Sunderland City Council

Sunderland

Oral Health Strategy

Contents

Vision

The vision of this oral health strategy is to improve the oral health of all people living in Sunderland. It aspires to promote the best available oral health across the life course, reduce oral health inequalities and lay solid foundations for good oral health throughout life.

Oral health is defined by the World Health Organization as "a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity.

Oral health promotion can be defined as the planned effort to build supportive public policies, create supportive environments, strengthen community action, develop personal skills or re-orientate health and social services in the pursuit of oral health goals. There are shared risk factors for both tooth decay and poor oral health and the major risk factors that cause major disease in our population. These risk factors include a diet high in sugar, smoking and alcohol consumption.

There is a clear causal relationship between deprivation and poor oral health outcomes across all age groups. Oral health inequalities are defined by the Office for Health Improvement and Disparities as 'the differences in oral health between different groups that are avoidable and deemed to be unfair, unacceptable and unjust'.[1] Good oral health is not enjoyed equally across all populations in England, and the impacts of poor oral health disproportionately affect vulnerable and socially disadvantaged individuals and groups.[2]

The 2019 National Dental Epidemiology Programme (NDEP) for five-year-olds showed that 34% living in the 10% most deprived areas of the country and 14% living in the 10% least deprived areas had experienced dental caries.[3] 38% of the variation in prevalence of dental caries and 42% of the variation in severity of dental caries were associated with deprivation. The rate of extractions per 100,000 population varies significantly between area-level socioeconomic groups, with the highest rates seen in the most deprived populations with the rate in the most deprived quintile over three times that of the least deprived quintile. The 2018 survey of adults attending dental practices showed that women had better oral health with respect to all outcomes except tooth loss and oral health related quality of life as compared to men.

There is an increased risk of poor oral health where there is a presence of other risk factors present, including:

- Being socially excluded
- Belonging to a particular minority ethnic group and/or migrant group
- Severe and enduring mental illness and/or a learning disability
- Substance misuse
- Homelessness
- Having limited mobility and/or being disabled
- Having a long-term medical condition
- Being a sex worker
- Being care experienced
- Being older and vulnerable (including adults in care and nursing homes)
- Refugees and people seeking asylum
- Having limited, restricted or no access to dentistry

1 Public Health England (2020) Inequalities in Oral Health in England (www.gov.uk/government/publications/inequalities-in-oral-health-in-England)

2 Public Health England (2020) Inequalities in Oral Health in England (www.gov.uk/government/publications/inequalities-in-oral-health-in-England)

3 Public Health England (2019) NDEP (National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2015 A report on the prevalence and severity of dental decay (publishing.service.gov.uk))

Introduction

What are we striving to achieve?

This strategy aims to improve oral health and reduce inequalities by identifying a range of actions that will support the delivery of five strategic priorities.

The strategic priorities have been developed from what we know works to improve oral health (the evidence base), specialist knowledge and Sunderland's oral health needs assessment (Sunderland's OHNA). As the risk factors for poor health are common to many other diseases, we have placed an emphasis on embedding oral health promotion across a range of local public health programme areas and have also maintained and improved upon specific oral health promotion activities.

Our aim	How we can achieve our objectives
Promote oral health through healthy food and drink	1 Support good oral health by encouraging and enabling healthier food and drink options which reduce sugar in-take
	2 Commission interventions that encourage and support breastfeeding and healthy complementary feeding (weaning)
	3 Promote healthy food and drink that are lower in sugar in settings that the local authority delivers or commissions e.g. leisure, education, social and residential care and local food outlets
Promote oral health by improving levels of oral hygiene	4 Increase the take up of supervised tooth brushing programmes for pre-school and primary school children at high risk of poor oral health
	5 Train front line staff to provide demonstrations on how to clean teeth among those at high risk of poor oral health
	6 Commission programmes that provide free toothbrushes and toothpaste to all pre-school and primary school children, prioritising targeted interventions for those at high risk of poor oral health
Improve population exposure to fluoride	7 Support the Department of Health and Social Care in any future consultation on fluoridation of water
	8 Increase the availability of free toothbrushes and toothpaste to pre-school and primary school children, prioritising targeted interventions such as fluoride toothpaste for those at high risk of poor oral health
	9 Commission targeted/universal fluoride varnishing programmes for young children in areas with high rates of tooth decay

Our aim	How we can achieve our objectives
Improve early detection, and treatment, of oral diseases	10 Maximise all opportunities for signposting to local NHS dental services
	11 Promote the benefits of visiting a dentist throughout the life course
	12 Raise awareness of eligibility for free check-ups, prioritising those at high risk of poor oral health
Reduce inequalities in oral health	13 Look for opportunities to embed oral health promotion within all health and wellbeing policies, strategies and commissioning
	14 Promote targeted oral health promotion activities and interventions among vulnerable groups; young children, children in cared for accommodation, people with diabetes, people who smoke, consume high quantities of alcohol or use drugs, people with a learning disability, older people and migrant/asylum seeker population.
	15 Equip the wider health and social care workforce with the knowledge and skills to recognise the link with neglect and complex social circumstances and ensure provision of care for those at high risk of poor oral health.

Background

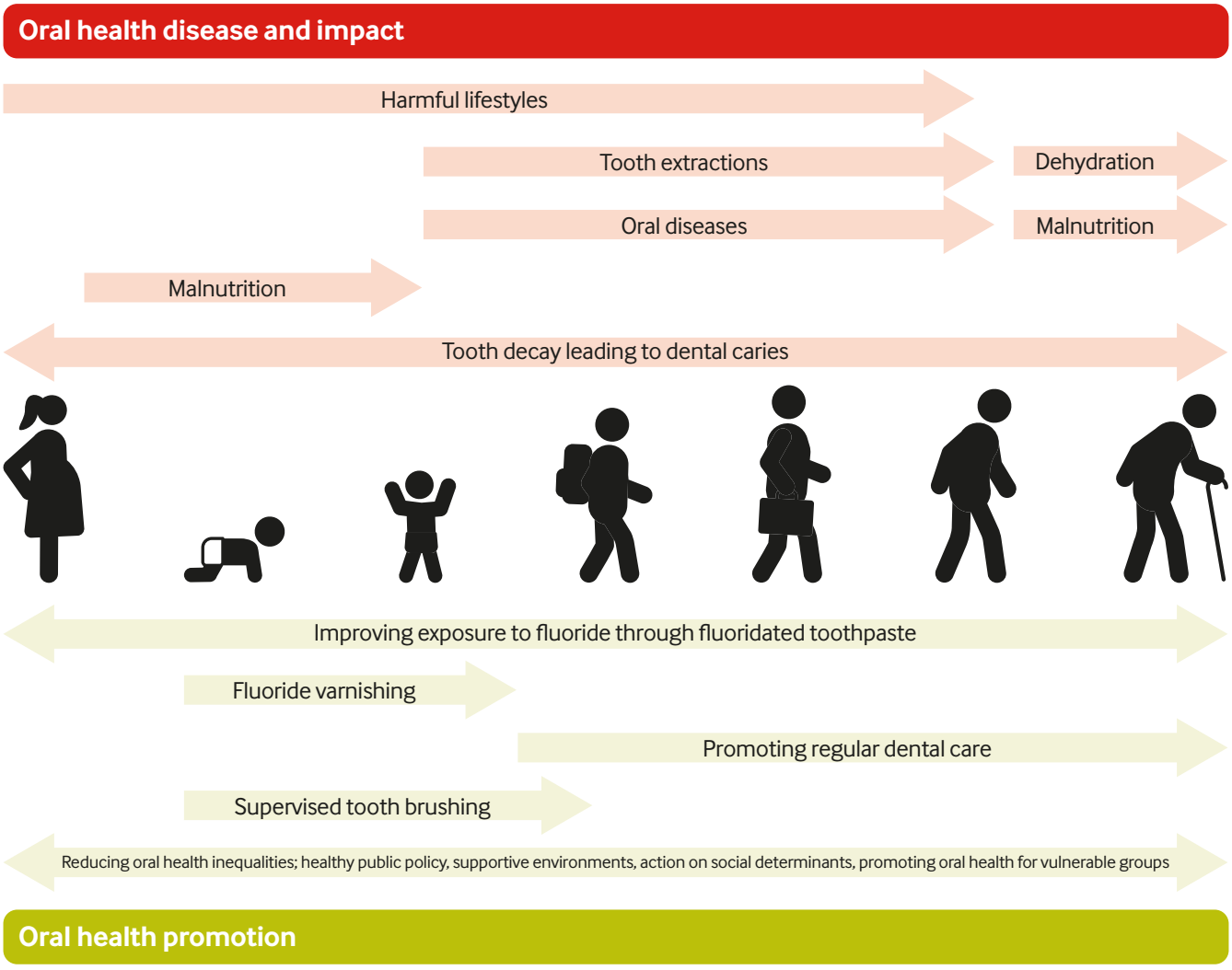
What is good oral health?

