Kingston children’s oral health survey (2017-18)

Report prepared 2018 on behalf of the Royal Borough of Kingston Public Health Team

PUBLIC HEALTH
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Healthy Teeth, Healthy Kids

Key findings (n=104)

- Almost half of local parents (46%) said their child had had at least one problem with their oral health over the past six months. The commonest reported were problems with the appearance of their teeth, mouth or gums.
- Just under one in three parents (32%) had felt stressed or anxious about their child's oral health in the last six months.
- Although 75% of parents said that it was easy to access dental care in Kingston, only 60% thought that it was easy to access oral health advice.
- Parents of younger children were less likely than others to say they had been given the right oral health advice and less confident than others about how to look after their child's oral health. Only seven in ten parents of 1 - 4 year olds had been given advice about how often to visit the dentist.
- Only 55% of parents said they had been given advice about what kinds of food and drink their child should be consuming.
- Seven in eight parents said their child had been to the dentist at least once. The commonest age to start going to the dentist was two years old, which is older than the age recommended by Public Health England for a first visit. More than a third did not go to the dentist until they were three or older.
- Among those who had used dental services, nine in ten said that their child's experience had been good or very good. The aspects of dental services with the most scope for improvement were length of wait for a routine appointment, and the child-friendly nature of the practice.

Recommendations

- Health Visitors, GPs, pharmacists and other healthcare professionals should ensure proactive oral health advice is incorporated into routine appointments and visits for young children.
- Schools and children's centres should incorporate oral health advice and a good environment for oral health as part of their work towards Healthy Schools and Healthy Early Years accreditation.
- All those who offer oral health advice should ensure it includes advice about what foods and drinks a child should be consuming and when to visit the dentist for the first time, as well as about toothbrushing and frequency of visits to the dentist.
- Dentists should prioritise prevention of decay for young children by ensuring routine appointments are available for families, including those with young children, and considering how to make their practices more child-friendly.

Background

In order to inform a chapter of the local Joint Strategic Needs Assessment, Kingston Public Health is reviewing information on the oral health of children aged under 12 who live in Kingston upon Thames. Inclusion of the views and experiences of local people are an important part of the approach to JSNA in Kingston.

The scope of the JSNA chapter includes

- Oral health improvement (health promotion) and population-level prevention of oral health problems for children aged under 12
- Oral health improvement (health promotion) in community settings for children aged under 12
- Oral health of vulnerable groups of children under 12, including children with special needs
- Preventative primary and secondary dental services for children under 12.

It does not include orthodontics or any other specialist dental services.

Kingston's rates of dental decay at age five are better than the England and London averages, at 22.9%, but given that almost all tooth decay is avoidable, there could be some scope to make improvements. Like many parts of London, Kingston also has higher rates of tooth extraction for children than for England as a whole. Understanding parents' experiences and concerns about their child's oral health may help to identify how to improve on oral health outcomes in the area.

Methods

The key themes for the survey were identified following discussion with the overall children's oral health JSNA chapter project Steering Group. The survey was aimed at parents of children aged under 12 and sought to identify:

1. The impact of children's oral health on local families
2. Families' confidence in managing oral health
3. Experience of oral health promotion and preventative dental care
4. Satisfaction with dental services

Wherever possible, questions were based on on those validated for use in existing national surveys, including the questionnaire for parents and guardians from the 2013 ONS Dental Health Survey of children and young people and the 2009 ONS Adult Dental Health Survey. Minor amendments were made to some questions to ensure the questionnaire referred to the respondent's child rather than themselves, and a small

number of new questions were devised, including an open question inviting feedback. The questionnaire was reviewed and tested by HealthWatch Kingston and Public Health England, and tested by a local parent.

The questionnaire collected demographic data including the age, gender and ethnicity of the child; the age, gender, ethnicity and highest educational qualification of the person completing the survey; the income of the household and the number of children in order to help identify whether different demographic groups have a different experience of oral health promotion and healthcare. Respondents who had more than one child were asked to complete the survey with reference to the oral health of their youngest child. Person-identifiable data were not collected and the survey was open to anyone to take online. Please see appendix for the full questionnaire.

