Northumberland
County Council

NORTHUMBERLAND ORAL HEALTH STRATEGY AND ACTION PLAN 2022-25

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1. INTRODUCTION

This document supports the comprehensive 2017 Northumberland Oral Health Needs Assessment (OHNA), which provides a full overview of oral health in Northumberland and highlights inequalities and issues for people across the county.

Oral health can be defined as "*a standard of the oral and related tissues which enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment and which contributes to general wellbeing*"[1]. In other words, oral health is an important part of the overall health and wellbeing of individuals, and poor oral health can have a significant impact on many aspects of an individual's life.

Oral health is a key public health issue because of its prevalence, impact on individuals and society, and the expense of treatment from both a medical and wider societal perspective. Tooth decay is largely preventable but it affects a significant proportion of the population. There are also inequalities in good oral health and like many other health issues, poor oral health is more prevalent in more deprived areas. Oral health also places a financial burden on services e.g. latest figures suggest the NHS spends £3.4 billion a year on dental care, including over £50 million for extracting decayed teeth in children[2]. Poor oral health can have an effect on the whole of an individual's life course as, in addition to the obvious pain caused by dental decay in childhood, it also leads to children missing school and a resultant effect on education attainment, parents and carers taking time off work and also poor self-esteem and anxiety as a result of the pain and subsequent treatment and appearance of decaying teeth. Oral health is an important aspect of a child's overall health status and of a child's readiness for school. It is often a marker of wider health and social care issues including poor nutrition and obesity. Oral health is also important in older people because it supports good nutrition and positive health and wellbeing overall.

Dental decay is the most common non-communicable disease worldwide[3]. Dental decay and other oral diseases such as gum disease and oral cancer share common risk factors with several other non-communicable diseases, such as diabetes, cardiovascular disease and chronic obstructive pulmonary disease. These risk factors include unhealthy diet (including excessive sugar intake and sugary drinks) and excessive alcohol consumption. Tooth decay and obesity are also more likely to occur together, given that social deprivation and excess sugar intake are associated with both.

This strategy and action plan is informed by local and national evidence, drawing on the recommendations from the 2017 OHNA; the NICE guidance on oral health for local authorities

[1] Department of Health and WHO definition

[2] Public Health England (2018) https://www.gov.uk/government/publications/child-oral-health-applying-all-our-health/child-oral-health-applying-all-our-health

[3] WHO (2018) https://www.who.int/news-room/fact-sheets/detail/oral-health

and their partners;[4] the NICE guideline on oral health for adults in care homes;[5] and the NICE quality standards on oral health promotion in the community.[6]

2. LOCAL CONTEXT

2.1 Children and young people

Oral health has improved considerably in the UK, with some areas now almost entirely free of dental decay in 5 year olds. However, pockets of inequalities and areas with greater need remain, as seen in Northumberland. Several key indicators are monitored by the Office for Health Improvement and disparities (OHID) on oral health[7,8], and these provide an indication of the current picture in Northumberland. The 2022 Oral Health Survey of five year olds shows that 16.7%% of 5 year olds in Northumberland had experience of tooth decay[9]. This is less than the average for England at 29.3% and less than the North East at 26%. In 2022 five year olds in Northumberland had an average of 0.5 teeth that are decayed, missing or filled (dmft), which is lower than the England and North East averages of 0.8[9]. As the majority of children had no experience of dentinal decay (that is tooth decay through the outer enamel surface and into the dentine layer underneath), it is important to look at the severity of disease in only those children who have experienced dentinal decay. Among these children in England, the mean number of teeth with experience of tooth decay was 3.5. The proportion of teeth with tooth decay which had resulted in tooth extraction in 5 year olds across England was 6.4%. At regional level this ranged from 3.9% in the South East to 13.4% in the North East and in Northumberland was 12.6%[9].

Evidence shows there is a clear link between deprivation and tooth decay. As is the case with general health, there is a a consistent stepwise relationship across the entire social spectrum with oral health being worse at each point as one descends along the social hierarchy, a relationship known as the social gradient[10]. Child poverty has increased in recent years, the proportion of children living in absolute low income families in Northumberland in 2021 was 23.4% (Figure 1). Poverty negatively impacts general health and wellbeing, including oral health.