Oral health refers to the health of people's teeth, gums, supporting bone and soft tissues of the mouth, tongue and lips. Good oral health is the ability to eat, speak, and socialise without active disease, discomfort or embarrassment. Having poor oral health can exacerbate existing health conditions and impact on people's mental wellbeing due to the experience of pain and limitations in communicating or socialising. Poor oral health can be an indicator of neglect or difficult social circumstances. Good oral health has a significant part to play in maintaining good overall health and wellbeing.

Promoting good oral health throughout life

Different stages of people's lives bring different oral health challenges. It is important that oral health promotion interventions are designed to address changes in need at an individual and population level. A life course approach to identifying need and appropriate timing of promotion of good oral health is summarised in Figure 1 below and described in more detail throughout the strategy.

Figure 1: A life course approach to promoting oral health



Risk factors for poor oral health

Poor oral hygiene from poor tooth brushing, insufficient exposure to fluoride and consumption of a diet that is high in sugar are the main direct risk factors for an individual's poor oral health. The circumstances in which people live and work has a profound effect on their health and wellbeing, including their oral health. The causes of oral diseases, and related inequalities, are therefore mainly social and environmental.

Contributory factors to poor oral health are shared by other major public health concerns; risk factors for obesity include consumption of food and drink high in sugar, while tobacco use, and alcohol consumption are risk factors for gum disease and oral cancer. There is a two-way relationship between gum disease and Type 2 diabetes and an association between human papilloma virus and oral cancer among young people. A common risk factor approach can be applied to the promotion of general health and wellbeing that supports good oral health for people throughout their life i.e., reducing sugar consumption will have a positive impact on tooth decay and obesity, stopping smoking will reduce oral and lung cancer, gum disease and cardiovascular disease.

High sugar consumption

The Scientific Advisory Committee on Nutrition (SACN) advises that 'free sugars'[4] in food and drink should contribute no more than 5% of dietary energy. This is about 30g (about seven teaspoons) of free sugars for anyone aged 11 or older. The current average consumption of free sugars is at least twice the recent 5% recommendation, and three time the 5% value in children aged 11–18. The main sources of our daily intake of free sugars are table sugar, preserves and confectionary (up to 27%); soft drinks, fruit juices and other non-alcoholic drinks (up to 25%) and biscuits, buns and cakes (up to 20%).

Consumption (frequency and quantity) of free sugars is associated with greater risk of tooth decay (dental caries). Tooth decay develops when acid dissolves the enamel surface and the layer under this, dentin; the acid is produced when sugars (mainly sucrose) in food and drink react with bacteria in the dental biofilm (plaque). Tooth erosion develops when acids either consumed in soft drinks, carbonated beverages and fruit juices or gastric reflux entering the mouth wears away the enamel on teeth. The SACN report concludes that reducing consumption of free sugars will help to reduce the risk of dental caries, as well as reducing the risk of diabetes, cardiovascular disease and obesity throughout life.[5]

Exposure to fluoride

Increasing population exposure to fluoride is also a key factor for improving oral health and reducing tooth decay. The main source of fluoride for most people is in toothpaste. Fluoridation of publicly provided drinking water is a safe and effective means of enabling community wide exposure to fluoride used in some areas.

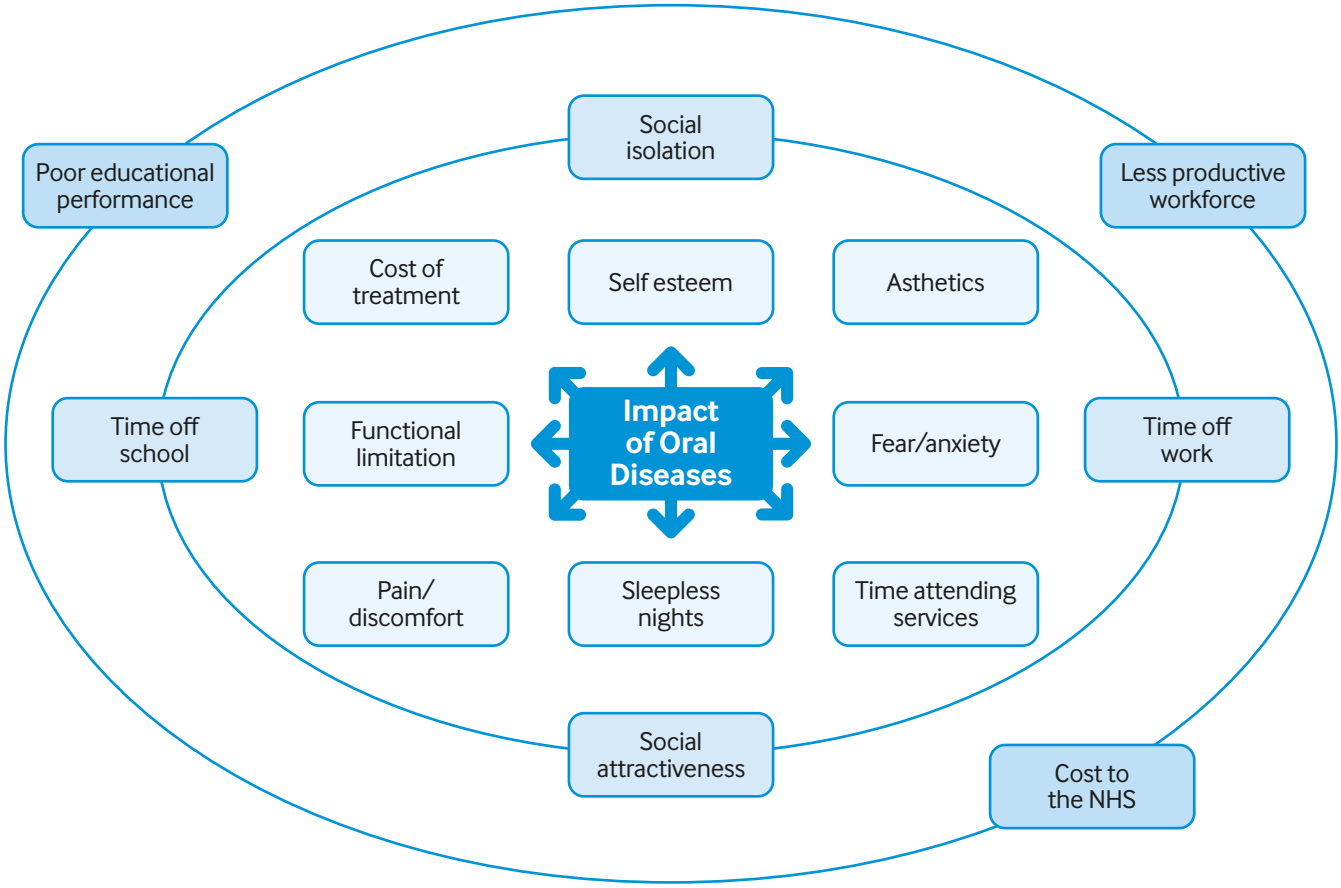
4 Free sugars includes all monosaccharides and disaccharides added to foods by the manufacturer, cook or consumer, plus sugars present in honey, syrups and unsweetened fruit juices. Lactose (milk sugar), when naturally present in milk and sugars contained within the cellular structure of foods (such as fruits and vegetables) are excluded

5 Office for Health Improvement and Disparities (2023). Scientific Advisory Committee on Nutrition (SACN). Available online at: Scientific Advisory Committee on Nutrition (SACN) - GOV.UK (www.gov.uk)

The impact of poor oral health

It is well established that poor oral health impacts significantly on people's physical and mental health, illustrated in Figure 2. The effects of poor oral health are evident across the life course and are described in the following sections.

Figure 2 Impact of oral disease on physical and mental health



Source: Choosing Better Oral Health. Department of Health, 2005 (11).

