Warwickshire County Council

Briefing Paper

Oral Health Promotion Needs in the Early Years in Warwickshire

April 2017

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1. Summary introduction

Nationally, the latest oral health survey of 5 year olds indicates an increase in the proportion of children with no experience of decay ($d_3$mft=0)[1] from 69.1% in 2008 to 75.1% in 2015. However, in Warwickshire there has been a decline from 79.4% in 2008 to 73.7% in 2015, with a notable drop in the proportion of 5 year old children with no experience of decay in Rugby Borough from 83% in 2008 to 59.9% in 2015 (see 2.1.1a, table 1). Similarly, a 2013 survey highlighted emerging poorer oral health amongst 3 year old children in Rugby, compared to the rest of the county (see 2.1.1b).

Ethnicity data from the 2015 survey of 5 year olds suggests that the prevalence of decayed, missing or filled teeth was higher amongst 'White other' children, with Rugby Borough housing a larger proportion of 'White other' children - predominately Polish (2011 Census).

The data from these surveys suggest the need to strengthen universal oral health promotion in the early years across Warwickshire, with a more targeted focus in Rugby Borough - particularly amongst 'white other' communities.

Findings from this paper also highlight skills and training gaps, and the need to equip early years workforces to deliver up-to-date oral health promotion messages. Priority early years cadres include health visiting staff, social care staff, family support workers, children centre staff, nursery, pre-school and day-care personnel, child minders and Integrated Disability Service staff.

2. Background

2.1 Data on oral health

2.1.1 Decayed, Missing and Filled Teeth ($d_3$mft)

The National Dental Epidemiology Programme regularly surveys the oral health of 5 year olds (2008, 2012, 2015). A survey of 3 year olds was also undertaken in 2013 but as this was the first time this age group had been surveyed, there is no trend data available. In the 5 year olds surveys, primary schools were randomly sampled and age-eligible pupils were identified (randomised sampling took place in larger schools). Findings are outlined below:

a) Five year old children with no decay experience[2] (PHOF 4.02)

In the 2015 survey, the Warwickshire sample was 1,670 children aged 5 years old. Of these, 1,214 (73%) agreed to participate and were examined within the school setting. This survey showed that 73.7% of 5 year old children examined across Warwickshire had no sign of decay experience . This is slightly lower than the national (75.2%) and West Midlands (76.6%) averages (see Appendix 1a).

Comparing the 2015 Warwickshire rate with other similar areas using CIPFA (The Chartered Institute of Public Finance and Accountancy) statistical comparators, the proportion of 5 year old children with no experience of decay in Warwickshire is lower than twelve of the fifteen CIPFA comparator areas (see Appendix 1a) which range from 85.0% in Hampshire to 67.8% in Cumbria.

[1] %d3mft=0
[2] PHOF 4.02 uses following indicator: % d3mft = 0

Within Warwickshire, 80.4% of 5 year olds examined in Stratford on Avon District and 78.5% in North Warwickshire Borough (78.5%) had no experience of decay – higher than the national and regional averages. However, In Nuneaton & Bedworth Borough, Warwick District and Rugby Borough the proportions of 5 year olds with no experience of decay were lower than the national and regional averages. See Table 1 below.

When compared across the West Midlands, only Herefordshire (58.7%) had a lower proportion of 5 year olds with no experience of decay than Rugby Borough (see appendix 1b).

Table 1: Proportion of 5 year olds with no decay experience (%$d_3$mft=0)

	Surveys			
	2008	**2012**	**2015**	
North Warwick Borough	77.3%	78.4%	78.5%	↔
Nuneaton and Bedworth Borough	73.5%	71.4%	74.5%	↑
Rugby Borough	83.0%	78.4%	59.9%	↓
Stratford-on-Avon District	82.0%	83.9%	80.4%	↓
Warwick District	81.4%	86.4%	72.8%	↓
Warwickshire	**79.4%**	**79.8%**	**73.7%**	↓

Source: Public Health England

CIPFA comparators can also be used to assess performance at district and borough level with areas across England. These show that Rugby Borough is not only the poorest performing area in Warwickshire but also the poorest when compared to its CIPFA comparators. Other than North Warwickshire, all districts and boroughs in Warwickshire performed poorly compared to their statistical (CIPFA) comparators, suggesting that oral health amongst five year olds is relatively poor across the county (see Appendix 1c).

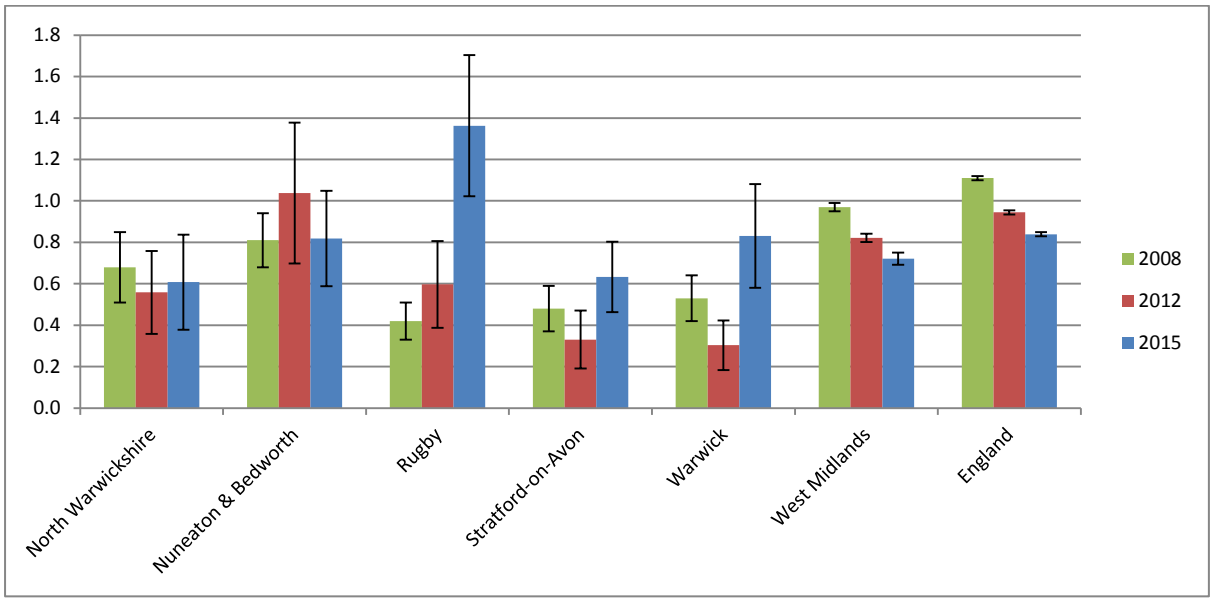
b) Three year old children with no decay experience

In the 2013 national oral health survey of 3 year olds, children surveyed in Rugby Borough (8.6%) had three times more decayed, missing or filled teeth compared to Warwick District, which had the lowest (2.9%) recorded dental problems. However, Rugby Borough's 3 year old children were found to have *less* decayed, missing or filled teeth than West Midlands (10.1) and England (11.7%).

c) Mean number of decayed, missing or filled teeth (dmft)

Relatively small numbers combined with wide confidence intervals mean it is difficult to assess trends from the three surveys for five year old children. However, regionally and nationally it seems that the mean decayed, missing or filled teeth ($d_3$mft) amongst five year olds is reducing. However, in Rugby Borough and Warwick District, there appears to have been a rise in the mean number of $d_3$mft between 2012 to 2015, with a significantly higher mean $d_3$mft in Rugby Borough in 2015, compared to the West Midlands and England mean (See Figure 1 below).

Figure 1: Oral Health Surveys of five year old children, mean number of decayed, missing or filled teeth (2008, 2012 and 2015)



Source: Public Health England

d) Ethnicity and $d_3$mft

In the 2015 survey, ethnicity coding was included for the first time. Of the 1,214 five year olds surveyed in Warwickshire, ethnicity was recorded for 1,197 (98.6%) of the children. When compared to the 2011 Census the ethnic breakdown of the surveyed children suggests a change in the population structure with the proportions of children of British and Irish heritage reduced from 88.6% in the 2011 census to 81.5% of those surveyed in 2015. The most marked increase is that of 'White other' (European) children who in the 2015 survey represented 6.8% of the five year olds surveyed, compared to the 2011 Census proportion of 3.2% of the overall population.

Across Warwickshire, whilst the 'White other' group comprised 6.8% of those surveyed, they were reported as having 22.1% of all decayed, missing or filled teeth. Within Rugby Borough there appears to be an even larger proportion of 'White other' children (12.2%) who had 38.7% of all the decayed, missing or filled teeth reported in the 2015 survey in Rugby. The picture appears to be similar in each District and Borough across the County with the proportion of that area's decayed, missing or filled teeth among 'White other' children being 2 or 3 times greater than the proportion of 'White other' children in the population.

Of the five year olds who had experience of decay (316 children) across Warwickshire when surveyed in 2015, numbers were too small to reach any conclusions for most of the ethnicity breakdowns other than British, Indian[3] and 'White other'. At district and borough levels, numbers are too small for any meaningful analysis.

It would appear that the proportion of Indian children with experience of decay is slightly higher than for the overall sample. However, there were only 17 children of Indian heritage who had dental decay, so the sample size may not be representative.

As regards 'White other' children, 41 (50.6%) of the 81 sampled across the county had experience of decay (compared to 26% of all children surveyed) and they had an average of 5.37 teeth which were decayed, missing or filled. This compares to an average of 3.16 decayed, missing or filled teeth per child with decay experience (ie $d_3$mft >0) across Warwickshire.

Looking at the whole sample (1,214), children of 'White other' heritage had an average of 2.72 decayed, missing or filled teeth compared to an average of 0.82 decayed, missing or filled teeth overall.

Table 2: Ethnic breakdown* of those with decay experience amongst 5 year olds surveyed in 2015
**see Appendix 1d for more detailed breakdown*

	Sample size	No. of children with decay experience ($d_3$mft >0)	% children $d_3$mft >0	Mean $d_3$mft. (where $d_3$mft >0)	Mean $d_3$mft (all sample/ethnic group)
WARWICKSHIRE	**1214**	**316**	**26.03%**	**3.16**	**0.82**
1 - British	973	225	23.12%	2.67	0.62
41 - Indian	53	17	32.08%	2.82	0.91
5 - White other	**81**	**41**	**50.62%**	**5.37**	**2.72**

Source: Public Health England, national dental epidemiology survey of 5 year olds (2015)

Although sample numbers are fairly small and based on a single survey (2015), where ethnicity has been reported, the suggestion is that children of 'White other' heritage appear to have poorer dental health than the overall population. The is supported by national data related to the 2015 survey which showed that the proportion of children with no obvious decay was significantly lower in the Chinese (48.7%) and Eastern European (52.4%) ethnic groups than for the remaining groups, which ranged from 55.4% to 78.6%.[4]

e) Oral health of children attending special support schools

The first national survey of oral health in special schools, in 2014, found that 5 year old children in special schools had slightly lower levels of decay experience (22%) than children in mainstream schools (25%), but had more teeth affected (average of 3.9). Also, teeth extracted for decay amongst 5 year old children at special support schools was double that seen in mainstream schools (6% and 3% respectively). See Appendix 1e

In Warwickshire, 17.6% of 5 year olds in special schools had decayed, missing or filled teeth compared to 26.3%[5] in mainstream schools – lower than the national average. On average, these children had 4.13 teeth affected compared to 3.1 in mainstream schools - higher than the national average.

f) Bespoke demographic coding

Local authorities can request bespoke demographic data profiles as part of these National Dental Epidemiology surveys. For example, the Black Country's data collection included a breakdown of 'Eastern European' and 'Arab' codes for the 2015 survey.

[4] National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2015 http://www.nwph.net/dentalhealth/14_15_5yearold/14_15_16/DPHEP%20for%20England%20OH%20Survey%205yr%202015%20Report%20FINAL%20Gateway%20approved.pdf
[5] Survey 2015/6 academic year

In the next survey of five year olds, Warwickshire has asked for a breakdown of the same codings used in the Black Country.

2.1.2 Dental extractions

National data on child hospital admissions for 2012/13 suggest that dental caries was the most common reason for children aged 5-9 to be admitted into hospital.[6]

In Warwickshire, between 2013/14 and 2015/16, a total of 41 boys aged 0-5 years old had dental extractions as inpatients. Thirty-four 0-5 year old girls had inpatients dental extractions[7]. Numbers are too small to draw any trend conclusions (ethnicity data not available). It is worth noting that activity data for dental procedures under general anaesthesia (GA) is reported through a number of different mechanisms and nationally reported data is often incomplete.

2.1.3 Access to NHS dentists

National guidance recommends that parents take their children to the dentist as soon as the primary teeth begin to emerge.

However, there is some anecdotal evidence in Warwickshire and other neighbouring counties that some dentists decline to see children under 3 years of age. NHS dentists are entitled to payment[8] for seeing infants and young children.

From March 2013 to December 2015 it was reported that less than half of all infants (aged 0-2 yrs) over a 24 month period had had a dental check-up with an NHS dentist, and in some wards this dropped to <18%. However, the picture improved amongst children aged 3-5, with the lowest access by ward being 48% and some wards achieving 100% access. Note: data on use of private dental practices was not available (see access maps by wards in Appendix 2)[9]. Overall there are highest access rates in Warwick District, and lowest access rates in some areas of Stratford District, the latter appearing to relate to there being an absence of local dental practices. Also of note, in Rugby, there appears to be lower access rates in areas with the highest numbers of dental practices (in central Rugby).

In the last 2016/17 HAPI[10] school nursing survey of Warwickshire's primary schools pupils, 83.1% had had a dental check-up in the last 12 months (north locality 80.4%, central locality 83.3%, south locality 86.3%[11]). In the same time period, 2.1% had had an emergency appointment at the dentist (north 2.6%, central 1.8%, south 2.2%). Note: there has been a 41%[12] completion rate for the HAPI survey.

Dental access in areas of deprivation

There is good evidence of a correlation between children who experience tooth decay and deprivation, with children from areas of higher multiple deprivation experience poorer oral health (PHE 2015). Appendix 3 shows maps of NHS dental access by district/borough over a

[6] Children in Hospital Episode Statistics 2012/13 http://content.digital.nhs.uk/catalogue/PUB11758/prov-mont-hes-admi-outp-ae-apr-jun-13-14-toi-rep.pdf
[7] Data accesses from Arden & GEM CSU
[8] Claim category: 1 UDA
[9] Note: data obtained from PHE Midlands. Currently, local authorities do not have routine access to data on up-take of dental checks in 0-5 childrenhowever data can be accessed via NHS England
[10] Health Awareness Prevention and Intervention
[11] 'Localities' relates to the three School Nursing Service geographical team areas, which are not coterminous with local authority or CCG boundaries
[12] Note: % may change slightly as survey submission not finalised.

