Public Health Guidelines

ORAL HEALTH – IN NURSING AND RESIDENTIAL CARE - Consultation on Draft Scope
Stakeholder Comments Table

Tuesday 3 June 2014 – Tuesday 1 July 2014

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Stakeholder Organisation	Section Number	Page No.	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Borrow Foundation	General		The Borrow Foundation fully supports the move to develop a public health guideline for oral health in nursing and residential care and as a registered stakeholder welcomes the opportunity to participate in the consultation.	Thank you for taking the time to read and comment on the draft scope.
Borrow Foundation	4.2.1 Section 4.2.1 a) Bullet point 4	7	One of the activities on which the guidance will focus is increasing access to fluoride for people living in care homes. We fully support this especially as several reviews have highlighted the unique role of fluoride in preventing and remineralising primary root caries lesions. Heijnsbroek M.*et al* Fluoride interventions for root caries: a review. Oral Health Prev Dent 2007; 5: 145–152. Griffin SO, *et al*. Effectiveness of fluoride in preventing caries in adults. J Dent Res 2007; 86:410–5. A study conducted in Sweden concluded that daily intake of milk (200 ml) supplemented with fluoride (1 mg) and/or probiotic bacteria may reverse soft and leathery primary root caries lesions in older adults. Petersson LG, *et al* ' Reversal of primary root caries lesions after daily intake of milk supplemented with fluoride and probiotic lactobacilli in older adults' Acta Odontologica Scandinavia, 2011; 2011 Nov;69(6):321-7, Enamel caries also affects older adults and a previous study in Sweden concluded that daily consumption of milk (150 ml) containing probiotic bacteria and fluoride (0.25 mg) reduced enamel caries in preschool children with a prevented fraction of 75%. Additional beneficial health effects were also evident. Stecksén-Blicks C *et al* 'Effect of Long-Term Consumption of Milk Supplemented with Probiotic	Thank you for these very helpful references about potential interventions. This consultation is about the draft scope document, which sets out what areas and populations the guideline will and will not cover. Thank you for these papers which we will pass on to our review team. The activities listed are intended as examples, not an exhaustive list, so although not explicitly mentioned, evidence about fluoridated milk in residential care settings is not excluded Once the scope is agreed and the evidence reviews commissioned, information will be identified systematically and presented to the committee in a series of reports or reviews. Any gaps in the evidence will also emerge and if required, a call for evidence to address particular questions will be made,

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			Lactobacilli and Fluoride on Dental Caries and General Health in Preschool Children: A Cluster-Randomized Study' Caries Res 2009;43:374–381 . Milk is one of the most nutritionally complete foods available on the food market to date. It provides a whole range of nutrients essential to growth, development and maintenance of the human body and contains no artificial preservatives or colourings. Relatively small quantities of milk can provide a significant proportion of daily nutrient requirements for all age groups making it nutrient rich relative to its energy content. Milk therefore makes a significant contribution to the human diet through provision of the macro-nutrients, vitamins and minerals.	at that point (or earlier) we request stakeholders to submit evidence to address gaps. We hope this is helpful, but if you require further information please look at the NICE methods or NICE Process manuals. PH Methods manual http://www.nice.org.uk/article/PMG4/chapter/1%20Introduction PH Process Manual http://www.nice.org.uk/article/PMG5/chapter/1%20Introduction
Borrow Foundation	Section 4.3 Key questions and outcomes Question 1	8	Question 1 on page 8 asks about approaches, activities or interventions that are effective and cost effective in promoting oral health, preventing dental problems ….. The bioavailability of fluoride in milk is well documented (Milk fluoridation for the prevention of dental caries, WHO Geneva 2009). The clinical effectiveness of milk fluoridation in preventing dental caries is supported by 23 published reports resulting from 18 studies in 11 countries.	Thank you for your comment, please see our previous response.

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			In vivo and *in vitro* demineralisation and remineralisation (enamel slab) experiments have indicated the low cariogenic potential of milk and also demonstrated its caries-protective role. http://www.borrowfoundation.org/why-fluoridate-milk/milk-and-oral-health.html Care homes will have an existing supply of milk. The actual process of adding fluoride to milk is relatively straightforward. Consequently, the cost differential between production of fluoridated and non-fluoridated milk is marginal and is generally absorbed by the milk producers.	
Borrow Foundation	Section 4.3 Expected Outcomes (2nd bullet point)	9	Given the importance of diet and nutrition on oral health a greater emphasis might be placed on healthy eating policies particularly in section 4.3	Thank you for your comment, noted. No particular emphasis is intended at this point, but we note your concern. Please see our previous response about the status of this document and be assured that this issue would not be excluded at this early stage.
Borrow Foundation	General		The Foundation supports the use of water fluoridation. However, in many places the addition of fluoride to the water supplies is not possible and, as a result, a high percentage of the elderly population is denied the benefit of fluoride. Milk with added fluoride could be supplied, relatively easily, to adults in nursing and residential care homes at very little or no extra cost.	Thank you for your comment. As you are aware, water fluoridation will not be covered by this guideline. We have noted your suggestions about milk, thank you.
British Association for the Study of Community Dentistry (BASCD)	General		BASCD as a registered stakeholder organisation are pleased to be able to comment on the draft scope and welcome the opportunity to meet with NICE as	Thank you for taking the time to read and comment on the document

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		1 1-2	detailed in the proposed schedule for the development of the guidance. We suggest changing title to Oral health: improving oral health, preventing oral health problems and enabling access to appropriate dental treatment for adults in nursing and residential care homes. Given the brief provided from the Department of Health we are pleased to see that the Guidance will be aimed at the range of stakeholders identified in Section 2(c), but think this should also include commissioners of dental services and commissioners of oral health improvement programmes.	We have amended the title in line with your suggestion, thank you. Re Section 2c, thank you, we have added these groups.
British Association for the Study of Community Dentistry (BASCD)	Section 2b) Section 3	1 3	Reference to Delivering Better Oral Health : an evidence-based toolkit for prevention should be updated to Version 3 We think that Valuing peoples oral health: a good practice guide for improving the oral health of disabled children and adults (Department of Health 2007) should be included in policy documents that support this guideline. It should be noted that poor oral health also has an impact on malnutrition and quality of life. (*Steele JG, Sheiham A, Marcenes W, Walls AWG. National diet and Nutrition Survey: people aged 65 years and over. Volume 2: Report of the oral health survey. London: The Stationary Office, 1998; Sheiham A, Steele JG, Marcenes W, Finch S, Walls AWG. The impact of oral health on stated ability to eat certain foods; findings from the National Diet and Nutrition Survey of older people in Great Britain. Gerodontology 1999; 16: 11-20.*).This should be made reference to in this section. Page 4 of the scope references findings from the Adult Dental Health Survey 2009	Thank you, for your very useful and helpful suggestions to this section, much appreciated. The purpose of the scope document is to set out broadly what the guideline may or may not cover, it is not intended provide a detailed overview of a topic area. We considered your suggestions but did not think it necessary to change the text on this occasion, but will cross refer to other relevant guidelines in the final guideline document.