A 2019 report from Public Health England reported that tooth decay can cause problems with eating, sleeping, communication and socialising, causing over 60,000 days being missed by school-aged children for hospital extractions alone.[6] It can also cause significant pain and discomfort and affect day to day functioning and self-esteem, with adults experiencing poor oral health reporting a negative impact on their confidence and their perceived prospects of gaining employment and being promoted at work.[7]

Poor oral health also disproportionately affects a number of population groups. In older people, including care home residents, poor oral health can lead to pain that significantly affects mood and behaviour, and limits food options due to the impact on chewing and swallowing food which can in turn lead to nutritional deficiency. There is also a clear link between poor oral health and pneumonia in older people, with the risk being greatest when periodontal disease, dental caries and poor oral hygiene are compounded by swallowing and feeding problems.

The cost to the NHS on treating oral health conditions is estimated to be around £3.4 billion per year.[8]

Poor oral health impacts children and families. It affects children's ability to eat, smile and socialise and causes

6 Public Health England (2019) Child Oral Health: Applying All Our Health (www.gov.uk/government/publications/child-oral-health-applying-all-our-health-child-oral-health-applying-all-our-health)

7 Public Health England (2019) Adult Oral Health: Applying All Our Health (www.gov.uk/government/publications/adult-oral-health-applying-all-our-health/adult-oral-health-applying-all-our-health)

8 Public Health England (2019) Adult Oral Health: Applying All Our Health (www.gov.uk/government/publications/adult-oral-health-applying-all-our-health/adult-oral-health-applying-all-our-health) last accessed 1 June 2022

infection with days missed at school, and parents' work, to attend a dental service to receive care. Dental decay is largely a preventable disease.[9]

The impact of COVID-19 and access to dentistry on oral health outcomes

During the first wave of the pandemic in the interest of patient and dental staff safety, routine dental services were paused in March 2020 and urgent dental care centres (UDCs) were established to provide access only to clinically confirmed urgent dental care. In July 2020 all practices gradually re-opened for limited face-to-face care in strict accordance with nationally mandated COVID-19 NHS Dentistry Standard Operating Procedures and IPC constraints. As part of those arrangements' practices were required to prioritise patients based on clinical need and urgency into their significantly reduced safe operating capacity, creating inevitable delays and backlogs over time for patients seeking non-clinically urgent and more routine dental care at that time. As part of those nationally mandated COVID-19 response arrangements practices were provided with income protection but also mandated to operate at significantly reduced and safe levels of face-to-face access levels throughout the prolonged COVID-19 pandemic period.

All dental practices are now able to safely provide a full range of treatment however demand for care remains extremely high with dental practices having to balance addressing the backlog of care with managing new patient demand, whilst also facing workforce recruitment and retention issues which continues to mean a delay in meeting demand for more routine and non-urgent care.

Work undertaken elsewhere in England to quantify the impact of COVID-19 demonstrates that it is significantly likely that measures taken to restrict COVID-19 had, and will continue to have, a detrimental impact on both the immediate and future oral health of the population. Factors that may have affected the oral health of Sunderland residents include:

- For three months at the beginning of the pandemic, no routine care was available
- In the absence of easy access to dentistry during the pandemic, opportunities for routine check-ups and good preventative care were limited for the whole population
- School closures, and other measures to reduce the spread of COVID-19 throughout the course of the pandemic such as limited health visitor home visits for all but the most vulnerable children, meant that many children and young people had no access to preventative and oral health services like supervised tooth brushing and fluoride varnish programmes
- General anaesthetic for dental care was affected by COVID-19 with loss of access to theatre capacity and clinical staff
- The reduction in the administration of general anaesthesia during COVID-19 will have resulted in longer periods of pain and antibiotic use, particularly for groups more likely to require a GA including people with additional needs, learning disabilities and people with dentophobia
- Untreated dental issues during this time would have impacted on whole families in the form of sleepless nights, difficulty concentrating on schoolwork and knock-on stress for parents
- Evidence of an increase in the consumption of sugary food across all age groups during the pandemic increases the risk of dental decay and widens existing oral health inequalities[10, 11]

9 Jackson et al; (2011) Impact of poor oral health on children's school attendance and performance. Available online at: Impact of Poor Oral Health on Children's School Attendance and Performance - PMC (nih.gov)

10 Ruiz-Roso MB, Knott-Torcal C, Matilla-Escalante DC, Garcimartin A et al (2021) COVID-19 Lockdown and changes of the dietary pattern and physical activity habits in a cohort of patients with Type 2 Diabetes Mellitus doi: 10.3390/nu12082327

11 Sylvetsky AC, Kaidbey JH, Ferguson K, Visek AJ, Sacheck J (2022) Impacts of the COVID-19 pandemic on children's sugary drink consumption: a qualitative study 10.3389/fnut.2022.860259

Populations at risk of poor oral health

It is important that universal approaches support and reach the whole population whilst ensuring targeted interventions reach those at higher risk of poor oral health. Those at risk of poorer health are summarised below.

Cared for and cared experienced children

The Children Act 1989 defined Looked After Children (LAC) (also known as Children Looked After) as any child under the care of the local authority or provided with accommodation for a continuous period of more than 24 hours by the local authority. The number of cared for children in the UK has increased over the past 10-years with more children entering than leaving care.[12]

Despite an earlier increase amongst this group having dental check-ups, this number dropped by over 50% in 2020–21 compared to 2019–20; marginal improvements were made in 2021–22 as dental practices recovered from the COVID-19 pandemic. Although general health checks were maintained during the pandemic, the proportion having dental check-ups fell from 86% to 40%.[13]

Cared for children were also identified as an under-researched vulnerable group in the 2021 Public Health England Oral Health Inequalities Report, which only included three peer-reviewed publications, limited grey literature and no evidence from local reports or health needs assessments. This demonstrated a clear research gap.[14]

This particularly vulnerable group of children have high dental needs. Oral health questions are included in the initial and review assessments for this group and they usually attend primary care dental practices to receive treatment. Children may live with foster carers or sometimes in a residential home. It is important that we ensure staff and foster carers are able to promote oral health, support children with their daily mouth care and recognise signs of neglect. Equipping children and young people with oral health knowledge and embedding good oral hygiene practices and habits will benefit them throughout life.

From a total of 499 care experienced children and young people in Sunderland 71% had seen a dentist in the past 12 months. This information includes both children new into care and those already in care who had their health reviewed during this time period. Breaking this data down further shows that those new into care (29%) had seen a dentist in the past year. This is a slight improvement compared to the year 2021–2022 which was 69%.[15]

Data on the number of children registered with a dentist cannot be extracted as this would involve an individual review of 499 records which is not possible. This therefore highlights a gap in data that we do not get a measure of.

Children with special educational needs and disabilities

The needs of this group can vary, some may have social, emotional and mental health needs, whilst others may have more sensory needs. These sensory issues may prevent children and young people from accessing mainstream dental services and impacting on oral hygiene.

Provision of specialist dental health support that encourages dentistry attendance in educational settings is seen as a high priority. Evidence from a national oral health survey of five-year-old and 12-year-old children attending special support schools found that there was greater polarisation of dental decay among children attending special support schools than is typically seen among mainstream educated children. Put simply, fewer children have experience of decay, but those who have tend to have decay more severely, with more teeth affected than mainstream educated children.[16]

12 Department for Education (2022). Statistics: looked-after children. Children looked after in England including adoptions

13 Local Government Association (2022). Number of children looked after who had their teeth checked by a dentist in Peterborough

14 Hurry et al; (2023). The dental health of looked after children in the UK and dental care pathways: A scoping review. Available online at: CDH 00252 Hurry_web.pdf

15 STSFT records data launchpad cared for children team pulled on 18/07/23. Lead Nurse, Children in Care Health Team. Sunderland Children Centre.

16 PHE (2015) Dental public health epidemiology programme Oral health survey of five-year-old and 12-year-old children attending special support schools 2014 A report on the prevalence and severity of dental decay: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774313/Oral_health_survey_for_children_in_special_support_schools_2014_Report.pdf

Learning disabilities

The evidence shows that people with learning disabilities have poorer oral health and more problems in accessing dental services than people in the general population. People with learning disabilities may need additional help with their oral care and support to get good dental treatment because of cognitive, physical and behavioural factors.[17]

Families, carers and staff who provide support to people with learning disabilities should receive oral health training and information to help prepare them to look after the oral health needs of those with learning disabilities.

