Qualitative Insight Research into Children's Oral Health for Derbyshire County Council

Insight Report

May 2021

Unique Improvements
Suite 3, 4th Floor,
1 City Approach,
Albert Street,
Eccles,
M30 0BG
E adrian.smith@uni.uk.net

Contents

Summary

- This report summarises insight into oral health in children 0-5 years, specifically attitudes towards dentistry services and dietary messages. The findings of the insight will be used to influence service delivery across target audiences. The key target sample was:

  Primary Audiences

  - Parents and carers within Bolsover and High Peak who have children aged 0-5 years old
  - Parents and carers within Bolsover and High Peak with children aged 6-10 years old. This gives us a focus on those parents within the target audiences as well as those just outside it with recent experience and insights.

  Secondary audiences
  - Staff and volunteers who work with the primary audiences

- The methodology involved a rapid evidence review, **nine** stakeholder interviews and **three** focus groups with **34** participants, all using a semi structured script.

- All recruitment and engagement methods were carried out on the telephone, or online using Microsoft Teams or Zoom. All focus groups were carried out online using Zoom.

- Large numbers of parents reported difficulties registering with a local dentist. In total, 7 of the parents (20%) reported problems registering with a dentist.

- Parents have concerns about receiving reminders about dental visits after lockdown changes. Around three quarters of parents and children had not been to the dentist in the past 12 months.

- Up to date information about dentists is difficult to source. This includes those open to new patients and those with child-friendly approaches and procedures. Most dentists have not submitted recent information to the NHS 'Find a Dentist' service.

- The Oral Health Promotion Service was a well-respected local service and in particular, was valued for training and partnerships with local organisations.

- Stakeholders were positive about the potential contribution of the Oral Health Strategy Group in Derbyshire, especially around its contribution to sharing best practice and tackling system wide barriers including reform of dental pathways.

- Low Health literacy is an issue and there is opportunity to collaborate with a wide range of activities to address this, including the Derbyshire County Council Public Health Practitioner with responsibility for health literacy.

- Interventions which maximise peer to peer activity should be included in social marketing and behaviour change approaches.

- There are times (such as teething) when parents are more open to peer-to-peer messaging and support which could have an implication for marketing approaches.

- Good examples of parent-involvement are happening across localities, particularly within Children's Centres. Service leads should build on this work and this report to engage more with parents to inform service delivery.

- Resources including free toothbrushes, have an important role in prompting discussions about teeth brushing, enabling services to actively prioritise oral health as well as supporting behaviour change/behaviour continuation. Staff and parents wanted them provided to more parents.

- Covid-19 has had a significant impact on service delivery and access to dentists. While there have been examples of changing delivery methods which will be sustained and incorporated into wider service offers, these were not consistent across services. Adoption of online training and remote engagement (including social media) for example, has happened 'in pockets' and there has been little or no attempt to spread skills and experience across networks or between organisations.

- Conversations about tooth brushing are easier to have than conversations about diet.

- There is an audience segment of parents who are motivated to prioritise good oral health in their children **because** they had themselves experienced significant poor oral health. This has implications for targeting messages in communications.

- There are knowledge gaps amongst parents about the importance of supervised tooth brushing and registering your child at the dentist early.

- There are knowledge gaps about NHS dental charging, in particular what is covered, what age it ends and if all dentists are covered.

- Campaigns and skill-based activity that gives parents practical tips for establishing and managing tooth brushing routines would be positive.

- Although there were positive views about health visiting support, not all parents could recall details about oral health brief advice conversations. None referenced their 'Red Book', and father's knowledge was more limited still.

- Best practice work to engage fathers should be shared and campaigns and activity delivered to engage them more.

- Grandparents can undermine efforts by giving treats and not adhering to healthy behaviours. Campaigns and activity should target grandparents who were identified as being important support and barriers to good oral health.

- The impact of Covid-19 appears to have magnified other concerns to the relative detriment of oral health. This is likely to be amplified by the removal of many sources of oral health messaging, advice and support. For example, the interruption of many nurseries, the closure of dentists and Childrens Centres.

- Approaches to improve dietary behaviours should include accessibility and affordability, not just awareness (of healthy eating). Local planning decisions (too many takeaways) were concerns and at a more local level, parents are exposed to mixed messaging around healthy diet. This includes confusion over the risk of tooth decay from fruits and fruit juice.

- Knowledge amongst parents about reducing sugar is high but there is confusion about sugary drinks and fruit, and how long to leave brushing after consumption.

- Covid-19 has impacted on children's eating habits. Changes in daily routines have contributed to an increase in snacking.

- Community focused campaigns, including engagement at venues and events resonates with parents. These approaches appear to be positive ways of tackling health literacy by engaging and sharing information in a variety of accessible methods. Related to these community focused approaches were examples of distributing tooth brushing resources.

- Whilst printed resources can be useful parts of social marketing campaigns, brief advice from professionals and peers is important. This reinforces the need for a mixed methods approach, taking into account health literacy and the role of enabling front line-staff to raise and reinforce messages.

1. Background and Objectives

1.1. Introduction

Derbyshire County Council commissioned Unique Improvements, a North West social enterprise, to undertake a qualitative piece of research to gain further understanding and behavioural insight into oral health in children, specifically attitudes towards dentistry services. The findings of the insight will be used to influence service delivery across target audiences.

> *"Dental decay among young children remains an important public health issue as it leads to pain and distress, sleepless nights for children and parents, and time off school and work. Measuring dental decay levels among 5-year-olds can give early indication of the success, or otherwise, of interventions aimed at improving the oral and general health of very young children including those designed to improve parenting, children's weight or overall health or diet."*[1]

A 2017 oral health survey of 5-year-olds in Derbyshire found 1:5 children experienced decay (decayed, missing or filled teeth) and 39% of 0–5-year-olds did not see a dentist. There are significant differences between localities within Derbyshire. Across several data indicators, Bolsover and High Peak display ranges which highlight poorer oral health. (Data taken from 'Oral Health in Derbyshire: With a focus on the Oral Health Survey of five-year-old children, 2017')[2].

- The rates of decay were highest in Bolsover 34.8% and in High Peak 25.2%. This compared to 20.4% in Derbyshire overall.
- In Derbyshire 134 children aged 0 – 5 years were admitted to hospital for an extraction due to decay. This is 89 per 100,000 (2015/16 – 17/18). In High Peak this figure was 219.5 per 100,000 and in Bolsover 156.5 per 100,000.
- In Derbyshire from June 2016/17, 61% of children aged 5 years old were seen by a dentist. This was higher than the average for England (58.2%).
- In High Peak, 36.4% of 0–4-year-olds attended the dentist compared to the Derbyshire average of 43.3% (2016/17 – 2017/18). In Bolsover 42.4% of 0–4-year-olds attended the dentist which is also lower compared to the Derbyshire average.