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		4	while noting more root caries and cosmetic dentistry (Thomson, 2004). We would note that the Adult Dental Health Surveys have always **excluded** care home residents. We suggest looking at data for older adults from ADHS 2009. Evidence collected in Wales in 2010 using the same ADHS 2009 criteria suggest that care home residents are more likely to have fewer teeth and more oral disease than older peers living in the community (*Karki A, Monaghan N, Morgan MZ, Johnson IG. Inequalities in oral disease among care home residents in Wales. In draft*). The spectrum of need includes edentate, partially dentate individuals with 7% potentially having a functional dentition of 20 or more teeth (*Johnson IG, Morgan MZ, Monaghan NP, Karki A. Does dental disease presence equate to treatment need among care home residents? Journal of dentistry 05/2014; DOI:10.1016/j.jdent.2014.05.010*). Care home residents also have a higher level of oral health impacts than older people living in the community (*Monaghan NP Donovan C, Karki A, Playle RA, Morgan MZ Inequalities in oral health impact among care home residents in Wales. In draf*t.). An oral health needs assessment for people in care homes and a follow up was commissioned from UCL by Islington PCT. These are similar findings to those from a small care home sub-sample within the National Diet and Nutrition Survey (*Steele JG, Sheiham A, Marcenes W, Walls AWG. National diet and Nutrition Survey: people aged 65 years and over. Volume 2: Report of the oral health survey. London: The Stationary Office, 1998; Sheiham A, Steele JG, Marcenes W, Finch S, Walls AWG. The impact of oral health on stated ability to eat certain foods; findings from the National Diet and Nutrition Survey of older people in Great Britain. Gerodontology 1999; 16: 11-20.*).	

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			We would suggest that the above evidence better describes the high and complex needs of this group than extrapolation from the ADHS and the Thomson 2004 reference.	
British Association for the Study of Community Dentistry (BASCD)	Section 3	5	Page 5 of the draft scope notes a recent survey by the British Dental Association about delivery of oral health care within the care home. In 2006/7 a largely postal survey of all care home managers in Wales, with an 81% response rate, looked at access to dental services, processes to incorporate oral health into written care plans and need for oral hygiene support and training to provide that support. While 88% of care homes had residents regularly requiring assistance in cleaning teeth or dentures only 55% of homes had staff trained to deliver this care (*Monaghan N, Morgan, MZ. Oral health policy and access to dentistry in care homes. Journal of Disability and Oral Health 2010, 11 (2), p.61-68*). We bring this evidence to your attention as it highlights the high levels of untrained staff assisting residents in cleaning teeth and dentures.	Thank you for this reference..
British Association for the Study of Community Dentistry (BASCD)	Section 3(g)	6	In addition to poor health and treatment for chronic medical conditions, care home residents present other aspects of complexity for delivery of oral health including: • Ability to communicate • Ability to co-operate • Oral risk factors • Access to oral care • Legal and ethical barriers to care (*Bateman P, Arnold C, Brown R, Foster LV, Greening S, Monaghan N,*	Thank you for your comment and helpful suggestions. Although we appreciate your suggestions, the current text in the scope would cover all of these aspects of oral health care for residents, therefore it is not necessary to amend the wording, but thank you.

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			Zoitopoulos L. (2010). BDA special care case mix model.Br Dent J. ***208:*** *291-6. doi: 10.1038/sj.bdj.2010.294.)* This complexity means access should be to **appropriate** dental services. In some cases a general dental practitioner will be appropriate in others not.	
British Association for the Study of Community Dentistry (BASCD)	Section 4	7	The first bullet point on page 7 suggests assessment of individual oral health on entry to the care home. Based upon the findings of the Welsh postal survey of care home managers, where oral health commonly did not feature in the written care plan, we would suggest that the assessment and resulting recommended actions should be part of the written care record (*Monaghan N, Morgan, MZ. Oral health policy and access to dentistry in care homes. Journal of Disability and Oral Health 2010, 11 (2), p.61-68*).	Thank you for your comment and reference, which we will pass on to our review team. The activities listed are examples of what could be covered, but we appreciate your concern. The scope sets out what the guidance may or may not cover and the potential questions the evidence reviews and reports may address. Examples are not intended to be exhaustive. The final recommendations will be developed by the committee following consideration of the evidence reviews and reports. We hope you will comment on the draft guidelines.
British Association for the Study of Community Dentistry (BASCD)	Section 4	7	The fourth bullet point should state appropriate level of fluoride as per DBOH V3. Bullet point five should explicitly state who the education and information will be	Thank you for your comment. Please see our previous response. We use the phrase 'role of diet' to capture a range of outcomes with

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			aimed at. Bullet point seven should include use of sugar free medicines where person can no longer swallow tablets or where medicines are only available as liquid or solution. Page 7 also notes the impact of diet, alcohol and tobacco on oral health. We would also note the suggestion that care homes offer easy to chew diets which may contribute to minor nutritional deficiencies (*Steele JG, Sheiham A, Marcenes W, Walls AWG. National diet and Nutrition Survey: people aged 65 years and over. Volume 2: Report of the oral health survey. London: The Stationary Office, 1998; Sheiham A, Steele JG, Marcenes W, Finch S, Walls AWG. The impact of oral health on stated ability to eat certain foods; findings from the National Diet and Nutrition Survey of older people in Great Britain. Gerodontology 1999; 16: 11-20*). This suggestion was confirmed by the findings from the Welsh postal survey of care home managers which found 28% of homes offered menus which assumed all residents had dentures or trouble chewing food (*Monaghan N, Morgan, MZ. Oral health policy and access to dentistry in care homes. Journal of Disability and Oral Health 2010, 11 (2), p.61-68*). Healthy eating policies should be included in this list.	regard to diet, trying not to limit research outcomes only to 'healthy eating policies'. The current text would not exclude any of your suggestions at this stage in the work. We considered your amendments but did not think it necessary to change the text on this occasion.
British Association for the Study of Community Dentistry (BASCD)	General/Section 4	7	The scope rightly underlines the importance of access to dental services on page 7. We would also note that the high levels of oral disease and oral health impacts do not tell the full story of need for treatment. Recent analysis of the Welsh data suggests that among the care home population disease presence does not directly equate to treatment need in the way it does for younger people (*Johnson IG, Morgan MZ, Monaghan NP, Karki A. Does dental disease presence equate to*	Thank you for your comment, please see our previous responses about the status and purpose of this document. We appreciate your concern and would like to reassure you that the committee will take these issues

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			treatment need among care home residents? Journal of dentistry 05/2014; DOI:10.1016/j.jdent.2014.05.010). Part of the reason for disease presence not equating to treatment need is the difficulty of delivering care. Another element is the balance between the benefit of treatment which may be for limited remaining life span versus the difficulties in receiving care. Among frail older people there are some aspects of oral disease where an aggressive approach to prevention for some diseases (e.g. root caries) might be complemented by watch and wait approach for some other conditions. This group is also at risk for oral cancer. The philosophy of care appropriate for care home residents may be different from that of older peers living in the community. Taken together these factors all argue for a philosophy of care which incorporates regular dental checks/chronic disease management and occasional need for more aggressive treatment. Ideally the guidance produced by NICE should reflect this.	into account when developing recommendations.
British Association for the Study of Community Dentistry (BASCD)	Question 1	8	Question 1 as drafted is actually 3 questions and may be better presented as bullet points for the 3 elements with the following changes: • Improving oral health? • Preventing oral problems? • Enabling access to **appropriate** dental care (including regular check-ups) for adults in care homes?	Thank you for your helpful suggestions, they are noted and we have amended the scope title. At this stage, these questions are intended to be fairly broad, over-arching questions for the guidance to address. They will be refined into more specific and focused research questions for the

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				evidence reviews.
British Association for the Study of Community Dentistry (BASCD)	Question 1	8	Question 1 on page 8 asks about approaches, activities or interventions are effective and cost effective in promoting oral health, preventing dental problems and ensuring access to dental care (including regular check-ups) for adults in care homes. On the matter of access to dental care we would note that there is evidence from the Welsh postal survey of care home managers that we have arrangements which have evolved over time reflecting local circumstances e.g. having 85% of all residents seen in the general dental service in one area and a similar percentage seen by the community dental service in another (*Monaghan N, Morgan, MZ. Oral health policy and access to dentistry in care homes. Journal of Disability and Oral Health 2010, 11 (2), p.61-68*). The data emerging from the 2010 survey of care home residents in Wales would suggest that about half of care home residents need to see a general dental practitioner with almost as many needing a dentist with special care experience and only a few needing a specialist. In each of these cases about half of the residents could have received care on a domiciliary basis only. The commonest response to the complex needs of this group was for additional clinical time to deliver care (*Morgan MZ, Johnson IG, Hitchings, E, Monaghan NP, KARKI A. Who and where? Dental treatment needs of care home residents in Wales. Submitted Gerodontology, May 2014*). If the aim is to ensure access to appropriate dental care then the need should be understood and the services designed to meet those needs. Regarding approaches, activities or interventions to ensure access to appropriate dental care we would note the frequent absence of systems and processes to get patients into regular dental care from time of admission to the home. We would however note that we have no proof that having a system or process increases	Thank you for your comments and suggestions, including further references, very helpful. Please also see our previous responses and note the status and purpose of this document. Thank you.