The survey was completed via Kingston Conversations (www.kingstonconversations.co.uk) which is the local authority's main digital engagement platform and data were stored securely while analysis was conducted, before being deleted. No identifiable records of which individuals responded to the survey were made.

Responses were collected between 18 December 2017 and 9 February 2018. The survey was promoted via the Royal Borough of Kingston upon Thames Twitter account, the RBK Matters staff newsletter, the Community Health Matters Newsletter, the HealthWatch Kingston newsletter and the local school newsletter. Parents attending a HealthWatch Kingston consultation session at the Quaker Centre on 20 January 2018 January and a community health event at the Hook Centre on 26 January 2018 completed the survey in person.

Data processing and analysis was conducted by the project lead within the public health team in Kingston local authority. Partially completed surveys were not excluded from the analysis and percentages were reported based on the number of people who responded to each specific question. Results were analysed by subcategories including the child's age group, gender, ethnicity and household income. Results are reported by percentage, but the overall base size (number of respondents) is also included in tables and figures.

Following discussion with members of Kingston's JSNA working group, it was agreed that it would not be necessary to suppress small percentages in this report. It was determined that the risk of identification of an individual through triangulation with other data was extremely low, since the survey was open to all and there were a number of different referral routes, meaning anyone could be a participant. In addition, the survey reports subjective views and experiences, so there is no way of knowing how any individual might have responded to any question.

No formal statistical tests were carried out.

Results

A total of 104 survey responses were submitted. The sample is small. More than 24,000 children aged under 12 live in Kingston, meaning that the sample for this survey reflects the experiences of less than 0.5% of the population. This means that all results should be treated with caution, particularly those for subgroups.

Most (60%) entered the survey page directly, 28% entered via social media, 2% entered via email, 1% via search engine, 5% by referral from others and 5% completed the survey in person at outreach events.

1. Demography

The survey was completed on behalf of 104 children, with the most common age range being the 5-8 age group. A total of 54% of the children were male and 46% were female. The most commonly reported ethnicity was White (68%), followed by Mixed (15%) and Asian or Asian British (11%). Kingston's overall population is approximately 69% White, 20% Asian and 5% Mixed. Most respondents reported that the child attended primary schools, with 66% reporting that the child attended primary school. Two percent attended secondary school, 6% attended a local authority nursery, 16% attended an independent nursery, 6% attended a childminder and 8% did not attend any of these settings.

Table 1: demographic characteristics of the respondent's youngest child

	%			%
Age of child (n=102)			**Ethnicity of child (n=104)**	
Under 1	3%		White	68%
1 to 4	37%		Mixed or multiple ethnic groups	15%
5 to 8	40%		Asian or Asian British	11%
9 to 11	20%		Black African, Caribbean or Black British	1%
Total responses	100%		Other ethnic group	2%
Gender of child (n=102)			Prefer not to say	3%
Male	54%			
Female	46%			

Almost all respondents were parents, though 1% were legal guardians and 1% were completing it as grandparents. Most respondents (84%) had qualifications at degree level or higher. The modal age category was 35 to 44 and most (91%) were women. Almost two thirds (61%) reported a household income above £40,000 per year and the modal number of children in the household was two.

Table 2: demographic characteristics of the household and the person completing the survey

	%			%
Age of respondent (n=104)			**Highest qualification of respondent (n=104)**	
24 and under	0%		Degree level or above	84%
25 to 34	12%		Another type of qualification	14%
35 to 44	60%		Prefer not to say	3%
45 to 54	26%			
55+	1%		**Children in household (n=103)**	
Prefer not to say	3%		1	36%
			2	55%
Gender of respondent (n=104)			3	6%
Male	9%		4	2%
Female	91%		0	1%

Ethnicity of respondent (n=104)			Annual household income (n=104)	
White	74%		Below £20,000	4%
Mixed or multiple ethnic groups	3%		£21,000 - £40,000	14%
Asian or Asian British	14%		More than £40,000	61%
Black African Caribbean or Black British	1%		Prefer not to say	22%
Other ethnic group	6%			
Prefer not to say	3%			

2. Experiences of oral health advice

A majority of respondents had received oral health advice, with 87% reporting that they had been given advice about cleaning their child's teeth and gums and 84% reporting that they had been given advice about how frequently they should go to the dentist.