[1] Oral health survey of 5-year-olds 2019. A report on the variations in prevalence and severity of dental decay. Public Health England 2019
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/873492/NDEP_for_England_OH_Survey_5yr_2019_v1.0.pdf
[2] Oral Health in Derbyshire: With a focus on the Oral Health Survey of five-year-old children (2017)
https://democracy.derbyshire.gov.uk/documents/s2370/Oral%20Health%20of%205%20Year%20Olds%202017.pdf

There is a strong correlation between increased tooth decay and higher levels of deprivation. Children living in areas of deprivation are less likely to brush regularly, not own a toothbrush, consume more sugary drinks and snacks, and visit the dentist less often[3].

1.2. Oral Health Promotion Messaging

As the basis for framing the discussions and referencing good oral health promotion messaging, we used four out of the following five messages from Derbyshire Community Health Service Foundation Trust[4]:

There are two, common oral diseases. These are tooth decay and gum disease. Both are preventable. In order to promote good oral health, there are five key messages.

- ***Diet**: Reduce the frequency and amount of sugary food and drink in the diet. Try to keep sweet things to mealtimes.*
- ***Toothbrushing**. Brush last thing at night and at least one other occasion. Spit out after brushing. Do not rinse with water*
- ***Fluoride**: use a toothpaste containing at least 1000ppm of fluoride. 0-3 years use a smear of toothpaste. 3 years and above, use a pea sized amount of toothpaste.*
- ***Dental Visits**: Visit the dentist regularly. Try to register children by the time they reach their first birthday. Treatment is free for children under 18 years.*
- ***Smoking Cessation**: Periodontal disease, oral carers and a range of chronic diseases are linked to smoking. There are a range of services to help you quit.*[5]

1.3. Sampling Criteria

The key target sample was

Primary Audiences

- Parents and carers within Bolsover and High Peak who have children aged 0-5 years old
- Parents and carers with children aged 6-10 years old. This gives us a focus on those parents within the target audiences as well as those just outside it with recent experience and insights.

Secondary audiences

- Staff and volunteers who work with the primary audiences

[3] Derbyshire Community Health Service NHS Foundation Trust Oral Health promotion http://www.dchs.nhs.uk/home/our-services/find_services_by_topic/early-years
[4] http://www.dchs.nhs.uk/home/our-services/find_services_by_topic/oral-health-messages
[5] Smoking cessation message not used with our discussions

2. Methodology

Table 1: Summary of Engagement Methods and Numbers

• Rapid **Evidence Review**
• **Nine** stakeholder interviews using a semi-structured interview
• **Three** focus groups with **34 parent participants** using a semi-structured script

The project commenced in February 2020 but was suspended from 01 July to 30 September 2020 due to the lockdown implemented as part of the Covid-19 pandemic. The contract was further extended when additional lockdown restrictions were put in place.

We populated a database of key stakeholders including locality workers, Voluntary, Community and Social Enterprise (VCSE) group leads, (Live Life Better Derbyshire (LLDB) contacts, staff from children and young people's services, other community focused services and school contacts within each locality.

A project summary was produced to inform people about the project aims and the 'ask' of them. The summary contained a link to register interest where details about postcode, age of children and the specific methodology that the person was interested in. In this way, we could filter and segment interest to ensure involvement of the target audiences.

Recruitment was focused on routes through local schools and the summary information was distributed to parents and carers through school social media and school discussion forums.

As a result of the Covid-19 pandemic, all recruitment and engagement methods were carried out on the telephone, or online using Microsoft Teams or Zoom. All focus groups were carried out online using Zoom.

2.1. Rapid Evidence Review

To inform our research, a rapid evidence review was completed. We drew on this evidence base to inform the semi-structured scripts for focus group discussions and interviews across the research.

Half a day was spent identifying and reviewing local and national policy documents to give the team an overview of topics for discussion and 'what works' to increase healthy oral health behaviours. This stage was used to identify local contacts and network leads.

2.2. Conversations

During interviews and group discussions, a semi structured script was used to generate discussion across a range of themes including

- the influence of others
- attitudes towards oral health
- experiences of dental services (for self and children)
- knowledge around diet
- knowledge and experience around tooth brushing behaviours

An example of the script for parents and carers is in **Appendix 1**

Discussions were recorded and transcribed. These were analysed and the significant themes are summarised below.

2.3. Parent Profile

Participants were recruited to interviews and focus groups using a variety of different routes.

- 34 parents took part in the conversations
- 14 parents had children aged 0-5 years old
- 20 parents had children aged 6-10 years old
- 20 parents were from High Peak and 14 parents were from Bolsover
- 29 parents were female, and 5 parents were male

2.4. Profile of Interview (Parent) Participants

Table 2: Interview Profile Detail

	Interviews High Peak	**Interviews Bolsover**	**Total**
Number of participants	5	5	10
Postcode	2x SK23 SK17 2x SK23	6 xS44	
Age Range of Children	2x 0-5 years old 4x 6-10 years old	2x 0-5 years old 4x 6-10 years old	4x 0-5 years 8x 6-10 years old
Gender	4 Female 1 Male	4 Female 1 Male	8 Female 2 Male

2.5. Profile of (Parent) Focus Groups

Three focus groups were held with **24 participants** using a semi-structured script.

Table 2: Focus Group Participant Profile Detail

	Focus Group 1 High Peak	**Focus Group 2 Bolsover**	**Focus Group 3 High Peak and Bolsover**	**Total**
Number of participants	12	6	6	24
Postcode	10x SK23 SK23 SK23	6 xS44	SK23 SK23 3x SK44 SK44 SK17	
Age Range of Children	3x 0-5 years old 9x 6-10 years old	3x 0-5 years old 3x 6-10 years old	4x 0-5 years old 2x 6-10 years old	10x 0-5 years 14x 6-10 years
Gender	10 Female 2 Male	6 Female	5 Female 1 Male	21 Female 3 Male

2.6. Stakeholder Interviews

Staff contacts who work across the oral health pathway were obtained from Public Health and the following work areas were covered. Nine staff took part in semi structured interviews.

- Childrens Centre staff
- Oral Health Promotion Service staff
- Nursery Staff
- Intensive Home Visiting Service staff
- Family Nursing staff

3. Stakeholder Insight

The staff stakeholder interviews identified several themes that were congruent with ones identified through the parent and carers engagement. We grouped the themes below across those relevant to services, and those relevant to parents and carers.

3.1. Service Themes

i. Access to dentists - new patient access:

Generally, there was a perception by all stakeholders that most practices were not accepting new patients, including children under the age of 18 years.

