Oral health in Brighton & Hove

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Part of the Brighton & Hove Joint Strategic Needs Assessment (JSNA)

NHS
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Brighton & Hove
City Council

Oral health in Brighton & Hove

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1 Why is good oral health important?

Oral health refers to the health of people's teeth, gums, supporting bones and the soft tissue of the mouth, tongue and lips. Good oral health is an important part of general health and wellbeing, allowing people to eat, speak and communicate effectively and socialise free from pain, discomfort or embarrassment. Oral health is linked to our overall quality of life, self-esteem, confidence and our overall physical and mental wellbeing.

Oral diseases such as mouth cancer, dental decay (caries) and gum (periodontal) disease are largely preventable. However, despite improvements in general oral health, many adults and children who are vulnerable, disadvantaged and socially excluded tend to have increased oral health issues, higher levels of disease and are more at risk of serious consequences (or death in the case of oral cancer) because of oral disease.

1.1 Children and young people

Tooth decay is the most common oral disease affecting children and young people (CYP) in England, yet it is largely preventable. While children's oral health has improved over the last 20 years, almost a quarter (23.4%) of five year olds still had tooth decay in 2019.[1]

Poor oral health impacts upon children and families' wellbeing. It can lead to absence from school and the need for parents to take time off work to take children to the dentist. Oral health is an integral part of overall health; when children are not healthy it affects their ability to learn, thrive and develop. Good oral health can also contribute to school readiness.[2] Nationally dental extractions due to tooth decay are the top cause of hospital admissions for 6-10year olds.[2]

Poor oral health may be indicative of dental neglect and wider safeguarding issues.[2] The risk factors for poor oral health include a frequent and high sugar diet, which is also common to diabetes and obesity. Topical fluoride such as in toothpastes, varnishes and mouth rinses helps to prevent tooth decay.[2]

1.2 Adults

There are a number of age-related dental problems and complications in later life, including: reduced salivary flow, receding gums, reduced manual dexterity, changes in diet that can increase the risk of tooth decay or loss, as well as reduced mobility making it harder to access dental services.[3]

Nationally adult oral health has been improving over the last 30 years, so that more people are retaining their teeth for longer. This means that many adults will continue to suffer from dental decay and periodontal disease and will have increasing demands for restorative dentistry.

2 Risk and protective factors for poor oral health

Oral health needs to be viewed as an integral part of overall health and wellbeing and not a separate aspect. Poor oral health is caused by unhealthy diets high in sugar, smoking and non-smoking tobacco use, and excessive alcohol consumption. Another risk factor is poor oral hygiene, including the lack of routine dental check-ups. Sunlight, human papilloma virus and immunosuppression can be risk factors for oral cancer.[4]

Regarding risk factors for poor oral health, Brighton & Hove had higher breastfeeding prevalence 6-8 weeks after birth 2019/20 (72%) than England (48%),[5] higher smoking prevalence in 2019 (18% compared with 14%)[6] and more adults who drink over 14 units of alcohol a week (41% of adults in the city), significantly higher than England (23%).[7]

3 Current picture in Brighton & Hove

3.1 Children and young people

The oral health of children in Brighton & Hove is measured through a series of nationally coordinated epidemiological surveys for three, five and twelve year olds. The requirement of positive consent from parents for their children to be part of the survey means the findings should be treated with caution due to the possibility of bias (as well as the small sample size).

Key definitions:

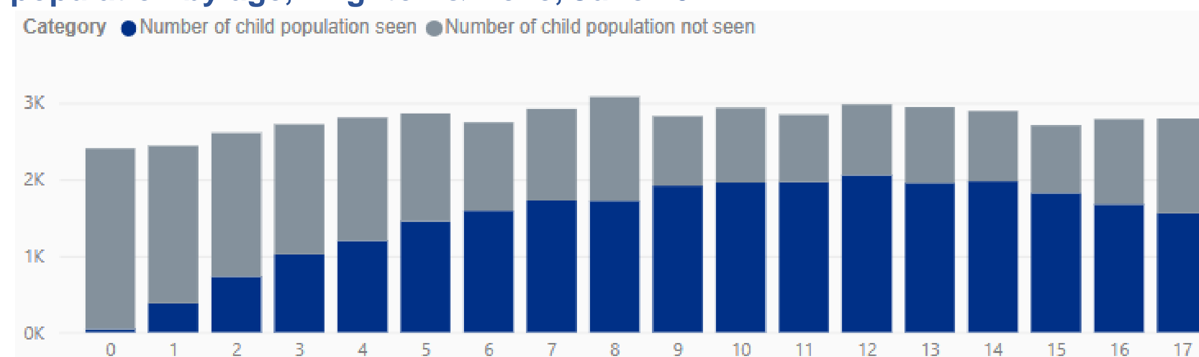
- Mean d3mft – average number of obviously decayed, missing (due to decay) and filled teeth per child
- % d3mft>0 – percentage of children with decay experience
- Care Index % - Proportion of teeth with decay that have been filled