24 month period, with 18 Warwickshire areas marked in blue that sit within the national top 20% most deprivation localities).

These maps illustrate variable and inconsistent access to dental NHS services amongst children living in the top 20% most deprivation localities in Warwickshire. However, there are 5 notable areas out of the 18 top 20% most deprivation areas (4 in Nuneaton and Bedworth, and one area in Rugby Borough) that show persistently lower access to NHS dentists between children aged 0-2 years of age and children aged 3-5 years old.

Children Looked After

Over the past five years the proportion of Children Looked After (aged 0-19) who had their teeth checked in Warwickshire has decreased from 87% (2011) to 80% (2015). In the same period, the proportion has increased nationally (England 82.4% to 85.8%) and amongst statistical neighbours (75% in 2012, increasing to 79.6% in 2015). In March 2015, Warwickshire was 5.8% percentage points lower than the England average.

2.1.4 Oral health in Eastern and Central Europe

Prior to 1989 oral health care for children was provided by public health services in most countries in Eastern and Central Europe (excluding Slovenia). Since privatisation most oral public health programmes have ceased or been scaled back.

The general prevalence of dental caries remains high in most of central and eastern Europea. In Poland, over the last three decades, the level of tooth decay in children (aged 12) has reduced by half, but it is still 3 times higher than other European countries (Gaszynska, 2014). In 2012, only 14.4% of Polish children (aged 6) did not have any signs of dental caries, tooth filling or tooth loss (Strzycka, 2014). Studies have shown that high numbers of Polish children only attend the dentist when in pain (Peterson, 2003).

Eastern and Central Europeans in Warwickshire

The 2011 Census identified a higher proportion of the population as being of 'White Other' in Rugby Borough (5.2%) compared to the county (3.2%) and more Europeans (5.9% compared to 3.9%). In 2016, 6.9% of Warwickshire's reception year pupils (aged 4-5 years) were coded as 'White Other', and 11% spoke a language other than English[13].

Rugby Borough accounted for 70% (n=107) of all state-funded Eastern European school pupils in Warwickshire (n=153), followed by Bedworth and Nuneaton Borough (24%, n=37)[14]. Anecdotal evidence suggests that migrant families arriving from rural areas of Poland, in particular, will have had poor access to government contracted dental services.[15]

2.1.5 Lifestyle choices information

In the latest Warwickshire 2016/17 HAPI school nursing survey, 7.1% of parents had concerns about their children's diet (north locality 8.1%, central locality 7.1%, south locality 6.2%[16]). It was reported that 63% of children never drank fizzy drinks, however, this dropped to 50% in the north locality (south 75%, central 63%). Forty-seven percent of children reported only drinking water, but this varied across the county (central 50%, north

[13] Source: January (Spring) School Census as at 21st January 2016
[14] Ibid
[15] Source: Polish Community Development Worker, Rugby Borough Council
[16] 'Localities' relates to the three School Nursing Service geographical team areas, which are not coterminous with local authority or CCG boundaries

37%, south 53%). Ten percent of pupils never drank water (central 7%, north 15%, south 7% localities). *Note:* there has been a 41% completion rate for the HAPI survey.

2.2 Local oral health promotion context

2.2.1 Community dental service and oral health promotion specialist

The Warwickshire Community Dental Service is based at George Elliot Hospital (GEH). Following the 2012 Health and Social Care Act, NHS England holds the contract and funding for all NHS dental services including the Community Dental Services; in Warwickshire, the community dental service provides the dental epidemiology surveys and oral health promotion. Warwickshire Public Health has responsibility for commissioning epidemiology and oral health promotion and with support from PHE, is expected to inform this investment to ensure local public oral health needs are met.

The GEH dental service has one oral health promotion specialist post (Band 5wte). This post was vacant for some time but is now filled. The job description for this post is primarily focused on oral health of special needs/learning disability groups and oral health training for related staff (Smiles Award) as well as dental nursing staff across the NHS dental practices in the county.

Note: NHS England West Midlands is currently completing a review of community dental services/contracts.

2.2.2 Warwickshire fluoridation

Since 1987, the whole of Warwickshire has been covered by fluoridation agreements with Severn Trent Water and South Staffordshire Water (West Midlands 70% fluoridation, England 10%).

2.2.3 Re-commissioning of health visiting and Family Nurse Partnership

The current health visiting contract will run until the 30th September 2017. Health Visiting/Family Nurse Partnership will then be re-commissioned for 1 year, with a further option of up to one year. New contract specifications are currently being developed.

2.2.4 Development of an integrated universal and early help service

In line with the Smart Start Strategy[17], tendering for an integrated early help service – to include 0-5 Children's Centre Services, Health Visiting and Family Nurse Partnership - is anticipated between October 2018 - September 2019 (tentative) [18].

2.2.5 Early years workforce development

a) Children's Centres (CC)

CC providers reported that their staff have never received any oral health training. Some CCs have run promotional events for National Smile Month and National Dental Health week, and a few have given out free baby toothbrushes and gum cleaners. However, they reported a lack of specific resources to deliver oral health messages. Resources were viewed as too expensive for settings to purchase on their own. Some staff said that they had

[17] Soon to be merged within WCC's Children Transformation Board plans
[18] This timeframe is subject to changes –given current political and funding environment

accessed free resources and props from GEH in the past, but that these were no longer available.

b) Private, voluntary and independent nurseries (PVIs)

For this report, a small sample (n=6) of Warwickshire's private day care nurseries, and one state maintained nursery, were interviewed regarding their oral health promotion activities. The findings are outlined below:

- None had received or sought oral health promotion training for their staff;
- None had policies specifically relating to oral health promotion, however, three reported having healthy eating policies (or something equivalent);
- None routinely offered supervised tooth brushing. However, one stated that they would do this if requested by parents. Another nursery had actively consulted with parents who felt it was unnecessary to brush teeth beyond morning and evening sessions at home;
- All would be willing and interested to receive oral health promotion training. However, this would need to be limited to 1 hour (and delivered in the evening, after closing);
- One nursery in Rugby reported that a local dental surgery had once come and delivered a tooth brushing puppet show, which was popular with children;
- The same nursery reported including a question about dentist registration within their registration form. They were surprised to find that some children had never been registered with a dentist (data not available).

2.2.6 Smart Start and Stepped Approach

One of the key outcomes for the Warwickshire Smart Start Programme (2016-20) is to improve 'school readiness' - with a shift in Good Levels of Development (GLD) from 67% (2105) to 80% in 2020. Whilst oral health is not a specific Early Years Foundation Stage (EYFS) indicator for GLD, the Smart Start needs assessment identified this as an important factor in school readiness.

It is envisaged that oral health information and resources will be included within the prevention and tier 1 (self-help) levels of the Children and Families 'Stepped Approach', currently under development and being overseen by the Children Transformation Board.

2.3 National Indicators, Responsibilities and Guidelines

2.3.1 National outcome indicators

There are two national indicators relating to improvements in oral health of children and young people:

- More children and young people grow up free of tooth decay (PHOF 4.02)
- Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (NHSOF 3.7.ii).

2.3.2 Local authority's role in oral health

The Health and Social Care Act (2012) amended the NHS Act (2006) and confers responsibilities on local authorities (LA) for health improvement, including oral health

improvement. LAs are statutorily required[19] to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas (PHE 2014a). See Appendix 4 for illustration of principles of commissioning better oral health.

2.3.3 Health visitors (and FNP) role

Health visitors (and FNP) have a clear responsibility in promoting and improving the oral health of children under 5 years of age, as outlined in NICE PH30 Guidance, PH55 and the recent PHE oral toolkit[20] (2014), including brief interventions, encouraging attendance at a dentist, a whole school/nursery approach to oral health promotion, and targeting children at higher risk of tooth decay.

2.3.4 Early Year settings

The latest EYFS statutory guidance[21] [22] makes no specific reference to oral health promotion. However, it states that providers *"must promote the good health of children attending the setting"* and that *"children know the importance for good health of physical exercise, and a healthy diet, and talk about ways to keep healthy and safe. They manage their own basic hygiene and personal needs successfully, including dressing and going to the toilet independently".* See Appendix 5 which highlight the EYFS 'must dos' for OFSTED inspection.

2.3.5 Restricting free sugar consumption

In 2015, the Government's Scientific Advisory Committee on Nutrition (SACN) recommended that 'free sugars'[23] account for no more than 5% of daily energy intake. This is:

- 19g or 5 sugar cubes for children aged 4 to 6
- 24g or 6 sugar cubes for children aged 7 to 10
- 30g or 7 sugar cubes for 11 years and over.

The latest NDNS data[24] suggests free sugars consumption currently makes up 13% of children's daily calorie intake.

2.4 What works to promote oral health in children?

2.4.1 Oral Health Toolkit

In 2014, PHE produced an evidence-informed toolkit for LAs on commissioning for better oral health for children (PHE, 2014a). The following interventions are supported by research evidence[25] and recommended for consideration:

- Oral health training for the wider early years workforce
- Integration of oral health into targeted home visits by health/social care workers

[19] NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations Statutory Instrument SI3094 (United Kingdom, 2012).
[20] Commissioning better oral health for children and young people: An evidence-informed toolkit for local authorities' (PHE, 2014
[21] DfE (2014) Statutory framework for the early years foundation stage: Setting the standards for learning, development and care for children from birth to five
[22] Standards and Testing Agency (2015) Early years foundation stage profile 2016 handbook, London:PSI
[23] SACN recommends the term '*free sugars'* is adopted, replacing the terms '*Non Milk Extrinsic Sugars'* and '*added sugars'*.
[24] PHE (2016) National Diet and Nutrition Survey (NDNS), London: PHE
[25] Recommended by PHE on the strength of 'strong', 'sufficient' or 'some' evidence

- Targeted community-based fluoride varnishing programmes (see 2.4.3)
- Targeted provision of toothbrushes and tooth paste (postal of via HV)
- Supervised tooth brushing in targeted childhood settings (see 2.4.2)
- Healthy food and drink policies in childhood settings
- Fluoridation of public water supplies
- Targeted peer (lay) support groups/peer oral health workers
- Influencing local government policies

2.4.2 Supervised brushing in EY settings

Evidence indicates that to maximise caries prevention in 0-5 year old children, they should brush their teeth at least twice a day with fluoride toothpaste. Under 3 year olds should use a smear of toothpaste containing no less than 1,000 parts per million of fluoride (ppm F), and 3-5 year olds should use a pea sized amount of toothpaste containing more than 1,000ppm F. They should spit not rinse after brushing and tooth brushing should be supervised by an adult (PHE 2016b).

In 2016, Public Health England produced a toolkit to support commissioning of supervised tooth brushing programmes in early years and school settings.

The toolkit recommends that, to be most cost effective and to maximise the return on investment, supervised tooth brushing programmes should be ***targeted*** at children and early years settings in the most disadvantaged communities. This recommendation is echoed in the latest NICE Pathway for improving oral health in early years settings (NICE 2016).

2.4.3 Fluoride varnishing in early years settings

In PHE's guidance for primary dental care teams (2014b), it is recommended[26] that ***all*** children aged 3-6 years have fluoride varnish applied to teeth two times a year.

In support of PHE's 'Improving Oral Health' toolkit for Local authorities (PHE 2014a), the latest NICE Pathway for improving oral health in early years (NICE 2016), recommends that if the supervised tooth brushing scheme (see 2.4.1) is not feasible, commissioners should consider the implementation of a ***targeted*** community-based fluoride varnish programme (2 applications a year) in nursery settings. Please note that fluoride varnish needs to be applied by a dental professional.

2.4.4 Children's Oral Health Improvement Programme Board

This national board was launched on 26 September 2016. It has produced:

- a rapid review of evidence on the cost-effectiveness of oral health interventions for 0-5s,
- a feasibility report on tooth brushing schemes in EYS,
- a return on investment (ROI) tool for oral health interventions for 0-5s,
- a PHE toolkit to support supervised tooth brushing programmes in early years and school settings.

[26] Recommended by PHE on the strength of 'strong' evidence

3 Benchmarking against national recommendations for child oral health

The table below benchmarks Warwickshire against national, regional and local oral health improvement recommendations, with a specific focus on oral health prevention of children (under 5 years):