We used the NHS 'Find a Dentist' online web service (https://www.nhs.uk/service-search/find-a-dentist). Of the 50 practices which came up from a 'Bolsover' search, **only one was identified as accepting new patients (children)**

- 37 did not have up to date information (submitted in the previous 90 days).
- 8 were not accepting new patients (children up to the age of 18 years)
- 4 were only accepting with the referral of another dentist
- 1 was accepting new patients (children up to the age of 18 years)

There is a lack of up-to-date information on those practices accepting new patients. There may be a proportion of those who have not submitted information, who are accepting under 18-year-old patients, but this puts another responsibility on parents to search further and identify and contact practices individually.

This was raised by stakeholders. Currently there is no contractual obligation for dentists to update web pages, so information is, as shown locally, very out of date.

> *"We need dental practice information on the NHS to be updated weekly. Have they got spaces, are they offering NHS treatment, what kind of staff do they have? I.e. Do they have experience of working with nervous patients, do they have female staff?"*

ii. Access to dentists - geography:

All stakeholders spoke about the geographical and physical barriers to access. In addition, the cost of local public transport is high and if the parent has additional barriers – they are pregnant or have young children, then this is a disincentive. There was a suggestion of commissioning a mobile dental service for hard-to-reach communities.

'Geography plays a big, big barrier. With some families they live quite remote so actually, to get in, they might not have great access to public transport if they don't have a car. To actually physically get to things is quite challenging for a lot of families.'

iii. Access to dentists – child friendly services

The skill set of dentists around working with children was another dimension of this discussion. Feedback highlighted that current dental contract does not incentivise additional time to be spent on as much prevention or with children.

In addition, more than one service stakeholder highlighted an inconsistent approach to registering children, even where lists are open to them.

"We still see that some dentists will see babies quite early and then some of them don't want to see them till they've got teeth or older. It doesn't help our work trying to early registration. Nor does it help the consistency of our advice.'

iv. Joined up pathways

Several of the stakeholders, including Health Visitor staff, Oral health Promotion Staff and Family Support staff said that a referral pathway into local dental practices would help with facilitating access into services. Only referrals into the Community Dentistry Service are possible, for patients with more complex needs including those children with additional needs, anxious patients requiring care under sedation or General Anaesthesia.

"There is no proper pathway with a local dentist where you could say, "I have a child I am concerned about." There is nothing like that"

v. Proactive oral health brief advice

Each of the service providers we engaged were positive about the oral health advice and support they provided across the child's first years. Health visitors for example were highlighted for their role in providing advice and support as part of the healthy child programme. This includes[6]:

[6]Guidance: **Health matters: child dental health**, PHE, Published 14 June 2017
https://www.gov.uk/government/publications/health-matters-child-dental-health/health-matters-child-dental-health

- universal interventions within the first year, providing oral health advice and support and signposting to dental services
- identifying families that need additional support, for example the siblings of children who have attended hospital for dental extractions due to tooth decay
- encouraging dental attendance when the first tooth erupts at about 6 months of age, to enable the dental teams to give preventive messages

Moreover, there was plenty of examples given of joined up services and complimentary activity across services, for example, Health Visiting, Midwifery, Oral Health Promotion and Childrens Centres. The benefits as articulated by the providers included

- consistent messaging
- early (and timely) interventions
- signposting and referral (where possible)
- proactive approaches that focus on prevention
- joined up approaches with nurseries and pre-school

The role of such early advice, support and information is undoubtedly important but as highlighted in the responses from parents and carers later, it is not always understood or incorporated because of low health literacy, or in some cases because of the volume of 'new' information that is shared by practitioners.

vi. Positive relationships with the Oral Health Promotion Service

All stakeholders were very positive about the contribution of the Oral Health Promotion Service in Derbyshire. Most spoke unprompted about the benefits of their training offer and campaign support. The role of Oral Health Champions within services was highlighted as a positive.

> *"XX [staff member] often did the oral health training. It was about an hour, and it was so snappy. It was it was really, really good fun and informative."*

vii. Strategic coordination across local networks and services is important

The newly formed Oral Health Strategy Group in Derbyshire was welcomed and mentioned by half of the stakeholders. Whilst they were positive about how joined up existing activities are between services, they felt in particular that the group would add to the sharing of information, best practice and inform planning. In particular, they saw this as a route to tackle the system wide barriers and opportunities, including reform of dental pathways and services where appropriate.

> *"I think strategically, I think the fact that this new group has been fairly recently, and I think I'm hopeful that actually there's now a forum to have these important conversations where there are barriers to families accessing a dentist, for instance."*

viii. Covid-19 has impacted on service delivery

Like most services locally, the impact of Covid-19 and social distancing has been significant. All stakeholders described a reduction in services, despite them shifting to include remote and online approaches. Face to face contacts were reduced across many services and the impact of reduced dental services was noted.

Whilst most services described positives about shifting delivery which would be maintained (use of social media, online engagement and training, production of toolkits for example) some admitted that these more distant / remote / online approaches had been slow to develop. In addition, the adoption of some of these approaches has not been consistent across services. Adoption of online training and remote engagement (including social media) for example has happened 'in pockets' and there has been little or no attempt to spread skills and experience across networks or between organisations. Stakeholders also reported their experience of changes in parent (and child) oral health behaviours as a result of Covid-19 and this is reported later.

3.2. Parent and Carer Themes

ix. Low health literacy

'*Health literacy is a social determinant of health and is strongly linked with other social determinants such as poverty, unemployment and membership of a minority ethnic group. Where health literacy differs from these other social factors is that it is, potentially, open to change through improving health systems and building patient and public awareness and skills.*[7]*'*

The target audiences for oral health promotion and support are often those who have lower health literacy. This was cited by stakeholders as well as several suggestions about ways to adapt approaches.

> *"We know that a large number of our clients have literary literacy difficulties, and they may prefer visual information. They might pick up on visual messages, but not quite get what the message means with words or written information. So there really does need to be a broad range of approaches in our experience."*

Service providers should be mindful not just of the style of patient and client information they produce, but also of the methods of communication more widely. Later in this document we also describe how the volume of information which new parents receive can also be a barrier to adoption and understanding. This was true across multiple topics and is expressed particularly around understanding good dietary information. The challenges for parents around sourcing and registering at

[7] Health Literacy UK. https://www.healthliteracy.org.uk/why-is-health-literacy-important

dentists is also part of high health literacy; the ability to be able to 'navigate they system'.

Adopting strengths-based approaches was advocated by one of the services. The benefits being that, in addition to improving health literacy, it maximises the opportunities for sustained behaviour change.

x. The influences on oral health are social

The evidence between deprivation and poor oral health were commonly referenced during our interviews. Several of the services work with vulnerable young parents who might have an array of other life pressures to manage, such as living arrangements, food, living on low incomes and so on. The need to understand the wider determinants of health was emphasised and the importance of working on the improvement of social determinants as part of strategic planning and delivery.