3.1.1 Children seen by a dentist

As at June 2022 53% of children aged 0-17 years in Brighton & Hove had been seen by an NHS dentist in the preceding 12 months, compared to 47% for England. This is an increase from 29% in March 2021 due to the impacts of the COVID-19 pandemic on access to dental care but remains lower than pre-pandemic levels (63% in March 2020).[8] Some children may be seen by a private dentist and therefore not included in these figures.

The numbers of children and young people seen, and not seen, by an NHS dentist by age is shown in Figure 1. Up to the age of six years, more than half of children are not seen by an NHS dentist. Around a third of children and young people aged 9-15 years have not seen an NHS dentist, and this increases to approaching half of those aged 17 years (44%). We do not have this information by area of the city, or demographic factors other than age.

Figure 1: Number of children and young people seen by an NHS dentist and population by age, Brighton & Hove, June 2022



Source: NHS Digital. NHS dental statistics for England dashboard. Available at: [Dentistry - NHS Digital]

The latest published figures for children in care who have had their teeth checked by a dentist was 48% for Brighton & Hove in the year to March 2021, this is higher than England (40%) and similar to the South East (45%). The proportion of children in care who had a dental health check fell significantly during the pandemic, as was seen for the whole population due to less access to dental care – in the year to March 2020, Brighton & Hove had a figure of 86% (the same as the South East and England). Provisional figures for the year to March 2022 show improvement, with 67.5% of children in care having had their teeth checked by a dentist (England and South East figures not available), but not back to pre-pandemic levels.[9]

3.1.2 Dental decay

3.1.2.1 Three year olds survey

The first national three year olds survey was conducted in 2012/13 in nurseries (private and state), nursery classes attached to schools and playgroups, with the most recent survey conducted in 2019/20. In 2012/13, for the first time data was included on early childhood caries. This is an aggressive form of decay that affects upper incisors and can be rapid and extensive in attack. It is associated with long term bottle use with sugar-sweetened drinks, especially when given overnight or for long periods of the day.

In Brighton & Hove, 6.6% of those examined had evidence of decay, compared to 10.7% in England, although none had early childhood caries compared with 3.4% in England (Table 1).[10]

Table 1: NHS Dental Epidemiological Programme for England. 2019/20 Survey of 3 year old children, Brighton & Hove and England

Indicator	Brighton & Hove	England
3 year old population (2019)	2,788	686,135
Examined (number of children)	117	19,479
Percentage of children with decay experience (%dmft>0)	6.6%	10.7%

Mean number of obviously decayed, missing (due to decay) and filled teeth per child (Mean d3mft including incisors)	1.5	2.9
% with incisor caries	0.0%	3.4%

Source: Public Health England. Oral health survey of 3 year old children 2019/20. Child and Maternal Health - OHID (phe.org.uk)

3.1.2.2 Five year olds survey

The most recent data for five year old children is based on the 2018/19 survey. Since the 2011/12 survey the proportion of five year old children in Brighton & Hove with decayed, missing or filled teeth has decreased slightly from 12% to 10%, which is lower than England (23%). The proportion with decayed teeth that have been filled has decreased from 19% to 10%, the same as England (Table 2).[1]

Table 2: NHS Dental Epidemiological Programme for England. 2018/19 Survey of 5 year old children, Brighton & Hove and England

Indicator	2018/19	2014/15	2011/12
Sample	2,932	2,965	2,808
Examined (% of sample examined)	354 (57%)	170 (54%)	87 (55%)
Percentage of children with decay experience (%dmft>0)	10%	18%	12%
Mean d3mft including incisors	2.8	0.4	0.3
Care Index	10%	22%	19%

Source: Public Health England. Oral health survey of 5 year old children 2020.