Recommendations	Recommendation sources	Rag rate	Warwickshire's current status
Strategic			
1. Develop a locally tailored oral health strategy, taking a life course approach with proportionate universalism (LAC, SEN/D, families in poverty, BAME).	LGA 2016 NICE PH55 2014		Currently there is no oral health strategy for Warwickshire. However, this document provides the basis for a 0-5 oral health action plan for Warwickshire.
2. If the JSNA demonstrates that poor oral health of children and young people (CYP) is a significant problem, it should be a key priority for the Health and Wellbeing Board and in the health and well-being strategy.	LGA 2016 PHE West Midlands Sept 2016 NICE PH55 2014		Oral health is not a specified priority within the H&W Board Strategy. However, it will sit within the Smart Start strategy's work programme for integration of an Early Help model.
3. Include oral health in all local early years and health and wellbeing policies.	NICE PH55 2014	NK	No current mapping of policies to assess oral health content. However, steps to be taken through PHE-led Oral Health Network (with local authority commissioners) to negotiate for a specific oral health reference within EYFS guidance for early years settings. *Note: this action also relates to recommendation 4.*
4. Healthy food and drink policies in childhood settings	PHEa 2014	NK	No current mapping of policies in these settings. OFSTED inspection framework looks at extent to which early years providers are successfully supporting pupils to gain *"knowledge of how to keep themselves healthy, including through exercising and healthy eating"*. All nurseries advised to adopt the Voluntary Food and Drink Guidelines for Early Years Settings. (Also see Appendix 5).
5. Work with NHS England to agree and implement outcome measures and a mechanism for monitoring	PHE West Midlands Sept 2016		Beginning to be addressed through PHE-led West Midlands Oral Health

data sharing between NHS England and local authorities.			Network. Warwickshire public health consultant lead on oral health is an active contributor to this network.
Epidemiology and needs assessment			
6. Carry out oral needs assessment, using a range of data.	NICE PH55 2014		Last oral health needs assessment 2009/10. The Warwickshire 2016 Director of Public Health Annual Report highlights increased dmft>0 in Rugby Borough and Warwick District. This document scopes needs and actions for early years.
7. Option to request a more detailed breakdown of ethnic groups within future oral health surveys.	PHE West Midlands Sept 2016		Request has been made for Eastern/ Central European coding breakdown for next 5 year olds survey. However, this has proved challenging given the ethnicity data currently collected by schools. This will be addressed for next survey.
8. Director of Public Health and Director of Children's Services to help implement PHE advice on improving oral health survey consent rates.	PHE West Midlands Sept 2016		Arranged for the 2016/17 survey.
9. Review dental service ward access data for very young (0-2 years).	PHE West Midlands Sept 2016		NHS England expected to give go-ahead for data to be routinely shared with LAs. In the interim, PHE has provided dental access rates of 0-2 & 3-5 year olds as a % of the area population (last 24 months) 2013 and 2015 (see appendix 2). More detailed work will be undertaken to look at access rates at small area level.
10. Monitor OC2 data for dental attendance of LAC Children with SEN/D	PHE West Midlands Sept 2016		Latest data cited in Warwickshire JSNA: Children Looked After Needs Assessment (2015) See para 2.1.3 Consultant in Public Health to lead some specific work with Coventry City Council regarding immunisations and oral health with

			respect to Looked After Children *Note*: need to ensure that 2014 survey data is included in SEN/D Needs Assessment (in progress). .
Integrated approaches			
11. Every contact matters: integrate oral health into all contract specifications for health, social care and early years services (and competencies of frontline workers).	LGA 2016 (PHE rapid review 2015) PHEa 2014 NICE PH55 2014 Smart Start Strategy 2016-20		Development of an integrated system for early help is a Smart Start priority. Need to ensure oral health sits within Smart Start's integration work programme. Plan to review and develop contract specifications to include oral health promotion role of HVs and FNP practitioners *(see example Appendix 6).* Plan to incorporate oral health promotion into Warwickshire County Council's 'Children and Families Stepped Approach'.
12. Facilitate links with wider early years workforce (possible development of early years 'oral health champions').	PHE West Midlands Sept 2016		Evidence of some generic coordination forums between children centres and local early years providers, but inequitable. No early years oral health champions currently exist in Warwickshire.
Co-Production and community involvement			
13. Listen to families and children, put them at the heart of what you do to improve oral health promotion. Family members and carers should be involved in the decision-making process about oral health.	LGA 2016		Extensive Smart Start engagement and social research undertaken with 1,135 parents/carers of 0-5s children. No specific engagement undertaken recently in relation to oral health promotion.
14. Improve intelligence on oral health behaviours of local Eastern and Central European families (targeting Rugby Borough).	Warwickshire Public Health		Little qualitative research available either nationally or regionally. Consider research in Rugby Borough, in order to co-plan and refine targeted interventions. *Note:* In Rugby, the NHS recently worked with Polish community to co-produce a tailored promotional campaign for the 111 service.

15. Targeted peer (lay) support groups / peer oral health workers.	PHEa 2014		No reported oral health promotion peer support groups/workers in Warwickshire.
Interventions and workforce development			
16. Fluoridation of public water supplies.	PHEa 2014		Warwickshire's water is fluoridated. However, there is a need to monitor patterns in fluctuation, by areas.
17. Nudge approaches: reminder to take child to dentist on relevant mailing envelopes (CHIS letters, HCP review reminders etc).	PHE West Midlands Sept 2016		Does not currently happen. Potential to add this to 8/12 and 2year developmental check invites.
18. Support local dental practices to promote the offer of dental check for infants as soon as first teeth emerge. Increase awareness amongst dentist that they can claim (1 UDA).	PHE West Midlands Sept 2016		Some reporting of parents and infants being turned away from appointment till infants are ≥3years old. PHE/NHSE need to engage with LDC (Local Dental Council).
19. Support dental practices to promote the wider public health agenda (healthy eating, breastfeeding* etc). (*See appendix 8 for current breastfeeding rates by borough or district)	PHE West Midlands Sept 2016		Some smoking cessation training for trainee dentists. No discussions have taken place with LDC to consider extension of MECC training to dental practices in Warwickshire. PHE/NHSE to liaise with LDC.
20. Every contact counts: Delivery of evidence-based oral health training to wider early years workforce so they can deliver universal and targeted oral health promotion: a. IHV *'Oral Health for Babies and Children'* fact sheet disseminated to all health visitors and EY workforce, as appropriate b. Disseminate E-Learning (ELfH) resource (up-dated version released on 29 Sept 2016) to HV and wider EY workforce[27])	NICE PH55 2014 PHE West Midlands Sept 2016 NICE PH55 2014 PHE West Midlands Sept 2016		Health visiting teams have not received any specific oral health training and up-dates over the last 6-10 years. Recent ELfH E-Learning up-date has been circulated via HV/SN locality managers for access and feedback. Four children's centre providers report that their staff have not received any oral health promotion training. A sample of maintained nurseries and PVI providers report not providing any oral health promotion training for staff.

[27]Resource titled *'Healthy Child Programme: Dental Health Promotion'* http://www.e-lfh.org.uk/latest-news/?#10633

			ELfH E-Learning is currently not easily accessible to non-health related workers. As part of a Building Community Capacity Project a group of health visitors developed an oral health promotion video targeting children in EYs settings. This video has potential value within the development of a broader oral health toolkit for EY settings. (See appendix 7 for numbers of early years staff). Local E-learning resource for Early Years staff is being developed
21. Promote use of oral health Apps (eg Sugar Swap and Brush DJ).	PHE West Midlands Sept 2016		Data not collected on oral health apps recommended by health visitors. Health visiting teams have not received any specific oral health training and up-dates over the last 6-10 years.
22. Consider introduction of accredited award for early years settings.	Smile Award Plus, Buckinghamshire (cited LGA 2016)		The Smile Award scheme operates in Warwickshire. This works to upskill qualified and unqualified care and support staff working with adults and children with learning disabilities and special care needs.
23. Consider targeted provision of toothbrushes and past (postal or via early years workforce).	PHE West Midlands Sept 2016 PHEa 2014		Some ad hoc distribution of free toothbrushes by children's centres – but lack of evaluation. There were plans to distribute to FNP clients and evaluate (on-hold).
24. Consider supervised tooth brushing schemes in nurseries in areas with higher levels of tooth decay.	NICE PH55 2014 PHEa 2014		Variation within Warwickshire's early years settings. Small sample interviewed for this scoping exercise. The majority reported they did not have sufficient staff resource or parental interest to do this.
25. Targeted community-based fluoride varnish programmes in areas with higher tooth decay *(note: PHE 2014b guidance*	NICE PH55 2014 PHE West Midlands Sept 2016		No targeted public health fluoridation varnishing programme. However, PHE guidance recommends universal approach for

recommends universal provision for 3-6 year olds).	PHEa 2014		3-6 year olds. No mapping available on current varnishing practices in Warwickshire. NHSE/PHE to liaise with LDC.
26. Need to expand the Community Dental Service's oral health promotion post. This post needs to: (a) reflect local strategic oral health promotion priorities, (b) develop targeted approaches to tackle local oral health inequalities, (c) offer targeted workforce development and training for early years professionals, (d) tailor oral health promotion campaigns alongside early years partners.	Warks Public Health and PHE West Midlands		Draft job description has been share with PHE and Warwickshire Public Health. West Midlands' PHE plans to work with the Community Dental Service to ensure this post more closely reflect current strategic oral health promotion priorities in Warwickshire.

4 Recommended next steps

Proposed actions arising from this brief needs assessment are listed below. Once agreed, these will provide the basis for a *'Warwickshire Action Plan for Oral Health Promotion in the Early Year':*

Actions	Responsibility
1. Agree an *'oral health promotion action plan for early years'* in Warwickshire.	Public Health/Health and Wellbeing Board
2. Develop an integrated oral health promotion workforce development plan for early years (see appendix 7 for numbers of EYs workforce).	Public Health
3. Include oral health promotion role and skills development of health visiting and FNP practitioners within new service specifications *(see example Appendix 5).*	Public Health commissioner
4. Set up a county-level task and finish group to develop an oral health training and resource toolkit in co-production with parents and Teaching School for: a. early years providers, early years settings , b. parents/carers (self-help tier 1 stepped approach – see 8 below).	Public Health/ GEH oral health promotion specialist
5. Explore feasibility of developing a network of oral health promotion champions, to sustain legacy of oral health promotion task and finish group (see 4 above).	GEH oral health promotion specialist

6. Incorporate oral health promotion messages within HENRY[28], FFL and Family Lifestyle curriculums that are consistent with the oral health training and resource toolkit (see 4 above).	Public Health commissioner
7. Purchase, adapt or develop an E-Learning oral health promotion training session, supported by resources, to be cascaded to all the early years workforce in Warwickshire (leverage through Teaching Centre, relevant appraisal systems, CPD offers, and healthy eating policies in early years settings).	Public Health
8. Gain strategic agreement for oral health promotion to be explicitly incorporated within 'Children and Families Stepped Approach' (tier 1) and planned Smart Start integrated early help model.	Smart Start/Children Transformational Board
9. Work with Teaching School to promote inclusion of oral health promotion within healthy food and drink policies in early years settings.	Public Health/GEH oral health promotion specialist
10. Expand remit of GEH dental service oral health promotion specialist post so that it takes a more strategic focus and is responsive to latest JSNA findings and recommendations.	Public Health/PHE/NHSE
11. Benchmark and continue to monitor dental access by age of child for targeted localities and groups (IMD, CLA, SEN/D, relevant ethnic groups, children in Need/CP).	Public Health/PHE
12. Nudge parents to take their infants for dental check/s by offering reminders with mail-outs for routine developmental check invites.	Public Health
13. Include specific oral health questions (including signposting to NHS dentists) within all 8 month, 2-2.5 years development checks undertaken by health visitors and early years settings. Also, include questions within 3 years check to be undertaken by school nurses (this check currently in development).	Public Health
14. Explore opportunity to work with the local dental profession to encourage improved attendance rates by 0-5 year olds and promote the use of fluoride varnish, alongside exploring the role of dental professionals in the wider public health agenda	PHE/NHS England
15. Ensure ethnicity coding collected through schools is sufficient for appropriate analysis of dental epidemiology data	Public Health
Targeted oral health promotion	
16. Nudge parents to take their infants for dental check/s by using mailed National Child Measurement Programme (NCMP) alerts for children (siblings) identified in school as being over-weight.	Public Health
17. Utilise Health Start vouchers scheme as a way of nudging parents to take	Public health

[28] Health Exercise and Nutrition for the Really Young - HENRY

their infants for dental check/s	
18. Explore targeted oral health promotion and nudge opportunities with 2Help children.	TBC
19. Upskill Rugby Borough pharmacists to make every contact count by promoting oral health with parents of children under 5 years of age. Utilise National Smile Month for more intense promotion,	Public Health/ GEH oral health promotion specialist
20. Undertake specific work to improve dental access for Children Looked After.	Public Health
21. Work in co-production with Eastern European families in Rugby Borough to develop targeted and appropriate oral health campaign and messages, and to co-evaluate.	Public Health/ GEH oral health promotion specialist/WCC localities team
22. Explore feasibility of targeted provision of toothbrushes within Rugby Borough, as part of a comprehensive targeted oral health campaign.	Public Health

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Appendix 1a

4.02 - Proportion of five year old children free from dental decay 2014/15 Proportion - %

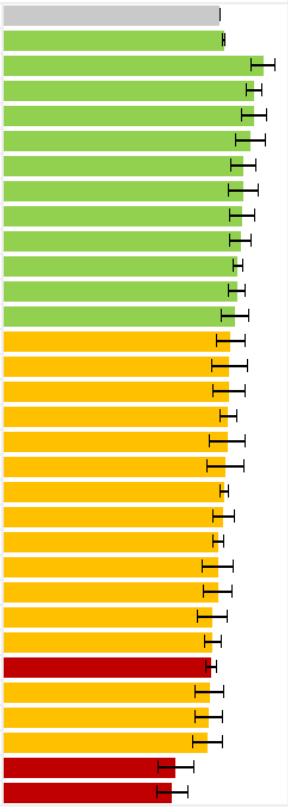
Area	Count	Value	95% Lower CI	95% Upper CI
England	84,100	75.2	75.0	75.5
West Midlands region	12,552	76.6	75.9	77.3
Birmingham	340	71.3	66.4	76.2
Coventry	207	71.6	66.3	76.9
Dudley	1,362	81.5	79.6	83.3
Herefordshire	174	58.7	53.1	64.4
Sandwell	1,972	76.6	75.0	78.3
Shropshire	156	78.5	72.1	84.9
Solihull	221	82.9	78.2	87.6
Staffordshire	1,356	82.2	80.3	84.1
Stoke-on-Trent	213	70.7	65.4	76.1
Telford and Wrekin	131	77.0	70.5	83.6
Walsall	1,254	74.8	72.7	76.9
Warwickshire	898	73.7	71.3	76.2
Wolverhampton	1,508	72.2	70.3	74.1
Worcestershire	2,760	79.0	77.7	80.4

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Appendix 1b

Proportion of five year old children free from dental decay 2014/15 - PHOF 4.02 *(West Midlands comparisons)*

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	84,100	75.2	75.0	75.5
West Midlands region	–	12,552	76.6	75.9	77.3
Cannock Chase	–	142	90.2	85.8	94.5
Bromsgrove	–	520	87.1	84.4	89.8
East Staffordshire	–	183	87.0	82.5	91.4
Tamworth	–	152	85.9	80.6	91.3
South Staffordshire	–	208	83.4	78.7	88.0
Lichfield	–	170	83.3	78.0	88.6
Solihull	–	221	82.9	78.2	87.6
Malvern Hills	–	313	82.3	78.5	86.1
Dudley	–	1,362	81.5	79.6	83.3
Redditch	–	451	81.1	77.8	84.3
Stratford-on-Avon	–	192	80.4	75.3	85.5
Staffordshire Moorlands	–	190	79.0	73.8	84.1
Shropshire	–	156	78.5	72.1	84.9
North Warwickshire	–	162	78.5	72.7	84.3
Wychavon	–	566	78.1	75.2	81.1
Stafford	–	139	77.8	71.3	84.3
Telford and Wrekin	–	131	77.0	70.5	83.6
Sandwell	–	1,972	76.6	75.0	78.3
Wyre Forest	–	371	76.4	72.5	80.2
Walsall	–	1,254	74.8	72.7	76.9
Newcastle-under-Lyme	–	172	74.5	69.0	80.1
Nuneaton and Bedworth	–	208	74.5	69.3	79.6
Warwick	–	192	72.8	67.3	78.2
Worcester	–	539	72.7	69.5	75.9
Wolverhampton	–	1,508	72.2	70.3	74.1
Coventry	–	207	71.6	66.3	76.9
Birmingham	–	340	71.3	66.4	76.2
Stoke-on-Trent	–	213	70.7	65.4	76.1
Rugby	–	144	59.9	53.6	66.3
Herefordshire	–	174	58.7	53.1	64.4



Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Appendix 1c

Proportion of five year old children free from dental decay 2014/15 - PHOF 4.02 (CIPFA areas)

Warwickshire CIPFA areas

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	84,100	75.2	75.0	75.5
Hampshire	–	15	1,971	85.0	83.5	86.4
Essex	–	13	3,120	83.9	82.8	85.1
Staffordshire	–	3	1,356	82.2	80.3	84.1
Gloucestershire	–	1	1,150	79.9	77.8	82.0
North Yorkshire	–	11	1,442	79.3	77.4	81.2
Suffolk	–	4	1,375	79.1	77.2	81.0
Worcestershire	–	2	2,760	79.0	77.7	80.4
Nottinghamshire	–	6	1,116	79.0	76.9	81.1
Derbyshire	–	7	1,143	77.8	75.7	79.9
Oxfordshire	–	12	1,139	77.3	75.1	79.5
Somerset	–	10	898	76.9	74.4	79.3
Buckinghamshire	–	9	887	76.5	74.1	79.0
Warwickshire	–	-	898	73.7	71.3	76.2
Northamptonshire	–	8	905	72.9	70.4	75.4
Leicestershire	–	5	1,106	71.6	69.3	73.8
Cumbria	–	14	1,207	67.8	65.7	70.0

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

North Warwickshire District CIPFA areas

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	84,100	75.2	75.0	75.5
East Staffordshire	–	10	183	87.0	82.5	91.4
Lichfield	–	12	170	83.3	78.0	88.6
Bassetlaw	–	5	157	80.4	74.8	85.9
North West Leicestershire	–	1	177	78.7	73.3	84.2
North Warwickshire	–	-	162	78.5	72.7	84.3
St. Edmundsbury	–	6	237	78.0	73.5	82.6
Newark and Sherwood	–	9	134	77.4	70.6	84.2
Selby	–	2	189	77.3	72.0	82.6
Tewkesbury	–	7	202	77.0	71.9	82.1
East Northamptonshire	–	14	158	75.8	70.0	81.5
Hinckley and Bosworth	–	13	148	75.0	69.2	80.9
West Lancashire	–	8	130	70.5	63.7	77.2
Daventry	–	4	111	70.0	62.8	77.2
Melton	–	11	137	69.2	62.6	75.7
Copeland	–	3	124	65.2	58.4	72.1
Rugby	–	15	144	59.9	53.6	66.3

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Nuneaton & Bedworth Borough CIPFA areas

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	84,100	75.2	75.0	75.5
Cannock Chase	–	3	142	90.2	85.8	94.5
East Staffordshire	–	13	183	87.0	82.5	91.4
Tamworth	–	8	152	85.9	80.6	91.3
Erewash	–	4	154	81.1	75.4	86.9
Bassetlaw	–	15	157	80.4	74.8	85.9
Gloucester	–	6	186	80.3	75.0	85.5
Kettering	–	5	170	78.0	72.6	83.3
Gedling	–	9	164	77.1	71.4	82.9
Ashfield	–	1	126	76.8	70.4	83.1
Wyre Forest	–	12	371	76.4	72.5	80.2
Mansfield	–	2	166	74.7	69.1	80.3
Newcastle-under-Lyme	–	7	172	74.5	69.0	80.1
Nuneaton and Bedworth	–	-	208	74.5	69.3	79.6
Worcester	–	11	539	72.7	69.5	75.9
Carlisle	–	10	242	67.8	63.0	72.5
Pendle	–	14	133	56.7	50.2	63.3

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Rugby Borough CIPFA areas

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	84,100	75.2	75.0	75.5
East Staffordshire	–	3	183	87.0	82.5	91.4
Ashford	–	4	208	84.5	79.7	89.4
Braintree	–	8	337	83.5	79.7	87.4
Lichfield	–	14	170	83.3	78.0	88.6
Taunton Deane	–	13	193	80.2	75.2	85.3
North Hertfordshire	–	12	329	79.0	75.0	82.9
Maidstone	–	6	229	78.9	74.3	83.6
South Kesteven	–	9	166	78.5	73.0	84.1
Cherwell	–	10	232	78.2	73.3	83.2
St. Edmundsbury	–	2	237	78.0	73.5	82.6
Kettering	–	1	170	78.0	72.6	83.3
Wellingborough	–	11	129	76.1	69.7	82.4
East Northamptonshire	–	5	158	75.8	70.0	81.5
South Ribble	–	15	191	75.6	70.2	81.1
Broxbourne	–	7	243	72.5	67.7	77.3
Rugby	–	-	144	59.9	53.6	66.3

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Stratford on Avon District CIPFA areas

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	84,100	75.2	75.0	75.5
Test Valley	–	5	167	90.6	86.4	94.7
Derbyshire Dales	–	13	148	90.5	85.8	95.2
Winchester	–	6	151	89.3	84.5	94.0
East Hampshire	–	7	121	89.0	84.0	94.0
Horsham	–	8	74	86.7	79.8	93.5
Sevenoaks	–	10	220	86.6	82.5	90.6
Cotswold	–	3	185	86.3	81.7	90.8
Babergh	–	11	194	83.8	78.8	88.7
Malvern Hills	–	15	313	82.3	78.5	86.1
West Oxfordshire	–	12	249	81.2	76.7	85.7
Harrogate	–	14	243	80.4	76.0	84.9
Stratford-on-Avon	–	-	192	80.4	75.3	85.5
Hambleton	–	2	209	78.8	73.8	83.8
Wychavon	–	1	566	78.1	75.2	81.1
Tewkesbury	–	4	202	77.0	71.9	82.1
North Dorset	–	9	82	76.4	68.1	84.6

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Warwick District CIPFA areas

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	84,100	75.2	75.0	75.5
Test Valley	–	15	167	90.6	86.4	94.7
Mid Sussex	–	10	190	86.9	82.6	91.2
Chelmsford	–	1	339	85.5	82.0	88.9
Dacorum	–	14	369	82.4	79.0	85.8
Tunbridge Wells	–	8	221	82.1	77.6	86.6
Cheltenham	–	2	186	81.9	76.9	86.9
Colchester	–	6	279	81.5	77.5	85.6
Harrogate	–	4	243	80.4	76.0	84.9
Taunton Deane	–	11	193	80.2	75.2	85.3
North Hertfordshire	–	9	329	79.0	75.0	82.9
Maidstone	–	3	229	78.9	74.3	83.6
Cherwell	–	13	232	78.2	73.3	83.2
Stafford	–	5	139	77.8	71.3	84.3
Warwick	–	-	192	72.8	67.3	78.2
Charnwood	–	7	127	67.2	60.6	73.7
Rugby	–	12	144	59.9	53.6	66.3

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Appendix 1d

Ethnic breakdown of experience of decaying teeth/dmft>0 amongst 5 year olds surveyed in 2015*

** suppressed numbers of below five*

	Sample size	No. of children with decayed teeth	% children dmft>0	No. of dmft	Mean no. where dmft>0	Mean (all sample)
WARWICKSHIRE	**1214**	**316**	**26.03%**	**997**	**3.16**	**0.82**
1 - British	973	225	23.12%	600	2.67	0.62
2 - Irish	*	*	*	*	*	*
21 - White Black Caribbean	11	*	*	7	*	0.64
22 - White Black African	5	*	*	7	*	1.40
23 - White Asian	16	*	*	12	*	0.75
24 - Mixed other	14	*	*	4	*	0.29
3 - Gypsy / Irish traveller	*	*	*	*	*	*
4 - Roma	*	*	*	*	*	*
41 - Indian	53	17	32.08%	48	2.82	0.91
42 - Pakistani	5	*	*	10	*	2.00
44 - Asian other	11	5	45.45%	33	6.60	3.00
5 - White other	**81**	**41**	**50.62%**	**220**	**5.37**	**2.72**
61 - Black Caribbean	*	*	*	*	*	*
62 - Black African	11	*	*	12	*	1.09
63 - Black Other	*	*	*	*	*	*
81 - Chinese	*	*	*	*	*	*
86 - Any other	*	*	*	*	*	*
(blank)	16	5	31.25%	24	4.80	1.50

Source: Public Health England, national dental epidemiology survey of 5 year olds (2015)

Appendix 1e

Oral health survey of 5 year old children attending special support schools (2014)

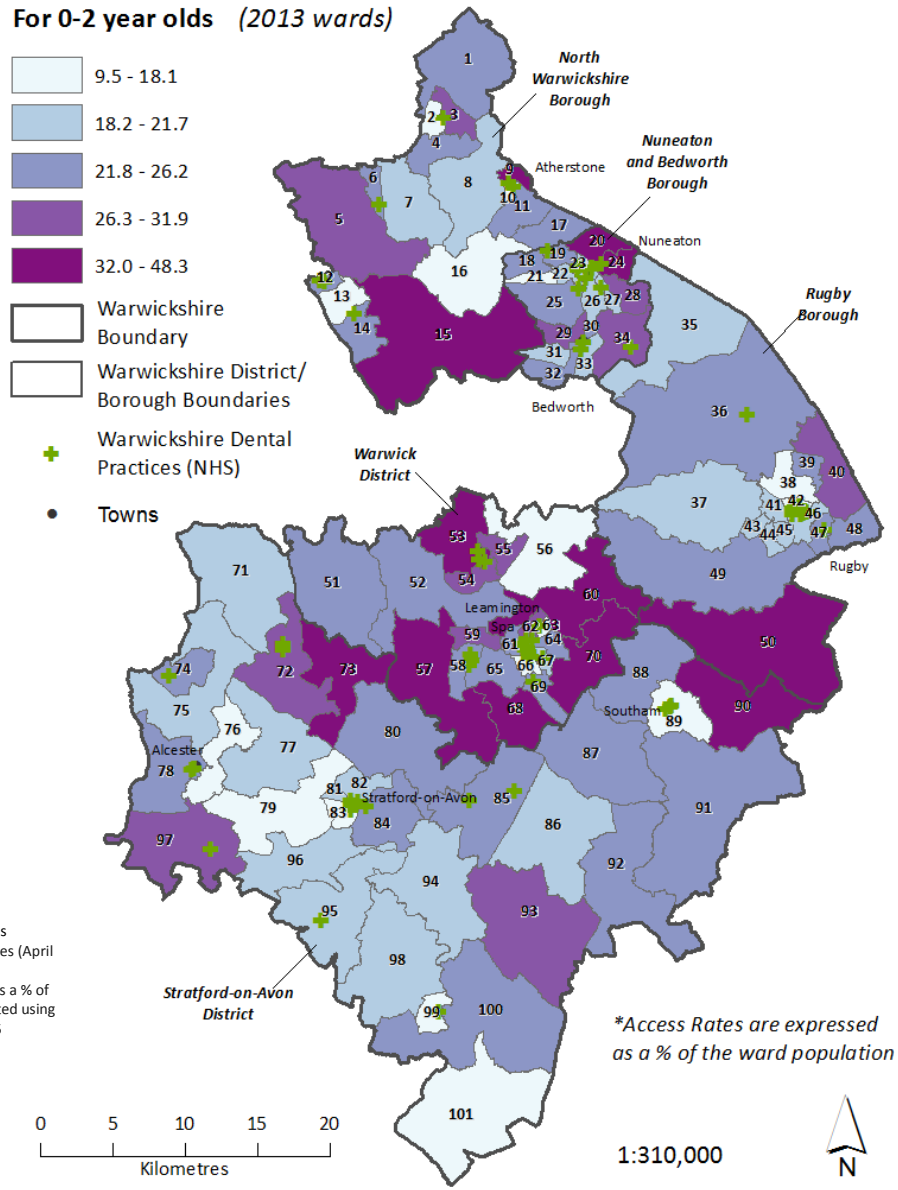
	Number surveyed	% d3mft>0	Mean d3mft
England	2,941	22.5%	3.9
West Midlands	466	16.3%	3.83
Warwickshire	45	17.6%	4.13

Source: Dental Public Health Epidemiology Programme for England, PHE Centre (2014)

Appendix 2

Dentist locations and 2015 Dental Access rates* by Warwickshire Wards

For 0-2 year olds *(2013 wards)*



*Access Rates are expressed as a % of the ward population

Source: NHS Business Services Authority, Information Services (April 2016)
Access Rates are expressed as a % of the ward population, calculated using 24 months data from2013-15

North Warwickshire Borough:

1 Newton Regis and Warton Ward
2 Polesworth West Ward
3 Polesworth East Ward
4 Dordon Ward
5 Curdworth Ward
6 Kingsbury Ward
7 Hurley and Wood End Ward
8 Baddesley and Grendon Ward
9 Atherstone North Ward
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12 Water Orton Ward
13 Coleshill North Ward
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15 Fillongley Ward
16 Arley and Whitacre Ward
17 Hartshill Ward

Nuneaton & Bedworth Borough:

18 Galley Common Ward
19 Camp Hill Ward
20 Weddington Ward
21 Kingswood Ward
22 Bar Pool Ward
23 Abbey Ward
24 St. Nicolas Ward
25 Arbury Ward
26 Wem Brook Ward
27 Attleborough Ward
28 Whitestone Ward
29 Slough Ward
30 Bede Ward
31 Heath Ward
32 Exhall Ward
33 Poplar Ward
34 Bulkington Ward

Rugby Borough:

35 Wolvey and Shilton Ward
36 Revel and Binley Woods Ward
37 Wolston and the Lawfords Ward
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46 Eastlands Ward
47 Paddox Ward
48 Hillmorton Ward
49 Dunsmore Ward
50 Leam Valley Ward

Warwick District:

51 Lapworth Ward
52 Leek Wootton Ward
53 Abbey Ward
54 St. John's Ward
55 Park Hill Ward
56 Stoneleigh Ward
57 Budbrooke Ward
58 Warwick West Ward
59 Warwick North Ward
60 Cubbington Ward
61 Milverton Ward
62 Manor Ward
63 Crown Ward
64 Clarendon Ward
65 Warwick South Ward
66 Brunswick Ward
67 Willes Ward
68 Bishop's Tachbrook Ward
69 Whitnash Ward
70 Radford Semele Ward