> *"Most of the clients that we work with are in areas of deprivation and so many of these young people… We know they have they don't have a toothbrush. They don't brush their own teeth. Poor oral status is quite visible and obvious."*

When asked, 'what can be done about them?' answers included:

- A joined-up strategy including oral health promotion within wider public health planning
- Needing to focus on communities who face the greatest inequalities
- Increasing access to a healthier diet is not always about awareness. It also includes accessibility and affordability
- Service barriers, specifically around the access to dentists

xi. Lack of peer-to-peer support and role modelling

Some of the audiences who would be at most risk of poor oral health had a lack of positive role models which means from an early age, they are more likely to have a lack of learned routines. Our stakeholders talked about young and lone parents in particular. The literature suggests that the role of parents as 'mediators/moderators of children's oral health' is significant[8]. If these influences and structure were also absent from parent's routines, then it is likely they will not have good, learned behaviours to share with their children in turn. The summary of this same research summarises that perceived influences on children's tooth brushing behaviour are primarily located within the direct family environment.

[8] Establishing oral health promoting behaviours in children – parents' views on barriers, facilitators and professional support: a qualitative study, Duijster, de Jong-Lenters, Verrips, and van Loveren, BMC Oral Health. 2015; 15: 157.

"A lot of the young people that we work with possibly haven't had particularly good role models when it comes to lots of things in life, but oral health as well."

Wider still, the absence of reinforcement - messages from peers for example - means that there is likely to be less 'social norming' around oral health behaviours. Related is the lack of peer-to-peer support. Our insight with parents in Derbyshire for example suggests that many parents don't talk about oral health, particularly when there are problems.

xii. Dads are not always 'present'

When asked about the role of fathers, several of the service staff said that although they are part of their target audiences, fathers are not always present during discussions. Families may be single mothers; fathers may be living in other accommodations (especially during Covid-19 restrictions), or they may be absent because of work or study commitments. Services wanted to involve fathers and the Children's Centres spoke about 'dad's groups' as a means of involving them.

"Dads may not always live at the same property. They may be out at work and college and not as involved with services. It's particularly true during Covid-19."

Where possible, fathers can of course be important enablers of good oral health strategies with children and where possible, their involvement should be sought, as a service priority.

xiii. Prompts (including free toothbrushes) work

Stakeholders, the Children's Centre staff in particular, gave very positive feedback about the importance and usefulness of tooth brushing packs locally. As with feedback from parents and carers, the brushes were felt to be beneficial for several reasons. These are in addition to providing the right equipment.

- a prompt for discussions about tooth brushing
- a prompt to brush teeth (behaviour change/behaviour continuation)
- services being seen to actively prioritise oral health
- examples of child-friendly toothbrushes

'It doesn't seem like a lot of money to you or I, to go out and buy a little toothbrush and some toothpaste. but for some of these families, that is the difference between a loaf of bread and milk. And so, they buy the loaf of bread and eat."

There was some discussion about their lack of universal provision, i.e., not every parent will be offered tooth brushing products, and this was felt to be restrictive.

xiv. Ask and Engage Parents

Some examples of parent-involvement were given. These ranged from engaging with groups in Children's Centres, through to informing parents in nurseries. All services spoke about a person-centred approach. Few of the examples however would demonstrate involvement that went beyond 'informing' and few had examples of needs assessment that engaged parents more broadly in influencing how service delivery happens.

It is hoped that this report can be used as a starting point for service leads so that they can discuss the implications for their client groups and identify where additional conversations would benefit planning and delivery.

> *"It will be interesting to do some kind of exploratory work with the families to ask them, because I don't think we're always very good at that, actually. You know, tell us what would help, what would be useful and what would make a difference."*

xv. Covid-19 has impacted on health behaviours

All services have been impacted by Covid-19. In addition to the reduction or removal of face-to-face engagements, there was a strong feeling that healthy behaviours had been negatively impacted,

Stakeholders were particularly concerned about missed dental appointments and the interruption of regular behaviours. There were examples shared of inconsistent approaches by dental practices to contact patients.

More generally, changes in routines were felt to have impacted on an increase in unhealthy eating. The evidence around users of Family Weight Management Services[9] and from speaking to Derbyshire parents backs this up.

All services had improved their online and remote access delivery. Some moved on to social media as a means of engagement, support and advice, others utilised telephone contacts, some groups had been attempted online, whilst others maintained less regular face to face contacts. Digital exclusion was thought to be less of an issue for their audiences than it would be for older people but nonetheless, there were concerns that it happened for people with low incomes.

xvi. Diet - Confusing messaging around diet and oral health

Conversations about the dietary part of oral health were largely secondary to discussions about dental topics. In all but one instance, discussion about 'oral

[9] Supporting weight management and wellbeing approaches during the COVID-19 pandemic Posted by:Jamie Blackshaw, Posted on:15 September 2020 https://publichealthmatters.blog.gov.uk/2020/09/15/supporting-weight-management-and-wellbeing-approaches-during-the-covid-19-pandemic/

health' started with teeth/tooth brushing/dental services and after prompting, went on to cover diet.

Despite this, examples of local work were shared, and this included examples of advice and support from Health Visitors, the Henry[10] programme in Derbyshire, and group-based interventions in Children's Centres.

Stakeholders emphasised the need to approach healthy diet from a whole-system perspective. Local planning decisions (too many takeaways) and food advertising (inappropriate exposure to children) were mentioned. At a more local level, there was a feeling that parents are exposed to mixed messaging around healthy diet. Two specific examples about the confusion over the risk of tooth decay from fruits and fruit juice were given.

> *"One of our clients had stopped giving her young child fruit as she thought it was bad for their teeth. There is a lot of confusion out there about healthy eating and tooth health."*

[10] https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/your-health/children-and-young-peoples-health/henry/health-exercise-and-nutrition-for-the-really-young-henry.aspx

4. Parent and Carer Insight

The following were the main themes from conversations with parents and carers across interviews and focus groups. We have grouped the themes below across those relevant to

- tooth brushing behaviours and knowledge
- dental services,
- NHS and wellbeing services
- diet and healthy eating
- social environment (including schools, peers, local environment)

4.1. Tooth brushing behaviours and knowledge

i. Oral Health is lower down on list of 'important topics'

Overall, parents and carers were involved and engaged in the discussions about oral health. This is likely to be a self-selecting bias from recruitment. Almost all recognised the importance of good brushing routines, regular dental check-ups and a good diet, even if they did not follow recommended guidance absolutely. All spoke about their desire for their children to have good oral health.