[4] NICE (2014). Public Health Guidelines [PH 55]. https://www.nice.org.uk/guidance/ph55

[5] NICE (2016). NICE guidelines [NG 48]. https://www.nice.org.uk/guidance/ng48

[6] NICE (2016). Quality Standards [QS139] https://www.nice.org.uk/guidance/qs139

[7] Source: OHID Fingertips Oral Health Profile (accessed 15 December 2022)

[8] Source: OHID Fingertips Child & Maternal Health Profile (accessed 15 December 2022)

[9] OHID: National Dental Epidemiology Programme (NDEP) for England: oral health survey of 5 year old children 2022: https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2022

[10] Sanders A E, Slade G D, Turrell G, John Spencer A, Marcenes W. The shape of the socioeconomic-oral health gradient: implications for theoretical explanations. Community Dent Oral Epidemiol. 2006; 34(4): p. 310-9.

Figure 1. Percentage of children in absolute low income families (under 16s) 2020/21

Area	Value	Lower CI	Upper CI
England	15.1	15.1	15.2
North East region	27.1	26.9	27.3
Middlesbrough	39.2	38.4	40.0
Newcastle upon Tyne	29.9	29.4	30.5
South Tyneside	28.4	27.6	29.1
Sunderland	28.0	27.5	28.6
Redcar and Cleveland	27.7	27.0	28.5
Hartlepool	27.3	26.4	28.2
County Durham	26.4	26.0	26.8
Gateshead	26.3	25.6	26.9
Darlington	25.8	25.0	26.7
Stockton-on-Tees	24.3	23.7	24.9
Northumberland	23.4	22.9	23.9
North Tyneside	21.8	21.2	22.4

Source: The Office for Health Improvement and Disparities

In 2021 to 2022 5 year olds in the most deprived 20% of areas of the country (35.1%) were 2.5 times as likely to have experience of dentinal decay as those in the least deprived 20% of areas[9].

Oral health data for older children is not collected as frequently as it is for 5 year olds. The last national survey of children's teeth, which included 5, 8, 12 and 15 year olds was in 2013. At that time the proportions of children with some untreated decay in their permanent teeth were 21% 15 year olds and 19% of 12 year olds. Free school meal eligibility was used as a proxy measure for deprivation and the data show that children who were from lower income families (eligible for free school meals) are more likely to have oral disease than other children of the same age. A fifth (21%) of the 5 year olds who were eligible for free school meals had severe or extensive tooth decay, compared to 11% of 5 year olds who were not eligible for free school meals. A quarter (26%) of the 15 year olds who were eligible for free school meals had severe or extensive tooth decay, compared to 12% of 15 year olds who were not eligible for free school meals[11]. This is national data, unfortunately we do not have a local breakdown of this.

Tooth decay remains the leading reason for hospitals admissions among 5 to 9 year olds. Data show that hospital admissions for dental decay of children aged 0-5 years in Northumberland was 738 per 100,000[12]. Figure 2 shows that this is the highest rate in the north east and is higher than the north east average. These indicators are important as they provide a direct measure of dental health and an indirect measure of child health and diet

[11] Child Dental Health Survey 2013, England, Wales and Northern Ireland: https://digital.nhs.uk/data-and-information/publications/statistical/children-s-dental-health-survey/child-dental-health-survey-2013-england-wales-and-northern-ireland. Accessed dec 2022.

[12] OHID Fingertips: https://fingertips.phe.org.uk/search/oral%20health#page/3/gid/1938133257/pat/6/par/E12000001/ati/402/are/E06000047/iid/93479/age/247/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0. Accessed dec 2022

overall. Hospital admissions due to tooth decay in children are noteworthy not only because of the significant pain and discomfort in terms of the caries and infection, but also because of the avoidable clinical risks associated with a general anaesthetic and the fact that surgery at a young age can be traumatic. However, for extensive decay in young children, a hospital admission is often the only way to extract the decayed teeth. The only way to reduce hospital admissions in young children is to reduce dental decay.