Migrants and asylum seekers

Migrants, asylum seekers, resettled refugees, and Gypsy, Roma, Traveller community studies have indicated a high prevalence of oral disease and unmet oral healthcare needs in refugees, often exceeding the levels experienced by the most disadvantaged communities of the host country. Most commonly, refugees experience high levels of dental caries, periodontal disease, oral lesions, and traumatic dental injuries.[18, 19]

Similar to the general population, people from migrant communities could be classified into three main groups in terms of their engagement with dental care services:

- People who wish to engage with services and require support to achieve dental fitness
- People who only wish to engage in case of an urgent need/pain
- People who do not wish to engage

When designing dental care pathways, some of the specific barriers for accessing care by migrants can be around:

- Language
- Prior beliefs about oral health
- Anxiety
- Understanding administration including exemption or partial exemption

Homelessness and rough sleepers

People with experience of homelessness commonly suffer from poor oral health and are likely to have low-level engagement with dental services. They may not have access to toothbrushes or toothpaste or facilities where they can clean their teeth. Prioritising shelter, food, financial, health and social issues are likely to be above oral health, however, there is a recognition that this group may have specific oral health care needs.[20]

People using alcohol and drug services

People who have a history of substance use problems are more likely to have poorer oral and dental health generally. This has been linked to a variety of potential contributory factors: smoking and tobacco use, dry mouth due to drug use and lifestyle factors e.g. poor diet often high in sugar, poor personal hygiene, less likely to attend dental appointments. The use of tobacco and alcohol is associated with increased risk of oral cancer.

17 Mac Giolla Phadraig et al (2014), National levels of reported difficulty in tooth and denture cleaning among an ageing population with intellectual disabilities. Journal of Dentistry and Oral Health. Available online at: (PDF) National levels of reported difficulty in tooth and denture cleaning among an ageing population with intellectual disabilities (researchgate.net)

18 FDI (2021) Leave no one behind: what can you do to help improve the oral health of refugees? Available online at: Leave no one behind: what can you do to help improve the oral health of refugees? | FDI (fdiworlddental.org)

19 Microsoft Power BI

20 Paisi et al; 2019. 'Teeth Matter': engaging people experiencing homelessness with oral health promotion efforts. Available online at: PubMed (nih.gov)

Policy context

The last national strategy that was designed to specifically address improvements in oral health was published by the Department of Health in 2005. Public Health England and the National Institute for Health and Care Excellence (NICE) have published toolkits and a number of evidence-based guidelines to support local authorities to improve the oral health of their populations. The responsibility of local authorities to conduct oral health surveys are carried out as part of the Public Health England (PHE) dental public health intelligence programme (formerly known as the National Dental Epidemiology Programme). The various NICE guidance documents on oral health covers both good practice and the clinical effectiveness and cost effectiveness of interventions for improving dental health, especially for local communities and residents in a close setting at greater risk of poor oral health, such as care homes and prisons.

Publication	Year	Summary
Choosing Better Oral Health: an oral health plan for England (Department of Health)[21]	2005	Focus on actions to address oral health inequalities, and social determinants of oral health, with six key areas for action: increasing the use of fluoride, improving diet and reducing sugar intake, encouraging preventive dental care, reducing smoking, increasing the early detection of mouth cancer, and reducing dental injuries.
Delivering Better Oral Health - an evidence-based toolkit for prevention (Public Health England)[22]	2017 (updated in 2021)	Evidence summary for interventions includes minimum concentrations of fluoride in toothpaste to prevent dental decay, advice on daily toothbrushing, and the important role of fluoride varnish as part of clinical activity to prevent tooth decay. 2021 update includes new guidance for brief interventions for dental professionals that bring positive oral health behaviour change, with a focus on good oral hygiene, optimising exposure to fluoride, reducing sugar consumption and encouraging healthier eating, stopping smoking and reducing the harm related to alcohol consumption.
Local authorities improving oral health: Commissioning better oral health for children and young people – an evidence informed toolkit for local authorities (PHE)[23]	2013	Includes the guiding principles of commissioning oral health services; evidence of effective oral health promotion interventions; recommendations regarding taking a life-course and integrated approach, partnership working, and putting children and young people at the centre of commissioning oral health services.

21 Department of Health (2005). Choosing Better Oral Health: an oral health plan for England (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH412321)

22 Public Health England Delivering Better Oral Health : an evidence based toolkit for prevention (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605 266/Delivering_better_oral_health.pdf)

23 Local authorities improving oral health: commissioning better oral health for children and young people: summary version (publishing.service.gov.uk)

Commissioning better oral health for vulnerable older people - an evidenced-informed toolkit for local authorities (PHE)[24]	2018	Covers a range of commissioning options that are supported by evidence including the daily use of higher fluoride toothpaste, the quarterly application of fluoride varnish, support with maintaining oral hygiene, staff training, protocols for oral care in care settings, routine denture identification marking, promoting dietary change in community settings, outreach and comprehensive geriatric assessment in primary care for older people living independently.
Improving oral health: a community water fluoridation toolkit for local authorities [25]	2020	A toolkit that outlines the role of fluoridation of water in local oral health improvement strategies – the document covers changes at a population level that do not focus on individual behaviour change.
NICE guidelines PH55: Oral health improvement for local authorities and their partners [26]	2014	Describes ways to improve oral health by improving diet and oral hygiene, and access to dental services. It recommends incorporating oral health promotion in existing services for all children, young people and adults at high risk of poor oral health.
NICE guidelines NG48: Oral Health for adults in Care homes NG48[27]	2016	Supports oral health for adults in care homes by recommending policies on oral health that are developed and followed. It advises residents to have their mouths assessed on their admission and that care plans are put in place which include daily mouth care. Staff should have the knowledge and skills to support people's oral health and undertake or support daily mouth care.
NICE Quality standard QS139L Oral health promotion in the community	2016	Covers activities undertaken by local authorities and general dental practices to improve oral health. It focuses on people at high risk of poor oral health or who find it difficult to use dental services. It describes high-quality care in priority areas for improvement.

Compliance with guidelines around maintaining or improving oral health in care homes is often assessed by the Care Quality Commission. A national report[28] showed that the awareness of the guideline recommendations was low amongst care home staff, and not all care home residents were supported to maintain good oral health. The report further showed that only around half of the care homes had provided training to their staff on supporting residents with their oral care. An oral health care home audit is currently being undertaken in Sunderland to review compliance with guidance and good practice, and there is a commitment to ensuring that all care homes within the local authority include oral hygiene and mouth care in the care plans of all residents. The care home audit should be available to review in September 2023.

24 Commissioning better oral health for vulnerable older people - GOV.UK (www.gov.uk)

25 Improving oral health: a community water fluoridation toolkit for local authorities (publishing.service.gov.uk)

26 Overview | Oral health: local authorities and partners | Guidance | NICE

27 Overview | Oral health for adults in care homes | Guidance | NICE

28 Smiling matters: oral health in care homes (2016) Smiling matters: oral health care in care homes - Care Quality Commission (cqc.org.uk)

The local authority role – policy context

The Health and Social Care Act (2012) amended the National Health Service Act (2006) to confer responsibilities on local authorities for health improvement, including oral health improvement, in relation to the people in their areas.[29]

Local authorities are statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas. They are also required to provide or commission oral health surveys to facilitate assessment and monitoring of oral health needs and the planning and evaluation of oral health promotion programmes and dental services.

There is guidance to help local authorities in providing their oral health function. In 2014 Public Health England published a toolkit to help local authorities fulfil their oral health responsibilities.[30] NICE also have a quality standard relating to oral health promotion in the community and there is NICE guidance[31] which covers improving oral health by developing and implementing a strategy that meets the needs of people in the local community. The NICE guidance makes 22 recommendations, and it is the aim of this oral health strategy to address local need and meet these recommendations.

As well as NICE guidance this strategy also draws upon the Joint Strategic Needs Assessment for Sunderland and the Oral Health Needs Assessment. Other policies including Commissioning Better Oral Health for Children and Young People, Delivering Better Oral Health and the PHE oral health return on investment have also been used to develop this strategy and action plan.

Links to other national and local strategies

Oral diseases share many risk factors with other chronic diseases. For example, excess sugar in the diet is a risk factor for tooth decay and in obesity; alcohol is a risk factor in many cancers including oral cancer and smoking is the main cause of lung disease and periodontal (gum) disease. Therefore, this strategy supports national strategies such as the Government food strategy 2022 and smoke free England ambitions. It also supports and is supported by local strategies.