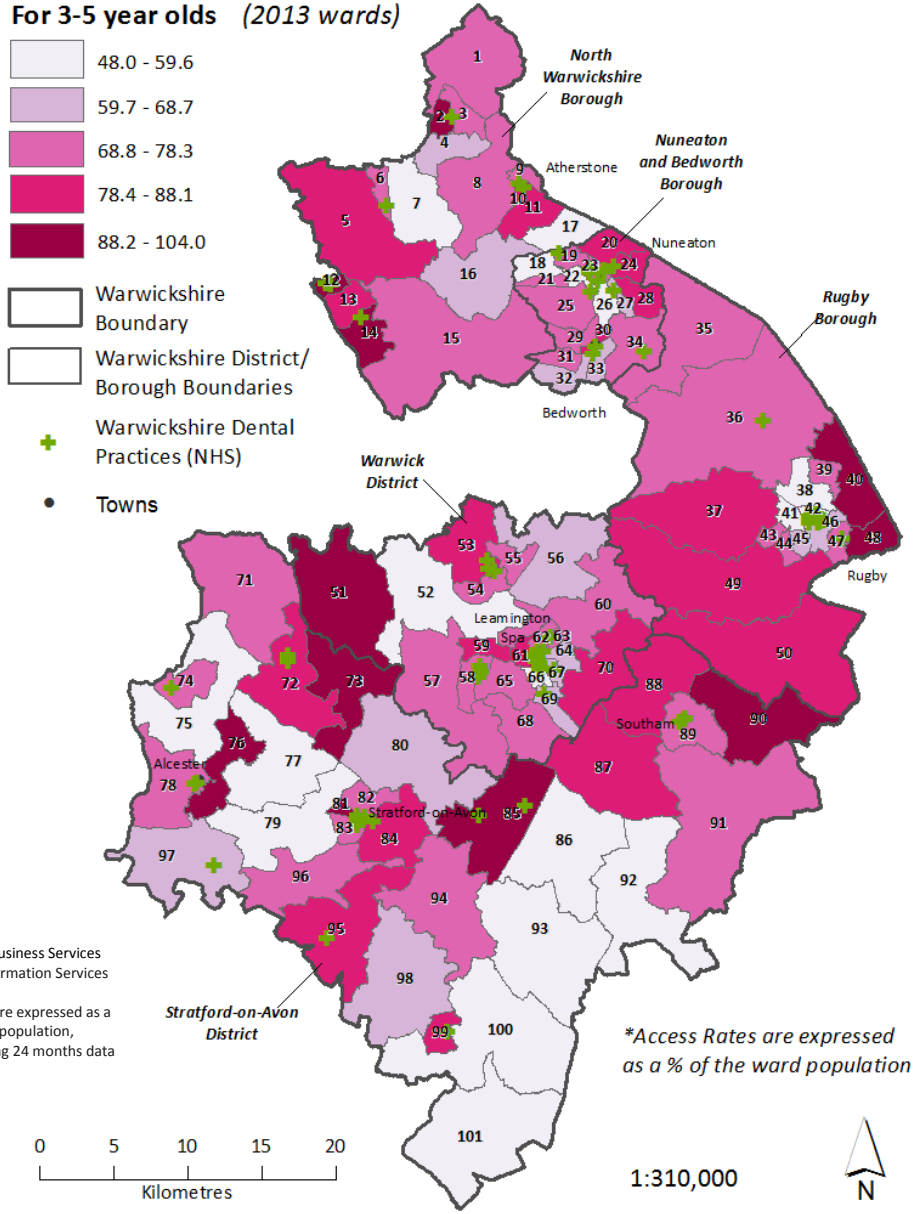
Stratford-on-Avon District:

71 Tanworth Ward
72 Henley Ward
73 Claverdon Ward
74 Studley Ward
75 Sambourne Ward
76 Kinwarton Ward
77 Aston Cantlow Ward
78 Alcester Ward
79 Bardon Ward
80 Snitterfield Ward
81 Stratford Mount Pleasant Ward
82 Stratford Avenue & New Town Ward
83 Stratford Guild & Hathaway Ward
84 Stratford Alveston Ward
85 Wellesbourne Ward
86 Kineton Ward
87 Harbury Ward
88 Long Itchington Ward
89 Southam Ward
90 Stockton & Napton Ward
91 Fenny Compton Ward
92 Burton Dassett Ward
93 Vale of the Red Horse Ward
94 Ettington Ward
95 Quinton Ward
96 Welford Ward
97 Bidford & Salford Ward
98 Tredington Ward
99 Shipston Ward
100 Brailes Ward
101 Long Compton Ward

Dental Practices (NHS) will be labelled on the District/Borough maps.

Warwickshire County Council

Dentist locations and 2015 Dental Access rates* by Warwickshire Wards



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Nuneaton & Bedworth Borough:

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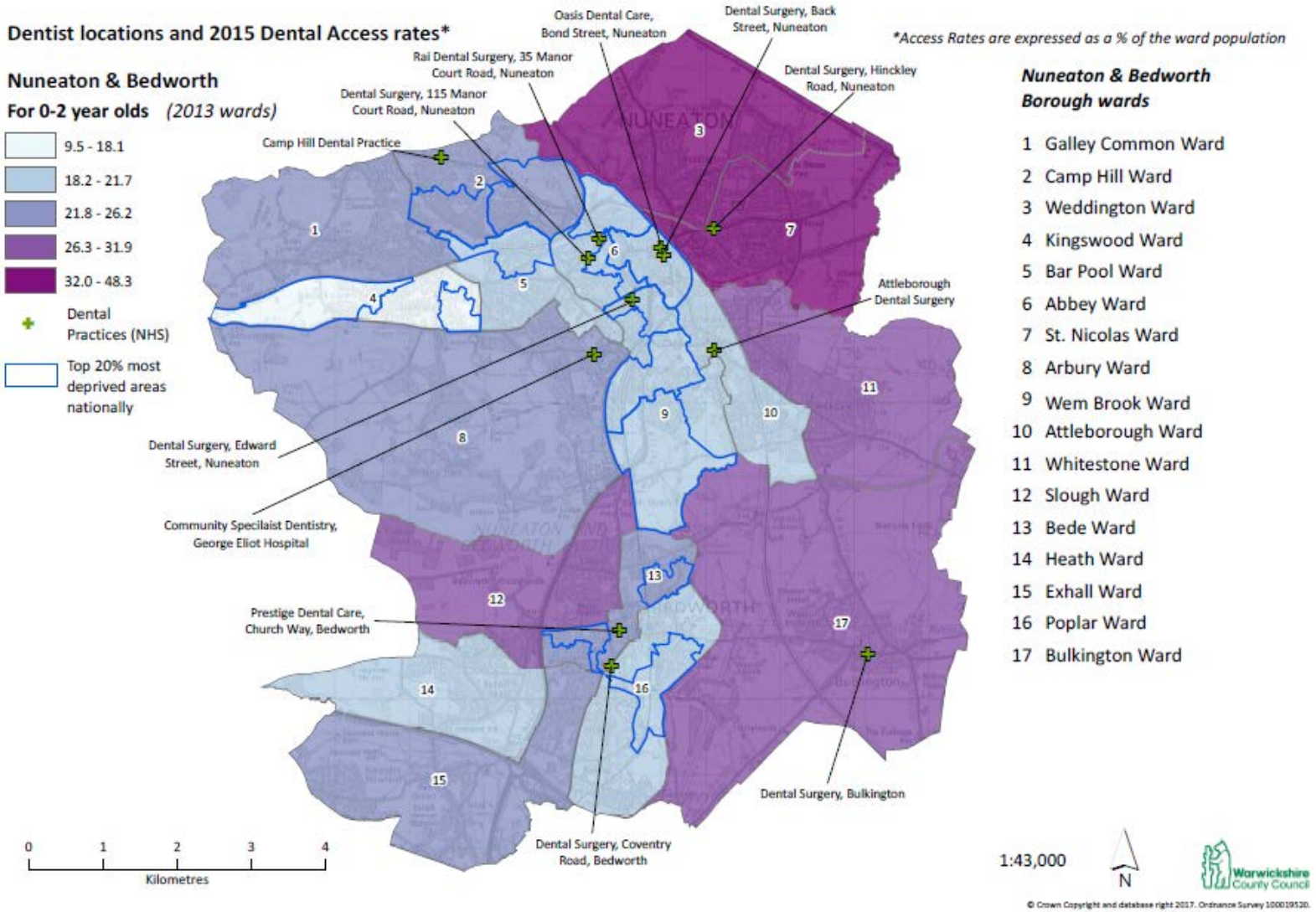
98 Tredington Ward
99 Shipston Ward
100 Brailes Ward
101 Long Compton Ward

Dental Practices (NHS) will be labelled on the District/Borough maps.

