontist working in Haverfordwest or Carmarthen, I think, but he retired. He was doing an unusual job, because he was working between three hospitals, one of which was in Aberystwyth. When he retired, they could not recruit anyone to that post.

[268] Orthodontics is much better. You have much better access to orthodontics than you do to paediatric dentistry, believe it or not. I work at Morriston Hospital, and I am the lead paediatric dentist for the south Wales cleft lip and palate team. I do two sessions every other week in Morriston Hospital, but I constantly get children who have special needs, and autistic children and sick children, referred to me. There is nobody else to see them. The worst thing is that, in the University Dental Hospital in Cardiff, we have three people who will be qualifying in the next year as specialists or consultants and we do not have any jobs for them. Yet we have children who are being treated for cancer in the children's hospital, who live in Pembrokeshire and have to be driven to Cardiff to get dental treatment. As you can tell, I am really passionate about this. Understandably, a local general dental practitioner will not treat them, because, if you take a tooth out, they are going to bleed everywhere as they have

problems with their blood and have difficulties with infection. They need specialist care. Yet, at the same time, we are training people and do not have jobs for them.

[269] **Keith Davies:** One of the cases I had was a girl with special needs. Trying to get her to an orthodontist—

[270] **Dr Collard:** Yes, it is very difficult.

[271] **Dr Bhatia:** There is not a simple solution, but I think that we need to recruit more specialist paediatric dentists.

[272] **Christine Chapman:** We will turn to Angela Burns and Suzy Davies, then I want to move on.

[273] **Angela Burns:** I just have a general comment. I think that your interpretation is correct, but I know that the Hywel Dda Local Health Board was offered a part-time orthodontist to carry on in Carmarthenshire, or anywhere else within the health board area, and it chose not to avail itself of that. So, in fact, the local health board has made a policy decision to send all the children from west Wales to Morriston. It has made that decision, and it is not because it cannot recruit people, because it was offered someone—I have all the facts, the evidence and the letters—but chose not to take up that offer. I think that that is appalling, and the LHB should be held to account for it.

[274] **Suzy Davies:** I have a question on this point. It is to do with Abertawe Bro Morgannwg University Local Health Board, which is in my area. Can I confirm that you would support the result of the specialist paediatric dental review of ABMU LHB? I think that it said that a 0.6 whole-time equivalent post would be required—

[275] **Dr Collard:** Those are my words, almost. I was involved in the review with Hugh Bennett.

[276] **Suzy Davies:** That is great. So, may I quote you on that?

[277] **Dr Collard:** A hundred per cent, yes. We desperately need someone in Swansea. I am there, but I am only contracted to deal with cleft patients. My difficulty is that, every now and again, I see someone who is not a cleft child because someone has referred them in and I do not have anywhere to send them and the parents say that they cannot afford to go to Cardiff or, say, have three other children and do not have transport. We desperately need someone down there.

[278] **Suzy Davies:** Thank you. That is what I wanted to know.

[279] You have already touched on the survey programme. Is it right that children are surveyed at the ages of five and 12? Why have those ages been chosen?

[280] **Dr Collard:** Those ages have been used for quite a long time. Initially, the plan was that all children would be surveyed at that age across the UK, so that we can compare children's dental health across the whole of the UK. Five-year-olds were chosen because we know that, at that age, children will have all their baby teeth, but they will not have started to get their adult teeth yet—or few of them will have adult teeth. Therefore, we are just surveying their deciduous, or baby, teeth. The age of 12 was chosen because, at the age of 11, children cross between primary and senior school, so you could be visiting a huge number of schools if you tried to survey 11-year-olds, whereas by the age of 12, everyone is in high school. I do not know why the age of 12 was chosen, and not 13.

[281] **Dr Bhatia:** They also have the full complement of adult dentists—

[282] **Suzy Davies:** Is surveying just those two ages sufficient to evaluate the Designed to Smile programme? I know that it is early days, but would you also like to see interim surveys?

[283] **Dr Collard:** We know that most children start to get tooth decay between the ages of two and three, so five is a good age to survey. I do not think that there is any need to do it before that. The difficulty begins if you survey between the ages of five and 12—you are not comparing like with like, because a number of children will still have deciduous teeth that are hanging on as the adult teeth are erupting, whereas other children will have all their adult teeth through. There is no reason that you should not do so, but it is quite difficult to compare two 10-year-olds. You can get quite a grown up, physically tall 10-year-old who has all his or her adult teeth, or you can get a 10-year-old who has nearly all his or her baby teeth. That is why I think that five and 12 are good ages to survey.

[284] **Suzy Davies:** Are they sufficient to help you evaluate Designed to Smile, even though it is early days?

[285] **Dr Collard:** I think so.

[286] **Christine Chapman:** Before we move on to Aled Roberts, who is going to ask about variation in dental decay, I want to ask a question. In your evidence, you highlight the importance of community-based and school-based programmes, including pre-school programmes, in addressing oral health problems in Wales. Are you satisfied that sufficient resources have been targeted at the pre-school age group through this programme?

[287] **Dr Collard:** I think that they do a really good job—they motivate the parents who attend the meetings. Not all parents attend, but a good number do. I am satisfied, but my concern is, as this gentleman said, the areas that do not have any input at all.

[288] **Aled Roberts:** Yr ydym wedi darllen yn eich tystiolaeth bod amrywiadau mawr o ran lefelau pydredd ar draws Cymru. Pa mor hyderus ydych chi y bydd y rhaglen hon yn mynd i'r afael â'r anghyfartaledd hwnnw?

Aled Roberts: We have read in your evidence about the wide variations in dental decay across Wales. How confident are you that the programme will address these inequities?

[289] **Dr Collard:** When the programme was set up, it looked at the areas that the data refer to, regarding the numbers of decayed, missing or filled teeth, which came from those surveys. Designed to Smile was set up to look at schools in which children have over a certain number of decayed, missing or filled teeth as an average, and they are the schools targeted first. Therefore, schools in areas with more decayed teeth will have had the Designed to Smile programme in place for the longest.

[290] **Aled Roberts:** O ran gwersi i'w dysgu, cawsom dystiolaeth yr wythnos diwethaf yn nodi bod y sefyllfa yn Lloegr llawer yn well nag yng Nghymru, a bod y rhaglen sy'n cael ei gweithredu yn yr Alban wedi arwain at welliannau. A ydych yn teimlo bod gwersi i ni yng Nghymru eu dysgu o rannau eraill o'r Deyrnas Unedig, nad ydynt wedi'u cynnwys yn y rhaglen ar hyn o bryd?

Aled Roberts: As regards lessons to be learned, we received evidence last week that the situation is far better in England than in Wales, and that the programme that has been implemented in Scotland has led to improvements. Do you feel that there are lessons that we in Wales could learn from other parts of the United Kingdom, which have not been included in the programme?