The Healthy Weight Programme and obesity

High sugar diets can lead to tooth decay, sometimes so severe that treatment is tooth removal. Eating too much sugar can also contribute to people having too many calories, which can lead to weight gain. Being overweight increases risks of health problems such as heart disease, some cancers and type 2 diabetes.

There are increasing levels of childhood obesity in Sunderland and prevalence of childhood obesity (reception and year 6) is greatest in areas with highest levels of deprivation. The prevalence of overweight (including obesity) in Sunderland is persistently higher than England with a high maternal BMI being a risk factor for both maternal and infant health.[32]

Sunderland Smokefree Partnership Action Plan

Smoking is a major risk factor for gum disease and mouth cancer.

Smoking prevalence in Sunderland is on a downward trend, with a rate of 15.2% recorded in 2022 which equates to approximately 34,000 smokers. However, there are significant geographical differences across the city, with

29 Legislation.gov.uk (2012). Health and Social Care Act 2012. Available online at: Health and Social Care Act 2012 (legislation.gov.uk)

30 PHE (2014), Local authorities improving oral health: commissioning better oral health for children and young people. Available online at: ttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf

31 NICE (2014) PH55, Oral health: local authorities and partners: https://www.nice.org.uk/guidance/ph55

32 Sunderland City Council (2023) Healthy Weight JSNA. Available online at: Healthy Weight JSNA (sunderland.gov.uk)

smoking rates higher in areas with the highest levels of deprivation. In addition, in a recent Health Equity Audit, it was estimated (using the ONS Annual Population Survey 2021) that smoking rates are higher amongst males (17%) than females (13.5%) and that smoking rates are higher amongst those within the mid-age categories (35 to 54-year-olds).[33]

Some populations have been identified as having higher smoking prevalence including those in routine and manual occupations with Sunderland rates high at 28.9%, compared to a regional average of 26.1% and England average of 24.5%. The ALS also highlighted adults with a learning disability (26.7%) reported significantly higher smoking prevalence than the Sunderland average. Those with mental health conditions have significantly higher smoking rates than the general population and smoking in pregnancy is a high-risk cohort.

Reducing tobacco prevalence is a key priority for the Sunderland Health and Wellbeing Board, with an agreed HWB aspiration to work towards reducing adult smoked tobacco in Sunderland to below 5% by 2030 and the Sunderland Smokefree Partnership, a multi-agency group, lead on achieving this strategic vision, in particular targeting those high prevalence and high risk populations.

Sunderland Alcohol Strategy

Alcohol is a risk factor in oral cancer as well as other cancers and chronic conditions and people involved in substance misuse usually have high dental needs.

Hospital admissions for alcohol-related conditions (broad) were at 2,668 (episodes per 100,000) for Sunderland for 2021/22 (North East average 2,323, England, 1,734) an increase on the previous year figure (longer term trend comparison is not applicable due to changes in how the statistics have been compiled).

Alcohol is a complex issue within our society and no single approach will be successful in isolation. Alcohol remains one of the key drivers of health inequalities and one of the key causes of premature death and therefore it requires commitment and contribution from a range of partners across the city. Our recently published partnership alcohol strategy, 'Calling Time: It's time to rethink drink' was launched to coincide with Alcohol Awareness week in July and has three key objectives:

- Objective 1- Prevention and early intervention
- Objective 2 - Providing specialist interventions to promote a quality treatment and recovery system.
- Objective 3 - Protecting children, young people and families from alcohol related harm.

The strategy is supported by an action plan that coordinates the ongoing work to reduce alcohol harms. This includes the expansion of the Alcohol Care Team within the trust, the review of the Statement of Licensing Policy, the funding of dedicated posts within the treatment and recovery system and the promotion of alcohol harm awareness raising initiatives and campaigns.[34]

Sunderland substance misuse JSNA

Many drugs can cause a craving for sugar, such as sweets and fizzy drinks, which can cause tooth decay. These drugs can also cause you to have a dry mouth which causes reduced saliva flow in the mouth which can lead to tooth decay and gum disease.

The Government's 10-year drug strategy from Harm to Hope, which was published in 2022, estimated that over 300,000 people are using heroin and crack cocaine in England. This is the biggest section of the illegal drugs market with an estimated value of £5.1 billion a year. The use of these drugs is thought to be linked to around half of all theft, burglary and robbery with, on average, people with dependency issues using drugs on 251 days of the year at a cost of £12,538.[35]

33 Sunderland City Council (2019). Smokefree Action plan. Sunderland Smokefree Partnership Action Plan

34 Sunderland Alcohol Strategy (2023). Available online at: FINAL_ALCOHOL_STRATEGY2.pdf (sunderland.gov.uk)

35 Department of Health and Social Care (2022). From Harm to Hope strategy. Available online at: From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)

Ageing well JSNA

Embedding oral health as an integral part of general health and wellbeing is important to ensure that older people can live happy, healthy, and connected lives for as long as possible.

Legislative measures to improve oral health

Obesity and soft drinks levy

The Childhood obesity plan and the Soft Drinks levy to tackle childhood obesity – Eating too much sugar can also contribute to people having too many calories, which can lead to weight gain. Being overweight increases risks of health problems such as heart disease, some cancers and Type 2 diabetes. Fizzy drinks are a source of sugar in many children's diets, and reducing the sugar content of these drinks will impact on oral health. However, switching to diet or sugar-free fizzy drinks is not the answer, the fizz in sugar-free drinks is still acidic, and can cause tooth erosion, so it's much better to switch to tooth-friendly alternatives like water or milk.

Planning system to control takeaways in Sunderland

The health of people in Sunderland is varied compared with the England average. Sunderland is one of the 20% most deprived local authorities in England and about 26% (12,600) of children live in low-income families. Life expectancy for both men and women is lower than the England average. Obesity is one of our most significant and complex challenges, undermining individual and family health and wellbeing, impacting on business and education, and contributing to significant costs across health, social care and a wide range of services.[36]

Public Health England estimated in 2014 that there were over 50,000 fast food and takeaway outlets, fast food delivery services, and fish and chip shops in England. More than one quarter (27.1%) of adults and one fifth of children eat food from out of-home food outlets at least once a week. These meals tend to be associated with higher energy intake, higher levels of fat, saturated fats, sugar, and salt, and lower levels of micronutrients. A recent study shows that the exposure to takeaway food outlets was positively associated with consumption of takeaway food.[37]

There are two specific Sunderland Local Plan policies proposed within the draft Core Strategy and Development Plan which cover hot food takeaways. Policy HWS1 indicates that the council will seek to improve health and wellbeing within the city by managing the location and number of, and access to, unhealthy eating outlets. Policy EP12 seeks to restrict the number and concentration of hot food takeaways within designated centres in order to protect their vitality and viability. Following the recommendations of the Health Impact Assessment for the Plan, representations received during the consultation on the draft Core Strategy and Development Plan, and discussions with public health partners, it has been deemed appropriate to include further guidance within the Plan on how the council will seek to restrict access to hot food takeaways in order to promote positive health outcomes.[38]

36 Public Health England (2017) Sunderland Health Profile. Available online at: E08000024 (phe.org.uk)

37 The British Medical Journal (2014) Associations between exposure to takeaway food outlets, takeaway food consumption, and body weight in Cambridgeshire, UK: population based, cross section. Available online at: Associations between exposure to takeaway food outlets, takeaway food consumption, and body weight in Cambridgeshire, UK: population based, cross sectional study | The BMJ

38 Sunderland City Council (2018) Public Health Evidence in relation to the use of the planning system to control hot food takeaways (April 2018). Available online at: oce21157 14 Public Health Evidence in relation to the use of the planning system to control hot food takeaways Report Cover A4.qxp (sunderland.gov.uk)

Oral health in Sunderland

Sunderland has a population of 274,171 (Census, 2021). Compared to England, the population of Sunderland has a higher proportion of older people. 20.5% of the population are aged 65 and over, higher than England at 18.4%.[39]

Tooth decay in children

Although oral health is improving in England, the oral health survey of five-year-olds in 2022 showed that nationally almost a quarter have tooth decay and in Sunderland it is 25.6%.[40] Each child with tooth decay will have on average three to four teeth affected.