However, when they were asked *'If you had to put oral health on a list of important things for your child, where would you put it?'* the overwhelming majority of people ranked it lower down the list of health and wellbeing concerns. These two responses are not necessarily incongruent. When engaged on the topic and when discussing details, parents saw it as an important topic.

> *"If Covid was not here it would be much higher.*

The impact of Covid-19 appears to have magnified other concerns to the relative detriment of oral health. This is likely to be amplified by the removal of many sources of oral health messaging, advice and support. For example, the interruption of many nurseries, the closure of dentists and Childrens Centres.

ii. Poor parent oral health can motivate parents

The evidence suggests that behaviours in parents such as tooth brushing habits are important determinants of these behaviours in their young children. Other parental factors influencing a child's oral health are poor education and socioeconomic status.

For a variety of reasons, the conditions and behaviours which lead to poor parent oral health may also be present and lead to poor child oral health.

However, there was a group of parents who prioritised good oral health in their children **because** they had themselves experienced significant poor oral health. This group of parents who had experienced traumatic oral health were much more motivated around protective behaviours, specifically mentioned were establishing good brushing routines and going to the dentist.

When asked what motivated them to break their own behaviours or experiences, common replies were a desire for their children to avoid similar 'trauma'. *One respondent in this group said, "I think for me it was when I had to have a tooth out. I had so many problems, I didn't want her [my daughter] to go through that"*

> *"So, for me, it's really important [oral health] and it's really important that I push that for my daughter. Part of that comes from the fact that, actually, my parents couldn't have given a damn at all."*

iii. Knowledge about tooth brushing is varied

Not all parents supervised their children's brushing, even at relatively young ages. There was a high motivation for their child to brush independently as soon as possible and this influenced the duration of their supervision. Some of the parents reported that they were encouraging some independent brushing before or around 5 years old. NICE Guidance recommends that supervised tooth brushing in areas where children are at high risk of poor oral health should take place in nurseries and primary schools[11].

Although the majority of the parents we spoke to had older children, not babies, less than half could recall brushing their young baby's teeth twice a day. Most said they did it once. NHS advice is to 'start brushing your baby's teeth as soon as they start to come through', and 'Do it at least twice a day'[12].

Some parents thought that structured tooth brushing routines were more important after they had grown adult teeth.

> *"I thought at first that they didn't need much dental help with milk teeth and that they might need it when they got their real teeth, so all the information was really valuable and relevant."*

[11] PH55 (2014) *'Oral health: local authorities and partners'*
[12] https://www.nhs.uk/conditions/baby/babys-development/teething/looking-after-your-babys-teeth/

iv. Many parents find establishing good tooth brushing routines hard

> *"It was a nightmare, getting them to do it. We had to stand over them and you don't always have time for that. As soon as you are not there to make sure it happens, they stop'*

Tooth brushing is interrupted by busy schedules. When asked about how strictly they adhere to twice daily routines, most parents said that whilst this was the ideal, there were many occasions when this did not happen.

Child behaviour and compliance was another factor in establishing routines and sometimes patents took a conflict-avoidance route.

When asked what helps, answers included:

- Turning it into a game as children get older
- Recognising it's as much about establishing routines as healthy behaviours
- Parent and child brush their teeth together

> *"My dad didn't have much of an impact on my life as a parent but the one thing that he really instilled was the importance of brushing our teeth…that was always drummed into my head from being little."*

v. Brief advice and information recall is mixed

The overwhelming majority of people received their first information about child dental care, from health visitors. Most remembered receiving a leaflet and a brief advice conversation, and some remembered receiving a toothbrush. Some referred to the 'red book' (Personal Child Health Record[13]) as part of their child oral health education. Although the standard Personal Child Health Record contains advice about dental health, none of the parents mentioned this.

Fathers' knowledge about sources of information, and the detail of information was much lower than mothers.

> *"If I am honest, I can't really remember [where they received their first information from]. It must have been from my Health Visitor, but there was so much new information. You did feel overloaded. I have no memory about it [oral health]. I do remember getting leaflets from nursery. That's where toothbrushing was really looked at"*

Some parents described feeling overwhelmed by the amount of new information and the complexity of information.

[13] https://www.healthforallchildren.com/download/1903/?uid=206b59a7f6

This highlights the need not to assume that the correct information has 'landed' after it has been told or that messages are as clear and 'simple' as they need to be. Reinforcement at different points and from multiple sources was important for parents. If there are lower levels of health literacy, then this is more likely to be needed. There was some evidence of new parents discussing teething and baby/child tooth brushing with peers and this is discussed in more detail later.

4.2. Dental services

vi. Parents have difficulty finding dentists that are open for new patients:

The registration access to dental practices highlighted by staff stakeholders were also raised by parents. It's worth nothing that some of these comments will be 'historical'; up to 4 years in some instances. In total, 7 of the parents (20%) reported problems, with 3 of these experiencing problems registering themselves as new residents. Overall, there was a general consensus that getting on a practice list as a new patient was difficult.

> *"At first, I could not find any spaces with my local dentist and had to go to Buxton to register with a dentist."*

> *"I had a problem with dentist shortages before the pandemic, I had quite a few appointments cancelled. My children were not able to be seen for a regular check-up, so I decided to go private and was seen within a few days which I wasn't happy about."*

> *"I inquired about getting a dentist closer to home [in Buxton] and the only other dentist that's here, and they told me there's a two-year waiting list and that includes children."*

A successful strategy employed by some parents was to take their new child when they visited the dentist for their own appointment. They felt this facilitated access, established a good routine and was a whole-family approach. Many of the parents said they visit as a family, and this was time and cost saving. It also gives more time in total, to talk with their dental team. This strategy of course also depends upon regular visits by the parent in the first instance.

One of the parents described how this strategy had actually started by their dentist spending a few minutes with their small child, talking, and reassuring them so that a subsequent visit could be booked in.

> "Mine was great. At the end of my appointment, they actually encouraged my toddler to come and sit in the chair and they spoke to them. They were the ones who encouraged me to make another appointment for him."

vii. Not all parents register their child as early as they should

Less than half of the parents we asked had registered their child before or around their first birthday. Although this is guidance and encouraged across the service interventions, this was new information for around half of the parents. By delaying their registration, parents delay prevention opportunities and also delay opportunities for support and advice.

viii. Dentists provided valued, regular information for parents

When relationships with dental teams are positive, they are important sources of information for parents. Dental teams were considered the 'experts' and were a valued place of advice and support.

Parents gave several examples when they had asked questions and other instances when proactive advice was given.

> *"I get so much help and information from my dentist about my child. I would probably say that they are the most important source of information. Last time I was asking about sugary drinks"*

It is worth highlighting that this was not the experience of every parent, and some reported that dental staff spent little time discussing things with them. These parents wanted information, particularly practical suggestions and advice about supporting healthy dental behaviours.

ix. Navigating the dental system can be tricky

The discussions in this theme

- how to find out who is taking new patients
- the cost of NHS dental charges for children

When asked, the majority of parents knew that NHS dental care for children is free but there was still uncertainty about what this covered, at what age it ended, and if all dentists provided this.