3.1.3 Tooth extractions in secondary care

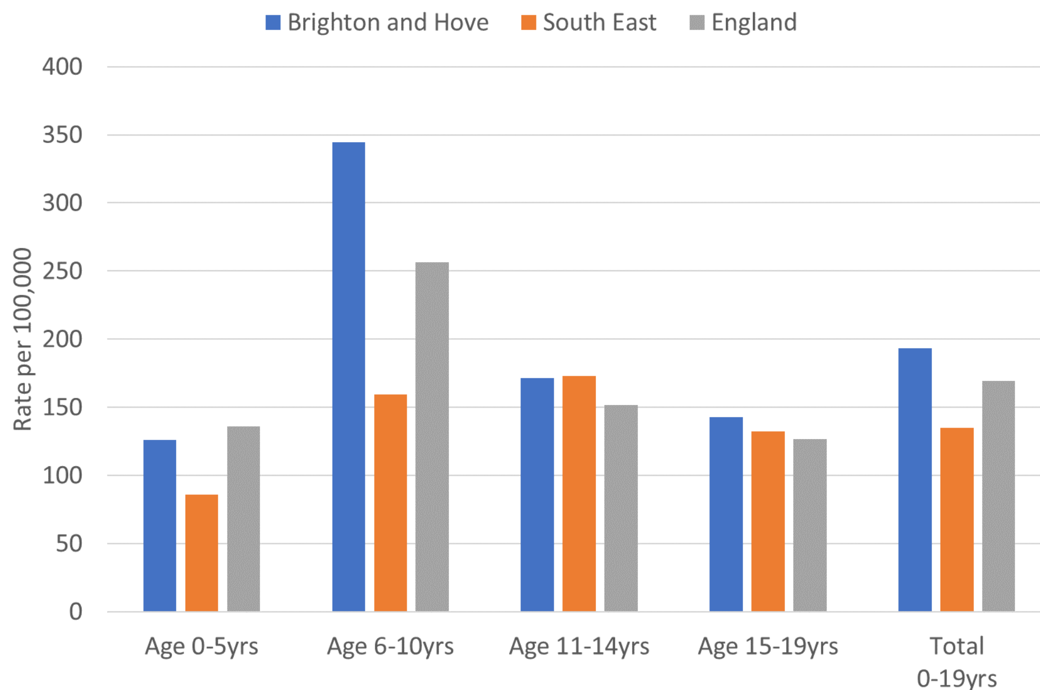
Dental treatment for young children can be challenging and often a general anaesthetic is used to manage to manage children with dental infections. It can also be used to extract decayed teeth due to extensive caries, which is a preventable condition. General anaesthetics take place in hospital and can have a negative impact on the child and their family. They also increase NHS costs. Hospital admission for tooth extraction due to caries is the most common reason for hospital admission in the 6-10 years age group.

In 2020/21, 115 children aged 0 to 19 in Brighton & Hove, were admitted to secondary care for dental extraction, of whom 30% had a primary diagnosis of dental caries.[11] The number of secondary care extractions decreased from 205 in 2019/20, which may have been related to access to dental care during the COVID-19 pandemic but had also fallen from 305 in 2015/16.

Significant inequalities persist, across England admission rates for tooth extraction in the most deprived communities are three times that of those living in the least deprived communities.

Brighton & Hove has a higher rate of children aged 0-19 years having dental extractions in hospital than England and the South East (193 per 100,000 for Brighton & Hove compared to 169 per 100,000 for England and 135 per 100,000 in the South East) in 2020/21 (Figure 2).

Figure 2: Tooth extraction rate (all diagnoses) per 100,000 target population, by age, Brighton & Hove, South East and England, 2020/21



Source: Office for Health Improvement and Disparities (OHID). Hospital tooth extractions of 0 to 19 year olds, 2021. [Hospital tooth extractions of 0 to 19 year olds 2021 - GOV.UK (www.gov.uk)](www.gov.uk)

3.1.4 Local inequalities

Children living in deprived communities have poorer oral health than those living in more affluent communities. They are more likely to eat diets that are high in fat, sugar and salt, contributing to higher rates of dental caries and obesity, as well as Type 2 diabetes, heart disease and cancer.[12]

Whilst children in poverty live across the city, in 2016 there were concentrations of children living in poverty in East Brighton (33%) and Moulsecoomb and Bevendean wards (32%). Child poverty is also more common among Black and Minority Ethnic groups, Gypsies, Roma and Travellers and families with disabilities.[13]

Nationally 5 year old children from Asian, Chinese and Other ethnic minorities have more decayed, filled or missing teeth than children from White and mixed ethnic groups.[14]

3.1.5 Ongoing interventions

General Dental Practitioners have implemented Delivering Better Oral Health and are following the prescribed patient care pathways, including the application of fluoride varnish.