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			access to appropriate care. We have seen extremes (e.g. general dental practitioner domiciliary contract for care homes) which may have increased access to dental services of questionable appropriateness for many care home residents.	
British Association for the Study of Community Dentistry (BASCD)	Question 2	8	Question 2 asks about methods and sources of information that will help care home managers and their staff identify and meet the range of oral health needs and problems experienced by their people living in care homes. There have only been occasional reports of needs assessments for care home residents in the scientific literature, and the appropriate data to inform such needs assessment is rarely collected in the UK. As has been stated above there is not a simple linear relationship between disease presence and treatment need for the frail older person living in a care home. Having said that, in Wales in 2006/7 even before survey teams finished collecting data some local community dental services were approached by care homes asking for assistance in training staff. Simply connecting the community dental services and the care homes led to action. The correct answer to question 2 should be needs assessment. Dental treatment need for care home residents is not straightforward (*Johnson IG, Morgan MZ, Monaghan NP, Karki A. Does dental disease presence equate to treatment need among care home residents? Journal of dentistry 05/2014; DOI:10.1016/j.jdent.2014.05.010*). We need to understand not just the nature and quantity of disease, but also its impact, (Oral Health Impact Profile 14?) and the balance between the difficulty in delivering care and the likely benefit. On the one hand some early treatments may be appropriate, on the other some conditions might be best managed monitoring. A personal relationship and chronic disease management model is more appropriate than a care model based upon 1-off interventions. Thus any needs assessment needs to reflect an appropriate philosophy of care for this population.	Thank you for your comments, although informative and helpful these are anticipating the recommendations the committee may make when they consider the evidence, but we will forward your references to the review team. We note your concerns, but please see our previous responses and note that some of your comments are anticipating the final recommendations of the committee. Further information about guideline development may be found through this weblink to the NICE methods and process manuals. PH Methods manual http://www.nice.org.uk/article/PMG4/chapter/1%20Introduction PH Process Manual http://www.nice.org.uk/article/PMG

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				5/chapter/1%20Introduction
British Association for the Study of Community Dentistry (BASCD)	Question 3	8	Question 3 asks what helps and hinders oral health promotion, prevents dental problems and ensures access to dental check-ups and treatment in care homes? As noted above we would point out that residents have a range of care needs for general dentist and special care experienced dentists, mainly for a mix of domiciliary and clinic based care. Simple general dental service domiciliary provision is not enough. For many care needs are complicated by complexity. Ideally a mixed model – probably with initial assessment by dentist with special dental care experience (as per examiners in Welsh 2010 Survey) would help with appropriate access to check-ups and treatment. In England and Wales, Since April 2006, provision of domiciliary care is no longer part of mandatory dental services in GDS/PDS contracts. The consequence of this is that in some areas, historic links between general dental practitioners and nursing and residential care homes has been lost.	Thank you, please see our previous responses.
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (1st bullet point)	9	The average time of living in a care home is between eighteen months and two years. Given the turnover the most likely factor to influence oral health amongst care home residents is the oral health status on admission. This should be borne in mind when assessing the impact of the guidance and is a further reason why oral health status should be assessed and the data recorded on admission.	Thank you, noted. Please see our previous responses.
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (1st bullet	9	We suggest following change to first sentence. Changes in the general health and quality of life of people living in care homes. Given that the average time living in a care home is between eighteen months and	Thank you, we note your point and the concerns raised about length of stay in care homes. Oral cancer is just an example of one of a number of conditions that could be

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	point – oral cancer)		two years. it is unlikely that actions to reduce incidence/ prevalence of oral cancer will ameliorate a lifetime's prior experience. As a result targets of this type would not be appropriate as the disease incidence/prevalence is unlikely to be significantly changed. This does not mean that actions which would reduce oral cancer risk should not be taken; there are other health gains and benefits from these actions. Conversely treatment of early stage oral cancer is more likely to be successful and actions to ensure disease is identified at an early stage are key.	considered as an outcome. We don't believe it would be appropriate to change the text on this occasion. We appreciate your concerns, but the content of the final guideline will be decided by the committee after they have reviewed the evidence. Please see our previous responses about the status and purpose of this document.
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (1st bullet point – Tooth decay)	9	It is not clear whether there is intent to demonstrate outcomes. Some measure of tooth decay (MT and FT) measure past disease experience. The tooth decay indicator of relevance for prevention relates to active decay (D_3T and active enamel caries). The most aggressive form of caries likely to be seen among care home residents is root caries, particularly among those taking too much sugar and/or with dry mouth.	Thank you for your comment, your concern is noted. Tooth decay is an example of one of many risk factors for oral health of residents, not intended as an example of a risk indicator. This section of the scope is intended to give a sense of the kinds outcomes we would be interested in, rather than specific outcome measures, The evidence reviews will assess the relative value of different outcome measures reported by studies and will inform the development of recommendations. Examples are not intended to be

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				an exhaustive list. Please see our previous responses.
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (1st bullet point – periodontal disease)	9	The measurement of periodontal disease is complex. At population level we would typically use the Community Periodontal Index of Treatment Need (CPITN) on up to 6 reference teeth. This provides a snapshot of estimated treatment need but it is questionable whether it is sensitive enough to measure improved periodontal health in a care home population. A measure of oral cleanliness may be more appropriate if there is a desire to measure outcomes.	Thank you for your comment, please see our previous responses. We considered your suggestions but did not think it necessary to change the text on this occasion.
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (1st bullet point – nutrition)	9	The measurement of nutritional status is complex. Use of 7 day weighed dietary methods or similar would be inappropriate for this target group. A short form nutritional assessment questionnaire together with measurement of BMI might be feasible. Alternative approaches may be more appropriate (Hatice Simsek, S. Sahin, R. Ucku, C. C. Sieber, R. Meseri, P. Tosun, F. Akcicek (2014) The diagnostic accuracy of the revised mini nutritional assessment short form for older people living in the community and in nursing homes. The Journal of Nutrition, Health and Aging. May 2014.). Recent published work suggests that some care home managers assume the lowest common denominator in terms of ability to chew food (*Monaghan N, Morgan, MZ. Oral health policy and access to dentistry in care homes. Journal of Disability and Oral Health 2010, 11 (2), p.61-68*) – so it is not just about the nutritional quality of the diet but also its limited variety and appeal which could affect nutritional status (*Sheiham A, Steele JG, Marcenes W, Finch S, Walls AWG. The impact of oral health on stated ability to eat certain foods; findings from the*	Thank you for your comment, and helpful suggestions, please see our previous responses.

