

PUBLIC HEALTH GUIDELINE

FINAL SCOPE

1 Guideline title

Oral health: approaches for general dental practice teams on promoting oral health

1.1 *Short title*

Oral health promotion approaches for dental teams

2 Background

- a) The National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health (DH) to develop a public health guideline for dental health practitioners on how to promote oral health. This includes how to make the oral health promotion aspect of any visit to the dentist a positive experience.
- b) This guideline will support a number of related policy documents including:
 - [Local authorities improving oral health: commissioning better oral health for children and young people](#) (Public Health England 2014)
 - [Delivering better oral health: an evidence-based toolkit for prevention](#) (DH and British Association for the Study of Community Dentistry 2009)
 - [Dental quality and outcomes framework](#) (DH 2011)
 - [Equity and excellence: liberating the NHS](#) (DH 2010)

- [Essential standards of quality and safety: guidance about compliance](#) (Care Quality Commission 2010)¹
- [Healthy lives, healthy people: our strategy for public health in England](#) (DH 2010)
- [Improving oral health and dental outcomes: developing the dental public health workforce in England](#) (DH 2010)
- [NHS dental contract: proposal for pilots December 2010](#) (DH 2010)
- [Smokefree and smiling: helping dental patients to quit tobacco](#) (Public Health England 2014)
- [The NHS outcomes framework](#) (DH 2010), Domain 4 – Ensuring that people have a positive experience of care
- [The operating framework for the NHS in England 2011/12](#) (DH 2010)

c) This guideline will provide recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness. It is aimed at dental health practitioners and their teams including dentists, dental hygienists, dental nurses, managers and administrative staff. It may also be of interest to members of the public.

d) The DH has also asked NICE to produce 2 additional NICE public health guidelines on oral health:

- [Oral health: local authority oral health improvement strategies](#).
- [Oral health in nursing and residential care](#).

The guideline will complement NICE guidance on dental recall and behaviour change. For further details, see section 6.

This guideline will be developed using the process and methods described in [Methods for development of NICE public health guidance](#) (2012) and [The](#)

¹ Outcome 1 – Respecting and involving people who use services.

3 The need for guidance

- a) Although people's oral health in England has improved significantly over recent decades there is considerable room for improvement. The [Adult dental health survey 2009](#) (Health and Social Care Information Centre 2011) reports that the proportion of adults in England without natural teeth has dropped from 28% to 6% in the past 30 years. In 2003, 47% of children aged 12 and 49% of young people aged 15 had fillings. This compares with 60% and 63% respectively in 1993 ([Child dental health survey 2003](#) Health and Social Care Information Centre 2005). However, tooth decay (dental caries) and gum (periodontal) disease remain widespread, despite being largely preventable (Levine and Stillman-Lowe 2009). The Adult dental health survey 2009) found that just under 31% of adults had obvious tooth decay. In 2012, 27.9% of children aged 5 had tooth decay ([National Dental Epidemiology Programme for England, oral health survey of 5 year old children 2012](#) Public Health England 2013). In addition, oral cancer is one of the UK's fastest growing cancers ([Cancer incidence in the UK in 2011](#) Cancer Research UK 2014).
- b) Oral health is important to general health and wellbeing. Poor oral health can be painful and can affect people's ability to eat, speak and socialise normally ([Dental quality and outcomes framework](#) DH 2011). It can lead to absences from school and workplaces. It can also affect the ability of children to learn, thrive and develop ([Local authorities improving oral health: commissioning better oral health for children and young people – an evidence informed toolkit for local authorities](#) Public Health England 2014). Left unchecked, gum disease may increase

people's risk of heart disease and heart attacks, stroke, diabetes (and its management), as well as rheumatoid arthritis . In addition, it can be expensive to treat. Each year the NHS in England spends around £3.4 billion on primary and secondary dental services ([Improving dental care and oral health – call to action](#) NHS England 2014).

c) Wide variations in oral health exist across England. For example, the prevalence of tooth decay among children aged 5 ranges from 12.5% in Brighton and Hove to 53.2% in Leicester ([National Dental Epidemiology Programme for England, oral health survey of 5 year old children 2012](#)). Factors associated with severe tooth decay include:

- living in a deprived area
- being from a lower socioeconomic group or living with a family in receipt of income support
- belonging to a family of Asian origin
- living with a Muslim family in which the mother speaks little English (Rayner et al. 2003), or
- having a chronic medical condition

([Valuing people's oral health: a good practice guide for improving the oral health of disabled children and adults](#) DH 2007). The prevalence of certain types of oral disease is also known to be higher among some black and minority ethnic groups ([Oral health and access to dental services for people from black and minority ethnic groups](#) Race Equality Foundation 2013). However the relationship between ethnicity and oral health is complex.

d) NHS dental services have over a million contacts with patients each week ([Improving dental care and oral health – call to action](#) NHS England 2014). In 2009, 76% of adults reported attending the dentist in the past 2 years ([Adult dental health survey 2009](#)).