In addition, parents described finding it difficult to find out which practices were 'child friendly' i.e., who had good reputations for treating children. Where parents had established good relationships with dental practices, they were very highly valued and as discussed later, were important sources of support and advice.

We did not explore with the Oral Health Promotion Service if their training offer includes child-focused topics with dental teams.

x. Parent and Carers relationship with dentists

The relationship a parent has with their dentist significantly impacts on the relationship they facilitate between their child and dentist. Regular dental visits by parents were an indication of prioritising dental and oral health for themselves, which is likely to mean prioritisation of their child's dental and oral health. One of the mothers spoke about her own fear of the dentist and so the child's father takes them.

> *"I think that it's just as important as taking them to the Doctor. I make sure that I book their next appointment when I'm leaving their last appointment and I make sure that they attend. I would put it in the top 3 health things."*

Some of the parents described their own use of dentists as tending to be more reactive. They went when they had pain or problems. This could be because of costs or a because they already had cavities and considered their dental health to be 'fixed'.

Parents were much more receptive and motivated by the idea of prevention when they discussed their children.

4.3. NHS and wellbeing services

xi. Free brushes and toothpaste packs are valued:

Although not every parent could recall receiving a free dental product to support their child's dental care, a majority did, and they highly valued it. Sources recalled were packs from nurseries and health visitors.

The packs supported the following behaviour change:

- prioritisation of dental care by parents. One parent said, *"It literally made it the important activity'.*
- increasing knowledge about good practice
- showing the right products for children to use
- encouraging toothbrushing between children (when they are used in nursery settings

This communal tooth brushing activity with older toddlers was an important activity which contributes to social norms by parents and children.

"I remember both the girls getting a pack with a leaflet and a little toothbrush. I'm not sure who sent this out. I found it all really useful as I had no idea at first."

"XX would come home and tell us that the nursery workers had asked her if she had brushed her teeth at home that morning. We thought that this was really good."

xii. Health Visitors are valued sources of support

Parents identified several sources of advice and support. The three main sources of advice (in order of value placed on it) were health visitors, dentists and nurseries. Other sources were mentioned, schools for older children in particular and web-based searches. Those parents who had used Children's Centres were very positive about their support and information. When asked about what they valued, parents considered health visitors a trusted source of information that is given at regular intervals.

The point of caution mentioned earlier was the need for reinforcement and not to assume that information has always been stored or understood by all parents. Parents said that practical support advice was the most useful. This included tooth brushing techniques, ideas for maintaining habits, and even discussions about food cupboard contents.

Nor does increased knowledge necessarily mean there will be behavioural change. The value put on dentists, Children's Centres and especially nurseries where supervised tooth bruising happens, was that it is more skill-based support. Each of these services gave, and in some instances demonstrated, practical strategies to help.

"My health visitor gave me leaflets around oral hygiene. We asked a lot of questions about it as we were first time parents. I trusted her and I feel informed. If I was unsure of something, then I would google. I feel that I have had lots of positive support from the GP, health visitor etc. There is a lot of good information and support out there."

4.4. Diet and healthy eating

xiii. Health literacy – mixed messaging about dietary advice and implementing change

Most parents knew about reducing intake of sugar to help prevent dental decay and most could recall receiving advice from a variety of sources, including Government

and advert messaging. In addition to motivations around good oral health, some parents were motivated by wanting to promote wider health benefits.

Although the importance of reducing sugars was known, there was more confusion around consumption of drinks and the advice around drinking before brushing. Fewer parents knew about wating 30 minutes before brushing after a meal or drinking for example. Some parents also had not considered the sugar content in fresh fruit juices. Somme found managing healthy dietary advice contradictory to oral health advice. Their perception can be summarised as 'more fruit = body healthy, but less fruit = mouth healthy'.

> *"I wouldn't say that my knowledge around it is amazing, but I understand the importance of not having too many sugary drinks – I make sure that juice is diluted down."*

Parents sometimes find it hard to put knowledge into practice. This can happen for a number of reasons:

- Contending with children's behaviour and preferences.
- The influence of grand parents and other carers can contradict their own control.
- Covid-19 has increased the amount of snacking on unhealthy foods (discussed more later).
- Environmental influences: the influence of wider advertising/availability/costs/price of healthier food and drinks.

As with dental behaviours, parents expressed a need for support to implement healthy dietary behaviours.

4.5. Social environment (including schools, peers, local environment)

xiv. Talking with peers about oral health

Very few parents said they regularly discussed oral health with their peers. Although parents spoke about the importance of prevention, when prompted, few said they discussed prevention with others. There was little evidence that parents amplify preventative messages to others.

The more common framing of answers when asked, 'Do you speak to other parents about oral health'? was to talk about poor dental health – cavities in particular. There were barriers to talking about poor oral health with others as this was framed very negatively and as a failing of parents.

> *"My niece had to have baby teeth taken out. I was literally thinking it was the worst thing in the world. So, I can imagine being distraught if it was my child. I wouldn't want to admit that to any of my friends"*

Some parents did not feel comfortable discussing oral health with peers and were not equipped to raise the topic.

> *"I wouldn't feel as comfortable talking to a parent at nursery about it unless they raised it first as I wouldn't want to sound all condescending."*

This suggests that there is room for facilitating more peer-to-peer conversations and this could be part of campaign approaches, project outcomes or simple encouragement to talk with others.

Whilst there was less discussion about tooth brushing and dental care generally, there was some examples of discussions around teething. This also prompted discussions and trading of techniques between people. This suggests there are times (such as teething) when parents are more open to peer-to-peer messaging and support which could have an implication for marketing approaches.

> *"Me and my two friends, we all had kids within six months of each other, so it was quite a hot topic. As soon as one got a tooth, we were checking gums kind of thing. And it did become a bit of a race and a competition of who could get like a full set first. But it did prompt a lot of 'well, what are you using for toothbrushing and how have you done this?' And it was good to have that kind of peer support, really, and especially with really early on toothbrushing".*

xv. Whole family approach.

The role of the wider family, particularly grandparents, was raised. Family and friends can both reinforce or hinder efforts to support good oral health. Parents more often spoke about diet rather than tooth brushing, and grandparents undermining efforts by giving treats and not adhering to healthy behaviours.

Given that parents are the focus of most brief advice conversations, campaigns and information it is not surprising that wider family members, including grandparents, are not as informed or supported to adopt healthier behaviours.

4.6. Covid-19

"Not very well informed especially now due to the pandemic, other health concerns are more pressing."

xvi. Dentists

All of the parents said Covid-19 had significantly impacted on their visits to the dentist.