[291] **Dr Collard:** We are a step behind Scotland, because its Childsmile programme started before we started Designed to Smile. We were at a conference in Glasgow a few weeks ago, and they were talking about the Scottish example. In Scotland, children's teeth used to be a lot worse than our children's teeth. They have been doing this longer, and have improved things. So, we have a lesson to learn from them. These schemes work. We have seen them work in Scotland, and I think that they could work in Wales, but we need to ensure that the children who need these services are getting them. My only other concern with this kind of programme is that I do not know how much encouragement is given to the parents to be involved. When they were first set up in schools and nurseries, parents were encouraged to come in. If children are brushing their teeth in school and are getting all the advice in school, that is great—especially for those children who may not be brushing their teeth at home—but the concern is that, if they are going home and drinking a litre of Coke, we will not get anywhere with those children. So, as well as eduacting the children, there needs to be an emphasis on educating the parents. Not growing holes in your teeth is not just down to brushing your teeth.

[292] Unfortunately, parents are blasted by the media with messages about what kind of toothbrush and toothpaste to buy. I am a mother of three sons. I go to Tesco to buy a new toothbrush and am dazzled by the array and amount available. That is sometimes the problem. Parents come in and say, 'I do not understand why my child has holes in his teeth, because I brush his teeth every day'. However, when you go through the child's diet with them on an individual level, you discover that the child's diet is very poor. The parents do not necessarily associate a fizzy drink or a hot chocolate before bed with causing tooth decay. So, that is the only thing that I do not have enough information about on the Designed to Smile programme to be able to tell you about it. However, I know that they have a meeting with the parents. I would be interested to know how often they see the parents, and how much the parents are being encouraged to learn a bit more about dental health.

[293] **Aled Roberts:** Hoffwn ofyn un cwestiwn arall ynglŷn â chymharu â gwledydd eraill. Yr oedd un pwynt nad oeddwn yn ei ddeall yr wythnos diwethaf. Cafwyd tystiolaeth bod y sefyllfa o safbwynt plant pump oed yng Nghymru yn waeth nag yn unrhyw le yn Ewrop, ond bod y sefyllfa yn Sweden yn waeth nag yng Nghymru gyda phlant 12 oed. Nid oeddwn yn deall ar y pryd yr ateb a gafwyd. A oes gennych unrhyw sylw? A allwch roi tystiolaeth ysgrifenedig i ni ynglŷn â hyn os nad yw'r wybodaeth gennych y bore yma?

Aled Roberts: I would like to ask one question about comparisons with other countries. There was one point that I did not understand last week. We heard evidence that the situation with five-year-olds in Wales is worse than almost anywhere else in Europe, but that the situation is worse in Sweden than it is in Wales with 12-year-olds. I did not understand the answer given at the time. Do you have any comments to make on that? Could you send us a note if you do not have the information this morning?

[294] **Dr Bhatia:** We can find out about this. If you can provide us with an e-mail address or a means of contact, we will be able to provide that information.

[295] **Simon Thomas:** Hoffwn ofyn ychydig yn rhagor am y rhesymau pam mae pydredd, yn enwedig ymysg plant pum mlwydd oed, fel y nododd Aled, yn waeth yng Nghymru nag yn Lloegr. Yn amlwg, mae ardaloedd difreintiedig yng Nghymru, ond mae ardaloedd difreintiedig sylweddol yn Lloegr hefyd, ac mae pethau tipyn yn waeth arnom–yr wyf yn cyfeirio at yr hyn a ddywedoch ynglŷn ag agwedd rhieni tuag at

Simon Thomas: I would like to probe a bit further about the reasons why decay, especially in five-year-olds, as Aled mentioned, is worse in Wales than it is in England. Clearly, there are deprived areas in Wales, but there are significant deprived areas in England too, and things are worse here—I refer to what you said about parents' attitudes to children losing their teeth, for example. Unfortunately, I am old enough to

blant yn colli eu dannedd, er enghraifft. Yn anffodus yr wyf yn ddigon hen i gofio adeg pan oedd fy nghyfoedion yn cael dannedd gosod yn anrheg ar eu pen blwyddi yn 18 oed. Yr oedd cael dannedd gosod yn anrheg, oherwydd bod agweddau mor wael. A ydym yn dioddef o rywbeth hanesyddol—bod diwylliant o oddef pydredd yng Nghymru? A yw hynny'n wahanol i ardaloedd eraill? Yr wyf yn parhau yn ansicr pam mae'r sefyllfa'n waeth yng Nghymru, o ystyried bod ardaloedd difreintiedig mewn mannau eraill, megis gogledd-ddwyrain Lloegr.

remember my contemporaries being given false teeth as birthday presents when they turned 18. That was the attitude towards it then—it was a gift for them to be given false teeth. Are we suffering here from something historical—a culture of putting up with decay in Wales? Is that different to other areas? I am still unsure as to why standards are worse in Wales, given that there are deprived areas in other countries, such as the north-east of England, for example.

[296] **Dr Collard:** We are undoubtedly dealing with a culture where baby teeth are considered disposable and not a problem because the adult teeth then grow through. We are also dealing with a culture where it has been normal for children to be on bottles for far too long—bottles during the night, for example; that gives you a better night's sleep, but milk in a bottle at night will cause tooth decay. Also, people put tea and sugar in bottles. So, we are definitely still dealing with that culture.

[297] **Simon Thomas:** You are talking about my upbringing. It took me a long time to give up sugar in my tea. [*Laughter.*]

[298] **Dr Collard:** If you look at the rest of the UK, sometimes the data that we look at are averages. There are areas of England with just as many problems as we have. One of my close colleagues is a paediatric cleft palate dentist in the West Midlands. Over 90 per cent of the children that she treats drink water that has fluoride in it, yet she still has lots of problems with tooth decay. So, although on paper it might look like we have bigger problems, there are pockets of this everywhere. It is certainly not just in Wales.

[299] **Angela Burns:** You have answered a lot of the questions that I was going to ask you about the need for paediatric dentistry. You have spoken about that. To clarify, you made a comment earlier about the fact that we are training people who cannot then find jobs. Who are we training? Is it paediatric dentists and and orthodontists who cannot find jobs or is it dentists generally?

12.00 p.m.

[300] **Dr Collard:** It is paediatric dentists—specialists and consultants in paediatric dentistry. We will have two people qualifying next year as specialists in paediatric dentistry, trained in Cardiff dental hospital. One of those has been trained in conjunction with the community dental service, so she has been working in the Hollies health centre, which is a community clinic in Merthyr. We are very keen to get specialists into community clinics, not just hospitals. At the moment, there is no guarantee that there will be a job for her in community dentistry. We are hoping that there will be, but there is no guarantee. There is another lady who will qualify as a specialist, but at the moment there is no job for her. The lady to my right here will qualify as a consultant in March next year and, at the moment, there are no posts in Wales.

[301] **Angela Burns:** Yet the need is there. The need is huge.