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			National Diet and Nutrition Survey of older people in Great Britain. Gerodontology 1999; 16: 11-20).	
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (1st bullet point – oral discomfort including pain)	9	Evidence from Wales suggests that care home residents suffered twice the level of impacts on oral health when compared with older individuals living in the community *Monaghan NP Donovan C, Karki A, Playle RA, Morgan MZ Inequalities in oral health impact among care home residents in Wales. In draf*t.). This was assessed using Oral Health Impact Profile -14 question tool. Clearly impacts are important and measurable. These impacts can affect personal dignity. Addressing impacts should be a key objective of providing access to dental services for this group.	Thank you for your comments, we note your concerns and suggestions. Please see our previous responses.
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (2nd bullet point)	9	We feel the first line should read. Changes in practice. The concentration for high concentration toothpaste should link to DBOH. We feel that the evidence base for use of fluoride supplements in this cohort of patients is unlcear. As diet can impact on dental caries, healthy eating policies should be included in this section.	Thank you for your comments, we note your concerns. The evidence will help the committee decide whether to recommend fluoride supplements or any intervention to promote and protect oral health. The sentence about the role of diet is deliberately worded to ensure information about a range of interventions around diet is identified in the evidence, including healthy eating policies. The final NICE guideline will link to relevant guidelines. Please see our previous responses to this suggestion and about the

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British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (3rd bullet point)	9	We suggest changing this bullet point to: Changes in policies or procedures in care homes to improve oral health.	Thank you for your suggestion. It may be that changes in a range of policies or procedures may also impact oral health so keeping the wording broader ensures we don't unnecessarily narrow the search for evidence.
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (5th bullet point)	9	We suggest changing this bullet point to: Changes in quality of life, including social and emotional wellbeing of residents,.	Thank you for your comment, please see our previous responses. As this outcome would not be excluded, we don't believe it essential to change the text in the scope document.
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (6th bullet point)	9	We suggest changing this bullet point to: Changes in knowledge and ability to improve and protect their oral health of residents, carers and care home staff.	Thank you for your comment, please see our previous responses. Although we agree, as this outcome would not be excluded, we don't feel it essential to change the text in the scope document.
British Association for the Study of Community Dentistry (BASCD)	Section 4.3 Expected Outcomes (7th bullet point)	9	We suggest changing this bullet point to: Changes in oral health behaviours of residents, carers and care home staff.	Thank you for your suggestions. Although we agree, as this outcome would not be excluded, we don't believe it essential to change the text in the scope document.

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British Association for the Study of Community Dentistry (BASCD)	General		**The focus to maximise impact** A final point to note about the care home population with implications for improving oral health is the spectrum of time residents may spend in the home. The average amount of time a person lives in a care home is just over 2 years. This masks a broad range from those who are frail with deteriorating health at one extreme for whom heroic dentistry is inappropriate, to those who need nursing care but are stable with long life expectancy at the other. On average all of these individuals suffer double the level of oral health impacts of older peers living in the community (*Monaghan NP Donovan C, Karki A, Playle RA, Morgan MZ Inequalities in oral health impact among care home residents in Wales. In draft*). For many of the residents addressing the impacts they are already burdened with will be more important than prevention of further disease.	Thank you for your helpful suggestions and comments. We will take them all into consideration and amend the scope where appropriate. We note your concerns about the complex needs of this population and these needs will be reflected in the final recommendations made by the committee. Again, your comments are very much appreciated, we hope you will read and comment on the draft guideline as the work progresses, thank you.
British Association for the Study of Community Dentistry (BASCD)	Appendix B	12	Both bullet point 2 and 3 should be evidence based and include a commentary on the evidence base.	Noted, thank you. This will be included in the evidence review. Please see our previous responses about the status and purpose of this document.
The British Dental Industry Association	General		The BDIA welcomes the opportunity to comment on the draft scope of the guideline and supports both the need for the guidance and the scope of the document. In particular, the BDIA supports the focus on improving access to dental care for vulnerable groups.	Thank you for taking the time to read and comment on the document.
The British Dental Industry Association	3	3-6	This guidance is extremely important as the demands of the UK's ageing population will continue to place increasing levels of strain on both health and social care services. The differing needs of people living in care homes with physical disabilities and mental health conditions (in particular dementia) are especially important and should be given proper consideration.	Thank you for your comment.

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The British Dental Industry Association	4.1	6	We support the focus of the guideline. It is important that the needs of groups not covered by the guidelines continue to be addressed separately.	Thank you for your comment, noted.
The British Dental Industry Association	4.2.1	7	We support the scope of the activities covered by the guidance. Ensuring easy access to dental services will be especially important. In particular, the emphasis on joining up dental health services with other health initiatives should be seen as a priority.	Thank you for your comment, noted. The committee will take these issues into account when considering the evidence and developing recommendations.
The British Dental Industry Association	4.2.1	7	It will be vital to ensure that proper resources are allocated for staff training, as care home staff will represent the link between care home residents and dental services.	Thank you for your comment, noted.
The British Dental Industry Association	4.2.1	7	We would like to emphasise the importance of the provision of oral health assessments, particularly as these form a key part of the care pathway approach of the current NHS dental contract pilots.	Thank you for your comment, noted.
The British Dental Industry Association	4.2.1	7	We would like to stress the importance of access to fluoride toothpastes, gels and other products as well as the provision of toothbrushes, especially electric toothbrushes, in care homes. A sufficient range of products should be made available to ensure that the full range of needs of people living in care homes can be met.	Thank you for your comment, please see our previous response.
The British Dental Industry Association	4.2.2	8	It will be important to monitor the development of new technologies and innovations in oral health when considering what activities should be covered.	Thank you for your comment. Although we appreciate the point, monitoring the development of new technology is not within the scope of this work. However, if appropriate and robust evidence is identified that indicates effectiveness for the use of new technologies for people in these

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				settings, the committee may take this into consideration when developing recommendations.
The British Dental Industry Association	4.3	8	We believe that these overarching questions are broadly appropriate. It will be important to give proper consideration to the measurement of expected outcomes and identification of clear goals.	Thank you.
The British Dental Industry Association	4.3	9	In terms of expected outcomes, consideration should also be given to changes in attitudes towards dental care and dental health amongst people living in care homes as a result of educational efforts.	Thank you for your suggestion,. We considered your suggestions but did not think it necessary to change the text on this occasion.. Please bear in mind the list of outcomes is not intended to be exhaustive.
British Society of Gerodontology	1.0	1	This is a long title which appears to have three separate aims, we hope the Short Title at 1.1 will be adopted and that the Title at 1.0 can become a subtitle Alternatively - "Oral health: promoting oral health, preventing oral problems and ensuring access to oral health care for adults in care homes"	Thank you for your comments, we have amended the scope.
British Society of Gerodontology	2 b)	1	Current references refer only to English policy - is this intended as an English or UK guideline?	Thank you for your comment. NICE public health guidance is for England only, but the final guideline may be considered for use and adapted by the appropriate bodies in Wales, Northern Ireland or Scotland if required.
British Society of	2 b)	1	No mention of policies for carers or nursing – vitally important to ensure this links	Thank you for your comment and

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Gerodontology			and uses the appropriate/same terminology and guidance that care home providers are using. There is no mention of the Francis Report or the Winterborne document?	suggestions. This consultation is about the draft scope. The purpose of the scope is to suggest what the guideline may and may not cover and to indicate which policies may be relevant. Scopes are not intended to be comprehensive overviews of a particular area. If relevant to the final recommendations of the committee, additional relevant policy documents may be identified at a later date.
British Society of Gerodontology	2 c)	1	Why would it not be of interest to people and family who reside in care homes - surely they are stakeholders and should also be influencing how this service is provided?	Thank you for your comment. This is mentioned on page 3.
British Society of Gerodontology	3 c)	2	Should include the DH/CDO commissioned document 'Meeting the Challenges of Oral Health for Older People: A Strategic Review' (2005) Gerodontology 22 (Suppl.) p2-48	Thank you for your comment and suggestion. Please see our previous responses.
British Society of Gerodontology	3 d)	2	The deprecated term "elderly" is used in place of "older people"	Thank you. The wording is taken directly from the Age UK document referenced, but we appreciate the point and have amended.
British Society of Gerodontology	3 e)	4	Should include reference to DH funded "Guidelines for the Development of Local Standards of Oral Health Care for People with Dementia" (2006) Gerodontology 23 (Suppl) 3-32	Thank you for your suggestion, please see our previous responses about the purpose of the scope, and references and documents.