Table 1: Percentage of five-year-olds with experience of visually obvious dental decay 2021–22

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	23.7	23.3	24.0
North East region	–	-	22.2	20.8	23.8
Middlesbrough	–	-	31.2	26.2	36.6
Gateshead	–	-	30.5	24.6	37.3
Sunderland	–	-	25.6	20.5	31.6
Darlington	–	-	24.8	19.7	30.8
Redcar and Cleveland	–	-	24.6	19.5	30.5
Newcastle upon Tyne	–	-	22.2	18.0	26.9
Hartlepool	–	-	21.0	16.7	26.1
South Tyneside	–	-	20.4	15.6	26.3
County Durham	–	-	20.3	15.4	26.2
Stockton-on-Tees	–	-	17.3	13.2	22.3
Northumberland	–	-	16.7	11.9	22.9
North Tyneside	–	-	16.6	12.7	21.4

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children (Biennial publication - latest report 2022) https://www.gov.uk/government/collections/oral-health#surveys-and-intelligence:-children

39 Sunderland Data Observatory (2023). Population report for Sunderland. Available online at: Population - UTLA | Sunderland

40 OHID Fingertips: https://fingertips.phe.org.uk/search/oral%20health#page/3/gid/1/pat/6/par/E12000001/ati/402/are/E06000047/iid/93563/age/34/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

The number of teeth affected by decay among five-year-olds is shown in Table 2. In Sunderland children had on average just over one tooth (1.1) with tooth decay or that had been filled or extracted.

Table 2: Mean decayed, missing or filled teeth in 5-year olds 2018–19[41]

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	0.80	0.78	0.81
North East region	–	-	0.82	0.75	0.89
Middlesbrough	–	-	1.68	1.31	2.05
Gateshead	–	-	1.15	0.78	1.51
Sunderland	–	-	1.10	0.80	1.40
Darlington	–	-	1.01	0.71	1.31
County Durham	–	-	0.81	0.58	1.04
Newcastle upon Tyne	–	-	0.78	0.61	0.95
Stockton-on-Tees	–	-	0.74	0.51	0.97
South Tyneside	–	-	0.73	0.46	1.00
Northumberland	–	-	0.68	0.48	0.87
Gateshead	–	-	0.58	0.40	0.77
Hartlepool	–	-	0.50	0.29	0.71
North Tyneside	–	-	0.41	0.28	0.55

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2019

Tooth decay can start early in life, and much earlier than age 5. In fact, as soon as first teeth start to appear in the mouth they will be susceptible to decay if the conditions promote decay, for example, high sugar diets. Survey data for 3 year olds shows that in 2020 in Sunderland 21.7% of 3 year olds had visually obvious tooth decay (see Table 3), ranked the highest level in the North East. In comparison Northumberland ranked the lowest at 6.4%.

This shows there is a real concern for the oral health of Sunderland's population and suggests an urgency to implement oral health promotion to those in most need and reinforces the need for early intervention to give children the best start in life.

Table 3: Percentage of three-year-olds with visually obvious tooth decay 2019–20

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	10.7	10.3	11.2
North East region	–	-	10.4	8.9	12.1
Sunderland	–	-	21.7	15.5	29.5
Gateshead	–	-	18.4	12.5	26.3
North Tyneside	–	-	16.3	8.6	28.7
Middlesbrough	–	-	14.9	9.3	22.9
County Durham	–	-	11.5	6.4	19.7
South Tyneside	–	-	9.9	5.9	16.2
Hartlepool	–	-	8.5	5.7	12.3
Newcastle upon Tyne	–	-	7.8	2.6	21.4
Darlington	–	-	7.8	4.9	12.1
Stockton-on-Tees	–	-	6.6	3.6	11.7
Northumberland	–	-	6.4	2.6	15.1
Redcar and Cleveland	–	-	*	-	-

Source: Dental Public Health Epidemiology Programme for England: oral health survey of three-year-old children 2020

The number of teeth affected by decay among 3-year-olds is shown in Table 4. In Sunderland children had on average 0.79 teeth with tooth decay or that had been filled or extracted. This is more than twice the average seen in England at 0.31 and the North East at 0.32.

41 Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children (Biennial publication - latest report 2019).

Table 4: Mean decayed, missing or filled teeth in 3-year olds 2019–20

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	0.31	0.30	0.33
North East region	–	-	0.32	0.25	0.38
Sunderland	–	-	0.79	0.49	1.09
Middlesbrough	–	-	0.72	0.27	1.17
North Tyneside	–	-	0.61	0.00	1.57
Gateshead	–	-	0.37	0.21	0.53
County Durham	–	-	0.35	0.07	0.64
South Tyneside	–	-	0.23	0.08	0.38
Hartlepool	–	-	0.20	0.08	0.32
Darlington	–	-	0.20	0.08	0.31
Stockton-on-Tees	–	-	0.18	0.01	0.34
Northumberland	–	-	0.12	0.01	0.23
Newcastle upon Tyne	–	-	0.10	0.00	0.22
Redcar and Cleveland	–	-	*	–	–

Source: Dental Public Health Epidemiology Programme for England: oral health survey of three-year-old children 2020

There is less data available for older children. The National Children's Dental Health Survey has been carried out every 10 years since 1973. It includes data on children aged 5, 8, 12 and 15 years, and reports on a dental examination and questionnaires for parents and 12- and 15-year-olds. The last survey took place in 2013. In 2013, nearly a half (46 %) of 15-year-olds and a third (34%) of 12 year olds had "obvious decay experience" in their permanent teeth. This was a reduction from 2003, when the comparable figures were 56% and 43% respectively.

Hospital admissions for tooth removal

The extraction of carious teeth has become the most common reason for hospital admission of under-18-year-olds in England. Tooth removal in hospital is usually provided under general anaesthetic. Despite an overall improvement in recent years, the available evidence indicates that oral health improvement programmes implemented at primary care level have not improved the oral health of children in a number of clearly defined local areas, mostly in northern England. Young children in these areas are now three times more likely than children in other parts of the country to be referred to hospital for tooth removal. Hospitals have faced unprecedented pressure due to the COVID-19 pandemic, increasing the burden on NHS services and resulting in long waiting lists for treatments, including tooth removal.

Table 5 shows that for the period 2018/19 – 2020/21 Sunderland's hospital admissions rate for tooth decay requiring tooth removal for 0–five-year-olds was 131 per 100,000. Although this is lower than the average for the North East region and significantly lower than its neighbours, these children are still receiving a general anaesthetic, which has inherent risks, for what is a preventable disease. At the same time, we must ensure that all children requiring this treatment are receiving the dental care they need.

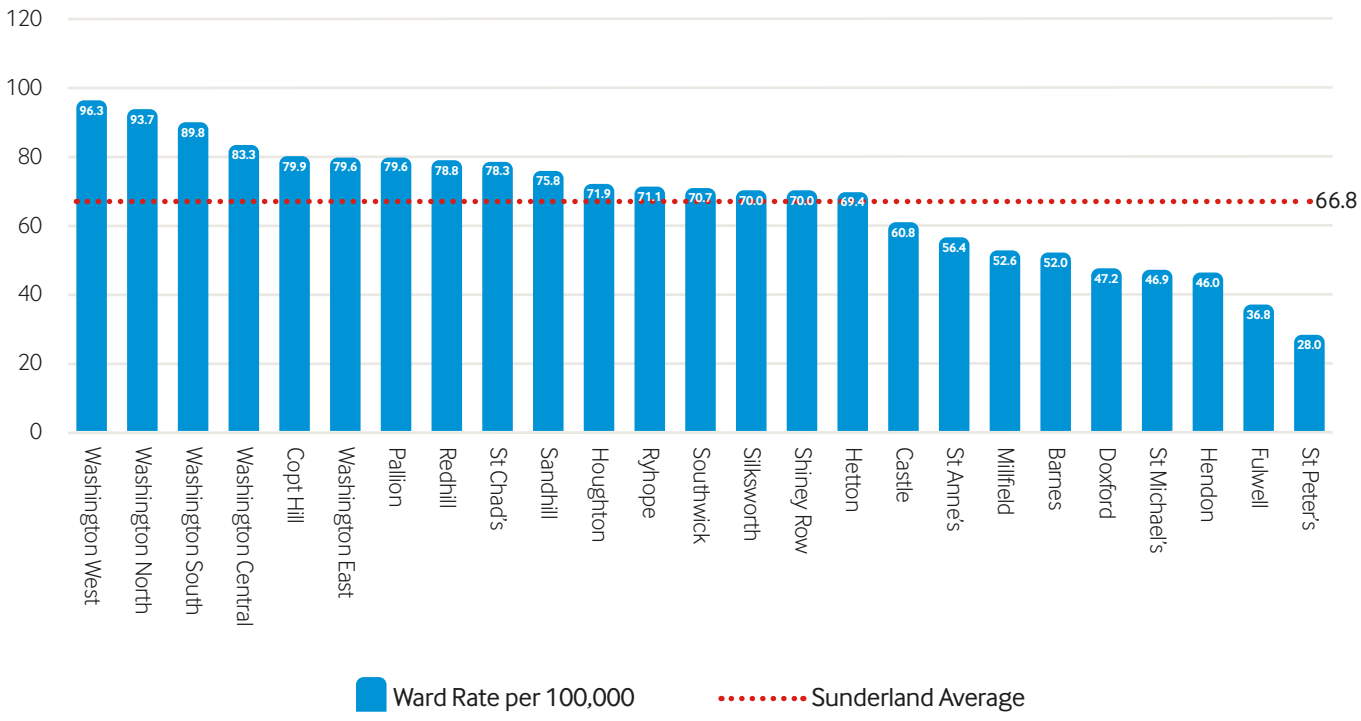
Table 5: Hospital admissions for dental caries in children aged 0-5 years, 2018–19 - 2020–21 (Crude rate per 100,000)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	26,427	220.8	218.1	223.5
North East region	–	2,080	403.8	387.0	421.9
Northumberland	–	395	736.1	668.8	816.3
Newcastle upon Tyne	–	430	719.4	653.0	790.8
North Tyneside	–	185	448.8	388.7	520.9
Gateshead	–	165	432.1	363.9	497.7
Middlesbrough	–	140	404.6	335.0	471.1
Darlington	–	85	401.6	329.0	506.6
County Durham	–	355	368.2	328.9	406.4
South Tyneside	–	80	268.2	209.7	330.3
Redcar and Cleveland	–	70	267.0	204.8	333.1
Stockton-on-Tees	–	90	216.2	176.0	268.3
Sunderland	–	70	131.1	100.5	163.5
Hartlepool	–	20	105.3	64.3	162.7