"Due to Covid we are all due for check-ups and our dentist has closed and not been in touch for appointments and I am concerned about my child's adult teeth coming through and would want to visit the dentist at the nearest opportunity."

- Around half of the parents could recall getting a text saying their dentist was open.
- Around one quarter had gone back to the dentist since lockdown restrictions eased
- Around one quarter had been to the dentist with their children in the past 12 months
- None of the parents knew about local urgent dental care and assumed they should go to A&E if their child had problems.[14] This is significantly lower than found in an online survey of the public, which was carried out in November 2020.

The issues with missed and delayed appointments are likely to be compounded if parents are missing reminders, not receiving reminders or there is a backlog and reduced capacity locally. At the time of discussions, most parents were reasonably confident about returning to their dentists which suggests that covid-hesitancy is less of an issue for many.

"Got one text reminder – that was it. Didn't have time to answer it so we have not gone back yet [over 1-year later]."

The positives are that parents are largely willing to return to their dentists and this is probably likely to increase as vaccination efforts roll out. Issues around reminders and access are likely to remain as barriers.

[14] COVID-19 and dentistry - survey of the UK public report, General Dental Council, November 2020, https://www.gdc-uk.org/docs/default-source/research/covid-19-and-dentistry-survey-of-the-uk-public-report0e677a96-bdc1-4447-a20e-1d402b7dbb4b.pdf?sfvrsn=8f04c781_12

xvii. Healthy Eating

The impact on healthy eating habits was acknowledged and a concern for many parents. There were two significant themes from conversations.

1. Less structure in people's days

Although younger children tended to be less affected by nursey closures during the pandemic, they still were affected by sibling's school closures, parents working from home and in some instances, individual closures due to staff absences.

When children were at home, parents described changes in snacking habits because of changes to this structure.

> *"…the children are not having school dinners and I don't think they are getting as much of a varied diet anymore. It is difficult to balance work and home schooling. The kids will have more treats on the weekend. "*

> *"Some of our good habits have changed with Covid, due to being stuck at home all day. The kids are sometimes bored, have nowhere to go, so they get more than they would with the occasional treat as entertainment, because we just feel sorry for them."*

2. Emotional stress

Related to the change in structure across the day was the increase in snacking across families.

> *"We have all snacked more, it's to relieve boredom and one of the things left to make you happy. It feels like there are worse things than chocolate for breakfast."*

5. Marketing

i. Campaigns, including outreach and engagement activity

Services, particularly the Oral Health Promotion Service and the Children's Centres, gave several examples around the importance of planning community facing campaigns and outreach. The strength of these approaches was evident in

- engaging nurseries, parent groups and pre-school organisations
- engaging with people in creative ways to disseminate key messages
- targeting those audiences at most risk of poor child oral health
- fostering skill-based approaches to improve brushing

> *"We've always got displays and what we used to call our roadshows. In the summer we ran activities in the community. Very visual and very in your face. We were very lucky that we always had our colleagues with us to promote things in a fun way that the parents took on board."*

These approaches appear to be positive ways of tackling health literacy by engaging and sharing information in a variety of accessible methods. Related to these community focused approaches were examples of distributing tooth brushing resources.

> *"Four years ago, we did a brush challenge project, which was absolutely brilliant. Health audit figures showed how much oral health it improved during that time. Just give them a toothbrush, some of that toothpaste. We support Smile Month, encourage brushing and 'Ditch the Dummy' campaign."*

Those services who utilised child toothbrushes and toothpaste giveaways described how useful they were at both prompting oral health conversations and supporting brushing activity. This is also highlighted by parents and carers.

ii. Nice smiles were associated with good dental care

Some parents described the importance of having a 'nice smile' (healthy looking teeth) for children and this was part of the motivation of following good oral health. In addition, this was also used as motivation for children. This has implications for messaging and campaigns, and it reinforces the use of local activity like Smile4life and Special Smiles.

iii. Marketing methods

People were supportive about good marketing campaigns. The evidence suggests that social marketing campaigns can be effective methods of promoting oral health and both NICE and PHE Guidance highlight good communication and social marketing approaches as part of behaviour change approaches.

Parents mentioned the amounts of leaflets they are given from a variety of sources. There is strong evidence that leaflets and written material are effective in promoting patients' knowledge but there is no evidence that leaflets are effective for changing people's behaviour[15].

"Not leaflets, we are given lots and often I don't have time to read them"

There is strong evidence that patients' knowledge levels can be improved by receiving oral health messages from an oral health practitioner[13]. This reinforces the importance of brief advice conversations, being proactive about using teachable moments with wider health and wellbeing staff, and perhaps wider still, encouraging peer to peer messaging. The same evidence review cited has moderate evidence that it is the values and beliefs of the person giving oral health promotion, and not their profession, which can act as a barrier or facilitator to effectiveness.

Parents were asked their ideas about promoting oral health and the following suggestions were made.

- Radio advert on local station.
- Social media. The additional suggestion was made that combining short, simple messages in nursery alerts and messages would be helpful

"You do spend a lot of your time looking on the web for information. I usually go to an NHS page but if there was a local site with information, I would value it."

- Pictures of gum disease are powerful.
- Educating parents with statistic=something real.
- Using books with stories and positive messages as part of other activities.
- Joined up approaches with nursery and schools, and Children's Centres.

"The book bag I received with my children at nursery still resonates in my memory. I trust the information received and feel well informed."

"The school sends something out about it [healthy eating] at least once a year – they're a really good school – if you need help then you just tell them, and they'll do their best to help"

[15] Oral Health: Approaches for general dental practice teams on promoting oral health Kay E, Hocking A, Nasser M, Nield H, Vascott D, Dorr C, Scales H. November 2015 https://www.nice.org.uk/guidance/ng30/evidence/evidence-review-pdf-2240895421

"When I had my first born (who is now 7) the Sure Start Centre would inform me of oral health very well, I remember getting a toothpaste pack and a lot more support from the very beginning."

"If there was like a drop-in session of some of the local dentists, that could come in [to school] and maybe come in and kind of inform parents. So, I think if you do it via school, that will then have a positive effect on those parents and the children as well"

- Most parents were confident using mobile apps or the web to search for information.