In 2013, 69.1% of children in England (aged under 18 years) had seen an NHS dentist in the past 2 years ([NHS dental statistics for England 2012–13](#) Health and Social Care Information Centre 2013). So dental teams are ideally placed to advise on modifiable risk factors and self-care approaches that can help prevent many chronic non-communicable diseases – including oral health disease. (Risk factors include tobacco use, alcohol consumption and a poor diet.) However, in the [Adult dental health survey 2009](#) only 9% of adults with teeth and 7% of adults without teeth recalled being asked about smoking (Health and Social Care Information Centre 2011). Similarly, 64% of adults in the survey did not recall being asked about their diet by the dental team.

- e) Reforms to the NHS dental contract look set to focus more on preventing poor oral health, as dental teams become responsible for improving the general health of their patients (Public Health England 2014). The [Adult dental health survey 2009](#) found that 78% of adults recalled being given advice at the dentist on cleaning their teeth or gums. And 75% of adults with natural teeth in England reported that they brush their teeth at least twice a day (76% using high or medium strength² fluoride toothpaste). However, 66% of adults surveyed had plaque on at least 1 tooth and 68% had tartar (hardened dental plaque) in at least 1 sextant³ of the dental arch (Adult dental health survey 2009). In addition, 37% of people who regularly go to the dentist said they do not use oral hygiene products such as dental floss and interspace brushes.
- f) According to the [Adult dental health survey 2009](#) 91% of those surveyed felt that the dentist they saw most recently listened

² The coding frame used in the [Adult dental health survey 2009](#) classified over-the-counter toothpastes by fluoride concentration. This was divided into 3 levels: high (1350 to 1500 parts per million), medium (1000 to 1350 parts per million) and low (550 parts per million or less).

³ One of the 6 equal parts into which the dental arch (the curved structure formed by the teeth in their normal position) may be divided.

carefully to them. Most (89%) felt they were given enough time to discuss their oral health and were involved in decisions about their care or treatment. And most (94%) understood the answers they received. However, 20% were not satisfied with the dentist. Those with a poor relationship with the dentist tend to rate their own oral health lower, leave longer intervals between visits to the dentist and are more likely to be extremely anxious about visiting a dentist.

4 The guideline

This document defines exactly what this guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on a referral from the DH (see appendix A).

4.1 *Who is the focus?*

4.1.1 Groups that will be covered

Adults and children.

4.1.2 Groups that will not be covered

Adults and children who do not visit the dentist.

4.2 *Approaches*

4.2.1 Approaches that will be covered

The guideline will focus on how dental teams can effectively convey the 'advice for patients' set out in [Delivering better oral health: an evidence-based toolkit for prevention](#) (DH and British Association for the Study of Community Dentistry, 2009)⁴. This includes how to deliver these messages in a way that

⁴ This contains advice on oral health behaviours including: oral hygiene practices (for example, tooth brushing and the use mouth rinses); using the appropriate concentration and amount of fluoridated toothpaste; maintaining good dietary practices (including reducing the amount and frequency of sugary food and drinks); not smoking or using smokeless tobacco; and keeping to guidelines on alcohol intake). The 3rd edition of [Delivering better oral health: an evidence-based toolkit for prevention](#) is expected before publication of this guidance.

ensures people leave the dentist satisfied about their visit and motivated to follow the advice. It will include the following approaches and activities:

- a) Verbal information (planned or as the opportunity arises) for example, brief or very brief advice, giving information on useful resources and motivational interviewing (helping motivate people to change their behaviour).
- b) Practical demonstrations, for example, of how to remove dental plaque and how to brush teeth properly.
- c) Leaflets, posters and other printed information. This includes different presentations (for example, visual and numeric formats) and different writing styles (for example, personal accounts and scientific facts).
- d) New media, including websites and social media, email and text messaging.