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British Society of Gerodontology	Section 3 (General)		People residing in nursing homes are more dependent, frail and require more intensive nursing care. No mention of dietary issues such as sip supplementation or frequent snacking due to malnutrition where residents require increased calories due to malnutrition (BAEPN have info on this) Any guidelines should avoid treating the Nursing and Residential Care population as an homogenous, generally healthy older population. They have often complex and disparate needs which need to be reflected in any health promotion programme	Thank you for your comments and suggestions. Please see our previous responses about the purpose and status of this document.
British Society of Gerodontology	4.1.1	6	This does not distinguish the different groups accommodated in "Care Homes" eg: those with learning disability, severe enduring mental illness, dementias, head injury, older frail and vulnerable adults, people with severe physical disabilities, those who are terminally ill receiving palliative care and those in rehabilitation care homes. Guidance needs to address that these differing groups which need different approaches. Many older frail vulnerable adults will only be in care homes for less than 2 years and will only want or be able to accept palliative or core dental care and support – it is vital that care homes for younger more independent adults are considered separately as their needs are different.	Thank you for your comments and concerns. We have clarified the populations and interventions described in the scope. The intention is develop generic oral health guidance for people in residential care not condition specific guidance which would require specialist training. All these issues will be taken into account by the committee when developing recommendations and there will be an opportunity to comment on the draft guideline. This is the draft scope document which sets out what the guideline may or may not cover. It may be the case that separate guidance is required for groups with different

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				needs, but we note and share your concerns.
British Society of Gerodontology	4.2.1	6	No mention of care plans – no point doing a risk assessment without acting on the outcomes No mention of induction training for care staff No mention of oral healthcare policies in care homes No mention of Care home champions in Oral Care in care homes who will act as the link for cascade training, monitoring, quality, oral health care risk assessment and care plan, No mention of joined up working regarding care provision for example occupational therapists for training in toothbrushing for residents with care resistive behaviour, dietitians re nutritional advice that has frequent high sugar content, GMP and xerostomic medication etc When conducting assessments of individual oral health in these groups there should be consideration of the value of pain assessment scores for non-verbal patients. Different teaching/training approaches in OH care for carers Training the dental profession in Oral Health Care	Thank you for your comment, the committee will take these issues into account when considering the evidence and developing recommendations. Examples in the scope are not intended to be exhaustive, nor is the scope intended to be a comprehensive overview of a topic, but we appreciate your concern. All of your suggestions would be covered by the current text in the scope. Please see our previous comments about the purpose and status of this document and the use of examples. Thank you. Further information about guideline development may be found here: PH Methods manual http://www.nice.org.uk/article/PMG4/chapter/1%20Introduction PH Process Manual http://www.nice.org.uk/article/PMG

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				5/chapter/1%20Introduction
British Society of Gerodontology	4.3 Question 1)	8	Recommended interventions Denture marking Denture hygiene training Identification of specific risk groups Management of patients with supplemental oxygen - dry mouth etc Advice on appropriate soft diets for patients who are unable to manage false teeth Dry mouth - medication and its management - not sugar containing sweets but xylitol containing sweets -evidence of inhibition of dental disease Thickeners used for patients with impaired swallowing, have high sugar content, users and carers need to be aware of risks	Thank you for your comments and suggestions, please see our previous responses.
British Society of Gerodontology	4.3 Question 2)	8	Mouthcare for Adults in Hospital in Wales 1000Lives plus - http://www.1000livesplus.wales.nhs.uk/mouthcare Caring for Smiles, Scotland http://www.nes.scot.nhs.uk/education-and-training/by-discipline/dentistry/areas-of-education/oral-health-improvement-caring-for-smiles.aspx British Society Gerodontology Oral Health Promotion for Older People Resources www.gerodontology.com	Thank you for your comments and suggestions, please see our previous responses.

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			Oral Health Care Champions in Care Homes Evidenced based approach to Oral Healthcare training	
British Society of Gerodontology	4.3 Question 3)	8	Lack of funds High turnover of care home staff Poorly paid care home staff Lack of national qualifications for carers Health Care Support Workers Lack of accountability of care homes in England for Oral Health Oral Health not a standalone section in Essence of Care England – different to Wales 'Fundamentals of Care' and Scotland CQC not looking at any specific standards that ensure that OH is carried out in care homes Poor access to domiciliary dental care in many parts of UK Lack of appropriate accessible public transport Dental premises not accessible for wheelchair users Dental workforce unskilled in providing care for people who have special care dentistry needs – i.e dementia Lack of understanding of the need for good oral health of carers Care homes staff not understanding that Dental health professionals need to know about medical health of residents Not using communication passports or medical passports Dental workforce should be using dental skill mix to provide dental care	Thank you for your comments and suggestions, please see our previous responses. We note your concerns.
British Society of Gerodontology			Lack of understanding of DoH that care home residents often only need or can accept palliative dentistry Poor understanding of dental profession regarding MCA, LPA for welfare, advanced decisions	Thank you for your comments and suggestions, please see our previous responses.

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			Increasing numbers of LPA for finance refusing to pay for dental care	
British Society of Gerodontology	4.3 Expected Outcomes	9	Mouthcare policy for care homes The home will have a mouthcare policy. Care plans must be devised for each individual resident. All staff must be trained in mouthcare on induction at the home and have regular updates. A champion/lead member of staff for mouthcare will be identified by the home. All residents will have a mouthcare risk assessment on arrival at the home and updated on a regular basis. All residents will have an oral care plan that is checked and updated regularly. All residents will have appropriate mouthcare products. All residents and their family and friends will have information leaflets about the need for good mouthcare. Residents who have dentures will have them labelled with their name. All residents will have a mouth check and receive regular dental care by a dentist. Residents receiving oral nutritional supplementation will be referred to the dental team for prevention advice. Any resident who has pain, discomfort or oral swelling will be referred to a dentist for assessment. The home will carry out regular audits to ensure good quality mouthcare for residents. Oral care pathways must be in place for these vulnerable groups.	Thank you for your comments and suggestions, please see our previous responses.
British Society of Gerodontology	References	13	The guidelines should reference the current Delivering Better Oral Health guidance from Public Health England (2014) British Society of Gerodontology - Oral Health Resources for Older People (http://www.gerodontology.com/ohr.html) may also be helpful.	Noted, thank you, and for your suggestions and references, we will consider your suggestions and amend the scope appropriately.