[302] **Dr Collard:** Yes, definitely. There will be jobs. It will just mean that colleagues like Dr Bhatia will end up moving to England to get jobs.

[303] **Julie Morgan:** So, there are actually no posts—there is nothing to apply for.

[304] **Dr Collard:** Yes, that is right.

[305] **Lynne Neagle:** So, basically, the problem is that the local health boards are not commissioning those posts.

[306] **Dr Collard:** Yes. I think that, sometimes, paediatric dentistry sometimes comes lower on the list of priorities. I can understand that, but, equally, as we were both saying earlier, general anaesthetic services represent a huge cost in Wales. That is one point that I would like to make: when general anaesthetic services are being set up or modified, we need to look at who is setting up the protocols for the treatment plans for those children. For example, if a child comes to the dental hospital and a treatment plan is made for an anaesthetic by someone who is a specialist or who has been trained by us, we will not just say that the child has one bad tooth causing them pain that must come out. We will look at that child, take x-rays, get an orthodontic opinion if necessary and, if the child is going down the route of a general anaesthetic, ask how we can ensure that they do not need a second general anaesthetic. I am not convinced that that is necessarily happening everywhere. It is something that we need to be very aware of.

[307] In Swansea, for example, there is going to be a big change in anaesthetic services for children, and I think that it is really important that we involve specialists and consultants to look at those services, so that we reduce the risk to the child of a second general anaesthetic and the cost of that.

[308] **Angela Burns:** You are right; I think that paediatric dentistry is very low on the list. Do you agree—I will try not to be too leading in my question [*Laughter*.]—that that is a crazy situation, because a child with bad teeth grows up to be an adult with bad teeth? A huge number of health problems can occur in adult life that stem from having rotten teeth, including heart problems.

[309] **Dr Bhatia:** Even in childhood, there is a cost in terms of missing school through toothache or going to the dentist, for example. There is the cost of the parents having to take time off to take the child for a general anaesthetic and the cost of the childcare. There is also a cost in terms of the general wellness of the child. If they have painful teeth, they are not eating or drinking well, and studies have shown that they are not growing well—the head circumference is smaller. They are not thriving because they have such painful teeth and they are not eating or drinking. So there is a cost to the health of the child. The child will grow up and, because they do not know any better, their children will be in the same situation. It is a vicious cycle that we must break.

[310] **Dr Collard:** I would say that, most weeks, we have to admit a child to the hospital because their teeth are so bad, either because they have a pre-existing medical condition that makes things worse or because they have attended with a huge facial swelling and the child is so unwell that they have to be admitted and put on an emergency surgical list. Sometimes, if the surgical lists are full, they may have to spend an entire weekend in hospital waiting to go on to one of our lists in order to have the extractions carried out as an emergency. Out of 52 weeks a year, I would say that, in 45 of those, we are admitting at least one child.

[311] **Dr Bhatia:** This is a preventable disease.

[312] **Julie Morgan:** Does having your baby teeth taken out in that way affect the adult teeth?

[313] **Dr Collard:** It does. You have five baby teeth in each quadrant of your mouth, and

your first adult teeth, when you are six, grow behind those teeth. In effect, they keep your back adult molars where they should be. Under each of those baby molars, in front of the adult molars, you have the second teeth due to come through. If you take the baby teeth out too early, your adult molars move forwards—all teeth naturally want to move forwards—and that means that you do not have room for your pre-molars to come through, which increases the burden of care in terms of orthodontics.

[314] **Dr Bhatia:** The mouth tends to get more crowded because the baby teeth are lost too soon.

[315] **Christine Chapman:** Thank you both, Dr Collard and Dr Bhatia, for your fascinating and very comprehensive evidence. You will receive a transcript of today's evidence session. You are welcome to check that. Thank you both.

12:05 p.m.

Ymchwiliad i Iechyd y Geg Mewn Plant yng Nghymru: Sesiwn Dystiolaeth
Inquiry into Children's Oral Health in Wales: Evidence Session

[316] **Christine Chapman:** I now welcome Nigel Monaghan and Maria Morgan from the British Association for the Study of Community Dentistry. Thank you for attending today. Some members may decide to speak in Welsh and if you wish to use the translation equipment, you will need to switch the headset on by pressing the button on the front. The translation will be on channel 1. We have had a look at your papers. Are you happy to move straight on to questions?

[317] **Ms Morgan:** That would be great, but shall I introduce us both and tell you what our official role is?

[318] **Christine Chapman:** Okay.

[319] **Ms Morgan:** Nigel and I are both involved in overseeing the British Association for the Study of Community Dentistry co-ordinated children's surveys in Wales. I work alongside Professor Chestnutt; I am a lecturer in dental public health, working at Cardiff School of Dentistry. My colleague Nigel works in Public Health Wales NHS Trust. We have a sort of dual remit: I have more responsibility for the oral health information side, in terms of the quality, data analysis and reporting, while Nigel has more of an epidemiology role.

[320] **Mr Monaghan:** I am a dentist by background, Maria is a nutritionist, and we work across the NHS and Cardiff University interface. Maria works on what was originally a Welsh Government contract, but now the money to fund the unit comes from the Public Health Wales where I am employed. While we are both members of BASCD, technically speaking, it just co-ordinates the surveys; it sees them as owned by the NHS in the various countries of the UK. Technically, we are probably not here formally from BASCD—certainly from its perspective—but we are involved on an NHS and academic side with the BASCD co-ordinated surveys. Does that make sense to people?

[321] **Christine Chapman:** Yes, that is fine. Can you tell us about the challenges associated with the child dental health surveys that you undertake? What implications are there for evaluating the effectiveness of the Designed to Smile programme?

[322] **Mr Monaghan:** We have given you some of the history of these surveys. They were originally embedded in something called a 'dental inspection'. If you want the distant history, it goes back to the Boer War, when plenty of the recruits coming through for the army were seen not to be fit for military service for dental reasons. The origins of what was, once, a

school dental service goes back to that, as does the idea of an inspection of children's teeth. We have had a survey programme that has always been tied in to schools. The surveys as surveys originated in the mid-1980s, when we moved from an inspection programme, where the nature of what was done and inspection of teeth was stated, but not the purpose. The purpose was usually to find children who might benefit from dental treatment and get them to see a dentist. At that point there was a split: there was an element of inspecting children's teeth to look for those who could benefit from treatment, but also an element of gaining some information that could be used to help plan services because we did not have that data.

[323] So, we are still tied in to a programme that was largely the one that we inherited from the mid-1980s. One of the challenges for us might, at some point, be to look at other age groups. However, one of the advantages of being in a school setting is that it gives us an easy population which allows us to organise a survey in an efficient way, using the school as a sampling frame. We have problems, however, with the consent, which I know have been picked up before. They arose from changes in the common law on consent, which came after the initial establishment of statutes, which were interpreted as giving us permission to work with children without having had the prior consent of the parent in written form, in advance, on every occasion. That custom and practice clearly was not in line with changes in the common law on consent—things like the Gillick judgment and other areas where the rights of parents to decide what happens to their children can be established. That has presented us with challenges, which I know that you aware of, and we now have a fault line through the data for five-year-olds. As it happens, I undertook a Master's degree in law back in the early 1990s that looked at the area of consent for children for these surveys in a school setting. It was not difficult, when you looked at the consent law and at what we were doing in practice, to see that there were issues and some possible responses, which were explored in my dissertation. Maria and I have been able to explore that area and look at Gillick competent consent for children in the school setting for children aged 12 and 14.