Among parents of younger children aged between one and four, 77% had received advice about brushing their teeth and 70% had received advice about going to the dentist. Among parents of children of Asian or Asian British ethnicity, 73% had received advice about how frequently their child should go to the dentist.

Parents were less likely to have been asked about, or to have received advice about their child's diet and its impact on oral health than about visiting the dentist. Only 54% said that a dentist or another professional had asked them about what kinds of food and drink their child consumes and only 55% had been given advice about what kind of food and drink they should be consuming.

Figure 1: advice about visiting the dentist (n=103)

The most commonly reported source of oral health advice was from a dentist, at a dental surgery. Of those who had received advice about going to the dentist (n=86), 96% had received it from a dentist and 11% had received it from a health visitor. Only 1% had received this advice from a GP. Of those who said they had been given advice about the types of food and drink they should be consuming (n=57), 91% said they had received the advice from a dentist, 4% had received it from a dental nurse, 7% said they had received it from a health visitor and 2% said they had received it from a GP.

Most parents (83%) agreed or strongly agreed that they were confident about their ability to manage their child's oral health on a daily basis. Among parents of younger children aged 1-4, 74% were confident, and among parents of Asian or Asian British children, 73% were confident. No major difference in confidence was identified between parents from households with incomes above and below £40,000 per year.

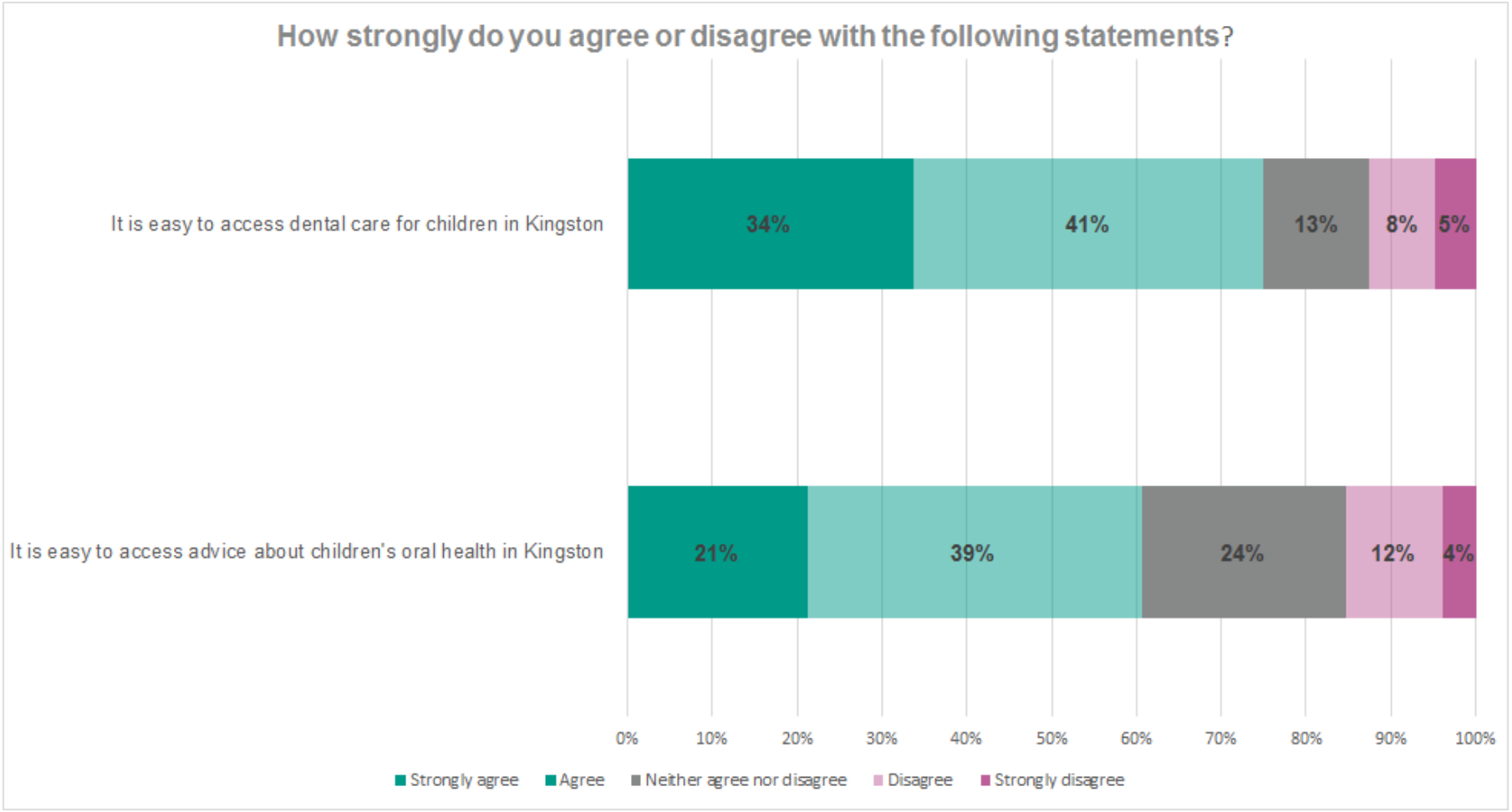
Qualitative comments about oral health advice included suggestions to:

- Give advice at children's centres and in schools
- Allow toothbrushing in schools
- Demonstrate correct tooth brushing in schools for younger children
- Give advice about snacking and sugary drinks, including advice about sugary snacks which are perceived as healthy such as dried fruit
- Give advice about supervised toothbrushing
- Make sure children are exposed to sugary foods less frequently
- Give advice about teething and thumb sucking

3. Experience of dental service access and quality

Most parents reported that it was easy to access oral health advice and dental services in Kingston, with 60% agreeing or strongly agreeing that it is easy to access oral health advice and 75% agreeing or strongly agreeing that it is easy to access dental services. Parents of younger children were less likely to say that it was easy to access dental service or oral health advice. Although only a small proportion of respondents felt that it was difficult to access services, this subject was raised by four people in response to an open question, with comments including that there was a limited choice of NHS dentists, that it was necessary to travel to be able access an NHS dentist and that there was a long waiting time to see an NHS dentist.

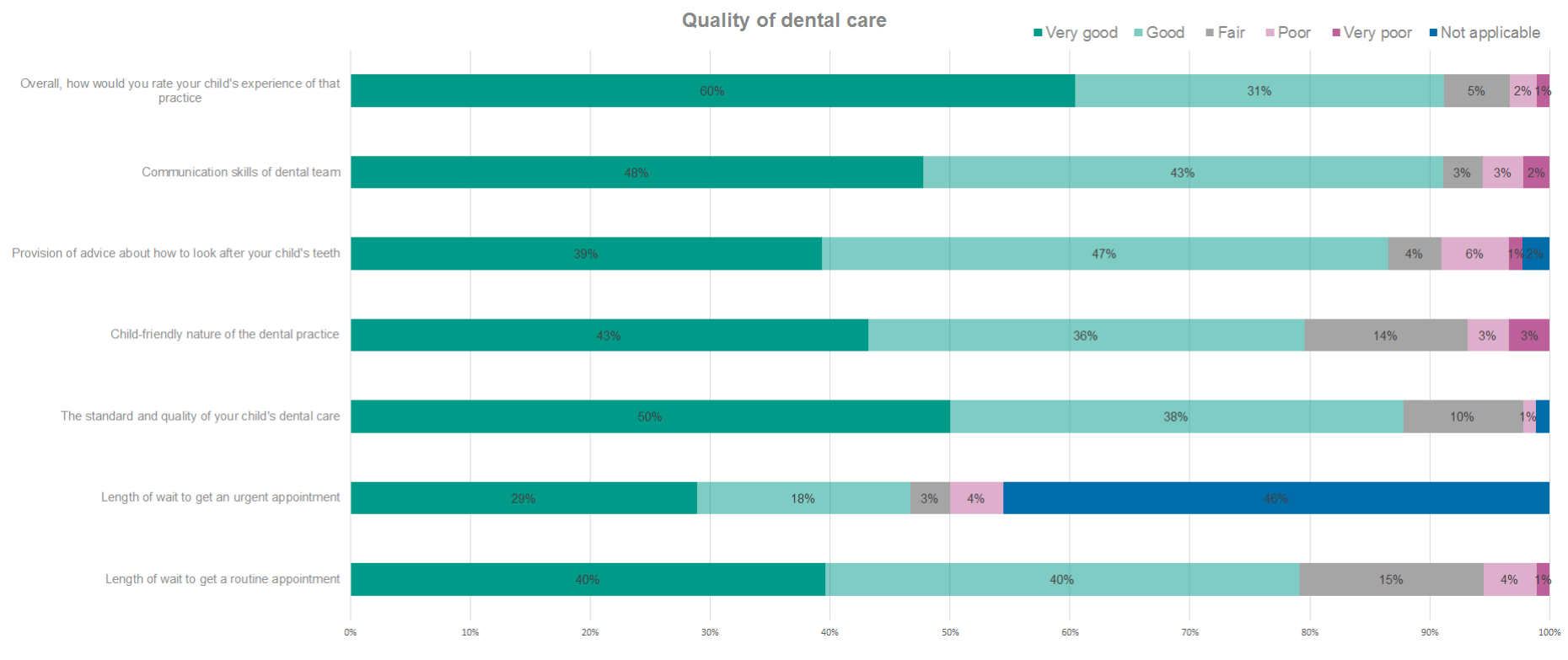
Figure 2: access to dental services and oral health advice (n=104)



Most parents (88%) reported that their child had been to the dentist at least once, with 56% having attended three times or more. The commonest age at which children had first been taken to the dentist was two years old, with 27% reporting that their child had first been to the

dentist at this age. A total of 17% had first been to the dentist before their first birthday, 20% had first been to the dentist between the ages of one and two, 20% had first been to the dentist between the ages of three and four, and 17% went to the dentist for the first time when they were four or older.

Figure 3: quality of dental care (n=91)



Most parents who had taken their child to a dentist reported that they were happy with their experience of the service. Overall, 91% of this group parents responded that their child's experience had been good or very good; 91% reported that the communication skills of the dental team were good or very good; 87% reported that provision of advice was good or very good; 80% reported that the child-friendly nature of the practice was good or very good; 88% reported that the standard and quality of dental care was good or very good; 86% who had relevant

experience reported that the length of wait for an urgent appointment was good or very good; and 79% reported that the length of wait for a routine appointment was good or very good.