The specification for the 0-19 years Public Health Community Nursing Service includes a requirement for dental care to be included as part of the 2- 2½ years review and for access to dental care to be included in the Reception Years health assessment questionnaire.

Actions to reduce the impact of dental decay in children are being implemented in the city as part of the oral health promotion programme and Public Health Schools Programme. This targets tooth brushing at children's centres, special schools, and early years settings; breakfast clubs and child health clinics. It also provides awareness training for the wider workforce and works with the Public Health Schools Programme to promote oral health.

During the pandemic oral health packs, which include toothbrushes and toothpaste have been distributed to children in a targeted way through Foodbanks and children's centres. The oral health interventions such as toothbrushing schemes have been restarted after being suspended during the pandemic.

3.2 Adults

3.2.1 Adults seen by a dentist

As at 30 June 2022, 80,463 adults (33%) had seen an NHS Dentist in the last 24 months. This is the same as the South East at 33%, but lower than for England (37%), and is in the lower third of all upper tier local authorities nationally.[15] This is a fall from 2019/20 at 42% for Brighton & Hove (South East 43% and England 48%).[16] The fall was very likely due to the ongoing limitations in access due to the Covid-19 pandemic as Dental practices were instructed to close and limit treatment to urgent cases only to reduce the risk of transmission of COVID-19 between the 25th March and 8th June 2020.

In the Brighton & Hove City Tracker Survey 2018, 69% of residents said that they were very or fairly satisfied with NHS dentists. Of those who had used NHS dentists recently, 86% were very or fairly satisfied. Satisfaction varied with age, with 62% of 55-64 year olds, 70% of 35-54 year olds and 67% of 18-34 year olds were very satisfied with NHS dental staff (all respondents).[17]

3.2.2 Dental treatment

Poorer oral health and particularly dental decay is a recognised health inequality as it is strongly correlated with deprivation. People experiencing greater deprivation are less likely to be able to pay for their preventative dental care and more complex treatments compared to those people in less deprived areas. This means that there are areas in the city where the need for dental care and treatment is high, but people are less likely to access it, resulting in apparent low demand for services. This, in turn, may impact on dental service provision reinforcing the inequality and so dental commissioning needs to take an account of deprivation. Issues around non-take up of services and failure to attend dental appointments are well documented in more deprived areas. Oral health promotion services, other health and care services using a making every contact count approach can help address this in part.[18]

Adults may receive dental treatment from three bands of care, each reflecting the complexity of dental care, with band 3 the most complex. Band 1 £23.80 for a basic

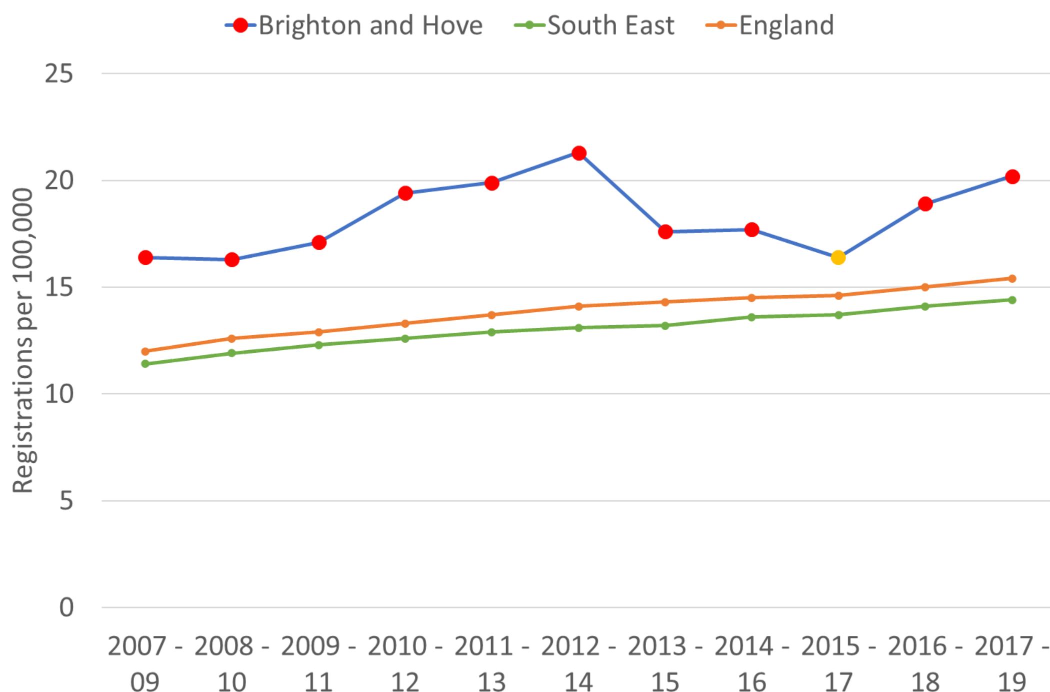
appointment, Band 2 at £65.20 for eg a filling, and Band 3 at £282.90 for eg a crown.[19] Certain groups of people are exempt charges including those on under 18, or under 19 and in full-time education, pregnant or have had a baby in the last 12 months, being treated in an NHS hospital by the hospital dentist (except for dentures or bridges), receiving low income benefits, or under 20 and a dependant of someone receiving low income benefits, pensioner on pensions credits. [20] The socioeconomic impact of the pandemic, subsequent cost of living rises plus higher dental charges and pandemic related delays in attending, directly impacts people just above the exemption thresholds. This will result in poorer oral health and more complex dental treatments for a bigger group of people and broadened the inequality.