Source: Hospital Episode Statistics (HES) Copyright © 2022, Re-used with the permission of NHS Digital. All rights reserved.

The number of teeth affected by decay among three-year-olds is shown in Table 4. In Sunderland children had on average 0.79 teeth with tooth decay or that had been filled or extracted. This is more than twice the average seen in England at 0.31 and the North East at 0.31.

Figure 3: Dental Caries Admissions by Ward in Sunderland 2018–19 to 2022–23



Oral health in adults and older people

The 2021 Adult Oral Health Survey (AOHS) was carried out in February and March 2021 with a representative sample of adults in England aged 16 and over. Women were more likely than men to have needed treatment or advice: 37% of women, compared with 33% of men. The need for dental treatment or advice increased with age, from 22% of those aged 16 to 24 years to 45% of those aged 75 years and over. More than half (56%) of adults who reported that their oral health was bad or very bad felt that they needed treatment or advice, compared with 42% of those with fair oral health and 30% of those who reported that their oral health was good or very good.

The proportion of adults who needed help due to toothache or pain increased from 27% among those in the fifth of households with the highest incomes to 40% among those in the lowest income quintile. Adults in the two highest income quintiles were more likely to report that they did not have a problem but wanted a check-up (30% in each quintile) than those in the lower income quintiles. This proportion was lowest (17%) among those in the lowest income quintile.

Figure 4 shows the number of patients seen (adult) in the 24 months leading up to 30 June 2022. The percentage of adults seen in Sunderland compared to the rest of England is higher with a difference of 7%.

44.4% of adults in Sunderland received NHS dental care in the 24 months to the 30 June 2022, compared to 37.4% for England. The number of adult patients seen increased towards the end of 2019 to 131,000, having remained stable at around 116,000 for the previous two years (rolling 24-month period). Since the start of the Covid pandemic there was a steady decline in the number of patients seen.

Figure 4: Sunderland residents in receipt of NHS dental care

Around 8,300 people are diagnosed with mouth cancer each year in the UK, which is about 1 in every 50 cancers diagnosed.

More than two in three cases of mouth cancer develop in adults over the age of 55. Cancer registrations for Sunderland for the period 2017-19 were 20.7 per 100,000, this is higher than both the North East and England average.[42]

42 OHID (2019) Public Health Profiles Oral Cancer Registrations 2017–2019. Available online at: OHID (phe.org.uk)

Table 6: Mortality rate from oral cancer, all ages 2017-19 directly standardised rate per 100,000[43]

Over the last decade in the UK (between 2003-2005 and 2012-2014), oral cancer mortality rates have increased by 20% for males and 19% for females.[44] Five-year survival rates are 56%. Most oral cancers are triggered by tobacco and alcohol, which together account for 75% of cases.[45] Cigarette smoking is associated with an increased risk of the more common forms of oral cancer.

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	7,445	4.7	4.6	4.8
North East region	–	476	6.0	5.4	6.5
Middlesbrough	–	33	8.9	6.1	12.6
Hartlepool	–	24	8.5	5.4	12.6
Sunderland	–	67	8.2	6.4	10.5
South Tyneside	–	38	8.1	5.7	11.1
Stockton-on-Tees	–	42	7.6	5.5	10.3
Redcar and Cleveland	–	31	6.8	4.6	9.7
Gateshead	–	35	5.8	4.0	8.1
Newcastle upon Tyne	–	40	5.8	4.1	7.9
Darlington	–	18	5.5	3.3	8.7
County Durham	–	85	5.2	4.2	6.5
North Tyneside	–	24	3.8	2.4	5.7
Northumberland	–	39	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

The risk among cigarette smokers is estimated to be 10 times more than that for non-smokers. More intense use of tobacco increases the risk, while ceasing to smoke for 10 years or more reduces it to almost the same as that of non-smokers.[46] Oral cancer mortality rates can be used in conjunction with registration data to compare survival rates across areas of England to assess the impact of public health prevention policies such as smoking cessation.

It is difficult to gather information on the oral health of our more vulnerable older adults. The CQC reviewed the state of oral health care in care homes across England in 2019 and found that improvements were needed to maintain good oral health for older people in care homes.[47] The report made several recommendations including the need to implement NICE guidelines, training for staff, assessment and daily mouth care for residents and better documentation and record keeping of oral health care delivered.

National outcome measures

There are three national outcome measures specifically about oral health.

The Public Health Outcomes Framework[48] has a single oral health outcome measure that measures the level of tooth decay in children aged 5yrs.

The NHS Outcomes Framework[49] has two outcome indicators:

3.7.i Decayed teeth - this indicator measures improvement of quality of life for people with dental disease, comparing improvement in oral health over long periods of time for people who regularly visit the dentist.

3.7.ii Tooth extractions due to decay in children admitted as inpatients to hospital, aged 10yrs and under - this indicator measures tooth extractions in children, which in many cases can be prevented with good, early, preventative dentistry.

43 OHID (2019). Mortality rates from oral cancer 2017-2019. Available online at: OHID (phe.org.uk)
44 Cancer Research Campaign (2000). Cancer Statistics: Oral – UK. London
45 Blot et al;1988. Smoking and drinking in relation to oral and pharyngeal cance
46 La Vecchia et al; 1997. Epidemiology and prevention of oral cancer.
47 CQC (2019), Smiling matters, oral health care in care homes: https://www.cqc.org.uk/sites/default/files/20190624_smiling_matters_full_report.pdf
48 Public Health Outcomes Framework - GOV.UK (www.gov.uk)
49 NHS Outcomes Framework (NHS OF) - NHS Digital

Sunderland's performance against these outcome measures is discussed in the following section titled 'what we are currently delivering'

What are we currently delivering?

Current oral health promotion services in Sunderland

Growing Healthy Sunderland (GHS) - Growing Healthy Sunderland provides an integrated Public Health service for expectant mothers, children and young people and their families in the city.

The oral health team facilitate a wide range of free oral health training packages to health and social care professionals including health visitors, school nurses, nursery nurses, childminders, Children Centre staff, and staff caring for vulnerable groups and patients with special care needs. The oral health team attend regular events, interacting with a variety of population groups to educate on the importance of good oral health. They also participate in national campaigns such as National Smile Month.[50]

There is an oral health action plan in place covering workforce training, dissemination of oral health messages, and implementation of tooth brushing scheme to early years settings in key localities using data from 0-5s registered with dentists. Local service data captured by GHS has demonstrated a decline in the number of children aged 0-5 years registered with a dentist. The average percentage registered in 2020–21 was 52.6%, latest available data for quarter 3 of 2021–22 shows a reduction to 44%.