6. Recommendations

The following recommendations are made

i. Locally, dentists should be encouraged to update their patient information on the NHS 'Find a Dentist' website and ensure this information is up to date on practice websites.

ii. Dental practices should display information about their child-friendly practice offer, including on websites.

iii. Seek opportunities to influence the wider determinants of poor oral health e.g., though local planning decisions for food outlets, and to include the accessibility and affordability of food within healthy eating work.

iv. Include oral health in service specifications of all relevant commissioned services which deliver to parents and children 0-5 years old.

v. Encourage the inclusion of child oral health within all activities to support staff to have opportunistic discussions with parents and carers. This could include Quality Conversation and 'teachable moment' initiatives.

vi. Extend distribution of toothbrush and toothpaste packs in line with NICE guidance and the PHE return on investment tool. This could be increasing the availability of products and information to more community and nursery venues as well drawing on the learning from the current pilot with foodbanks in targeted areas across the City and County.

vii. Encourage more needs assessment activity involving and co-produced with parents and carers. This could include developing simple resources to help them have conversations and ask meaningful questions with peers.

viii. Continue to support and promote the training offer by the Oral Health Promotion Service to local organisations, particularly to those organisations working with target communities.

ix. The Oral Health Promotion Service, in conjunction with Derbyshire County Local Dental Committee, to explore developing training around child-friendly approaches.

x. Strengthen existing work around local referral pathways, with the continued involvement of Derbyshire Oral Health Steering Group.

xi. Dietary messaging around tooth decay should also consider framing messaging around healthy smiles and physical health.

xii. Continue to monitor and understand the impact of Covid-19 as services and communities move into 'recovery'. Of particular importance is prioritising activity that addresses access and backlog. Practices should be proactive in engaging patients and keeping them up to date with information and reminders where appropriate.

xiii. The Oral Health Steering Group should explore work to increase understanding around health literacy and involve the DCC Public Health Practitioner with responsibility for health literacy work.

xiv. Work to share learning about service adaptation and delivery innovation that has happened as a result of Covid-19. The Oral Health Strategy Group could play a role in sharing best practice examples for the benefit of all.

xv. Awareness raising approaches (including social marketing campaigns) should include peer-to-peer work to support parents and carers to discuss oral health and spread positive messages. There is local evidence that changes like teething can be useful developmental stages to build this around.

xvi. Where brief advice conversations highlight poor experience of parents and carers, this can be used as motivator for proactive behaviours with their children.

xvii. Targeted work with fathers should be developed and examples might include task-finish groups within the Oral Health Strategy Group, development of training courses and targeted campaigns.

xviii. More emphasis should be placed on supervised toothbrushing – in campaigns conversations and developing projects with partners.

xix. Awareness of early and proactive registration of children with dentists (within the first year) is low and efforts to address this should be planned – in conversations, in assessments and in social marketing campaigns.

xx. Parents would like more practical and strategy-based interventions that support them to implement healthy behaviours around diet and tooth brushing.

xxi. Appropriate inclusion of healthy eating **and** oral health should be included in healthy eating campaigns and delivery so that mixed messaging does not happen.

xxii. When social distancing allows, targeted community facing activity and campaigning should be resumed. Opportunities for joint planning and delivery with partner organisations should be explored so that they receive expert support around targeting messages and audiences. Where this can be linked into Oral Health Champion work and training, it will support sustainability.

xxiii. Social marketing campaigns – including local adaptation of national campaigns – should be continued and where possible, developed further. Different target audiences will need different messages and delivery routes. Work with nurseries and Children's Centres in particular is likely to resonate.

Appendix 1 – Focus Group and Interview Script

About

Main Question	Additional Questions and Prompts
How is everyone today?	Put people at ease, get them into talking. Take time to make sure people have their names on display, explain the process, people can raise hands or electronically 'raise their hand'
How important is <u>your own</u> oral health on a list of important things? • Why? • Where would you put it?	Prompt: Where would it fit in relation to: • Physical health, • vaccinations, • emotional health • general wellbeing What are the benefits of looking after your oral health? ?
Can we talk a bit about your own experience of and attitudes towards Dental Services?	• Is it expensive? • Do you know how the NHS costs and pricing work? NB no need for you to go into detail; it's about their knowledge and perceptions • Does it impact on your use of services?

Questions about oral health

Registering your child with a dentist Who has registered their children with a dentist? Did you register your child before the age of 1 year old. Why did you do that? What motivated you?	You might have to do and say a count of hands • Do you know how to register with a dentist? Do you know how to register a child? • How important do you think it is for a child to be registered with a dentist? • What stops people going to a dentist with their child? Explore in detail Explore PRACTICAL reasons influencing decisions (money, proximity of dentist) and EMOTIONAL reasons (important, concern about wellbeing)
We're going to talk about what you know about Child oral health	• From a family member / friend? • From the school • From a staff member (who?) • Publicity (i.e., poster, leaflet, radio article)

Can you think about the time it was first spoken about with you Do you talk to others about your child's oral health? Tell me more.	• Something you have always considered
If you had to put oral health on a list of important things for your child, where would you put it?	Prompt: Why do you say that? Probe attitudes… Where would it fit in relation to: • Physical health, • vaccinations, • emotional health • wellbeing What are the benefits of looking after their oral health?
How informed do you feel about oral health issues for children?	Do you feel confident knowing about • Healthy food and oral health (sugars) • Oral hygiene (tooth bushing) • What the recommended advice is for good oral health for children? • Registering with a dentist Try to explore in as much detail as you can to explore knowledge, 'ease' and familiarity with the 'key messages. I.e. supervised brushing, frequency, dietary knowledge, etc
Tell us about the information you have received about child oral health	Tell us about the information • What kind of information is it? • Where from? • Do you trust it? • Does it make you feel informed?
Can I check how many people have had some kind of support for their children's oral health? *may have to clarify what this is This could have been • receiving some oral advice from health visitor	COUNT THIS OUT LOUD so the person facilitating can record in the notes. • Who can recall receiving some oral advice from health visitor • Who can recall receiving getting a pack (with leaflet and toothbrush) • Who can recall receiving being part of a specific scheme to promote tooth brushing • Other Was it useful / helpful / beneficial? Why / why not?

	• getting a pack (with leaflet and toothbrush) • being part of a specific scheme to promote tooth brushing	Take some time to understand what people are saying about their understanding of Oral health interventions. They might have had something but not sure where it has come from
	Thinking about Child oral health	• Tell me about why you think people shouldn't or wouldn't do it? • What would you say to encourage others to do it? • If you were in charge of it and trying to get people to use it, how would you promote it?
	Diet – sugar If not explored earlier Who feels informed about the right diet for oral health and children?	• Tell me what you think the best advice is? • Are you able to put it into practice? Why/why not? • Prompt to discuss sugary foods/drinks (Does anyone have any concerns about sugary foods and drinks?)
	Tooth brushing If not explored earlier Who feels informed about the right way to get your child to clean their teeth?	• Tell me what you think the best advice is? • Do you feel able to put it into practice? Why/why not? • What would motivate you to make sure your child gets into a regular, teeth cleaning twice a day routine?
Finishing up		
1. Ask if we have missed out anything. 2. Is there something we have not discussed		