Access to dental services and treatments has been consistently lower than the England and regional averages since 2015. The Brighton & Hove rate was marginally higher than the England average during the pandemic but everywhere provision and attendance had fallen significantly.[21]

3.2.3 Oral cancer

Between 2017 and 2019, the age standardised rate for oral cancer registrations per 100,000 population was significantly higher for Brighton & Hove (20.2 per 100,000) compared with England (15.0), with 138 oral cancer registrations in the three year period.[22] This higher rate trend peaked in 2012-14, when it started to fall but has been rising again since 2015-17 (Figure 3).

Figure 3: Oral cancer registrations, directly age-standardised rate per 100,000, Brighton & Hove, the South East and England



Source: Public health profiles - OHID (phe.org.uk)
Key: comparison to England at the 95% confidence level

Better 95% Similar Worse 95%

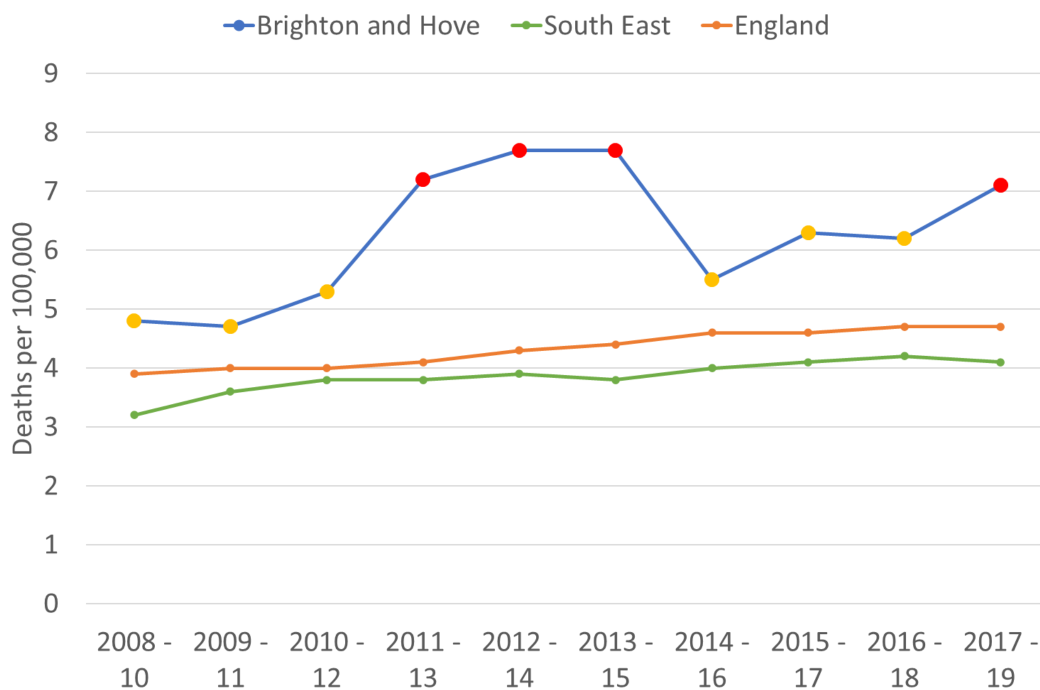
Across England, oral cancer registrations are a third higher in the most deprived areas (decile) than in the least deprived areas (this information is not available for below Brighton & Hove level).