Through the GHS service the Health Visiting Service discuss oral health at mandated visits (six–eight weeks, 12–15 months, two–two and a half years, three–four years) and encourage dental registration.

GHS Service also provide supervised tooth brushing in schools - The supervised toothbrushing programme is an evidence-based programme which is just one of our public health interventions that has successfully continued to be delivered into schools and nurseries throughout the Sunderland area. It is a good example of collaborative working between colleagues in education, local authorities, oral health promotion team, parents/carers and the children themselves.

Every school and nursery that takes part in the toothbrush bus programme is supported by a designated Oral Health Practitioner. This support includes monitoring, evaluation, and stock replenishment, a dental health talk to the children, parents and staff training. Positive parental consent is mandatory for participation in the programme and consent rates across Sunderland are above 99%. There are a total of 22 schools/nurseries participating in the programme. All venues participating in the supervised brushing programme have had supervised brushing support via telephone or face-to-face.

Elderly population - There is a pilot planned where the focus is on targeted fluoride varnish in five residential homes, delivered by South Tyneside and Sunderland Foundation Trust.

50 NHS Harrogate and Districts NHS Foundation Trust (2023). Oral Health Promotion Team. Available online at: Harrogate and District NHS Foundation Trust (hdft.nhs.uk)

Partnership working

Local authorities have an important role to play in the promotion of good oral health. Health and education programmes as well as social care services managed by local authorities reach much of the population. Local authorities, Integrated Care Boards, dentists and dental care professionals will need to align their efforts to broaden the reach of oral health promotion within communities. This will include commissioning of services and programme management to achieve the strategic goals by implementing the objectives of this strategy. Support should be sought from the Health and Wellbeing Boards for each local authority area.

Improving oral health requires embedding oral health promotion within a wide range of health and social care strategies, policy, programme design and delivery mechanisms, key areas are outlined below.

Local authorities

Key responsibilities include:

- Ensure oral health is considered as a key component of the Health and Wellbeing Strategy for example, through broader goals such as reducing health inequalities, giving every child the best start in life and by improving the quality of life for adults and older people
- Ensure oral health needs of local populations are articulated in chapters of each local authority Joint Strategic Needs Assessment
- Ensure all service specifications include training for frontline health and social care staff on oral health promotion
- Ensure all health and social care service specifications maximise opportunities to promote oral health

Local authorities and Integrated Care Boards

Policy and strategy development and the commissioning of services are often developed in collaboration among organisations. Key areas for partnership working include:

- Review all health and wellbeing and disease prevention policies for opportunities to include oral health promotion through integrated activities
- Ensure all jointly commissioned service specifications include oral health promotion
- Commission training for all frontline health and social care staff working with high risk groups
- Consider commissioning tailored services for vulnerable groups
- Review all early years' services to provide oral health information, advice and services including tailored advice for high risk groups
- Encourage and support breastfeeding
- Raise awareness of oral health by working with occupational health and human resources of all public sector employers

Challenges moving forward

Dental workforce recruitment and retention

General recruitment issues attracting new dentists into NHS Dentistry due to a range of issues including but not limited to; difficulties securing GDC and Performers List registration for overseas dentists, Dental Student and Foundation Dentistry Places being limited nationally and dentists not perceiving working within the current NHS Regulatory arrangements as being attractive in terms of pay, conditions, work life balance etc. This creates difficulties for NHS dental practices locally and nationally to maintain and/or replace the level of clinical workforce they need in order to reliably deliver their full NHS dentistry capacity as they continue to try to fully recover from COVID-19 pandemic impacts.

Access to dental services

There appears to be a crisis of access in NHS dentistry. Many people are unable to access an NHS dentist or are travelling significant distances to get to one. Access varies across the country and is being experienced unequally by different groups. Lack of access is impacting on the wider resources and places further pressure on the NHS, for example with patients developing conditions like diabetes, sepsis or oral cancer as a result of lack of routine care and treatment. Being unable to see a dentist at routine intervals can also have implications for wider oral, physical health, mental health and social wellbeing.

A lack of public awareness about NHS dental services and how practices operate is contributing to access issues.

The dental contract

Fundamental reform of the dental contract is essential and must be urgently implemented, not only to address the crisis of access in the short-term, but to ensure a more sustainable, equitable and prevention-focused system for the future.

Integrated Care Systems

The dental profession should be represented on Integrated Care Boards to ensure they have the necessary expertise to inform decision-making around contracting and flexible commissioning. This should include wider engagement with the profession locally, for example through Local Dental Committees and Local Dental Networks.

In light of the current national contracting arrangements, NHS England must provide clarity to Integrated Care Boards (ICB) about what flexibilities they have with regard to commissioning NHS dental services and targeting resources according to the needs of their populations.[51] ICBs have been delegated responsibility for commissioning dental services by NHS England. They offer an opportunity to improve access locally, better integrate services around patients and address inequalities.

Limitations of epidemiological and NHS data

Variations in oral health were not reported in epidemiological surveys and registers across all dimensions of inequality. For example, variation in oral health diseases by area deprivation was not reported in the 2009 adult dental health survey. Furthermore, there was no information describing variations in oral health by ethnicity, pregnancy and maternity, religion or homelessness in the 2009 adult dental health survey or the 2009 oral

51 House of Commons Health and Social Care Committee (2023). NHS Dentistry. Available online at: NHS dentistry (parliament.uk)

health surveys of adult subgroups. Prisoners were not included in these surveys. None of the adult dental surveys reported on trends in oral health inequalities. Variation in oral cancer by socioeconomic position, protected characteristics (except sex) or vulnerability types was also not reported in the cancer registers. With respect to children, there was no information describing variations in oral health by religion or vulnerability types in any of the children's surveys.

Variations in dental service commissioning, delivery and utilisation were not reported across all dimensions of inequality. For example, no information was available of such variations by the majority of protected characteristics (for example, disability, pregnancy and maternity, religion) or vulnerability types. Additionally, no data was available from the private dental sector or on inequalities in access to specialised care (apart from hospital tooth extraction).

In terms of recommendations, future epidemiological surveys should endeavor to report on variation in oral health across additional dimensions of inequality and data should be collected to enable trends of oral health inequalities amongst adults to be determined. Future NHS data should include information on variations by different dimensions of inequalities in relation to general and specialised care. A system should be set to collect data from the private dental sector.

Glossary

Populations at high risk of poor oral health

The term 'high-risk groups' refers to groups in which high levels of oral disease are seen, compared with the national average. It includes 'vulnerable 'populations that may have relatively low levels of disease but for whom poor oral health has more serious consequences.

Examples include: people living in relative social deprivation, people who are homeless, traveller communities and older people who are frail but living independently in the community.

People at high risk of poor oral health generally, but not always, live in areas that are described as socially and economically disadvantaged. Local authorities (and other agencies) define disadvantaged areas in a variety of ways. An example is the government's Index of Multiple Deprivation 2010 (ID 2010).

This combines economic, social and housing indicators to produce a single deprivation score. See 'Indices of English deprivation 2010' Department for Communities and Local Government (2011).

Free sugars

Free sugars includes all monosaccharides and disaccharides added to foods by the manufacturer, cook or consumer, plus sugars present in honey, syrups and unsweetened fruit juices.

Lactose (milk sugar), when naturally present in milk and sugars contained within the cellular structure of foods (such as fruits and vegetables) are excluded.

Oral health

Oral health refers to the health of people's teeth, gums, supporting bone and soft tissues of the mouth, tongue and lips. Oral health is 'a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity."(WHO 2014).

Oral health promotion

Oral health promotion is any planned effort to build supportive public policies, create supportive environments, strengthen community action, develop personal skills or re-orientate health and social services in the pursuit of oral health goals (adapted from Sprod,1996).

Tooth decay

Tooth decay develops when acid dissolves the enamel surface and the layer under this, dentin; the acid is produced when sugars (mainly sucrose) in food and drink react with bacteria in the dental biofilm (plaque).

Tooth erosion

Tooth erosion develops when acids either consumed in soft drinks, carbonated beverages and fruit juices or gastric reflux entering the mouth wears away the enamel on teeth.

Universal approaches

Universal approaches are interventions that aim to support and reach the whole population.

Targeted approaches

Targeted approaches are interventions may be distinct from, or an adaptation of a universal approach. For example, an oral health home visiting service provided by a health visitor for all new parents may be adapted to meet the needs of young parents living in a disadvantaged area. The resulting service may offer longer visits and provide parents with more detail about other health services.

Sunderland
City Council

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