Figure 2 Hospital admissions for dental caries (0-5 years) 2018/19-21/22 (Crude rate per 100,000)

Area	Value	Lower CI	Upper CI
England	221	218	224
North East region	404	387	422
Northumberland	736	669	816
Newcastle upon Tyne	719	653	791
North Tyneside	449	389	521
Gateshead	432	364	498
Middlesbrough	405	335	471
Darlington	401	329	507
County Durham	368	329	406
South Tyneside	268	210	330
Redcar and Cleveland	267	205	333
Stockton-on-Tees	216	176	268
Sunderland	131	101	164
Hartlepool	105	64	163

A large health and wellbeing survey of Northumberland school children, in both primary and secondary schools, is carried out every two years. These results are from a survey collected in the academic year 2021-2022 from a sample of pupils in year 6 in 29 primary or middle school settings, and a sample of pupils in years 9 and 11 in 5 secondary school settings, in Northumberland. The survey includes some questions about how often children brush their teeth and how many times they had visited the dentist for a check-up and treatment (e.g. filling or a tooth removal). The survey showed that:

- 81% of secondary school children and 75% of primary school children reported brushing their teeth at least twice a day
- 39% of secondary school children and 38% of primary school children report visiting the dentist once in the last year, and 46% and 43% respectively reporting they had visited the dentist twice in the last year. These are lower than the results from the previous survey, however, this may be due to the impact of the coronavirus pandemic.
- 16% of secondary school children and 19% of primary school has not visited the dentist at all in the previous year.
- Children were also asked about their food and drink choices. 31% of secondary school children and 23% of primary school children reported drinking fizzy drinks on a daily basis. Fizzy drinks are often high in sugar and therefore cause decay, however, even

sugar-free fizzy drinks are not good for dental health because they are acidic and can cause tooth erosion (wear).

- Children were also asked about what they eat before school. In secondary school children 4% reported having biscuits, 5% cakes/muffins and 6% chocolate/sweets. Among primary school children there were similar findings, 4% had biscuits, 4% cakes/muffins and 6% chocolate/sweets. This enforces the need for key messages around diet advice and dental health for children and families.

2.2 Oral health and ageing well

Oral health is also a key issue for adults, and the 2017 Oral Health Needs Assessment noted the needs of the older population and the likely increase in the size of this group in the future. In terms of other indicators of oral health, the age standardised oral cancer mortality rate per 100,000 of the population in Northumberland in 2017-19 was 3.4 (i.e. 3.4 deaths per 100,000 of the population each year), which is lower than the England value of 4.7 and the North East value of 6.0[13].

Figure 3 Mortality rate from oral cancer 2017-19 (Directly standardised rate per 100,000)

Area	Value	Lower CI	Upper CI
England	4.7	4.6	4.8
North East region	6.0	5.4	6.5
Middlesbrough	8.9	6.1	12.6
Hartlepool	8.5	5.4	12.6
Sunderland	8.2	6.4	10.5
South Tyneside	8.1	5.7	11.1
Stockton-on-Tees	7.6	5.5	10.3
Redcar and Cleveland	6.8	4.6	9.7
Gateshead	5.8	4.0	8.1
Newcastle upon Tyne	5.8	4.1	7.9
Darlington	5.5	3.3	8.7
County Durham	5.2	4.2	6.5
North Tyneside	3.8	2.4	5.7
Northumberland	3.4	2.4	4.6

Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Registrations Extract and ONS Mid Year Population Estimates

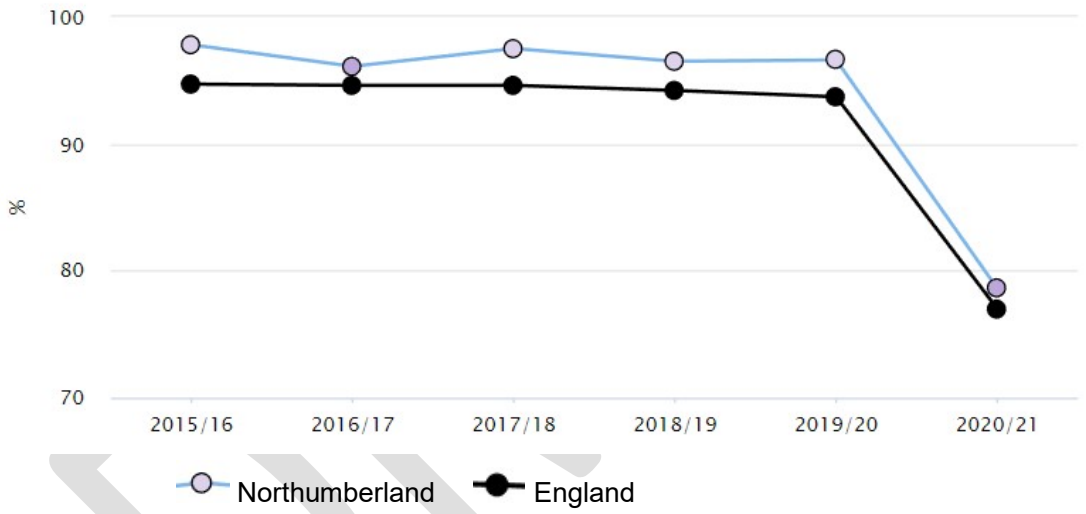
Data are also available on smoking status which is directly related to oral cancer. In 2021 in Northumberland 11.8% of the adult population (aged 18+) are current smokers, this is less than the average for the North East at14.8% and lower than the England average of 13%[14].