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			The paper cited by Rayner J, Holt R, Blinkhorn F et al. may not be relevant to the nursing and residential care population.	At time of publication for this draft scope document, the DBOH 2014 was not published, but thank you.
British Society of Gerodontology	General Comments		People who are dependent on others for their mouthcare are not specifically mentioned in the Scope. We think that this does not promote equality of opportunity relating to their disability. We think it is important to specifically refer to them as they can so easily be neglected. We would like Question 1 to have 'including those who are dependent on support staff for mouthcare' added at the end. If interventions to manage behaviours associated with resisting care or treatment will not be covered (4.2.2) then it will not be possible to answer Question 2 fully, re meeting the range of oral health needs experienced.	Thank you for your comment. Please see our previous responses about the status and purpose of this document and use of examples. The scope of this work includes all adults who live in residential or nursing homes and who are dependent on others for their oral hygiene. The intention is develop generic oral health guidance for people in residential care not condition specific guidance which would require specialist training. As mentioned previously, this is a heterogeneous group with complex needs. Other guidance addresses people living independently in the community. See http://www.nice.org.uk/guidance/indevelopment/GID-PHG61

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				We appreciate the point about resistive behaviour and share your concern, but disagree. Techniques and legislation to safely provide health and care related treatments or interventions, already exist and compliance is a legal requirement and common across a range of physical and mental health conditions. Whilst we understand your concern, we do not believe it appropriate to alter the current scope of work. The committee will carefully consider any care and safety issues during guideline development, but it is not within the remit of this guideline to address the broader issue of consent to care and treatment. The intention is not to duplicate existing national or international guidelines that are already in place and to be mindful of the limitations of this scope of work.
Community Dental Service, County Durham & Darlington NHS Trust	General		There is no mention made that there need to be consequences for carers who fail to provide adequate oral care	Thank you for your comment. This consultation is about the draft scope document, which sets out

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				what areas the guideline will and will not cover. This document is not the guideline. Although we appreciate your suggestions, the activities listed are examples of what could be covered and not intended as an exhaustive list. Once the scope is finalised and the evidence reviews commissioned, information will be identified systematically and presented to the committee in a series of reports or reviews. Any gaps in the evidence will be highlighted and attempts made to lose these gaps where feasible. The committee will make recommendations based on the evidence available, taking into account views of stakeholders. We hope this is helpful, but if you require further information please look at the NICE methods or NICE Process manuals. PH Methods manual http://www.nice.org.uk/article/PMG4/chapter/1%20Introduction

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				PH Process Manual http://www.nice.org.uk/article/PMG5/chapter/1%20Introduction
Community Dental Service, County Durham & Darlington NHS Trust	general		Patients in residential or nursing homes may, through, illness, infirmity, or lack of capacity to understand or tolerate medical procedures, struggle to cope with dental treatment with local anaesthesia alone, necessitating possible resort to sedation or general anaesthesia.	Thank you for your comments we note your concerns. Please see our previous responses.
Denplan	3	3-6	Denplan is pleased that NICE and the Department of Health have recognised the unarguable links between poor oral health and general health conditions, especially chronic and costly co-morbidities. Age UK reports the number of care home residents has increased by 21% between 2005 and 2013, totalling 431,500 people. This is spread across over 20,000 registered homes. We must ensure the system adapts to meet the oral health needs of this growing population.	Thank you for taking the time to read and comment on the draft scope.
Denplan	3b	4	The guidelines should also reflect the high number of adults that have undertaken complex dental restorative treatment during their lives. These patients may also require intensive maintenance procedures with the aim of retaining their teeth.	Thank you for your comment, your concern is noted and these issues will be considered by the committee when they are developing recommendations.
Denplan	4.1.1 – 4.1.2a	6	Denplan would strongly encourage the guidelines include the 414,700 adults living independently in receipt of homecare, as well as those in care homes. These adults will also have the high levels of unmet oral health needs referenced in section 3f. 7.4m people of all ages want to access NHS dentistry but report being unable to do so (Age UK), therefore it is important this equally hard-to-reach group is not excluded from the benefits of these guidelines.	Thank you for your comment. This population is covered under a separate piece of work due to publish in October later this year. Please see: http://www.nice.org.uk/guidance/indevelopment/GID-PHG61

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				This scope document is one of three pieces of work commissioned by the DH. We hope you will continue to comment on these documents. Thank you.
Denplan	4.1.1 – 4.1.2a	6	The guidelines should consider the dental care and management of patients living with dementia, as this population is growing alongside the evidence base linking poor oral health to the disease. With many people living with dementia at home, it is important for dental professionals to have access to this group. With dementia patients in particular, conducting assessments in familiar surroundings is crucial as compliance and cooperation can otherwise deteriorate significantly.	Thank you for your comment. People with dementia living in the in residential care are included in this guidance, with regard to people living with dementia in the community, please see our previous responses and work in development.
Denplan	4.1.2.b	6	Denplan is aware that dental care is also offered at a growing number of medium secure psychiatric units. With many patients unable to self-care, significant oral health needs exist in these settings. They should therefore be included in the guidelines.	Thank you for your comment, we agree and note your concerns. The aim of the work requested by the DH is to produce generic guidance about oral health delivered in care homes with or without nursing provision. While we share your concerns about other settings offering highly specialised treatment and care, this work will not develop guidelines to manage specialised oral health care needs for health

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				(including mental health) a range of conditions. If you think additional, more specific guidance should be considered by NICE please get in touch. Suggest a topic http://www.nice.org.uk/about/nice-communities/public-involvement Thank you for raising.
Denplan	4.2.1.a	7	The draft scope lists approaches that will be covered by the guidance to promote oral health. Conducting assessments of an individual's oral health requires clarification as this is a clinical intervention and should be understood as such. Section 4.2.2.b excludes the activities of dental clinical interventions from the guidelines. An examination is intervening in the care and wellbeing of the patient. It must also be conducted by a dental professional.	Thank you for your comments. This is the draft scope and sets out what the guideline may or may not cover. The examples given in the document are not intended to be exhaustive and the use of the term 'assessment' is simply meant to convey that this is an area the committee will consider. The final content of the guideline is not yet determined and what an assessment of oral health should cover on entry to care will be determined by the evidence and the committee. We note your concerns. The aim of the work is to produce generic

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				guidance about oral health delivered in care homes with or without nursing provision. While we share your concerns, this work will not develop specialised guidelines to manage oral health for specific health (including mental health) conditions. We considered your suggestions but did not think it necessary to amend the text in the scope.
Denplan	4.2.1.a	7	Maintaining access to dental services must be strengthened in the guidelines to include access to dental professionals. Whilst providing dental healthcare advice and guidance is prudent, without deploying the skills of a dental professional there will be no defined outcomes or measurements by which to quantify whether oral health has improved. The latter point on this bullet regarding 'joining- up dental health services with other health initiatives' should be understood in the context of the wider integration agenda. Dentistry is an integral part of healthcare and should be recognised as such.	Thank you for your comment, your concerns are noted. Please see out previous response about the status and purpose of this document.
Denplan	4.2.1.a	7	Denplan is fully supportive of training care home staff in oral health. This should be included in the training curriculum for all staff caring for vulnerable, ageing or disadvantaged patients.	Thank you for your comment and raising your concerns. Please see out previous response about the status and purpose of this document.
Denplan	4.2.1.a	7	Denplan strongly recommends that vulnerable, ageing or disadvantaged patients exclusively use fluoride toothpaste that is at least 1,350ppm fluoride. Denplan would however question the evidence base of fluoride supplements as we are as yet, unaware of their effectiveness in this age group.	Thank you for your comment and raising your concerns. Please see out previous response about the status and purpose of

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				this document.
Denplan	4.2.1.a	7	More resources both in terms of staffing levels and equipment will be required to effectively improve the oral hygiene of patients in residential settings. The equipment and facilities used are expensive and needed for use in practices and in general, non-compliant with current regulations. Additionally there are not enough dental professionals, inclusive of hygienists, to treat the volume of patients in these settings.	Thank you for your comment, your concerns are noted. Please see out previous response about the status and purpose of this document.
Denplan	4.2.1.a	7	Denplan would encourage NICE to consider the increased risk of infection if electric toothbrushes are shared. Oral B is developing an initiative to prevent handle contamination and cross-infection risk by providing multiple heads and handles, as well as decontamination facilities.	Thank you for your comment, your concerns are noted. Please see out previous response about the status and purpose of this document.
Denplan	4.2.1.a	7	Managing transitions in cases where oral function deteriorates or a person's diet changes is very important and Denplan supports the inclusion of this in the guidelines.	Thank you.
Denplan	4.2.1.b	7	Denplan is supportive of this point.	Thank you.
Denplan	4.2.2.a	8	The failure of the guidelines to cover dental clinical interventions directly contradicts 4.2.1.a on page 7, in which the conducting of assessments of an individual's oral health are included. This is a clinical intervention in the care and wellbeing of the patient.	Thank you for your comment, please see previous responses. For the purposes of this document the term 'assessments' is intended to be interpreted more broadly, so is not a contradiction. But thank you for raising the issue. The purpose of this work is to develop generic oral health guidance, so specialised oral health interventions for specific health