Warwickshire County Council


Dentist locations and 2015 Dental Access rates*
*Access Rates are expressed as a % of the ward population
Nuneaton & Bedworth
For 0-2 year olds (2013 wards)
9.5 - 18.1
18.2 - 21.7
21.8 - 26.2
26.3 - 31.9
32.0 - 48.3
Dental Practices (NHS)
Top 20% most deprived areas nationally
Oasis Dental Care, Bond Street, Nuneaton
Dental Surgery, Back Street, Nuneaton
Rai Dental Surgery, 35 Manor Court Road, Nuneaton
Dental Surgery, Hinckley Road, Nuneaton
Dental Surgery, 115 Manor Court Road, Nuneaton
Camp Hill Dental Practice
Attleborough Dental Surgery
Dental Surgery, Edward Street, Nuneaton
Community Specilaist Dentistry, George Eliot Hospital
Prestige Dental Care, Church Way, Bedworth
Dental Surgery, Bulkington
Dental Surgery, Coventry Road, Bedworth
0 1 2 3 4
Kilometres
Nuneaton & Bedworth Borough wards
1 Galley Common Ward
2 Camp Hill Ward
3 Weddington Ward
4 Kingswood Ward
5 Bar Pool Ward
6 Abbey Ward
7 St. Nicolas Ward
8 Arbury Ward
9 Wem Brook Ward
10 Attleborough Ward
11 Whitestone Ward
12 Slough Ward
13 Bede Ward
14 Heath Ward
15 Exhall Ward
16 Poplar Ward
17 Bulkington Ward
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Warwickshire County Council
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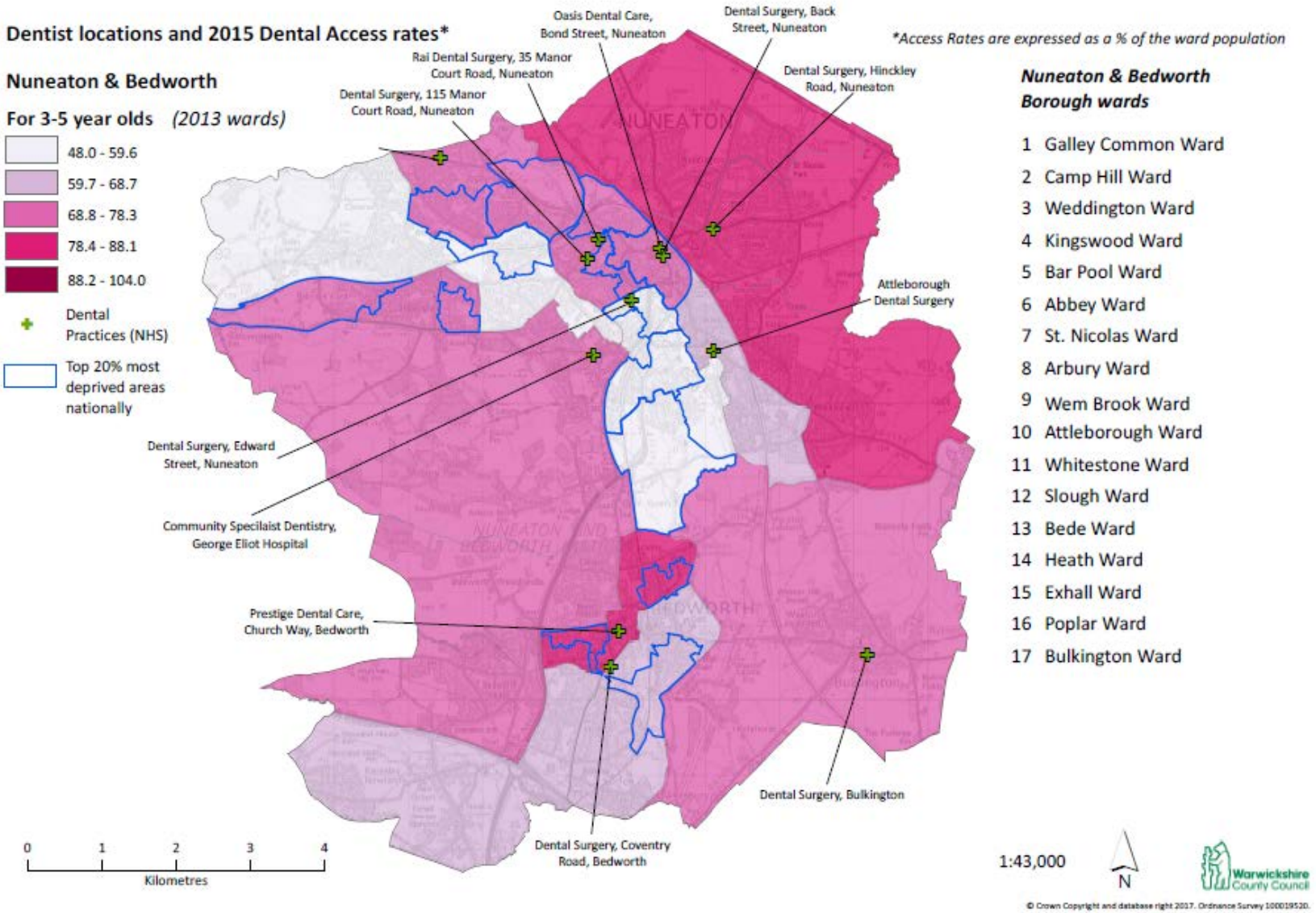
Dentist locations and 2015 Dental Access rates*
Nuneaton & Bedworth
For 3-5 year olds (2013 wards)
48.0 - 59.6
59.7 - 68.7
68.8 - 78.3
78.4 - 88.1
88.2 - 104.0
Dental Practices (NHS)
Top 20% most deprived areas nationally
*Access Rates are expressed as a % of the ward population
Oasis Dental Care, Bond Street, Nuneaton
Dental Surgery, Back Street, Nuneaton
Rai Dental Surgery, 35 Manor Court Road, Nuneaton
Dental Surgery, Hinckley Road, Nuneaton
Dental Surgery, 115 Manor Court Road, Nuneaton
Attleborough Dental Surgery
Dental Surgery, Edward Street, Nuneaton
Community Specilaist Dentistry, George Eliot Hospital
Prestige Dental Care, Church Way, Bedworth
Dental Surgery, Bulkington
Dental Surgery, Coventry Road, Bedworth
0 1 2 3 4
Kilometres
Nuneaton & Bedworth Borough wards
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12 Slough Ward
13 Bede Ward
14 Heath Ward
15 Exhall Ward
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17 Bulkington Ward
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N
Warwickshire County Council
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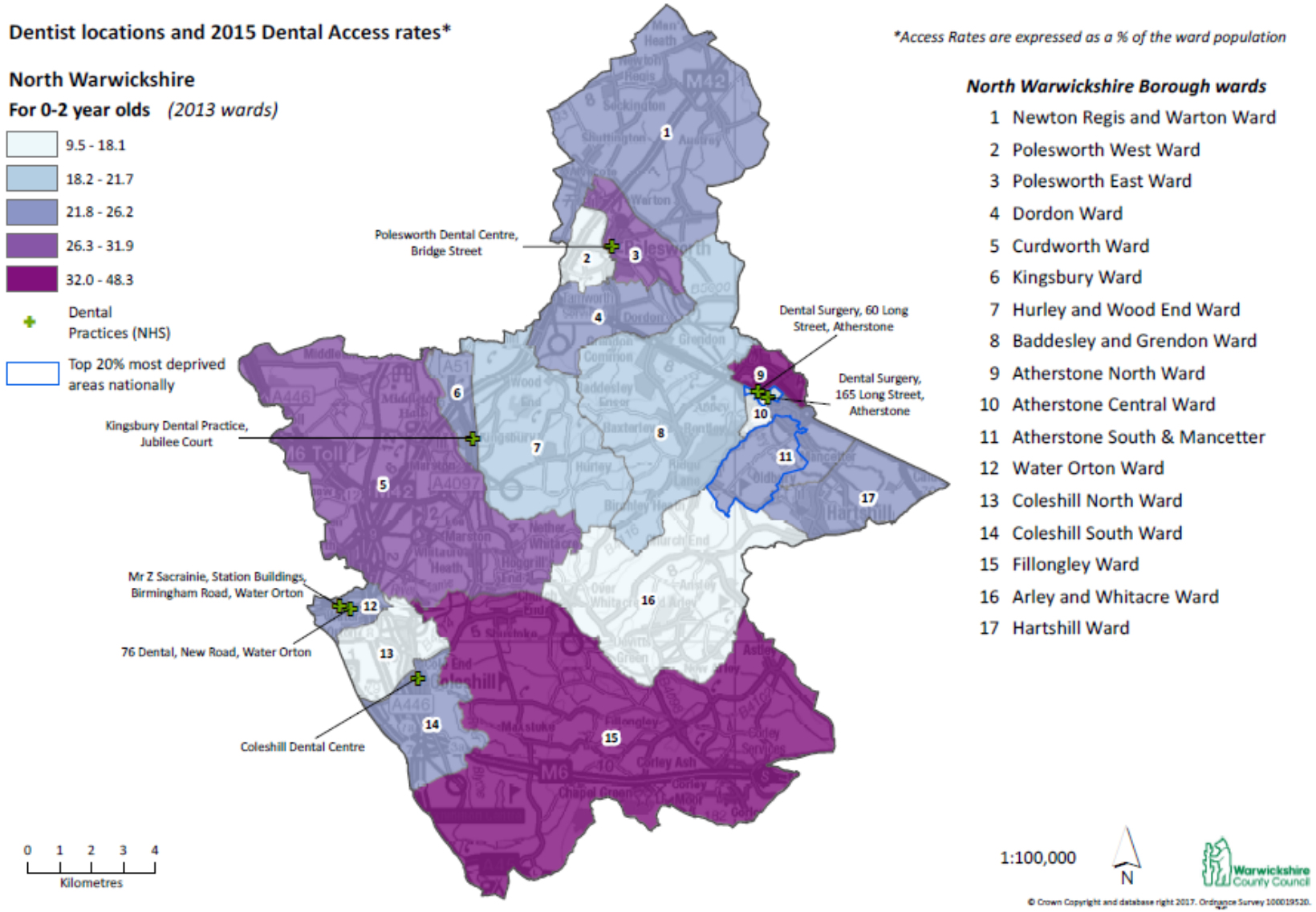
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North Warwickshire
For 0-2 year olds (2013 wards)
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18.2 - 21.7
21.8 - 26.2
26.3 - 31.9
32.0 - 48.3
Dental Practices (NHS)
Top 20% most deprived areas nationally
Polesworth Dental Centre, Bridge Street
Dental Surgery, 60 Long Street, Atherstone
Dental Surgery, 165 Long Street, Atherstone
Kingsbury Dental Practice, Jubilee Court
Mr Z Sacrainie, Station Buildings, Birmingham Road, Water Orton
76 Dental, New Road, Water Orton
Coleshill Dental Centre
0 1 2 3 4
Kilometres
North Warwickshire Borough wards
1 Newton Regis and Warton Ward
2 Polesworth West Ward
3 Polesworth East Ward
4 Dordon Ward
5 Curdworth Ward
6 Kingsbury Ward
7 Hurley and Wood End Ward
8 Baddesley and Grendon Ward
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11 Atherstone South & Mancetter
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13 Coleshill North Ward
14 Coleshill South Ward
15 Fillongley Ward
16 Arley and Whitacre Ward
17 Hartshill Ward
1:100,000
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Warwickshire County Council
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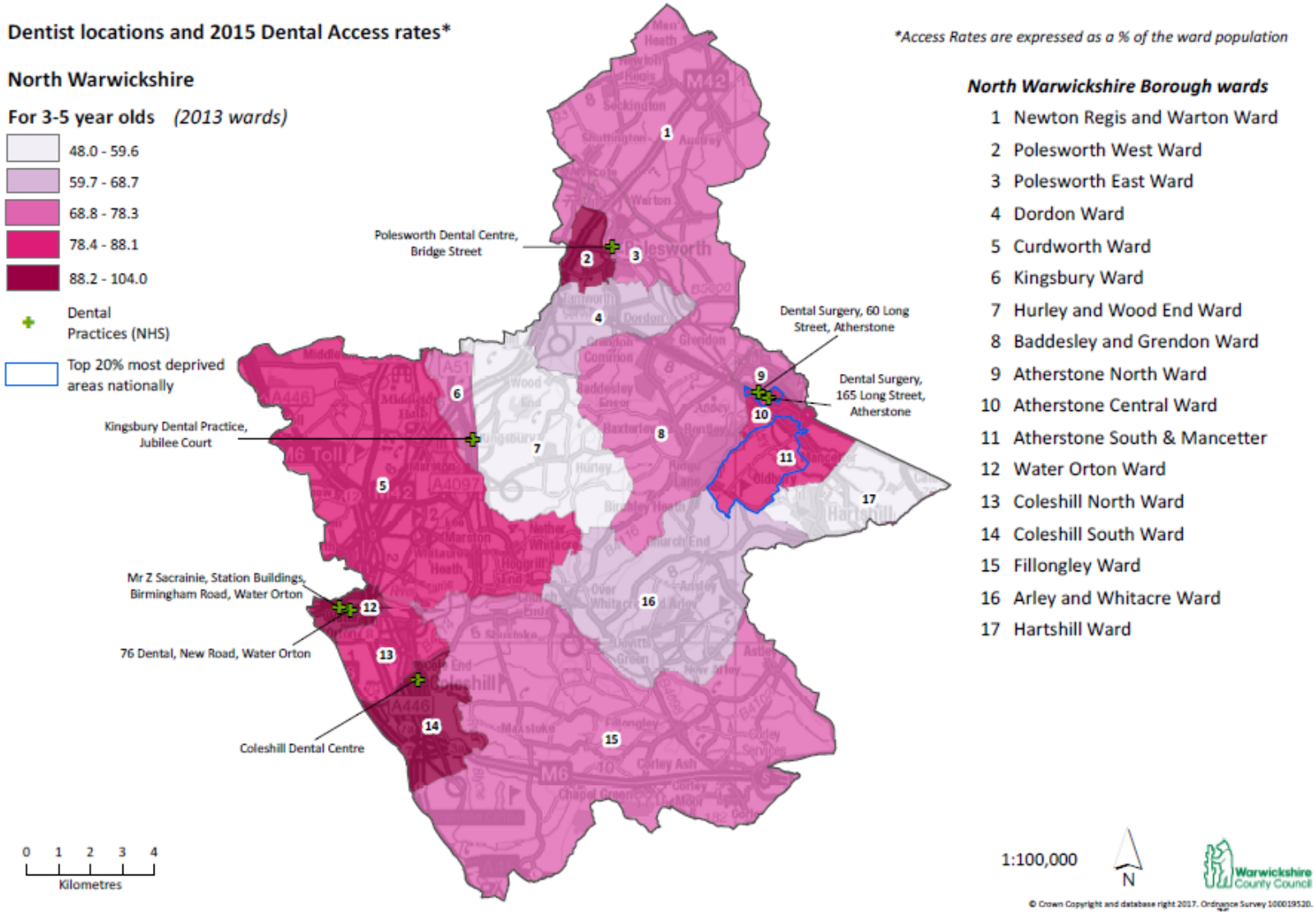
Dentist locations and 2015 Dental Access rates*
North Warwickshire
For 3-5 year olds (2013 wards)
48.0 - 59.6
59.7 - 68.7
68.8 - 78.3
78.4 - 88.1
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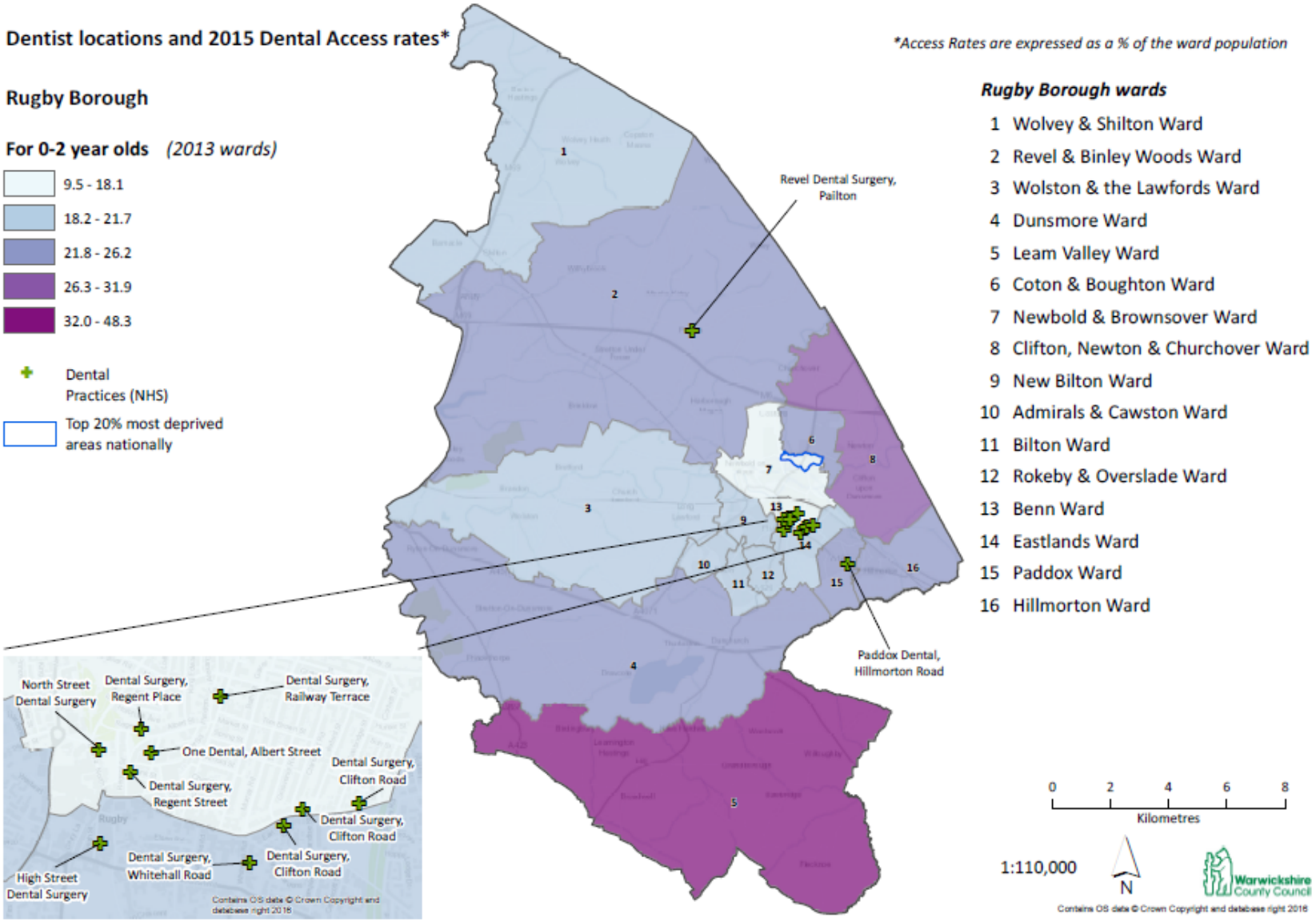
© Crown Copyright and database right 2017. Ordnance Survey 100019520.