[13] OHID Fingertips: https://fingertips.phe.org.uk/search/oral%20cancer#page/3/gid/1/pat/6/ati/402/are/E06000057/iid/92953/age/1/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0 Accessed Dec 2022

[14] OHID Fingertips: https://fingertips.phe.org.uk/search/smoking#page/3/gid/1938132885/pat/6/par/E12000001/ati/402/are/E06000047/iid/92443/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0 Accessed Dec 2022

Data are not currently monitored on how many people are 'registered' with a dentist as the current arrangements do not record access in this way, and dental services are not currently provided on a 'registration' basis in the same way that GP services are. We can look at the proportion of people who are able to get an appointment with a dentist if they want one. In Northumberland in 2020/21 78.6% of the population has successfully obtained a dental appointment, which is slightly lower than the average for the North East at 80.1% but higher than the England average of 77%[15]. This is lower than in previous years and figure 4 shows the impact of the coronavirus pandemic which impacted dental services severely in 2019 and recovery has been slow[14]. The graph shows adults aged 18+, however, access for children followed a similar pattern.

Figure 4 Access to NHS dental services – proportion of adults who successfully obtained a dental appointment from 2015/16 - 2020/21



A 2013 report from PHE[16] noted good access in Northumberland in children followed by a decline in young adults, particularly young males. Despite this, almost 40% of young males accessed dental services in the period under review. Access was noted to increase with middle age and then decline again from the age of 70. The report highlighted geographic inequalities across the county, with less than 40% of the populations of Amble and Wooler accessing a dentist compared to 68% in Hexham West. The report recommended improving access in those areas where uptake was low; and for Northumberland County Council (NCC)) and NHS England to work together to address inequalities. Dentistry access remains a national and local issue in 2022, exacerbated during the COVID-19 pandemic and whilst the sector is still in recovery. Northumberland County Council will continue to monitor the situation and work with partner organisations wherever possible to address any inequalities.

[15] OHID Fingertips: https://fingertips.phe.org.uk/search/dental%20access#page/3/gid/1/pat/6/par/E12000001/ati/402/are/E06000057/iid/92785/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/tre-do-0 Accessed Dec 2022

[16] D Landes **(2013).** Access to NHS Dental Services 2012/2013 - Northumberland Council And Cumbria, Northumberland and Tyne & Wear NHS England Area Team. (Available on request from PHE)

The Organisation of Dental Services

NHS England (NHSE) and NHS Improvement (NHSI) have direct commissioning responsibilities for primary dental and secondary dental care, for the population of England. Dental practices can offer both NHS and private dental care. NHS dental treatment has associated dental charges which will apply unless people are in an exempt group eg pregnant, in receipt of certain benefits such as Income Support.

Specialised dental services are commonly provided by community dental services. This service is also directly commissioned by NHSE and NHSI. Community dental services are available in a variety of places to ensure everyone can have access to dental health. People who may need community dental services include: children with physical or learning disabilities or medical conditions, adults with complex needs. In Northumberland these services are provided by Northumbria Healthcare NHS Trust.

From April 2023 it is expected that NHSE and NHSI will delegate responsibility for commissioning dental services to local Integrated Care Boards.(ICB).

The Local Authority Role

Although not responsible for clinical services, local authorities are statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to an extent that they consider appropriate in their areas.

Northumberland County Council leads a multi-disciplinary, multi-agency steering group which has guided the development of this strategy and action plan. We have developed an action plan to improve oral health across the county using evidence based interventions. There is guidance available to help local authorities in this role eg NICE guidance, and all available guidance has been followed in the development of this strategy and action plan[4,5,17].

