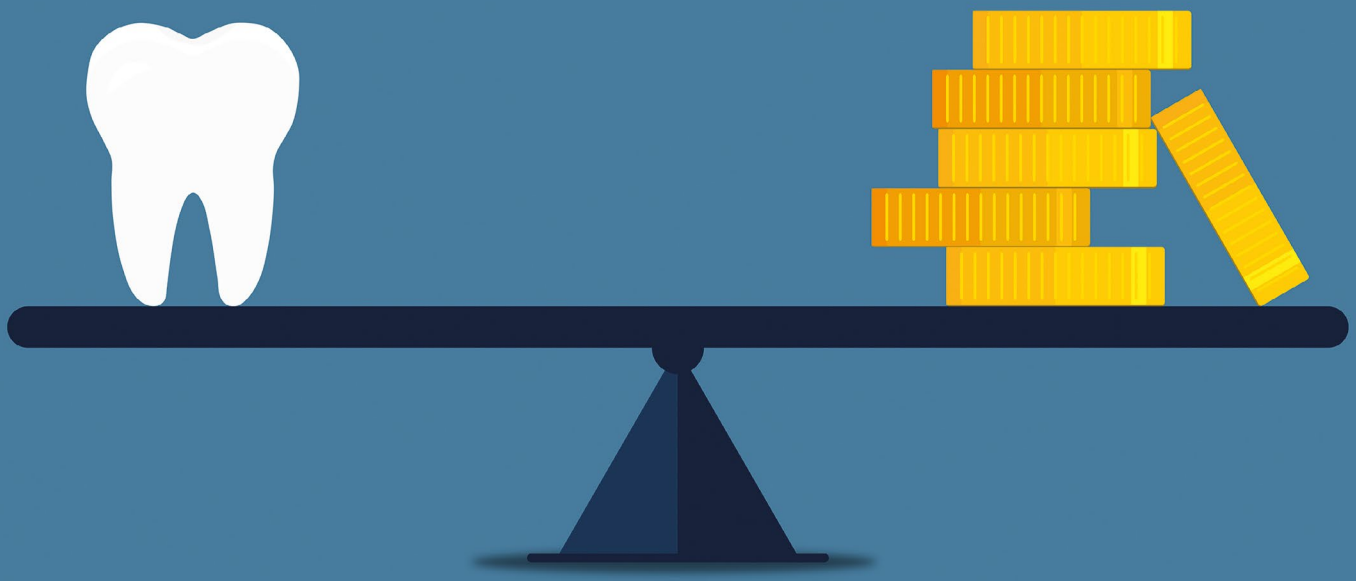

'Make equity a guiding principle of oral care'

In the second part of her series on prevention, **Caroline Holland** learns how deepening inequalities and the aftermath of COVID-19 are reshaping the dentistry agenda, particularly in relation to children.

What is NHS dentistry doing to ensure equitable access to dental services for all? This was the question posed by Nishma Sharma, a Clinical Advisor to the Office of the Chief Dental Officer and Sophia Morris, system clinical lead for health inequalities for mid and South Essex Integrated Care System, writing in the *British Dental Journal*.[1] Describing dental services in England as neither freely accessible nor fit for purpose, their implicit answer on our behalf was 'not enough'.

Their concern is justified. Along with the climate emergency, worsening inequalities are the major healthcare challenges of the post-COVID era. Among the people and organisations advocating for policies to reduce inequalities is Simone Ruzario, a Bedfordshire-based dental therapist. She is Honorary Treasurer of the British Society of Dental Hygiene and Therapy (BSDHT) and is a dental co-lead for Health Pioneers, a charity established to tackle health and education inequalities.

'I want to take things to the next stage, to help reduce inequalities among those who do not cross the threshold of a dental practice. For this group, it's much more complex. It's not just that they live in a deprived area, but they are facing a range of social issues.'

Research undertaken by Professor Wayne Richards, Professor of Community General Dental Practice at the University of South Wales illustrates this complexity. An experienced GDP who spent 40 years in general dental practice, he is on a mission to ensure that the scale of the challenge is understood by commissioners.

His research explores policy issues around inequalities in caries experience in Wales, highlighting that in addition to the social division we all recognise, between the non-deprived and the deprived, there is a sub-group of the deprived who are hardest to reach. It is this cohort that are most likely to need multiple extractions under general anaesthesia.