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				conditions, which is particularly important given the heterogeneity of the populations identified. Please see our previous responses. If you think that NICE should consider other guidelines around this topic please get in touch: http://www.nice.org.uk/about/nice-communities/public-involvement
Denplan	4.2.2.c	8	Denplan agrees with this approach.	Thank you.
Denplan	4.2.2.d	8	Denplan is concerned that the training of carers in specific techniques to help people with their oral health, will not be covered in the guidelines. It is important for carers to know how to perform and supervise the carrying out of oral hygiene when patients are unable to self-care. Without essential training of care staff, the guidelines will only raise awareness similarly to information dissemination.	Thank you, we note your concern but try to avoid duplicating other guidelines or legislation. The final guideline may signpost to training delivered by the appropriate national bodies. Please see our previous responses.
Denplan	4.2.2.e	8	Denplan agrees that interventions to manage behaviour should not be included as this is a particularly difficult area to prescribe for. We would argue however, that where poor oral healthcare poses a risk to life, such as when patients are unable to eat, some form of restraint may be ethically required subject to usual precautions. Precautions would include the sensitive handling of the situation and effective communication to explain the patient's best interests.	Thank you for your comment and for raising this point. The committee will take into consideration any health and safety concerns during guideline development and the final

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				guideline will cross reference to the appropriate guidelines or legislation. Techniques and legislation to safely provide health and care interventions, complying with existing consent procedures already exists and are common to a number of conditions. Whilst we share your concerns, we do not believe it appropriate to alter the scope.
Denplan	4.3. Question 2	8	The recent publication by Public Health England on 'Delivering better oral health: an evidence-based toolkit for prevention' presents the professional standards which should be included in NICE guidelines.	Thank you for your comment. We are aware of the work but the more recent document was not published at the time we went to press. The final scope document will be amended appropriately.
Denplan	4.3. Question 3	8	Help: 1. Effective liaison with local health professionals, including dental public health professionals, GPs (particularly those providing domiciliary services), as well as salaried services, will help to identify need. 2. Raising general public awareness around core dental health messages. 3. Training programmes for carers. 4. Routine inclusion of oral health in individual patient care plans 5. Management responsibility assigned for oral healthcare and ongoing assessments. 6. Initial and regular assessments of oral health.	Thank you for your suggestions. Please see our previous comments and reference to other work in development. We considered your suggestions but did not think it necessary to change the text on this occasion, as these activities will not be excluded by the current wording.

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			7. Access to effective local dental services through improved and incentivised provision of both private and publicly-funded dental domiciliary services. 8. A systematised approach to access whether publicly or privately funded would significantly reduce associated costs.	
Denplan	4.3. Question 3	8	Hinders: 1. Prevailing failure to integrate dentistry into the wider health care system. 2. Continued lack of knowledge by general public and health professionals of the importance of oral health promotion in the context of general health. 3. Limited provision of NHS contracts for domiciliary care. 4. Limited awareness by relatives and attorneys of the importance of oral health to the wellbeing of a person requiring care. 5. Lack of suitably compliant equipment to conduct assessments in domiciliary settings due to numerous regulatory barriers.	Thank you for your comments and helpful suggestions. Please see our previous responses about the status and purpose of this document. We hope you will comment on the draft guidelines when they are available.
Department of Health	General		I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you.
East Cheshire NHS Trust	3. a)	3	Include prevention of aspiration pneumonia and references in this section.	Thank you for your comment and suggestions, we appreciate your concern. This consultation is about the draft scope document, which sets out what areas the guideline will and will not cover, it is not intended to be a comprehensive overview of a topic area. We considered your suggestions but did not think it necessary to change the wording on this occasion.

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				If you require further information please look at the NICE methods or NICE Process manuals. PH Methods manual http://www.nice.org.uk/article/PMG4/chapter/1%20Introduction PH Process Manual http://www.nice.org.uk/article/PMG5/chapter/1%20Introduction
East Cheshire NHS Trust	General		Specify CQC outcomes oral health links with, and suggest roles and responsibilities of care home staff and dental team to comply.	Thank you for your comment. This is the draft scope which sets out what the guideline may or may not cover. Examples of outcomes or activities are not intended to be exhaustive and if required the final guidelines will cross refer to other relevant guidelines. The final content of the guideline will be considered by the committee.
East Cheshire NHS Trust	General		Include triggers and references for Mental Capacity Act Assessments and Best Interest Assessments.	Thank you for your comment and suggestions. Please see our previous responses. The committee will take these issues into account when considering the evidence and

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				developing guideline recommendations. The final guideline will cross refer to relevant guidelines and legislation.
East Cheshire NHS Trust	General		Include guidance for when oral health falls below what is expected e.g. framework for onward referral – senior qualified staff, home manager, quality monitoring team, CQC	Thank you for your comment and suggestion, please see our previous response.
East Cheshire NHS Trust	General		Include a reference to Essence of Care 2010 – benchmarks for personal hygiene.	Noted, thank you.
HEE KSS Postgraduate Deanery	3 (a) 3rd paragraph	4	Could mention oral health and increased risk of dementia and quote some references	Thank you for your comments and helpful suggestions. We considered your suggestion but did not think it necessary to alter the current wording of the scope. This consultation is about the draft scope document, which sets out what areas and populations the guideline will and will not cover, so is not intended to be a comprehensive overview of a topic area. If you require further information please look at the NICE methods or NICE Process manuals. PH Methods manual http://www.nice.org.uk/article/PMG

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				4/chapter/1%20Introduction PH Process Manual http://www.nice.org.uk/article/PMG5/chapter/1%20Introduction
HEE KSS Postgraduate Deanery	3 (f)	5	Barriers to frontline staff carrying out oral health related activities could be referenced here	Thank you for your comment and suggestion. Any examples of outcomes or activities are not intended to be exhaustive.
HEE KSS Postgraduate Deanery	4.2.1a) bullet 4	7	Fluoride mouthwashes could be mentioned here to increase access to fluoride for people living in care homes.	Thank you for your suggestion.
Pennine Care NHS Foundation Trust – Community Dental Service	General		The Community Dental Services hosted by Pennine Care NHS Foundation Trust already promote some of the activities outlined in the draft document. There is a focus in the educational activities in view to reduce the establishment and/or progression of oral diseases. Unfortunately we are at the moment reliant on the referral from the Care Homes or associated health professionals before we can visit their residents. It is our opinion that a mandatory oral health check on entry with the establishment of a oral care plan with regular visits and tailored education measures when appropriate (for both resident and carer staff) should be a mainstay of the guidance. We already endeavour to reach this status. We are very fortunate in the fact that we still have an in-house Oral Health Promotion team.	Thank you for taking the time to read and comment on the draft scope. We hope the final guideline will be useful to your organisation and look forward to receiving your comments when the draft guideline is released.
Public Health England	1	1	We fully support that the guideline should apply to all adults in nursing and residential care settings and not just older people.	Thank you for taking the time to read and comment on the draft