In 2019/20, there were 63 hospital admissions of Brighton & Hove residents for oral cancer.[23]

In 2017 to 2019, Brighton & Hove had a significantly higher rate of oral cancer mortality (7.1 per 100,000) than the South East (4.1) and England (4.7).[24] Brighton and Hove has the highest rate in the South East for upper tier local authorities, and is fourth highest when compared to CIPFA nearest neighbours.

Following falling rates from 2013-2015, rates have been increasing in Brighton & Hove in recent years (Figure 4).

Figure 4: Mortality rate from oral cancer, directly age-standardised rate 100,000, Brighton & Hove, the South East and England



Source: [Public health profiles - OHID (phe.org.uk)]

Key: comparison to England at the 95% confidence level

Better 95% Similar Worse 95%

3.2.4 Local inequalities

There are socio-demographic variations in the distribution and severity of oral diseases with vulnerable groups experiencing significant oral health problems.

There is a lack of local information on adult oral health below city level figures. Most information on adult dental health is provided by the Office of National Statistics decennial Adult Dental Health Survey and some is only available at the national level so an overview for England is given here:

- The most recent survey was undertaken in 2019 and although the latest evidence demonstrates that there have been improvements since 1998, the same evidence identifies a serious underlying issue of social inequalities whilst particularly highlighting the link between poverty and oral health[25]
- The Survey found that very few adults (3%) in England do not have any natural teeth; they are largely to be found among adults aged 75 and over, 19% of whom are edentate. More than four fifths of adults (84%) have 20 or more natural teeth, the number considered to represent functional dentition
- The proportion of adults with no teeth varies according to both household income and area deprivation, and the same is true for the prevalence of functional dentition
- Adults in lower income households and in more deprived areas are more likely to have no natural teeth and less likely to have functional dentition
- Nationally 16-34 year olds have good dental health. 35-44 year olds start to require higher levels of treatment and 45–54 year olds have significant dental needs as fillings need replacing. By 55–64 years complex dental work is required and levels of periodontal disease increase. More of the 65 plus age group will retain their teeth and require complex restoration work; with increasing numbers requiring domiciliary dental care.

Sussex Community NHS Foundation Trust's Oral Health Promotion Team has continued to deliver a comprehensive range of oral health promotion activities to vulnerable adults and training for staff, including online and increasingly in person training. The delivery programme includes targeted interventions with vulnerable adults: people experiencing homelessness, people with learning disabilities, Gypsies, Roma and Travellers, people with substance misuse issues, those with mental health problems and vulnerable migrants. It also includes training in oral health awareness for residential, care home and domiciliary staff, nurses, and Early Years staff. Specific subgroups of the population are covered below:

- People experiencing homelessness
- Black and Minority Ethnic (BAME) groups
- Gypsies, Roma and Travellers
- People with serious mental illness
- People with physical disabilities
- People with learning disabilities.

3.2.4.1 People experiencing homelessness

The life circumstances of people experiencing homelessness can mean they are often those most in need of dental services but can face major barriers to treatment.

These include cost, difficulty keeping appointments, low sense of priority for oral health and a reluctance by dentists to register homeless people who are perceived as problematic.[26]

There has been a sharp decrease locally in the number of recorded rough sleepers in the city. There were 88 in 2019, falling to 37 in 2021 recorded in the rough sleeper count.[27] These figures are likely to be an under-estimate.

The Brighton & Hove Homeless Health Audit in 2014 found that 38% of single homeless participants were registered with a dentist and recommended that access to dental services for homeless people is improved.

The Sussex Community NHS Foundation Trust provides dental services to homeless people. These include a weekly drop-in dental clinic and regular visits by the Oral Health Promotion Team to hostels and homeless day services in the city. However, the dental clinic was suspended during the pandemic and people who are homeless find it extremely difficult to access NHS dental care in the city.