Many of the initiatives are already in place across Northumberland to improve the oral health of young children. For example, the 0-19 Public Health Service delivers various sessions at various stages including general education on cups and bottles, dummies and sugary drinks as part of the universal offer and more targeted work like the Wriggly Smile Programme and National Smile Month.

The COVID-19 Pandemic

Inequalities in oral health are evident in the UK across the social spectrum and across the life course largely reflecting the socio-economic inequalities that impact on general health. The COVID-19 pandemic is likely to have widened these inequalities as well as having a direct impact on dental care provision. Health behaviours, which also impact on oral health, such as smoking and alcohol consumption have increased during the lockdown periods associated with the pandemic[18]. During the first lockdown period in England all routine and non-urgent

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17 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf

18 Arora and Grey (2020) Health behaviour changes during COVID-19 and the potential onsequences: A mini-review. Journal of Health Psychology 2020, Vol. 25(9) 1155–1163

dental care stopped as practices were unable to operate safely. Once NHS dental services were restored, uptake of care happened more quickly for adults than children.

Secondary dental care was also affected as general anaesthetic tooth extraction lists in hospitals were cancelled and postponed. There may also be an impact on oral cancer rates. Routine dental examinations allow for screening of the mouth for early signs of oral cancer, however, during the pandemic there has been a decrease in routine examinations and a decrease in urgent referrals for suspected oral cancer[19].

The British Dental Association reported in December 2021 that nearly 1000 dentists left the NHS in the previous year during the pandemic and that over half of dentists they surveyed stated they are likely to reduce their NHS commitment, putting further pressure on the NHS dental system and making it more difficult for patients to get an appointment[20].

Water fluoridation

In the North East of England, the lowest rates of dental decay in children are found in areas such as Hartlepool, North Tyneside and Newcastle. These areas have fluoridated water, either through naturally fluoridated supplies (Hartlepool) or artificial water fluoridation schemes. A lack of fluoride does not cause dental decay but fluoride increases the tooth's resistance against the effects of frequently consumed sugar.

In Northumberland, 135,480 residents received fluoridated water in 2014 and 179,139 were supplied by water that did not contain high enough levels of fluoride to be considered fluoridated. Data presented in the 2017 OHNA highlighted that the rate of dental extractions performed under general anaesthetic on under 18 year olds in 2013-2015 was almost double in areas without water fluoridation compared to those with a fluoridated supply when matched for deprivation decile.

At a population level, water fluoridation is the most effective way of reducing inequalities, as it ensures that people in the most deprived areas receive fluoridated water and it does not require any behaviour change among the population. The Office for Health Improvement and Disparities (OHID) monitor the effects of water fluoridation schemes on the health of people living in the areas covered by these arrangements and reports its findings every four years. The findings of the 2022 health monitoring report are consistent with the view that water fluoridation at levels within the UK regulatory limit (<1.5mg/l) is an effective, safe, and equitable public health intervention to reduce the prevalence, severity, and consequences of dental decay. It reported strong statistical evidence for a clinically significant reduction in dental caries, indicated by prevalence, severity, and hospital admissions for extraction, with increasing fluoride concentration. The greatest benefit was seen in the most deprived areas,

[19]Stennett and Tsakos (2022), The impact of the COVID-19 pandemic on oral health inequalities and access to oral healthcare in England. British Dental Journal volume 232, pages109–114 (2022)

[20] . British Dental Association: https://bda.org/news-centre/latest-news-articles/Pages/England-New-targets-force-more-NHS-appointments-despite-Omicron-wave.aspx

supporting previous conclusions that drinking fluoridated water is an effective public health intervention for tackling dental health inequalities[21].

Water fluoridation should be part of an overall oral health strategy, it is one intervention which should run alongside others, for example, distribution of oral health packs by health visitors. NCC has an oral health promotion strategy which aims to support all residents with their oral health. There is an associated action plan which outlines the interventions in place, these take a life course approach, with a particular focus on those at high risk of dental disease, including vulnerable groups.

Since 2013 local authorities have had the responsibility, through the Water Industry Act 1991, to propose and consult on new fluoridation schemes and variations to or termination of existing schemes. The Health and Social Care Act 2022 transfers the responsibility and powers for water fluoridation to the Secretary of State, which allows central government to directly take responsibility for fluoridation schemes. Final details of how the new process will work have not been released at the time of writing. NCC will continue to monitor the situation and advise and work with partners as appropriate.