Like Simone, he recognises that a key behaviour change is to get those who would most benefit from dental care to cross the threshold of the practice. A study[2] by Professor Richards and his collaborators at the University of South Wales (USW) argues for the training of dental teams in managing this cohort of children and their parents to avoid unintended social exclusion.

Simone Ruzario

He observes that 10% of the annual £3 billion NHS for England budget is unspent. 'Dentists are not fulfilling their contracts. It's crazy that money is being handed back when there is such a need to address inequality.'


Nishma Sharma


Sophia Morris


Oosh Devalia

The study sought the views of dentists and their teams on caries in children. The 2006 NHS contract was identified as having created a situation where patients with high needs and more time-consuming management issues, such as anxiety, were excluded from dental services, both unintended consequences.

The contract has possibly been more divisive and challenging in England than in Wales or Scotland. One associate dentist who has been committed to the NHS for 20 years is in the process of reducing their commitment to the NHS because they found they were losing empathy for their patients.

'A high needs patient would come in and I would be paid three UDAs – each worth only £11 to me as an associate – to treat this patient – but the value of the treatment was more than £2,000. My role should be to help that patient, but a total payment of £33 for three hours of my time is not sustainable. The contract was making me lose my passion for caring for my patients. And that's not me, that's not who I am.'

Professor Richards and team have as their declared aim to put equity ahead of equality as a key policy driver in Wales. They recommend:

- A targeted approach based using traditional caregivers so the most deprived sub-group is not stigmatised – for instance educating health visitors to deliver oral health advice
- Development of school toothbrushing promotion as per Childsmile in Scotland and Designed to Smile in Wales.

They also advocate for oral care and prevention in the community, in nurseries and schools for instance. But thorough training should be provided to nursery and primary school staff, so they are knowledgeable and confident.

In October, the Labour Party announced its plans to rescue NHS dentistry. Among their undertakings is a commitment to introduce supervised toothbrushing in schools for 3–5-year-olds, targeted at the areas with highest childhood tooth decay.

> *'There are already successful models which demonstrate that regionalised schemes can work well.'*

There are already successful models which demonstrate that regionalised schemes can work well. The charity Teeth Team in Hull is an outreach programme focused on treating children who are unlikely to step across the threshold of a dental practice. Dental nurses employed by 543 Dental Centre, owned and run by Chris Groombridge and supported by dentists and dental therapists, go out twice a year to each of the 12 schools on behalf of Teeth Team. The dental nurses train teaching staff to manage toothbrushing sessions and each term they provide toothbrushes and toothpaste. The children have bi-annual assessments and where treatment need is identified and the child does not have their own dentist, the charity ensures the children receives it and, where appropriate, fluoride varnish is also applied. All this is done with positive parental consent. Chris said: 'We have had great success over many years. What we are doing is delivering DBOH.[3] We take it off the shelf and make it happen.'

Most recently, Chris has been invited by his regional Integrated Care Board (ICB) to set up a programme on its behalf. CORE20PLUS5 is an NHS England programme to tackle inequalities, delivering additional support to 20% of the most deprived in England in five key areas. Oral health is a priority in the Children's and Young People's (CYP) version of CORE20PLUS5. Chris says his ICB wants prevention, access and treatment delivered to children in their area, starting with Hull and East Yorkshire and is then expanding until the region is covered.

Dr Morris describes the very focused work underway in deprived areas of Mid and South Essex, which have recently been chosen as an NHSE [NHS England] CYP Transformation pilot site. 'We are delivering a two-year pilot, focusing on reducing child oral health inequalities through embedding child oral health interventions within the family hub structure.'

Family hubs are centres in deprived area providing support to families. Dr Morris and her team, including a dentist and a dental nurse, have three community-based steams of work, including supervised toothbrushing and the training of non-dental professionals to help manage the community-based programmes.

She says: 'In Mid and South Essex we are taking a "whole systems" approach; we have three local authorities in our area which are fully engaged with the work we are doing. I am clear that there is a lot that can be done in the community.'