[324] It was more challenging to try to explore what we could do on child consent, and we looked at school entry as a possibility. We approached the Chief Dental Officer for Wales's office within the Welsh Government, in the hope that colleagues in the education division could identify whether there were other more general issues, not just dental ones, regarding children's health and wellbeing that would benefit from having school entry as the major consent point at which parents would receive a reminder of when the dentist or other interventions were due in and would be given an opportunity to opt out.

[325] **Aled Roberts:** I am the father of two children and every September I sign a form that states that I give consent if the child requires medical attention. So, I am a bit surprised that I cannot give the same consent on that form as a matter of course as far as dentistry is concerned. The vast majority of people would have no problem with that.

[326] **Mr Monaghan:** You may hold that view, but many people do not. When I started my dissertation I was based in England and I was taking calls from all over the UK from parents—who were typically solicitors—who were livid that their child had been examined in school without their consent. I therefore had to help colleagues with reference to the Education Act 1944, section 48, or the Education Act 1996, section 520, and all of the other bits of information that explained the background as to why we had got into this position. There were usually bits of statute that the solicitors were not aware of because they were buried away in these education Acts.

[327] The Children Act 1989 states that anyone who has care of the child can consent for the purpose of safeguarding or promoting the child's welfare. So, a dental inspection for a survey is not normally seen as falling within that.

[328] On your comment about the specifics of a form, while you do that in your area, it is

not uniform across Wales. If we had a different interpretation of the approach to consent to a survey depending on which local authority area you are in Wales or even which school your children attended, that would introduce differences in terms of the participation in our surveys, which would make our data less consistent, reliable and compatible.

[329] **Angela Burns:** At what point does consent need to be gained from the child? You may have a parent who gives it, but a 14-year-old may turn around and say, 'No chance'.

[330] **Mr Monaghan:** To go back to the Gillick case, Lord Denning, in a subsequent case, likened consent to a flak jacket and said that a health professional or equivalent only needed valid consent from one source to be covered medically and legally—that is, that they would have acted with positive consent. So, a child or a parent can give consent, but a problem that we grapple with when giving advice to our staff concerns what to do when there are two parents who are not necessarily talking to each other and one and of whom wishes to give consent but the other does not. How do we manage that sort of issue? How do we manage the child who asks the dentist in a school setting for dental treatment when the parent has refused? Our advice to our staff at the moment is that they should tell the child to come to their clinic for treatment, because there is a specific Act that states that they should not examine the child in a school setting if the parent has refused. So, it must not be done in the school setting. If the child presents to them at their clinic, they are in a different scenario and the child can then give Gillick competent consent.

[331] **Angela Burns:** What is the age of consent for a child?

[332] **Mr Monaghan:** There is no specific age. There are a number of issues here and one of which is that there is no defined method in children's related law that states that this is how you judge a child has capacity. However, the Gillick judgment also stated that it is a clinical judgment for the individual as to whether a child has capacity or not. There is a presumption in that law that the child does not have capacity unless you can show that they do. By contrast, the Mental Capacity Act 2005 has now given us a framework for judging capacity for adults, where there is a presumption that the adult has capacity. They have to understand the information that is presented to them; they have to retain it long enough to form a judgment upon it; they have to weigh it and make a judgment; and then express their decision. If they can do all four of those things, the adult has capacity.

12.15 p.m.

[333] With the advice and guidance that we give to the dental examiners and their recorders, we have tried to build those tests into the process by which we gain consent. We have a standard script that we use to explain the information to children and we have reduced the reading age of that to the lowest level possible, with support from an academic colleague who has now moved on to Bristol. We require the dental nurse to confirm that that script was used on the data recording sheet, and that the child was individually asked to respond 'yes' or 'no' as to whether they had understood what had been said and whether there were any questions that they wanted to ask. We capture all that information before we then ask the child for permission to proceed. We are trying to build in something that parallels what goes on under the Mental Capacity Act for adults and using the same test, which seems consistent and reasonable. However, the presumption is that a child lacks capacity unless they can show that they have understood the information that has been explained to them, they have weighed it, they have made a decision and they have expressed that decision.

[334] **Angela Burns:** I assume that if a child says, 'No, I don't want you to look at my teeth', you will not touch them.

[335] **Mr Monaghan:** No, we will not examine them, even if the parent has said 'yes',

because it would not be helpful for a dentist to try to examine an uncooperative child.

[336] **Angela Burns:** I understand. It is also about the rights of that individual child.

[337] **Mr Monaghan:** The child has a right to be as involved in the decision process as they should be. We have signed up to the United Nations Convention on the Rights of the Child and, therefore, we try to take that principle forward. So, even if the parent says 'yes' and the child says 'no', we respect the child's decision. If the child says on the day of the examination that their mum or dad says that we are not to examine them that day, we take that at face value as a communication from the parent, even if it may not be.

[338] **Suzy Davies:** To go back to the issue of the consent form, it is now coming to light that there is no standard practice across local authorities to include in the handbook that kids get at the beginning of every term, where parents sign their consent for all sorts of things, a question on parental permission for this survey, for example. That first prompts us to say that that should be fairly easy to standardise and ask why we do not do it. However, is the issue that, because examining a child's teeth is quite an invasive procedure, if you do not get the consent of two parents, it is likely to give rise to specific issues applications?

[339] **Mr Monaghan:** We have never asked for the consent of two parents. From where we are sitting, if one parent says 'yes', that is fine, but we are in a three-way relationship with the school, the parent and the child. When we are doing a survey, we interfere with that relationship. We try not to do anything that would disrupt the school's relationship with the parents, and that is an important point.

[340] **Suzy Davies:** However, we are talking about parents signing a specific consent form at the beginning of term.

[341] **Mr Monaghan:** If a school is aware of issues, I would hope that teachers would draw it to our attention by saying that, although one parent has said 'yes', they know that the other one would not be happy. That is the way that we manage it. We do not try to get consent from two parents; we need it from only one source from our viewpoint. It would complicate our procedures immensely, because not every child has two parents. You have all those issues to consider.

[342] **Suzy Davies:** So, to push you, effectively, there is no real reason why you could not have a standard request on these multiple consent forms that we all sign.