3. STRATEGIC OBJECTIVES

The 2017 OHNA made 15 recommendations for Northumberland Council and partnership organisations and these are addressed in this action plan in order to address the oral health needs of Northumberland's population and improve the dental health of all age groups, with a specific focus on those groups identified as having additional needs in the HNA.

This document sets out recommendations to improve oral health and reduce inequalities in Northumberland by endorsing the following four strategic priority areas:

- Giving every child the best start in life and best opportunities for oral health
- Improving the oral health of older people
- Service development and commissioning
- Partnership working

The 2010 report from the Marmot Review (Fair Society, Healthy Lives)[22] remains a key reference source in reducing health inequalities. The document highlighted the differences in health and wellbeing outcomes between people living in the least and most wealthy neighbourhoods. The review advocated a "proportionate universalism" approach whereby health improvement work is universally available, but with an intensity proportional to need. This approach supports work to reduce the gap between the best and worst off, and in reducing the entire social gradient. Drawing on this approach, we should be identifying initiatives which will improve oral health across the county, whilst also targeting some

[21] OHID: Water fluoridation Health monitoring report for England (2022): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1060471/water-fluoridation-health-monitoring-report-2022.pdf

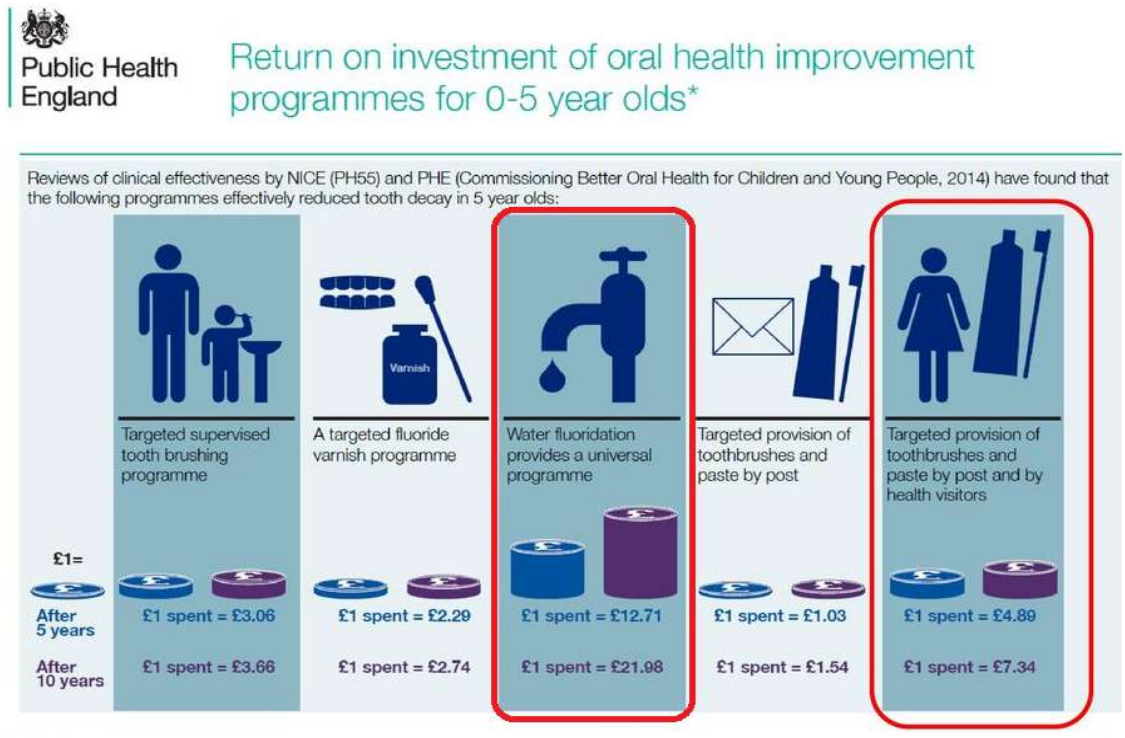
[22] https://www.local.gov.uk/marmot-review-report-fair-society-healthy-lives

interventions in our most deprived communities, who experience the worst oral health outcomes in the county.