Dentist locations and 2015 Dental Access rates*
*Access Rates are expressed as a % of the ward population
Rugby Borough
For 0-2 year olds (2013 wards)
9.5 - 18.1
18.2 - 21.7
21.8 - 26.2
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32.0 - 48.3
Dental Practices (NHS)
Top 20% most deprived areas nationally
Rugby Borough wards
1 Wolvey & Shilton Ward
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6 Coton & Boughton Ward
7 Newbold & Brownsover Ward
8 Clifton, Newton & Churchover Ward
9 New Bilton Ward
10 Admirals & Cawston Ward
11 Bilton Ward
12 Rokeby & Overslade Ward
13 Benn Ward
14 Eastlands Ward
15 Paddox Ward
16 Hillmorton Ward
Revel Dental Surgery, Pailton
Paddox Dental, Hillmorton Road
North Street Dental Surgery
Dental Surgery, Regent Place
Dental Surgery, Railway Terrace
One Dental, Albert Street
Dental Surgery, Regent Street
Dental Surgery, Clifton Road
Dental Surgery, Clifton Road
Dental Surgery, Whitehall Road
Dental Surgery, Clifton Road
High Street Dental Surgery
Contains OS data © Crown Copyright and database right 2016
0 2 4 6 8
Kilometres
1:110,000
N
Warwickshire County Council
Contains OS data © Crown Copyright and database right 2016

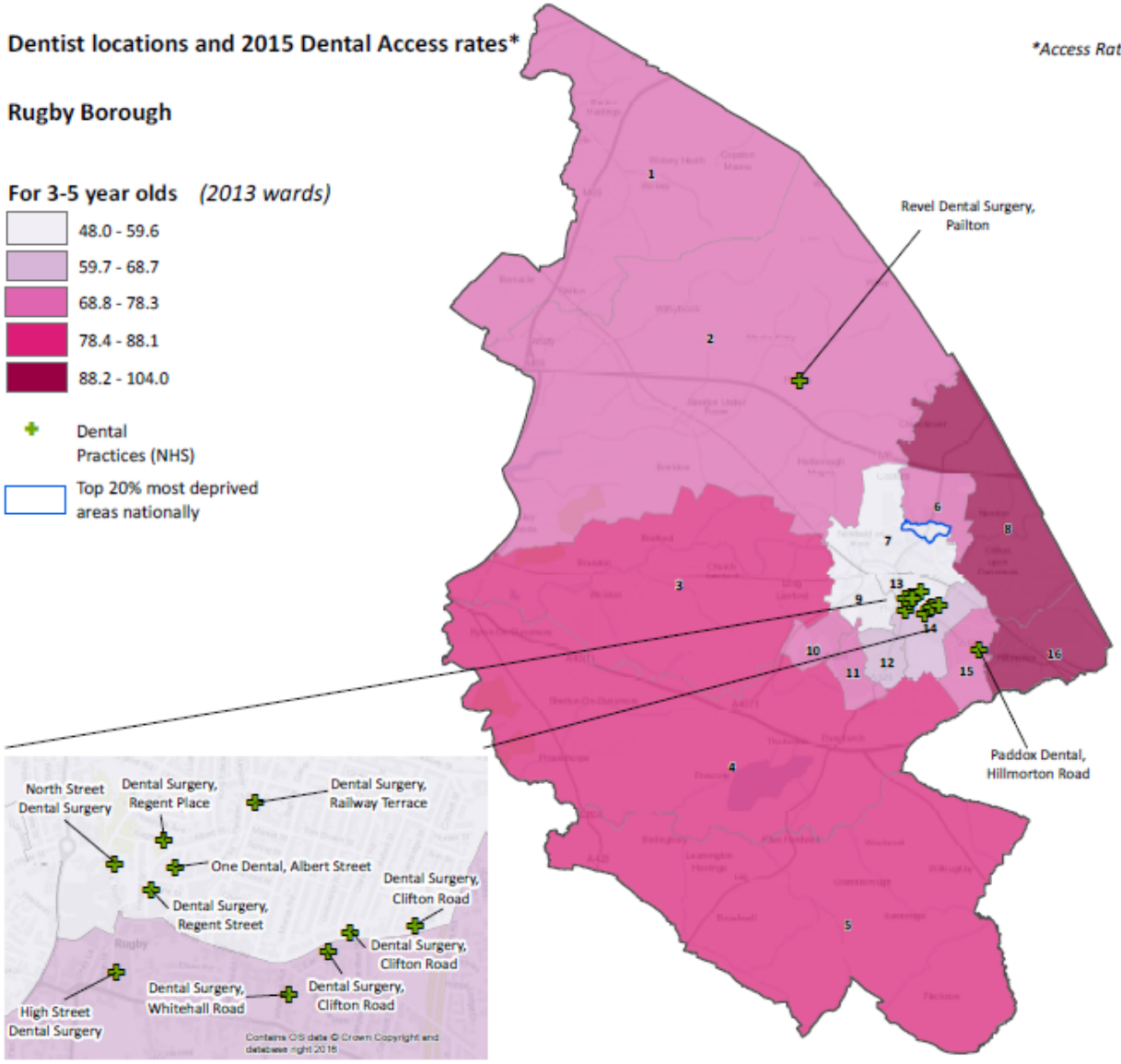
Dentist locations and 2015 Dental Access rates*

**Access Rates are expressed as a % of the ward population*

Rugby Borough

For 3-5 year olds *(2013 wards)*

- 48.0 - 59.6
- 59.7 - 68.7
- 68.8 - 78.3
- 78.4 - 88.1
- 88.2 - 104.0
- Dental Practices (NHS)
- Top 20% most deprived areas nationally



Rugby Borough wards

1 Wolvey & Shilton Ward
2 Revel & Binley Woods Ward
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5 Leam Valley Ward
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7 Newbold & Brownsover Ward
8 Clifton, Newton & Churchover Ward
9 New Bilton Ward
10 Admirals & Cawston Ward
11 Bilton Ward
12 Rokeby & Overslade Ward
13 Benn Ward
14 Eastlands Ward
15 Paddox Ward
16 Hillmorton Ward

0 2 4 6 8
Kilometres

1:110,000

N

Warwickshire County Council

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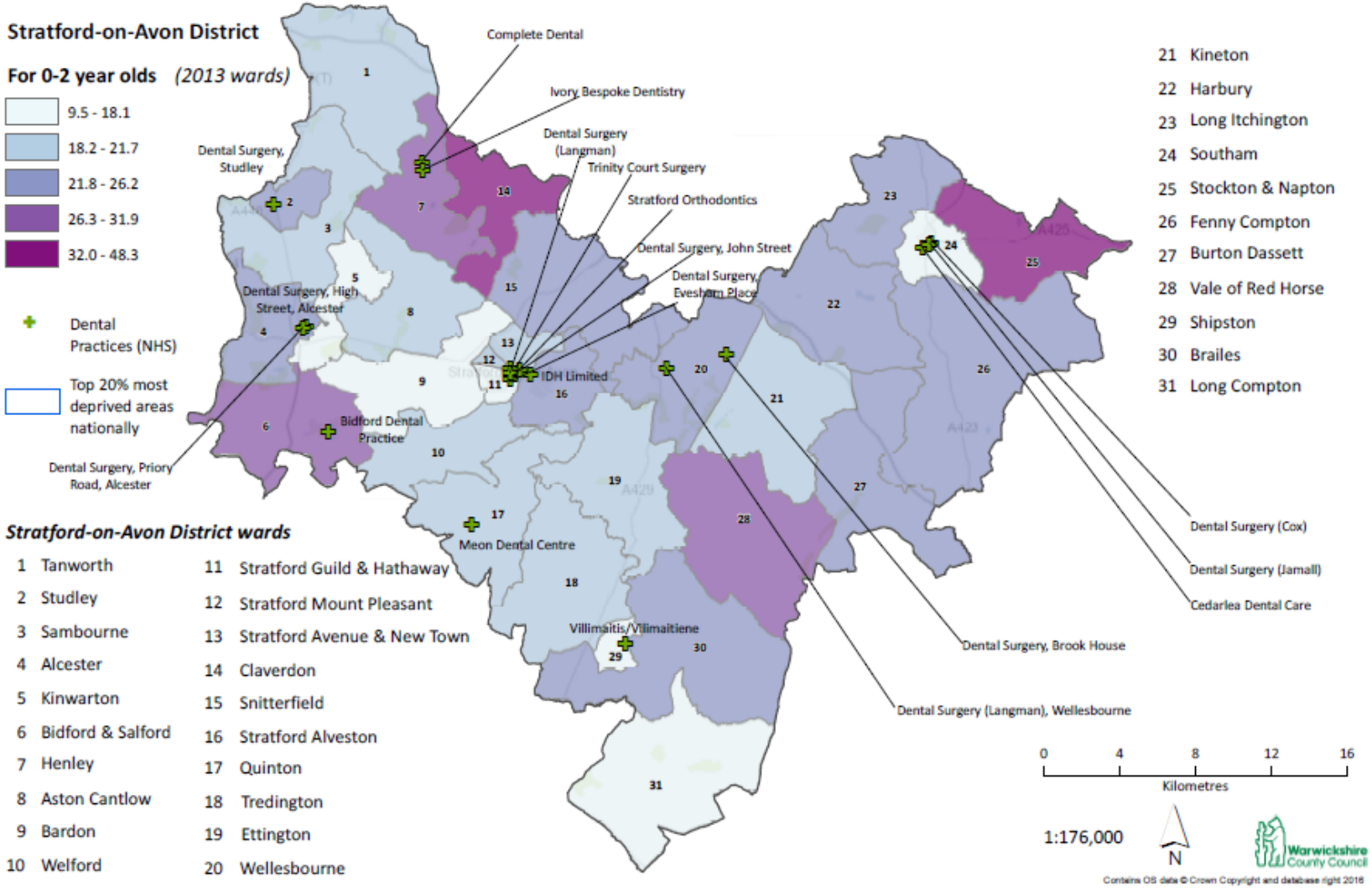
Dentist locations and 2015 Dental Access rates*

**Access Rates are expressed as a % of the ward population*



Stratford-on-Avon District wards

1 Tanworth
2 Studley
3 Sambourne
4 Alcester
5 Kinwarton
6 Bidford & Salford
7 Henley
8 Aston Cantlow
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10 Welford
11 Stratford Guild & Hathaway
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18 Tredington
19 Ettington
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29 Shipston
30 Brailes
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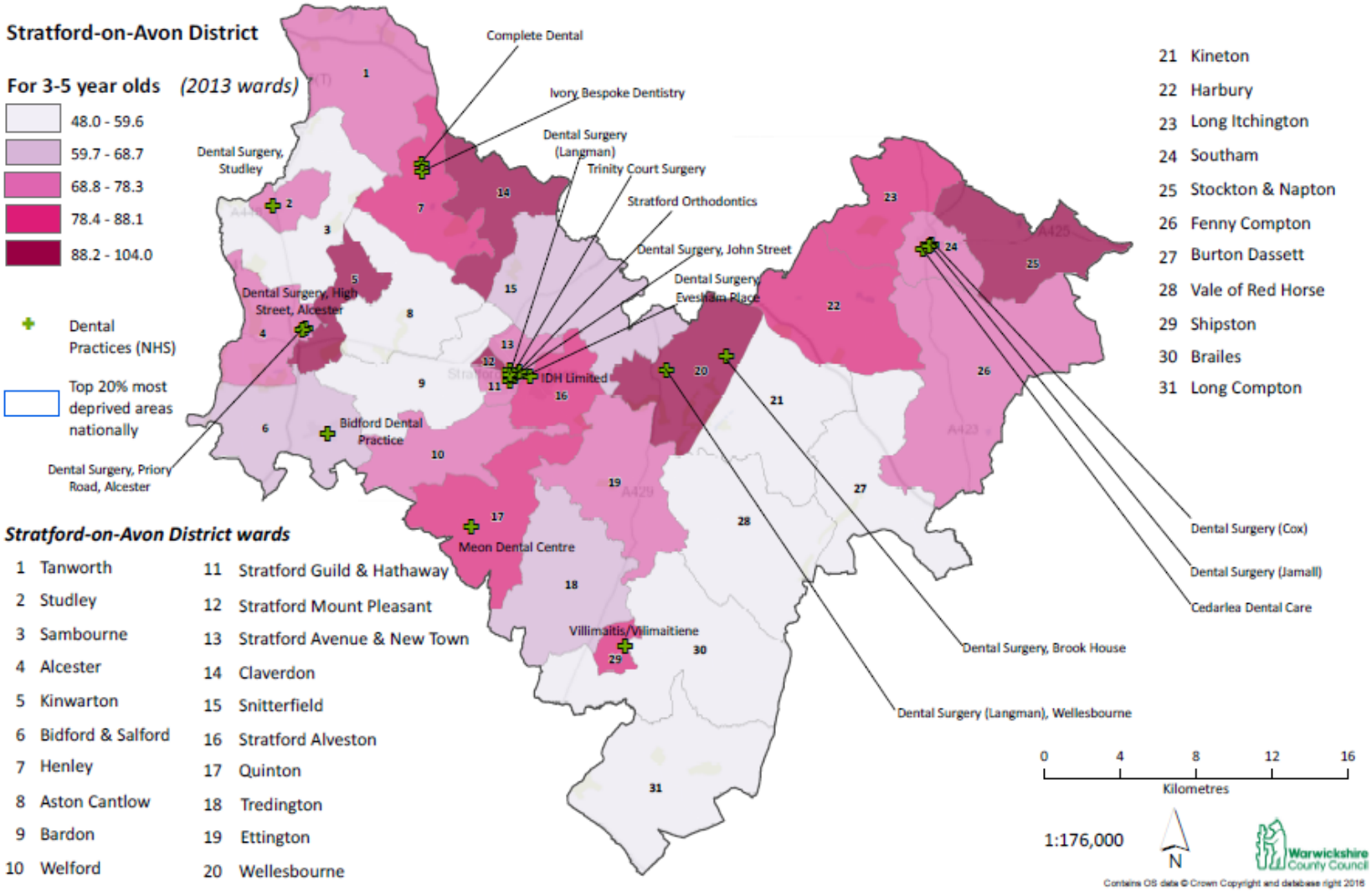
Dentist locations and 2015 Dental Access rates*