[343] **Mr Monaghan:** Let me explain who does the surveys. The community dentists, namely the people who are called school dentists about whom Sue Greening spoke the other day, are our data examiners and recorders. They are taken away from clinical work with children or with people with special needs to do the surveys. This forms about 10 per cent, at most, of my working life. For 90 per cent of my week, I am a generic consultant of public health these days. Dental public health takes up about 10 per cent of my week, and almost all of that is this work. We try to run a survey in which, to describe the survey protocol, the minimum of key information that should be collected is collected, because we want to see large numbers of children to generate small, local area statistics to compare the child dental health surveys and the adult dental health surveys. However, we do not want a huge bureaucratic exercise with our staff having to send out lots of letters and chase them up. That would take up a considerable amount of time. We go through the school and operate through it. Not all schools want us in there. That is one of the reasons we no longer see 14-year-olds.

[344] **Suzy Davies:** That is possibly the cause of this.

[345] **Mr Monaghan:** We are dependent on the co-operation of the school and of the local

authority. Some years ago, a new person came in as the director of education at Bridgend, who, quite rightly, wondered who the heck these people were who were coming into the schools and wanted to know more about what we were up to. They were quite keen that we continued to liaise with the schools and that we explored school-entry consent. However, I do not have any powers to impose on schools across Wales that they must send out a form at the beginning of term. Not only that, but I am a public health consultant too. I do not think that doing that in isolation for dentistry would be a good idea.

[346] It would be better to do it for a range of health and welfare concerns, such as school bullying policies and all those other issues. In addition to that, we are more likely to get a positive buy-in from parents if this is seen as one of a string of forms, as part of the school entry process and procedure, as opposed to an isolated form. So, for various reasons, the best route forward is not to have me in a state with no real power to make a huge difference; I would much prefer us to do it in a co-ordinated way across Wales. It is important that we conduct the surveys in a consistent way because, if we have different things in different places, the data are not necessarily comparable.

[347] **Christine Chapman:** I want to move on to other areas, but Jenny, do you want to say something briefly?

[348] **Jenny Rathbone:** Yes, I want to look at the safeguarding aspect of this. An earlier witness told us that it is often the parents of children with the worst teeth who deny consent for their child to be examined. However, if a child tells a teacher at primary school that their teeth hurt, there is a clear wellbeing issue that needs to be addressed. Where does that fit in your detailed legal knowledge?

[349] **Mr Monaghan:** We first introduced specific content in links to the surveys and protocols on child protection issues about five or six years ago. I happen to work alongside the child protection nurse, not directly, but within Public Health Wales. We ensure that our surveys, protocols and contents include references to the guidance and to the links for child protection issues to be picked up. There is a chance that a dentist, on examining a child, may see something that raises concerns, such as a bite mark, so we need a mechanism to resolve that. We cover child protection issues in the training and calibration exercises that we run before each survey—that is the mechanism by which we maintain the quality. One piece of advice that we have always given in these exercises is that, if you as the examining dentist are approached by the teacher of a child who is in pain or discomfort—this links in to the consent issue that we covered—because the teacher has responsibility for the welfare of the child under the Children Act 2004, they can ask you to examine the child, not as part of the survey, but as a case of immediate need. It is not impossible for us to address some of those issues, but I cannot say that we have any access to those children whose parents have refused consent and who do not present for us to examine within the survey programme. That is a challenge for us all, because it is one of the problems that mean that we cannot correct this fault line in our data. We do not know what the dental health is of children we do not examine, because we have not examined them.

[350] **Ms Morgan:** I would like to add one point. It is not about parents of children from deprived areas denying consent; it about them not opting in. It is not about denying consent; that is a distinction.

[351] **Lynne Neagle:** I just want to clarify something. When you go to a school, do you examine all the children whose parents have consented, or do you have a sample?

[352] **Mr Monaghan:** There is a sampling frame. We are trying to generate a statistically valid sample for every unitary authority in Wales, of which Merthyr Tydfil is the smallest. There was a time when we examined the whole cohort of children in Wales, but that was a

huge use of clinical time. The principle of sampling is that you get valid data without having to see everybody. The surveys in most of the rest of the UK were conducted using sampling. We moved to that approach some years ago, because there are better uses that could be made of the children's time, and the fewer data that Maria had to clean in her role, the more time she had to analyse and present the data back for all of us to use with regard to planning and evaluating services. The sampling varies for the two levels. In the senior schools, it is approximately one in four children. For the younger children, they are stratified according to the size of the school; we do not have any really large junior schools in Wales, so we see all of the children in the small schools that we sample, and we see half of the children in the medium-sized schools that we sample. A sample is designed to ensure that both are represented as a proportion of the population of five-year-olds in a unitary authority area. So, we will see a randomly selected sample of small schools and a randomly selected sample of larger schools; within those, we see some randomly selected children. It is truly random.

[353] **Lynne Neagle:** If you find children who have particular problems, would you give them a letter to take to their parents to say that they need to see someone?

[354] **Mr Monaghan:** There is feedback to the parents if we think that a child is in need. The problem is at what level you set that threshold. Not all caries in deciduous teeth that are about to be lost from the mouth of a five-year-old child will require a dentist to take an active decision to do something in the here and now. If the tooth is close to being naturally exfoliated, you would not want to put a child through an extraction or a filling. So, just because disease is present, it does not mean that we jump in. We look for signs of sepsis in the mouth. We look for swellings and what we call a sinus—a little tract where there was a swelling that has since burst and from which puss could be coming out. We look for signs of that and, if we see something like that, we refer the child. We look for things that we think would benefit from treatment in the near future. I do not think that we have ever had an example of something really urgent, but we would expect an urgent referral for something really serious. So, if a child has a fat face on the day that we are going in, the chances are that the child will not be in school if they are like that, as they would not be well enough.

[355] **Christine Chapman:** Keith Davies, do you want to add anything?

[356] **Keith Davies:** Yn eich tystiolaeth ysgrifenedig, yr ydych yn sôn eich bod wedi casglu data bob 10 mlynedd. Yr ydych hefyd yn dweud nad ydych yn glir beth fydd y sefyllfa yn 2013. Beth yw'r rheswm dros hyn?

Keith Davies: In your written evidence, you state that you have been collecting data every 10 years. You also state that you are not clear what the situation will be in 2013. What is the reason for that?

[357] **Mr Monaghan:** Maria, as you negotiated the adult dental health survey, perhaps you could answer that.

[358] **Ms Morgan:** In a way, there are two sets of surveys. The surveys are organised by the Office for National Statistics and, every 10 years, we have adult dental health surveys and national children's surveys. The last children's survey that was done on a UK national level was undertaken in 2003. We are scheduled to have one in 2013. This gives you country-level data, whereas the surveys overseen by the British Association for the Study of Community Dentistry produce more local data, and this is where we have our survey programme looking at five and 12-year-olds. We have also moved on to look at older people in care homes.

[359] There has been a decision in recent years relating to the Office for National Statistics surveys that are co-ordinated with us and with a group from academia. There have been questions regarding the value of those surveys and whether or not there may need to be a move to a different approach to assess the oral health of children. So, the shape of the 2013

survey may be different. I will now hand over to Nigel to discuss the suggestions.