The Committee will take reasonable steps to identify ineffective approaches.

4.2.2 Areas that will not be covered

- a) The evidence base underpinning oral health advice for patients. This is already covered in guidance provided by the DH and British Association for the Study of Community Dentistry (see 4.2.1).
- b) Clinical dental treatment.
- c) Approaches to tackling clinical diagnoses of dental anxiety and phobia (listed a specific phobia in the [Diagnostic and Statistical Manual of Mental Disorders 5](#)).
- d) Oral health needs assessments.
- e) Community-based oral health promotion programmes and interventions.

- f) Oral health promotion and dental treatment in residential or care settings (including hospitals and nursing and residential care homes for children, young people and adults).

4.3 Key questions and outcomes

Below are the overarching questions that will be addressed, along with some of the outcomes that would be considered as evidence of effectiveness:

Question 1: What are the most effective and cost-effective approaches that dental teams can use to convey oral health promotion messages to patients?

Question 2: Are oral health promotion messages more likely to have an effect on patients if they are linked with wider health outcomes, such as heart and lung disease or diabetes?

Question 3: What helps dental health teams to deliver oral health promotion messages? What prevents effective delivery?

Question 4: What helps patients to understand and act upon oral health promotion messages? What stops them from understanding or taking action – or not following the full advice - even if they do understand the messages?

Question 5: How can oral health promotion messages be delivered in a way that ensures people leave the dentist satisfied about their visit and motivated to follow the advice given?

Expected outcomes

- Changes in the dental health team's knowledge, ability, intentions and practice in relation to promoting their patients' oral health.
- Changes in people's experience of visiting the dentist. For example, changes in their satisfaction levels with oral health promotion advice.
- Changes in dental patients' knowledge and ability to improve and protect their oral health.
- Changes in dental patients' oral health behaviours.

- Changes in the oral health of people who go to the dentist. For example, changes in the incidence and prevalence of oral cancers, tooth decay, gum disease and dental trauma.
- Changes in dental patients' quality of life, including their social and emotional wellbeing.

4.4 Status of this document

This is the final scope, incorporating comments from a 4-week consultation between 18 March and 15 April 2014.

5 Related NICE guidance

Published

- [Behaviour change: individual approaches](#) NICE public health guidance 49 (2014)
- [Patient experience in adult NHS services](#) NICE clinical guideline 138 (2012)
- [Smokeless tobacco cessation –South Asian communities](#) NICE public health guidance 39 (2012)
- [Maternal and child nutrition](#) NICE public health guidance 11 (2008).
- [Behaviour change: the principles for effective interventions](#) NICE public health guidance 6 (2007).
- [Dental recall](#) NICE clinical guideline 19 (2004)

Under development

- Oral health: local authority oral health improvement strategies. Publication expected October 2014
- Oral health in nursing and residential care. Publication expected June 2016.

Appendix A Referral from the Department of Health

The Department of Health asked NICE to develop:

‘Guidance for dental health practitioners on effective approaches to promoting positive oral health behaviour, including a positive patient experience of attendance at the dentist.’

Appendix B Potential considerations

It is anticipated that the Public Health Advisory Committee (PHAC) will consider the following issues:

- Target audience
- Actions taken to promote oral health and to ensure patients are receptive to oral health messages.
- Whether approaches are based on an underlying theory or conceptual model.
- Whether approaches are effective and cost effective.
- Critical elements. For example, whether effectiveness and cost effectiveness varies according to:
 - the diversity of the population (for example, in terms of age, gender, ethnicity, religion, education level, fluency in English, physical or mental disabilities)
 - the role, skill mix and status of the person delivering an activity
 - the frequency, length and duration of an activity, the medium through which it takes place, the techniques used, where it takes place and whether it is transferable to other settings.
- Any trade-offs between equity and efficiency.
- Any factors that prevent – or support – effective implementation.
- Any adverse or unintended effects.
- Current practice.
- Availability and accessibility for different groups.

Appendix C References

Levine RS, Stillman-Lowe CR (2009) The scientific basis of oral health education: sixth edition. London: British Dental Journal

Rayner J, Holt R, Blinkhorn F et al. (2003) British Society of Paediatric Dentistry: A policy document on oral health care in preschool children. International Journal of Paediatric Dentistry 13: 279–85