The Child Focused Dental Practice (CFDP) scheme is another example of an innovative approach designed to help the most vulnerable children and young people. Initiated in Manchester (where it was the Child Friendly Dental Practice scheme), it was rolled out as a national pilot by the Eastman Dental Education Centre (EDHEC) with Consultant in Paediatric Dentistry Urshla (Oosh) Devalia as clinical lead. Its over-arching aim was to stop the onward referral of children from a dental practice into secondary care services. In some areas, primary care teams were funded to spend time delivering evidence-based interventions which varied according to the needs of the child. Early


Professor Claire Stevens

indications of the pilot show that the 22 dental practices involved in the programme succeeded in attracting patients from more deprived areas.

It would seem that fluoride varnish (FV) isn't necessarily a key ingredient of a child-focused programme. Professor Claire Stevens, spokesperson for the British Society of Paediatric Dentistry (BSPD), says: 'As a chairside intervention, fluoride varnish application delivers a benefit but in terms of addressing inequalities, it does not have a massive impact. It relies on the child going into the dental practice or for a trained healthcare professional to see the child in another setting, such as a school. Prior to COVID, 40% of children were not seeing a dentist and this has been exacerbated by the pandemic.'

Professor Richards agrees. FV varnish is not essential, he says, for children and young people with minimal caries. The priority should be to ensure the most deprived get access to oral care and preventive advice. He advocates that this cohort of children and young people should have FV placed once they are on a pathway to a mouth free from active disease.

Between 2013 and 2016 he and his colleagues undertook three research projects designed to explain why there is continued social division in the distribution of caries in the child population.

The first of their three studies[4] showed a gap in the knowledge held by lay persons, healthcare professionals and dental professionals. Their other studies explored perceptions of:

- Oral health promotion by school nurses and health visitors which showed weaknesses in their ability to deliver[5]
- Oral health knowledge and practices among parents and teachers and parents of children and, surprisingly, found that parents felt responsible for their child's oral health.[6]

This was one of several misconceptions identified by the team. Another was a belief that all children experienced dental caries, rather than a sub-group. The team also found that patients and their parents were being given ambiguous, unclear and sometimes inaccurate oral health advice.

> *'The challenge in England is to embed oral care more widely into the community, to bring dentistry into the mainstream.'*

Professor Richards added: 'Equity should drive the service. NHS business models need to utilise dental teams to deliver behaviour changes in the patient groups with the greatest need.' He believes that while parents may struggle to get their children to brush their teeth, it is more likely to happen in a classroom due to peer pressure to participate in group activities.

Having explored the relationship between deprivation, dental workforce and oral health, the University of South Wales team concluded that the oral health of a diverse population like Wales cannot be achieved by increasing the dental workforce alone. Targeted approaches and behaviour change are key.[7]

In the most recent update of 'Delivering better oral health' (DBOH),[3] there is a greater focus on behaviour change. This is welcomed by Charlotte Jeavons, president-elect of the British Association for the Study of Community Dentistry (BASCD) and Head of the School of Human Sciences at Greenwich. One of the great strengths of DBOH, she says, is as a repository of the evidence. In 2023, BASCD launched a series of Masterclasses to build awareness of DBOH.

She believes the challenge in England is to embed oral care more widely into the community, to bring dentistry into the mainstream. 'Childsmile is fantastic because it takes clinical care into the community. From a population point of view, this is the way to do it. In England, access to services is patchy and the services themselves are less comprehensive. Patchiness of service provision does not lend itself to addressing inequalities in a comprehensive way.'

Simone Ruzario agrees. 'A whole team approach is essential to tackle inequalities in oral health. It's also a question of working with voluntary and community groups. I think we under-use the voluntary sector to provide access to population groups which do not normally access dental services. There are grounds for optimism that children in deprived communities can and will be reached. Dr Morris again: 'I am optimistic about our work because we have taken a systems approach. We have made it clear that what we are doing is early intervention and prevention and we are talking to commissioners about looking at access.'

This two-part article series was intended as a paean to fluoride varnish and the DCPs who deliver it. But in the process of speaking to key spokespeople and researchers in dentistry, I have discovered that the key challenge today is to drive down inequalities and make equity a guiding principle of oral care. Fluoride varnish has the potential to exacerbate inequalities if it is only applied to children who access routine dental care; so, the priority today, should be targeted approaches, early intervention, and community engagement.

Part 1 of this series, 'The battle to make prevention central to dental care', can be found at: https://www.nature.com/articles/s41407-024-2053-0.

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