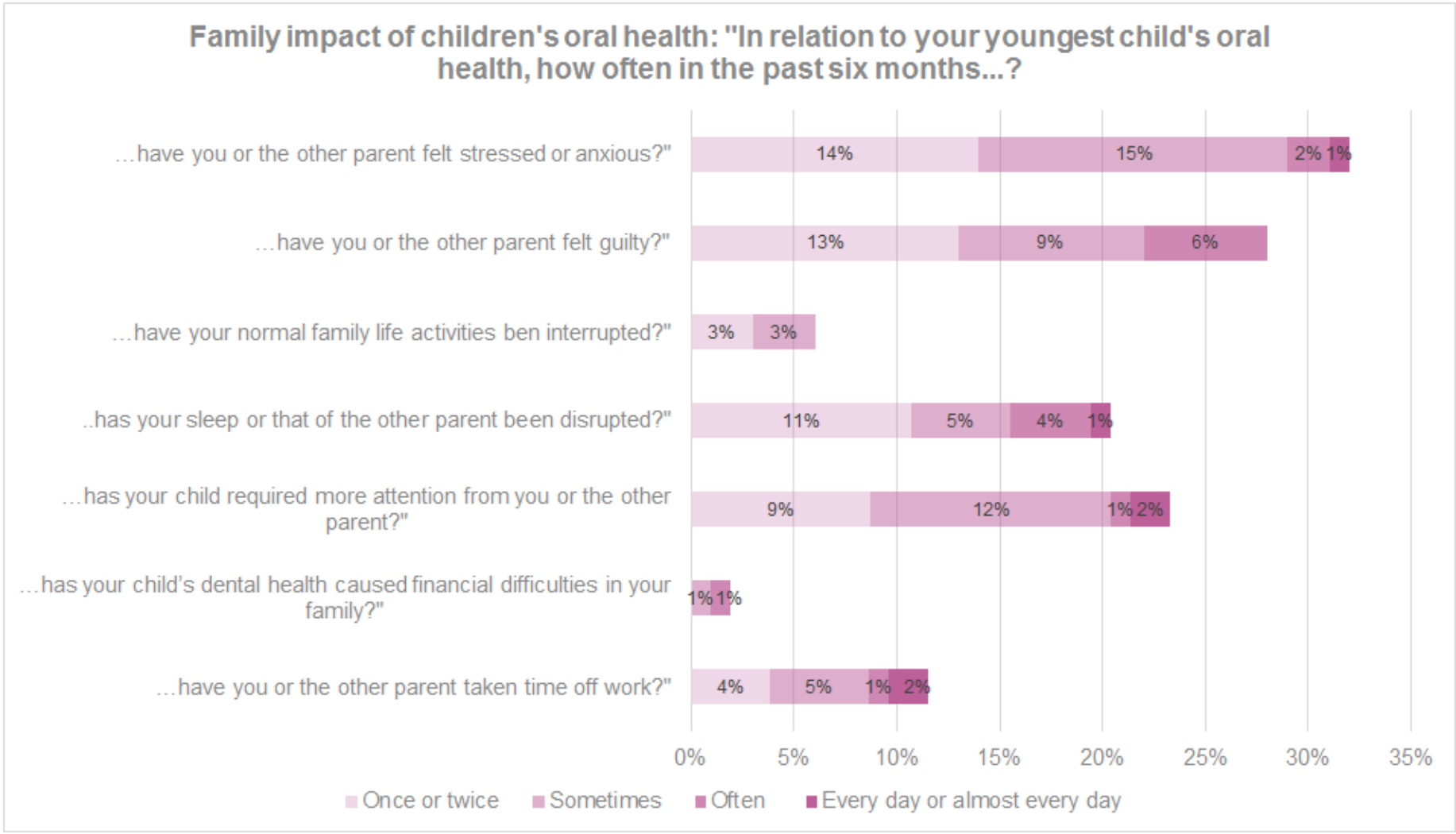
Qualitative comments highlighted that potential areas for improvement in dental practices include:

- Provision of appointments outside working hours, or offering family appointments
- Lack of time to talk about prevention of oral health problems
- Availability of staffing and equipment
- Lack of access to fluoride varnish for NHS patients
- Clarity about funding and availability of orthodontic treatments

4. Oral health at home and its impact on the family

Just under half of parents, 44%, reported that their child had had at least one problem with their oral health in the past six months. The most commonly reported issues were problems with the appearance of teeth, gums or mouth, reported by 13%, followed by pains in the mouth other than toothache which affected 9%, and bad breath, which affected 8%. Seven percent had experienced bleeding gums, 4% had experienced toothache and 3% had experienced tooth decay.

Figure 4: reported impact of children's oral health on the wider family (n=104)



Most parents did not report that their child's oral health had affected their quality of life in the past six months. Just under a third (32%) of parents said that they had felt stressed or anxious about it at least once, 28% had felt guilty about it at least once, 6% said it had interrupted their normal activities, 20% said that their sleep or the other parent's sleep had been disrupted, 23% said their child had needed more attention, 2% reported financial difficulties and 12% had taken time off work.

The most common age at which to start brushing teeth was between six months and one year. Of those whose children brushed their teeth or had them brushed, 22% reported that they started brushing before their child was six months old, 52% started brushing when their child was between six months and one year old, 21% started brushing when their child was between one and two years old, 1% started brushing when their child was between two and four years old and 2% started brushing when their child was between four and six years old.