**Access Rates are expressed as a % of the ward population*



Dentist locations and 2015 Dental Access rates*

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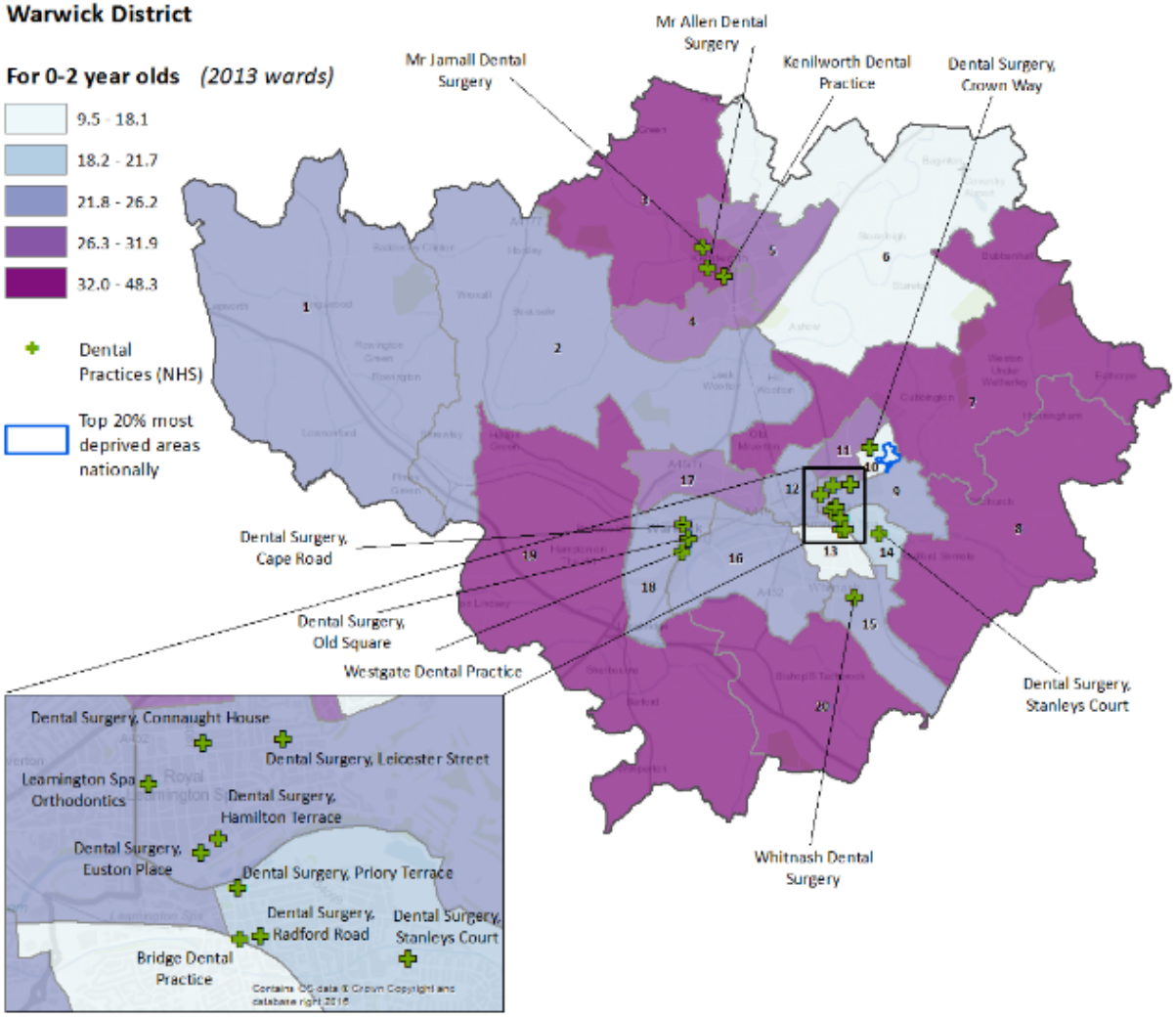

Warwick District wards

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0 2 4 6 8
Kilometres

1:100,000

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Warwickshire County Council

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Dentist locations and 2015 Dental Access rates*

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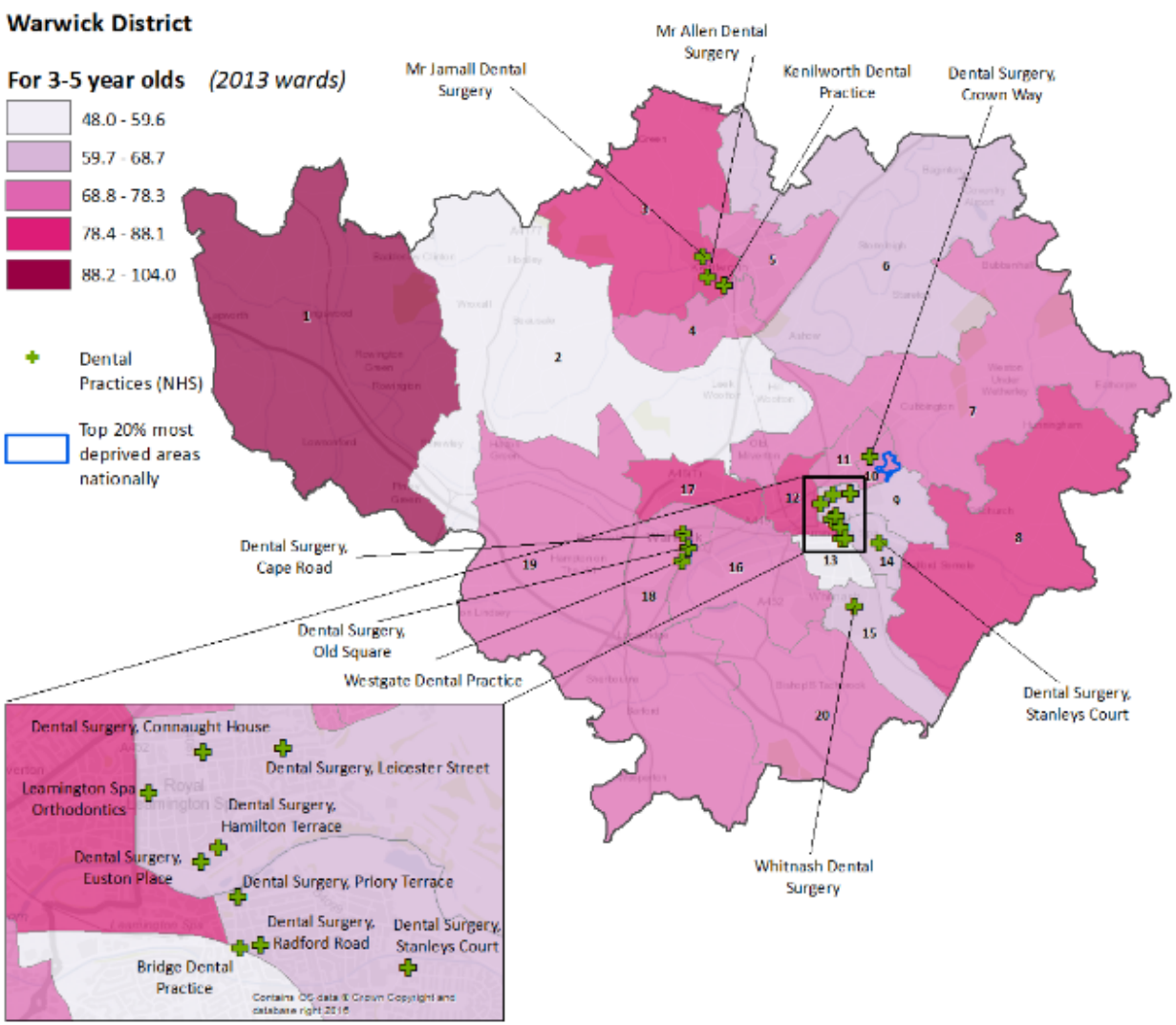

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0 2 4 6 8
Kilometres

1:100,000

N

Warwickshire County Council

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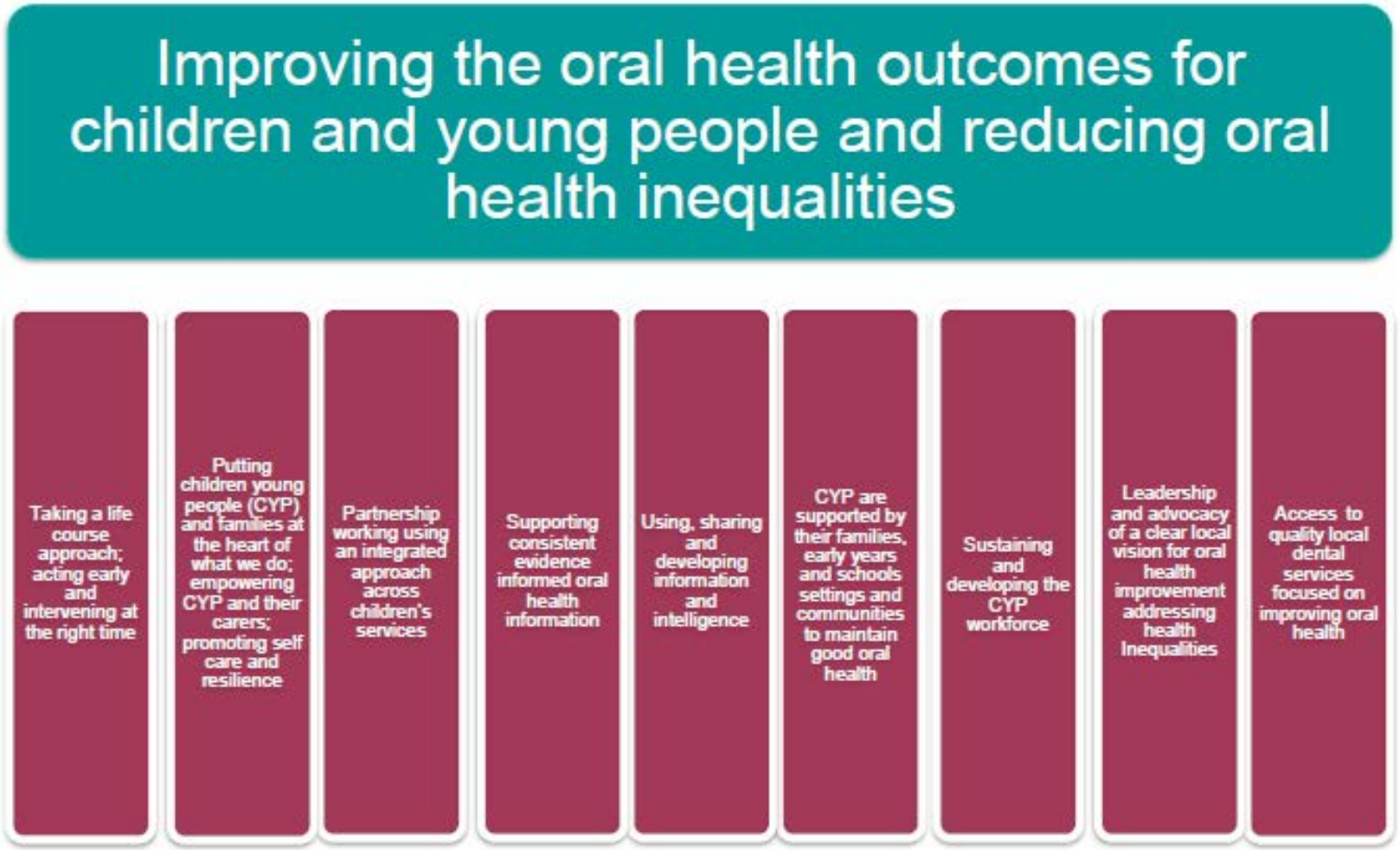
Appendix 4: Principles of commissioning better oral health for Children and Young People (PHE 2014a)



Appendix 5

Statutory framework for the early years foundation stage: Setting the standards for learning, development and care for children from birth to five (DfE, 2014)

Ofsted may ask questions about good practice in relation to the EYFS statutory requirements (page 26 see below). Where it says MUST it is a legal requirement - so inspector will check on implementation.

Food and drink

3.47. Where children are provided with meals, snacks and drinks, they **must be** healthy, balanced and nutritious. Before a child is admitted to the setting the provider **must also** obtain information about any special dietary requirements, preferences and food allergies that the child has, and any special health requirements. Fresh drinking water **must be** available and accessible at all times. Providers must record and act on information from parents and carers about a child's dietary needs.

3.48. There **must be an area** which is adequately equipped to provide healthy meals, snacks and drinks for children as necessary. There **must be** suitable facilities for the hygienic preparation of food for children, if necessary including suitable sterilisation equipment for babies' food. Providers **must be confident** that those responsible for preparing and handling food are competent to do so. In group provision, all staff involved in preparing and handling food **must receive training in food hygiene**.

3.49. Registered providers **must notify Ofsted or the child minder agency with which they are registered of any food poisoning affecting** two or more children cared for on the premises. Notification must be made as soon as is reasonably practicable, but in any event within 14 days of the incident. A registered provider, who, without reasonable excuse, fails to comply with this requirement, commits an offence

Appendix 6

Examples of oral health content within health visiting contract specification

(supplied by Mary Tomson, PHE Midlands)

Promoting oral health:
Health visitors should promote oral health at key assessment points, by conveying the 'key oral health messages' (based on the 'Scientific Basis of Oral Health Education' and 'Delivering Better Oral Health').

Signposting to services:
Health visitors should signpost children and carers to local dental services from the age of 6 months.

Training:
Health visitors should be trained to promote good oral health so that they can convey the key oral health messages and recognise when a child needs prompt signposting to dental services. Health visitors should receive update training as appropriate.

Appendix 7

Number of estimated early years staff in Warwickshire to be targeted for delivery of oral health promotion

Early Years services	No. of facilities / providers	Worker/professional groups	Number of staff
Health visiting		Health Visitors	133
		Community staff nurses	1
		Nursery nurses	39
Family Nurse Partnership		Nurses and nurse managers	15
Children Centres[29]	39	Family Support Workers	30.2 (WTE)
		Management/reception/admin	39∞
		Volunteer coordinators (and volunteers)	3
Early Years Education[30]	54	Maintained nursery classes/school	162*
	6	Maintained Nursery Schools	84
	19	Nurture Nurseries	57*
	103	Pre-schools	309*
	141	Day nurseries	423*
	89	Other (crèche, home childcare)×	
	212	Other (out of school care, holiday scheme)×	
	15	Other (private nursery schools/units)×	
		Child minders	510
Mother and toddler groups	NK	Leaders and volunteers×	
Priority Families		Family Support Workers	33
Warwick District Council		Family Support Workers	1
CAF		Family Support Workers	12
Children's service – social care		Social workers	
		Family Support Workers	
HENRY Project			1
Soil Association			2
Housing Associations		Housing Support Officers×	NK
CAB		CAB advisors×	NK
		Total staff (excluding non-priority facilities)	1,812

** Estimated on an average of 3 staff per session*
× Lower priority for training
∞ Estimated on 2 staff per centre

[29] Data from Warwickshire Childcare Sufficiency Jan 2016
[30] Data from Nov 2015

Appendix 8

Breastfeeding in Warwickshire in 2015/6

In 2015/6 in Warwickshire, 72.3% of mothers breastfed in the first 48 hours after delivery. Of all infants due a 6-8 weeks check 46.5% were totally or partially breastfed – higher than the England (43.5% and West Midlands (39.8%) averages.

In the Rugby Borough Council area the breastfeeding initiation average (79.1%) is higher than the county average (72.3%). At 6-8 weeks 50% of infant were totally or partially breastfed – higher than the county average (46.5%) but slightly lower than the South Warwickshire CCG average (52.6%).