[360] **Mr Monaghan:** I do not know whether it will happen. If you go back to the adult dental health survey, which was due to take place in 2008, we had plans then to run a care home survey in 2009, one year later. In England, the money for this survey was passed to the NHS Information Centre, which then had delegated responsibility and decided that it probably did not want to run that survey. It was not until there was a review in Westminster by a select committee and the Minister put on the spot and asked whether collecting these data would be a good idea that a statement was issued announcing that the money would be found and the survey would go ahead. It ran a year later; the planning was delayed by a year.

[361] In an ideal world, I would like to think that the dental information system that interacts between a community or a general dental practitioner and a child would generate data that could be used to measure the health of children. However, the information systems have never done that. The survey programme that we currently run would not be needed in this format per se; there may be other ways in which data could come and we could be involved in analysing them. We are not in a position to do that at the moment. The BASCD surveys exist, and I can imagine someone questioning the need to conduct a children's survey every 10 years as well. However, the difference is the different sort of data that we get. We get much more qualitative data about children's experiences of dentistry and of other aspects of dental health problems, such as the erosion of teeth or other issues, which our surveys do not collect. We are monitoring the common, high-impact disease in children—tooth decay, in the main. We do look at other aspects: our questionnaire asks about general anaesthesia and we have previously collected data on orthodontic need; we have also attempted to collect data on things such as erosion, but the data have not been published because questions have been asked about the reliability of the index that we have been using, as we are still developing that.

[362] Our survey is about five-year-olds. The child dental health survey that we talked about covers all ages and is much more detailed. However, even if Wales wants to go ahead, there is a need to consider the scale of that. A few hundred thousand pounds go to the academic institutions and the Office for National Statistics to do that work. The surveys that we do are run on £10,000 a year, plus a little bit more to run the training calibration, to fund the unit that Maria works with, a bit of my time as a consultant, and the time of the community dental staff. We run our programme as part of an NHS care process, whereas the child dental health survey will need hundreds of thousands of pounds. Wales's proportion of that is smaller than England's, and if England decides not to run it, it may not happen. With the adult dental health survey, Scotland did not fund it. It made a decision not to join in.

12.30 p.m.

[363] **Angela Burns:** You said that you did a survey of five-year-olds, and that the adult survey covers the whole spectrum of the adult population. Is that the reason Wales suddenly leaps from having the worst teeth in the universe, practically, at the age of five to being good again at age 12? We have asked this question of other people who have come before us, and we have not had a good explanation of why we go from being very bad in the UK at 5 and then good at 12.

[364] **Mr Monaghan:** I cannot give you a full explanation, because any survey that we get involved in will tell you what is going on, but not necessarily why. It will tell you what the outcome is.

[365] **Angela Burns:** Your survey is UK-wide. You could compare us with the rest of the UK.

[366] **Mr Monaghan:** We make comparisons with the other nations. Fluoride toothpastes have to be part of the issue, and they are widely used in the UK—among those who use toothpaste at all. You would struggle to find a non-fluoride toothpaste. That might not be true in some other European countries. Deciduous teeth—that is, baby teeth or milk teeth; the first teeth—are less well mineralised, they have more organic material, and they benefit less from exposure to fluoride than the adult teeth. Young children do not necessarily start brushing early. There are other factors that may lead to early decay, and I heard some of the comments made earlier. We may have cultural expectations about the way that our children are rewarded at young ages that may contribute to decay—the use of sugar, and other things. Decay in five-year-olds has levelled off in recent years; it has not improved, but it continues to do so among 12-year-olds. There is something going on, which is probably partly related to dietary awareness, which comes through the school curriculum, among other things, as well as the use of fluoride toothpaste, and that is benefiting the adult teeth at age 12.

[367] I would just put a rider on anything you say about the decay levels. You need to be aware that what we gather are data based on a visual examination of the teeth with a light that is little better than a 60W tungsten-wire bulb. We are not using x-rays, and quite rightly so. Why would we use x-rays for a survey like this? However, we know that surveys like this do not find all the decay that may be present, and it is also known that, when teeth are exposed to fluoride, it becomes harder to diagnose decay, particularly in the permanent, adult teeth. If you speak to dentists about it, they often talk about hidden decay—they see a tiny hole, but once they have drilled in and got through to the decay that is underneath the enamel on the outside, it turns out to be a lot larger than they were expecting. I have worked in a fluoridated area in the past—in Bedfordshire—and I have seen that, as well as working in other areas when I was a clinical dentist. Overall, I would say that I cannot give you the answers as to what is going on.

[368] Which is the more important dentition? I would argue that it is the adult one. I am pleased therefore that the data on 12-year-olds are improving. I would like more success in reducing decay levels for five-year-olds. What we are currently doing does not seem to be working, but this is not a simple problem. Whether children are being exposed to sugar, between meals in particular, and whether they are brushing their teeth, fluoride is the only bit that prevents decay. Brushing your teeth does not stop tooth decay; it is putting the fluoride in the mouth that helps. There are very few studies that have ever shown that cleaning teeth stops decay. The sugar gets in there, it gets into the places that the toothbrush cannot reach, and it can be turned into acid that will demineralise the teeth. Dentists, in the main, do not prevent decay. They are great if you need a filling or a tooth extracted, but they are an expensive resource to try to prevent decay with. To have a dentist sit there and talk to a child—there are other people we can pay to do that, or other things that we can do to deliver fluoride. Overall, I would like to see us do more, but the things that we have been doing in past decades have not taken us any further. We got fluoride toothpaste in the 1970s, but before that, I was a child who ended up having a general anaesthetic to have a tooth taken out. I had lots of filling. I have so much metal in my mouth I know which way north is. Actually, that is partly what made me decide that I wanted to be a dentist. I wanted to know what these instruments were and what was going on in my mouth. I wanted to make sure that other children did not suffer what I was going through. That was one of my motivating factors for becoming a dentist.

[369] So, things have improved, but they have levelled off. We will have to do something new that we have not been doing in the past. Hopefully, we will change behaviours. A number of people have asked whether this review is making a difference, and I think that you are right to want to know whether it makes a difference. However, I want to know whether people want to make a difference for a cohort of children who will receive the programme for three, five or however many years. Are we going to run this programme for long enough so that a cohort of children who are the next generation of parents are routinely brushing their

teeth and will therefore make sure that the next generation routinely brush their teeth? I think that it needs to run for 15 or 20 years if it works. If it does not work, that is another matter, but if it does we will need to run it for a long time and then perhaps, one day, we will have a sustainable position whereby parents routinely introduce their children to brushing their teeth from a very young age—as soon as the first tooth is in the mouth. Even just 10 years ago, a number of young dentists would say that that is too young an age for a child to start brushing their teeth. No, it is not. The topical effect of fluoride starts at a young age. We also need to work with mothers before they become mothers in antenatal care clinics, and educate them about sugary drinks.