3.2.4.2 Black and Minority Ethnic (BAME) groups

The relationship between ethnicity and dental decay is complex and controversial.[28] Asian adults have been found to have higher levels of gum disease than other ethnic groups.[29] People from Black and Minority Ethnic (BAME) groups are less likely to access NHS dental services with barriers including cost, language problems, and mistrust of dentists as well as cultural and religious influences.[30].

3.2.4.3 Gypsies, Roma and Travellers

The Brighton & Hove Gypsy and Traveller Rapid Health Needs Assessment 2012 identified oral health as a priority health condition in the local gypsy and traveller population, due to a high consumption of fizzy drinks and poor oral hygiene.[31]

3.2.4.4 People with serious mental illness

People with serious mental illness have higher rates of tooth loss, gum disease, dental decay and poorer mouth hygiene than the general population.[32] The city has a higher prevalence of severe mental illness than England.[22]

3.2.4.5 People with physical disabilities

People with disabilities have complex health and care needs associated with poor oral health and less regular contact with dental services.

3.2.4.6 People with learning disabilities

People with learning disabilities have similar rates of decay as the general population, but are less likely to have functional dentition, have poorer oral hygiene, a greater prevalence and severity of gum disease, higher levels of decay, have less contact with dental services and are less likely to clean their teeth twice a day. Those with profound learning disabilities are more likely to have poorer oral health than those with mild learning disabilities.[33]

3.3 Older people

Older people in particular are at risk of poorer oral health. Furthermore, older people living in deprived areas are more at risk of having fewer teeth than those in the least deprived areas.[34]

There are around 39,000 people aged 65 or over in Brighton & Hove, based on 2020 mid-year estimates. This is projected to increase to around 47,600 people by 2030.

Older people living in care homes have higher rates of dental decay than the adult population. In 2022, there were 2,150 registered care home beds in the city provided by 87 residential care / nursing homes.

National evidence has found the main barriers to dental care for older people to be: low user/carer perception of need, living alone, cost of services, patients' gender, lack of education, cultural barriers, lack of dental skills in treating the frail elderly and those with dementia. As well as lack of equipment in care homes, transport difficulties and dental anxiety.[35,36,37]

Evidence from existing surveys in England & Wales has been combined and found:[38]

- Older people living in residential and nursing homes are more likely to have no teeth and less likely to have functioning teeth
- The majority of residents in care homes with teeth have active decay
- Older people living in their own home have higher rates of dental decay than the general adult population but not as high as those in care homes
- Untreated severe decay is more common in the oldest age groups in all settings and higher than the general adult population
- Gum disease is most common 65-84 year olds
- Poor oral health often impacts on ability to eat a healthy diet, confidence to smile and people's self-esteem.[39]

The surveys also found that: older people appeared to have a poorer oral health related quality of life; Care Home Managers found it harder to access dental treatment compared to older people at home; often no regular or emergency dental care arrangements existed for care homes, whose residents would find it difficult to access General Dental Practitioners; little is known about access to dental services for older people receiving care at home services but oral hygiene support from staff is more common in care homes than for those receiving care at home or who are hospital inpatients; staff require training on recognising urgent dental problems and how to access emergency care.

A survey of adults in England aged over 65 years living in supported housing was conducted by Public Health England in 2016 with results also presented at upper tier local authority level (Table 3).[40] This was the first oral health survey of this population group and it has not been repeated so no more recent information is available.

Table 3 shows that in 2016, adults aged over 65 years living in supported housing in Brighton & Hove were much less likely to have seen a dentist in the last 2 years (60% compared to 24% for England). Brighton & Hove was had the highest figure in the country, along with Salford, for the proportion needing urgent treatment (13% compared to 3% for England).

Table 3: Responses on oral health and access to dentists, Brighton & Hove and England, survey of adults aged over 65 living in supported accommodation, 2016

Indicator	Brighton & Hove	England
Not seen a dentist within the last 2 years	59.5%	24.0%
Can't find an NHS dentist	8.0%	7.3%
Edentulous	35.0%	27.0%
With fixed tooth replacement	15.0%	7.5%
With removable tooth replacement	52.5%	53.1%
Full dentures in need of replacement	13.3%	14.8%
Urgent need for treatment	12.9%	3.2%
Require domiciliary treatment	5.1%	5.1%

Source: Public Health England. Oral health survey of mildly dependent older people 2016. Available from: https://www.gov.uk/government/publications/oral-health-survey-of-mildly-dependent-older-people-2016 [Accessed 15/12/2021]

In 2019 Healthwatch visited 20 care homes across Brighton and Hove and spoke to care staff and to residents including frail older people, younger adults, and people of all ages with long-term ill health, Learning Disabilities and mental health conditions. The aim was to understand how staff assessed residents for oral health, whether they assisted residents with cleaning their mouths, including teeth and dentures and whether residents had regular and easy access to a dentist.