Most children who brushed their teeth did so with supervision. Thirty-eight percent said their child brushed their own teeth, 12% said that an adult brushed their child's teeth, and 50% said that an adult and their child together brushed their child's teeth. Supervised brushing is recommended for children aged under seven. Of the children below this age, 17% brushed their teeth alone. Fifteen percent had teeth brushed once a day, 84% had teeth brushed twice a day 1% had teeth brushed three times a day. Toothpaste was used by 89%, non-electric toothbrushes were used by 73%, electric toothbrushes were used by 55%, mouthwash was used by 15%, dental floss by 11%, dental disclosing tablets by 7%, chewing gum by 7% and fluoride tablets by 2%.

In qualitative comments, parents reported various challenges in looking after their children's teeth including lack of confidence, resistance to toothbrushing from the child, difficulty in explaining the importance of oral health to young children, and difficulty avoiding sugary foods and drinks, and problems with thumb sucking.

Discussion

Most of the people who responded to this survey were relatively confident in managing their child's oral health, and reported that their child had received good oral health advice and dental care. Most said they had received oral health advice, including advice about tooth brushing and visiting the dentist. However, the main source of this advice was dentists themselves. This means that parents who don't already know when and how to visit the dentist may be be missing out on advice about how to manage their child's oral health. The parents of younger children were less confident about how to look after their child's teeth and less likely to say they had received the right advice. Parents from Asian and

Mixed backgrounds were less likely than White parents to report that they had been given advice about how often to visit the dentist and Asian parents were less confident about how to look after their children's teeth, though it is important to note that the sample size is small.

These findings imply that it would be helpful to look for earlier opportunities for oral health promotion and for oral health advice to be given routinely outside the dentist, particularly for parents of younger children and perhaps also targeted to some BAME communities. However, further research with a larger sample size would be helpful to be confident about which groups feel they would benefit most from which advice.

Only 55% had been given advice about what kinds of food and drink their child should consume. Sugar was raised as a concern by many parents in the qualitative comments section of the survey, suggesting that there may be scope to improve on both the frequency of advice about sugar consumption and the support parents get to avoid sugar in their child's diet.

Seven in every eight children had been to the dentist at least once, and the commonest age to first visit the dentist was two years old. Public Health England advises that children should visit the dentist before their first birthday, or when their first tooth emerges. This suggests that there could be scope to encourage local parents to take their child to visit the dentist sooner.

Most parents rated the quality of dental services their child had received relatively highly, with potential areas for improvement highlighted as being the length of wait for a routine appointment, and the child-friendly nature of the practice. However, it should be noted that some people who live in Kingston use private dental services or NHS services in neighbouring boroughs and that this survey did not collect data to distinguish between these services. This means it is likely that the experiences of dental care reported here do not all relate to NHS dentistry in Kingston.

There are many other limitations and reasons for caution in interpreting the results of this survey. Responses were anonymous and there was no verification of local residency in Kingston or of where in the borough people live, meaning that it was not possible to identify from this survey whether there are particular wards or areas where parents are more likely to have problems with their child's oral health. In addition, it was based on a self-selected and opportunistic sample of local residents, meaning that we cannot be confident that their views reflect those of the local population. Those who did participate may have had a particular interest in oral health, meaning that their knowledge of oral health advice and of how to access local services may be better than for those who did not participate. In addition, it was conducted online, in English, which means that those who are digitally excluded and those who do not understand written English would have been unable to participate.

As noted above, the sample is also small, which means we can be less confident of how well it reflects the whole population's views. This is particularly the case where very small percentages have been reported. These may give an indication that an issue is not widespread in Kingston, but should not be interpreted to represent the size of that issue in the population.

Nevertheless in conjunction with other sources of data about children's oral health in Kingston, this may be helpful to inform future commissioning of oral health promotion and dental services. Further research would be particularly helpful to identify the extent of oral health inequalities in Kingston, including collection of more localised information to identify whether there are differences in experience between different parts of the borough and collecting more data about Kingston's BAME communities, who were under-represented in this survey.