As set out in section 2 of this document, Northumberland's children have the highest rates of general anaesthetics for tooth decay in 0-5 year olds in the north east so this age group will be a focus for strategic efforts in 2022-2025. To reduce the number of children who need general anaesthetics to have teeth removed we need to reduce the number of children who need to have teeth removed in the first place through a combination of population and targeted measures.

Many clinical oral health interventions focus on increasing the use of fluoride in children and young people. There is a useful evidence base behind many of these interventions to understand what is cost-effective and provides the best return on investment for local authorities. Figure 5 shows the differences between five interventions and shows that the largest return on investment is from water fluoridation and the targeted provision of toothbrushes and toothpaste. Consideration of both approaches in Northumberland would result in actions at both a population and more targeted needs-based level.

Figure 5 – Return on investment of oral health improvement programmes in under 5s[23]



We are also committed to improving the oral health of older people as part of our ageing well approach. We know that we have a disproportionately older population in Northumberland

[23] Public Health England **(2018) –** Oral health improvement programmes commissioned by local authorities https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/707180/Oral_health_improvement_programmes_commissioned_by_local_authorities.pdf

compared to other areas, and this is expected to increase in the future. Therefore, we will work jointly to improve the oral health of people in residential care and increase awareness of oral cancer in the county.

We have also considered our vulnerable groups in the development of the action plan eg learning disabilities.

In line with NICE guidance, frontline staff working in health, children and adults services should be using every possible opportunity to promote oral health and emphasise the links with general health and wellbeing. If services can help prevent oral disease from occurring in the first place and reduce the burden when it does occur, then the overall health and wellbeing of the population of Northumberland can improve and inequalities reduced.

4. ACTION PLAN

Giving every child the best start in life	
1	Delivery of Oral Health (OH) packs by Health Visitors(HV) at 3-4 month visit to continue as part of universal offer. Consistency of key OH messages delivered alongside distribution of dental packs by HVs.
2.	Develop online access to the Integrated Wellbeing Service children and young people's oral health workbook via Learning Together and develop a workbook/ training resource focussing on adults. Promote and evaluate the Early Years (EY) training programme.
3.	Maintain ongoing assurance of Breastfeeding (Bf) advice including benefits to oral health, delivered by HVs, midwives and EY as part of partnership between NCC and NHS providers. This should include review of Bf policy annually or at appropriate times.
4.	Explore opportunities for supervised brushing in those areas with the highest risk of dental decay.
5.	Work with schools to promote good oral health and develop an oral health promotion campaign, with particular consideration given to special schools eg LD, SEND, those permanently excluded from school (Alternative Provision)
Improving the oral health of older people	
6.	Support residential care settings to improve the OH of residents. Including introducing an Oral Health Lead in every residential care setting and compliance with NICE guidance
7.	To seek to understand provision of domiciliary dental care for those who cannot access care from routine dental practices.
Service development and commissioning	
8.	Ensure that oral health improvement strategies are mandated in all service specifications for appropriate local authority commissioned services for children and older people.
9.	To incorporate oral health training into existing staff training for staff working with Looked After Children (LAC) and foster carers
Partnership working	

10.	To support SoS and national team in the public consultation on Community Water Fluoridation (CWF). CWF remains a critical pillar in the Northumberland Oral Health Strategy.
11.	Through the Northumberland Cancer Strategy, encourage partners to work together to increase awareness in Northumberland residents of oral cancer and the risk factors associated with it, especially for those most at risk (e.g. smokers, those drinking more than 25g alcohol per day and those at increased risk of exposure to Human Papillomavirus).
12.	To refine process for delivery of oral health packs to vulnerable groups, including Foodbanks, and distribution through children's centres/family hubs.
13.	To support Better Health At Work Award (BHAWA). Also, to explore food choices at local authority and community venues to ensure sugar free options available and promotion of plain drinking water (including vending machines).
14.	Work with partners at NHSE/OHID to explore available data on dental contracts to highlight areas in Northumberland at risk of poor access to primary dental care services.
15.	Proactive use of Making Every Contact Count (MECC) to promote oral health. To explore developing an OH MECC for use by frontline staff eg primary care staff including GPs, pharmacists. There should be a focus on vulnerable groups.
16.	Work with Northumbria Healthcare NHS Trust (NHCFT) and Health Education England (HEE) in delivery of OH training for carers of adults with Learning Disabilities.
17.	Undertake regular monitoring and review of the oral health promotion plan to demonstrate progress and determine any additional actions required.