Key findings:

- 55% of homes have no visiting dentist but 91% of residents are not well enough to visit a dentist surgery
- 48% of care home staff do not carry out routine oral health checks on admission
- 37% of care home staff have had no training in oral health
- 41% of care home staff did not know if their care home had a policy covering oral and dental health
- Specialist training improves oral health, but is not compulsory.[41]

The Care Quality Commission national review of Oral Health, 'Smiling Matters', found very similar results to the local Healthwatch review in Brighton and Hove. Their main findings:

- The majority (52%) of care homes visited had no policy to promote and protect people's oral health
- Nearly half (47%) of care homes were not providing any staff training to support people's daily oral healthcare
- 73% of residents' care plans we reviewed only partly covered or did not cover oral health at all – homes looking after people with dementia being the most likely to have no plan in place

- 17% of care homes said they did not assess people's oral health on admission.[42]

4 Impact of the COVID-19 pandemic

Dental Public Health research on the impact of the COVID-19 pandemic on oral health inequalities and access to oral healthcare in England shows that inequalities in England are widening.[43] Key findings from the research found:

- People in more deprived areas are more severely affected by the suspension of oral health promotion programmes and reduced access to dental care
- Navigating changes to systems for accessing NHS dental care has also been more problematic for people who were already experiencing disadvantage.

5 What we don't know

In November 2021 Health Watch contacted all NHS dentists in Brighton & Hove and found that none were currently taking on new NHS patients. NHS Dentistry remains the second most common reason why people contact Healthwatch. The impact of the Covid-19 pandemic continues to exacerbate lack of dental access. There is no other recent public voice study available locally.

In the absence of a recent local epidemiological dental survey of adults we do not have up to date local information on the condition of adult teeth in the city. Dental epidemiological surveys and dental activity data does not report by ethnic group, so there is no local data available. There is also no local data available on the prevalence of dental decay amongst people who have a disability, physical health condition, or learning disability of for those with serious mental health problems.

Due to the small sample sizes, we do not have a comprehensive picture of the prevalence of dental caries in five and twelve year olds.

There is no up-to-date local data describing health inequalities in the oral health of children and young people.

6 Key evidence and policy

The most recent oral health evidence and policy guidance can be found at Oral health - GOV.UK (www.gov.uk)

Office for Health Improvement and Disparities and Department of Health and Social Care. Delivering better oral health: an evidence-based toolkit for prevention Delivering better oral health: an evidence-based toolkit for prevention - GOV.UK (www.gov.uk)

Key interventions for improving oral health in children: make fluoride available; healthy eating; tooth brushing schemes in nurseries and primary schools in areas at high risk; oral health promotion incorporated into all children and young people's services, including early years; whole school approach; universal and targeted interventions; oral health promotion training for frontline workers; sugar free medication; promoting the Dental Check by 1 and healthy dental behaviours supported with resources from the Starting Well resource pack.

Information on policies for children's oral health can be found at Oral health - GOV.UK (www.gov.uk)

Key interventions across the adult population include:

- Oral health promotion training for frontline workers so to make oral health part of lifestyle conversations and wider health services using a making every contact count approach
- Ensuring oral health is included in service commissions eg such as weight management, stop smoking support, substance misuse
- Explicitly including oral health as part of work to address health inequalities such as with those experiencing homelessness and rough sleepers
- Working with communities via their trusted voices and VCS partners to deliver oral health promotion and toothbrushing schemes eg with Gypsy Romany Travellers, or vulnerable migrants
- Oral health promotion at community-based events and regular communications campaigns to raise general population awareness of key oral health promotion messages and how to access good dental services
- Ensuring all services supporting older people and those with learning disabilities are training to deliver good oral health promotion and care
- Dental practices to have an oral health and prevention champion. Dental reception staff trained in increasing access for vulnerable groups, ensuring availability of information in easy read and other formats
- All dental staff to be trained in delivering Better Oral Health, Making Every Contact Count[44], reducing inequalities in access/making reasonable adjustments for vulnerable groups.[45]

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