[370] **Angela Burns:** What you say is interesting and absolutely valid. I know that it is a silly question, but, when you do the survey at the age of 12 and look at decay in teeth, do you count a tooth that has been removed or a tooth that has been filled as decay, or do you count decay as stuff that is going on that has not been treated, because I still cannot understand why the degree of decay at the ages of five and 12 is so different?

[371] **Ms Morgan:** We have two indices, one of which is the decayed, missing and filled teeth index—DMFT—and figures are presented for those. Primary dentition in younger children is presented as 'dmf'. For older children with adult teeth, it is 'DMF'. We have variables which just focus on the decayed element—but, generally speaking, we use the decayed, missing due to caries, and filled teeth index. They are not comparable, because one is of five year olds, and so focuses on the primary dentition, and one is of 12-year-olds, which focuses on adult teeth.

[372] **Mr Monaghan:** Do not forget that a five-year-old who has had some tooth decay is quite likely at some point to come into contact with members of the dental team. When the dental team see decay, advice will be given about how to prevent decay in future for the new teeth coming through and the importance of looking after them. One of the issues at the heart of it is that we still have decent access to dentistry in most parts of Wales, although I know that there have been pockets in the past where that has not been the case. However, compared with England, we are way better off in terms of access to dentistry across Wales. It is much more uniformly common in England for people to struggle to find an NHS dentist, although I know that there are also pockets of Wales where you will struggle—the further west and the further north you go, the more that becomes an acute problem. That is why the dental school is outreaching teaching.

[373] While that might not be the greatest comparator in the world—England at its worst—we probably have an effect where families, parents and children together, are learning that they have failed with the first child and that they have a chance with the second child of preventing decay. We are not alone in seeing this change across the UK—the data for 12-year-olds in other parts of the UK is still improving. England has the same problem of relatively flat-lining decay among five-year-olds. Scotland is seeing an improvement, but it has been running a tooth-brushing and fluoride exposure programme for longer than we have in Wales. We used to be on a par with north-west England; that was our comparator region. North-east England has quite large areas of deprivation, but it also has some fairly affluent bits. North-west England always had the worst level for tooth decay, and it was our comparator. We have fallen slightly behind that area, but it is still the worst part of England for tooth decay.

[374] I saw the looks around the table, and I apologise if you believe that access to dentistry is not wonderful here, but access is worse in some parts of the UK than it is here.

[375] **Angela Burns:** I think that I probably feel sorry for the UK then, for once, because access to dentistry in west Wales is an ongoing nightmare.

[376] **Mr Monaghan:** I accept that, and that is a place where we have these problems. You do not have problems close to dental schools; people go away to study, they make links and networks in the community, and dentistry is a five-year course, so they make strong links and they tend not to want to move away. We have had great success recruiting dentists in Merthyr Tydfil since I first came to Wales in 1999. It is great—there are no problems in Merthyr, because of the A470 dual carriageway. It was not difficult to sell to candidates—there was lots of need, they needed to support a community, and could still, if they chose, continue to maintain the networks that they had grown up with nearer to Cardiff. The further you get from a dental school, the harder it is, and that is why we are outreaching teaching.

[377] **Christine Chapman:** Okay, thank you. We have covered some of the questions that Members wanted to ask—

[378] **Jocelyn Davies:** And much more.

[379] **Christine Chapman:** And much more, yes; it has been a fascinating evidence session this morning. I want to move on now to the expansion of the programme to children from birth up to the age of three. I will bring in Jenny Rathbone on this one.

[380] **Jenny Rathbone:** Thank you very much. We have had excellent explanations as to why we focus on five-year-olds and 12-year-olds in our surveys, so I will not ask you about that. I note in your evidence that you talk about the importance of fluoride toothpaste, but you and others have also mentioned the link with diet. In an ideal world, all babies would move straight from breastfeeding to beakers, so what are we doing to reduce the use of bottles, and particularly sugary drinks in bottles? It is that sucking process that really gets the sugar into the teeth, is it not?

[381] **Mr Monaghan:** As part of the dental survey programme, we are not doing anything on that specifically.

[382] **Jenny Rathbone:** Should we?

[383] **Mr Monaghan:** The problem is that we are not going to ask a five-year-old about their historical behaviour; it is just not appropriate to that part of the survey programme. I am aware of programmes that have run in the past on exchange schemes, encouraging parents to bring in a bottle to get a free beaker. Certainly, when I was a trainee in Doncaster in the south Yorkshire coalfield area, we were running a scheme of that sort. That may be one of the sorts of issues that we are seeking to address. Tooth decay is associated with deprivation. We talk about fluoride, but fluoride is still something of a sticking plaster. It helps and can make a difference, but a lack of fluoride is not the root cause of tooth decay: it is the sugar between meals, the dietary habits and all the rest of it. That will take time to change; it is human behaviour. I do not know about you, but I can think of cases when I was a clinical dentist when I changed behaviour in some of my patients. I remember a little Italian boy with his parents; the family were all on benefits and he was the translator for the family. He proudly came in and told me that he had only had one sweet since I had seen him last week. There were not that many cases where I achieved the sort of change I got with that little lad, and within Italian family culture that was a challenge, believe me. That was rare; it is the exception and that is one of the problems for us.

[384] We are trying to get teeth in contact with fluoride and so we are requiring a change in human behaviour, because the best way to get teeth in contact with fluoride is every day, not when you see a dentist, because that gives the most protection. However, to do it every day, we have two main vehicles: people either do it at home, or we stick it in the water supply. Putting it in the water supply would be easier, from a technical viewpoint, and would deliver it to everybody. That would make it easier to get everybody's teeth exposed to fluoride, but it

is not necessarily easy to do because of a range of issues to do with opposition and ethical arguments, political decisions and the rest. I have certainly argued for some time that the policy in Wales should be getting the teeth of the people of Wales in contact with an optimum level of fluoride in the most effective, cost-effective and acceptable way. The whole 'Designed to Smile' programme is centred around that sort of philosophy, because the alternative would be water fluoridation. However, in truth, we still have to address the whole deprivation agenda. We have to work with young women before they become mums, while they are pregnant. We have to work with the young people and change those expectations in order to change behaviour, and that does not happen quickly or easily.

[385] **Christine Chapman:** Thank you very much. On that point, about the poverty agenda, I will bring Aled Roberts in.

[386] **Aled Roberts:** Yr oeddwn eisiau gofyn cwestiwn ynglŷn â sut mae'r data yr ydych yn eu casglu fel rhan o'r arolygon hyn yn mynd i gyfrannu at fesur llwyddiant y rhaglen wrth ystyried tlodi plant a iechyd y geg yn 2020.

Aled Roberts: I wanted to ask a question in relation to how the data that you collect as part of these surveys will contribute to measuring the effectiveness of the programme in considering child poverty and oral health in 2020.

12.45 p.m.

[387] **Ms Morgan:** I have been involved with developing the child poverty targets related to oral health, and there are four of them. There are two that relate to five-year-old children; the first is, by 2020, to take the average decayed, missing and filled index for five-year-olds in the most deprived group to the middle group through the levels that represent the middle group. The baseline was set in 2003-04 and the data was collected via the negative consent surveys. So, that is our first child poverty indicator. The second relates to five-year-olds and is about the prevalence of dental caries—the percentage of decayed, missing and filled teeth greater than zero. We then have two other indicators relating to 12-year-old children on the average DMFT and the prevalence. So, we have a dilemma with the five-year-olds in that, as I said, the baseline was set in 2003-04 using a survey methodology of the negative consent format. We are now undertaking surveys using a positive consent format. You will know from reading the paper that we submitted to you that we have looked at ways of trying to model and rework the data to reflect the methodology that we used before. We have decided that that is just not feasible and given advice to the chief dental officer that we need to set a new baseline using data based on 2007-08, so that we can monitor time forward. By 2020, we are hoping to have two more surveys, at least, so that we can monitor whether the caries levels of children in the most deprived fifth move down as we move down towards the middle fifth. You will be aware of the slope associated with morbidity and deprivation, which happens in all sorts of morbidity indicators, not just dental caries. We want to even out that slope, so that, by 2020, the children in the more deprived groups reflect more the level in the middle groups. Hopefully, over time, we can make that as flat as possible.

[388] **Mr Monaghan:** The data that we collect form the intended outcome indicator. So, we either need this programme, or, failing that, a programme of some sort that collects equivalent data in 2020, or at any milestones before that year, to show whether this programme has made a difference. The way that Ivor Chestnutt and colleagues have been running the programme is to look at the process measures of whether the programme is reaching the people it should in the short term, to ensure that the programme is on track, with the expectation that, when we do these surveys at intervals, the data will show change for children, particularly those who are in the most deprived quintile. We should be looking for a narrowing of the most deprived quintile with the others, but there may also be some areas where the programme is not reaching. We may get data on children from their home postcode that identifies them as living in the most deprived quintile of postcodes. If some of those children are in areas where the

programme is not running, that gives us a control to say, 'Hang on a minute—are they improving at the same rate?', in order to show whether this programme is working. So, while I understand that the committee has concerns about all children getting this at some point, in these earliest years of the programme, when it is still being rolled out, the fact that it has not rolled out to some people gives us a control that helps us to establish whether it is working. If it is working, that becomes an argument for rolling it out to everybody. We have access to the process and I think that 7,000 or 8,000 children will be examined, typically, in a year, so we get data on fairly large numbers across Wales. When we put them then into quintiles, there are more children in the deprived fifth than there are in the most affluent fifth in Wales, so that gives us more numbers in that group to look at.

[389] **Julie Morgan:** Are you satisfied that you are collecting all the data required to assess the cost-effectiveness of the 'Designed to Smile' programme?

[390] **Mr Monaghan:** I cannot answer that because I am not close enough to the programme. Colleagues are involved in the collecting of the data associated with how the programme is running and what it is doing. I am collecting the DMFT data, which has traditionally been used for helping to plan and evaluate NHS dental services. It also now forms a target for 'Designed to Smile'. Are you involved in any work in relation to 'Designed to Smile', Maria?

[391] **Ms Morgan:** I help to oversee the monitoring of 'Designed to Smile' in terms of counting the numbers of children who are tooth-brushing and the number of schools that are taking part. It is very much a process measure. Currently, I am analysing data that have been sent to me by the community dental services for the previous financial year, so that is for April 2010 to March 2011. We are now in just under 1,000 schools in Wales, and there are around 67,000 children tooth-brushing. So, the work that I am involved in is counting and accounting for where the finances are going, as regards the number of personnel who are working in the CDS. In terms of evaluating the success of the intervention, my colleague Professor Chestnutt has been looking more at that side of things.

[392] **Mr Monaghan:** Maria works in a unit that supports Professor Chestnutt, as well as helping us to undertake the surveys.

[393] **Julie Morgan:** Is enough data being collected?

[394] **Ms Morgan:** From the process monitoring side, I would say so, in that we are able to count whether we are accountable for tax payers' finances and that side of things, because that is what I am involved in. However, as regards cost effectiveness, are you also implying evidence of—

[395] **Julie Morgan:** I just wondered whether you wished that you were undertaking more extensive surveys, for example.

[396] **Mr Monaghan:** For me, the problem with the survey agenda is that we have focused on only children for almost 20 years. We do not get any data on adults either. We have a fair handle on what is happening with deciduous teeth from the data on five-year-olds—it is a good proxy for what is happening at the age of three. The pattern of decay gives us a feel for that. With 12-year-olds, we cannot get much data on them later—it is harder, because of pressure on the school curriculum and achievement. However, it gives us a feel for the direction in which it is going with adult teeth. Therefore, if you ask we whether we could do more, I would not necessarily be talking about Designed to Smile. It might be nice to do a survey on three-year-olds at some point, if we could get access to a valid sample of children without disproportionate cost or burden of work and without it being a distraction for community dental staff. We have not yet worked out whether that is possible. As regards care

homes, our most frail, older people are another Welsh Government priority and, therefore, if you are asking me about the BASCD survey programme and whether we would do more with children as the next priority, my answer would probably be 'no'.

[397] We are currently collecting data, for the first time, on residents in care homes. We are paralleling what the adult dental health survey did for free-living older people. It did not grapple with adults lacking capacity, which we are doing. We have gathered data on that, but it will not be reported on until next year—that is when the first data will emerge. That is because I am having to grapple with all of the problems for dental health. We have done some previous work that suggests that there are problems in that area, and no-one has been looking at them. I want to unpick the unmet need and I would say that I have an adequate handle on what is going on in Wales to know where the problems are in children—geographically, in terms of the nature of the diseases, and where we ought to be targeting.

[398] **Jocelyn Davies:** Out of curiosity, was there a significant difference between the genders at the ages of five and 12?

[399] **Ms Morgan:** That is an interesting comment because, in the past, when I was working on earlier surveys, we found that there were no significant differences and we no longer, in fact—

[400] **Mr Monaghan:** Due to data protection issues, we truncate dates of birth so that we do not collect the day, the home postcode is geo-coded, and because we found no merit in collecting gender differences, we no longer collect that data.

[401] **Jocelyn Davies:** That is fine; thank you.

[402] **Christine Chapman:** Thank you, Nigel and Maria, for your evidence. It has been an interesting, comprehensive session and we look forward to you coming back to the committee at some stage in the future. Thank you, it has been very helpful.

[403] Finally, the date of the next meeting will be Wednesday, 5 October, when we will be scrutinising the Minister for Local Government and Communities on youth justice and considering the annual report of the Children's Commissioner for Wales. Thank you.

Daeth y cyfarfod i ben am 12.54 p.m.
The meeting ended at 12.54 p.m.