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				scope.
Public Health England	2b	1	Reference should be made to "Choosing Better Oral Health, DoH 2009" and should be updated to include the latest edition of "Delivering Better Oral Health DoH 2014"	Thank you, the final version of this document was not available at the time the scope went to publication. We will amend the final scope to reference the published final version.
Public Health England	2c	2	It is important that the guidance is explicit about the need for effective quality assurance of oral health care in residential settings, both in the quality of care provided by staff in the residential setting and also for visiting oral health care professionals.	Thank you for your comment and helpful suggestion, your concern is noted. The committee will consider the evidence and any issues about quality assurance when they are developing recommendations if appropriate.
Public Health England	2e	3	This makes a reference to section 6 which is not present in the document.	Thank you, this has been corrected.
Public Health England	3b	4	The reference that cosmetic dental care is causing more complex oral health needs is confusing and suggests that problems arise from only cosmetic care. The key issue is that the Adult Dental Health Survey 2009 shows that elderly people have heavily restored dentitions and that this is the most significant burden for future complex restorative care for elderly people.	Thank you, your concern is noted.
Public Health England	4.1.1 a	6	The definition of adults in residential care needs to be explicit that it covers all client groups, patients with learning disabilities, neurological disabilities and those clients requiring extensive residential based rehabilitation, including veterans.	Thank you for your comment, we have amended the final scope to include 'all adults'. The final scope population is for all adults in residential care with or

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				without nursing provision.
Public Health England	4.1.2	6	We consider that is inappropriate to specifically exclude people who are receiving end of life care from this guideline. It is not appropriate to exclude people who are terminally ill. Such individuals may have a life expectancy of many months or years after a diagnosis of a terminal illness; a time period where significant dental disease may develop. Terminally ill people should not be put at risk of developing further diseases which may adversely affect their quality of life.	Thank you for raising this important point. We agree, it was never the intention to exclude these populations from the guidance and we have clarified the final scope. However, the aim of the work is to produce generic guidance about oral health delivered in care homes with or without nursing provision. This work will not develop specialised guidelines to manage oral health for specific health (including mental health) conditions. We have amended the scope to clarify this aim and hope this is helpful. If you think that NICE should consider developing other guidance about oral health please see: Suggest a topic http://www.nice.org.uk/about/nice-communities/public-involvement

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				For further information about NICE public health methods and process please see: PH Methods manual http://www.nice.org.uk/article/PMG4/chapter/1%20Introduction PH Process Manual http://www.nice.org.uk/article/PMG5/chapter/1%20Introduction
Public Health England	4.1.2	7	Assessment of clients oral health needs should be undertaken on a regular basis not just on entering a residential setting. Any key changes in a client's health status should trigger a review of their oral health care plans.	Thank you, please note this is the draft scope and these examples are not intended to be exhaustive. The content of the recommendations in the final guideline will be determined by the committee. The current text of the scope would not exclude consideration of the frequency and type of assessment, so on this occasion we have not changed the current wording, but thank you for your helpful suggestion.
Public Health England	4.2.1	7	Access to dental care should include issues of governance and quality assurance.	Thank you for your comment and

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			Effective records must be kept of which oral health care professional or practice/service is providing care for an individual and the contact details of the provider. Access to dental care should include the need to insure both accesses to routine dental care as well as the provision of urgent and unscheduled care required, to effectively meet the varying needs of clients.	suggestion. The committee will take these issues into account when considering the evidence and developing recommendations. Please see our previous responses.
Public Health England	4.21	7	Staff training should include the need for a minimum standard of training for all staff providing personal care. This should have defined oral health content and a quality assurance process. Training should be subject to regular evaluation and refresher training should be provided at set regular intervals for all staff. The requirement for training and a summative assessment for all staff should be part of the contract specification for all providers of adult residential care. It is important to recognise the need for all oral health care professionals to provide consistent advice, training and education to staff providing personal oral health care in residential settings. Without a consistent approach there is a danger of inconsistent and conflicting advice being given to staff.	Thank you for your comment and suggestions, please see our previous responses.
Public Health England	4.2.1	7	Maintaining access to dental care should specifically recognise the need to insure that clients have care provided in appropriate settings. A proportion of a client's care may be met by domically care but some clients will only be able to have their clinical needs met in a dental surgery setting. The Guidance must state that transport to dental facilities should be available and that these faculties must be fully accessible for people with all levels of disability.	Thank you for your comment. We share your concerns, but please see our previous responses about the status and purpose of this document.
Public Health England	4.2.2	8	The scope of the guidance should include concentrations of fluoride for clients	Thank you for your comment.

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			using different vehicles for their delivery. Building on best practice as set out in "Delivering Better Oral Health" This is excluded but should be covered in the document.	Public health guidelines do not cover the content of particular preparations, in this case concentration of fluoride in any particular product. The final guideline will refer to the most recent guidance from DBOH, as other NICE oral health work has done.
Public Health England	General		The guidance does not include the issue of consent for clients with cognitive impairment. This is an important issue both for the provision of personal care, tooth brushing but also to enable active dental treatment to take place where a client has active dental pathology.	Thank you for your comment. Just to clarify, this is not the guidance, this is the draft scope, and sets out broadly what the guideline may or may not include. Please see our previous responses about the status and purpose of this document. The content of the final guideline will be determined by the committee taking into account the evidence and considering any relevant issues of health and safety in relation to person centred care. The issue of consent is common across many conditions and across a range of populations, and is already covered by existing national and international

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				guidelines and legislation. Iit is not within the remit of this guideline to address the broader issue of consent to care and treatment. We have considered your comments but do not believe it is appropriate to alter the wording in the final scope document about this issue.
Public Health England	General		There is a need to identify effective leadership for the strategic development of oral health care and services for people in residential care. This should include, LA Directors of Adult Social Care, NHS England (which would include representatives of the local dental profession), Consultants in Dental Public Health, Consultants in Special Care Dentistry and Residential Care Facility providers.	Thank you for your comment and helpful suggestions, please see our previous response.
Royal College of Nursing	General		The Royal College of Nursing was invited to comment on the draft scope for the oral health in nursing and residential care guidance. The document was circulated to RCN staff and members working in this area of practice for their views. Find below comments received from the reviewers.	Thank you for taking the time to read and comment on the scope.
Royal College of Nursing	Section 3, paragraph e)		This paragraph states that 43% of residents have a diagnosis of dementia (2011). One member commented that in her experience it is nearer to 70% of adults living in care homes that have a diagnosis of dementia. Is there more recent data available considering that this was published in 2011?	Thank you for your comment. We would agree that practitioner experience suggests the rates of observed dementia are higher than the AGE UK data implies . However, it has proved difficult to obtain accurate national data for England to give an informed

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				picture of this particular group of people living in residential care. If you or colleagues have any current reliable data we would be delighted to receive it. However, this does not affect the development of the guideline nor any potential recommendations for this group.
Royal College of Nursing	Section 4.1.2, b)		Greater clarity is needed in relation to the phrase 'residences offering end of life care'? Is this just referring to hospices or are care homes included within this group? End of life care should be covered in this guidance as this is relevant to all care homes.	Thank you for your comment and for raising this important issue. We agree, it was never the intention to exclude these populations from the guidance. We have clarified the final scope and hope this is helpful. The aim of the work is to produce generic guidance about oral health for all adults delivered in care homes with or without nursing provision. This work will not develop specialised guidelines to manage oral health for specific health (including mental health) conditions.

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				For further information about NICE public health methods and process please see: PH Methods manual http://www.nice.org.uk/article/PMG4/chapter/1%20Introduction PH Process Manual http://www.nice.org.uk/article/PMG5/chapter/1%20Introduction We hope this helps.
Royal College of Nursing	Section 5		The following RCN guidance may also be helpful to note when developing these guidelines, as it is relevant to all settings, especially community services and care homes. ***Promoting older people's oral health. Nursing Standard Essential Guide***, Hazel Heath, Deborah Sturdy and members of the British Society of Gerodontology Oral Health Promotion Working Group. 2011.	Thank you for your comments and helpful suggestions. We will pass your references to the review team.
Royal College of Nursing	General		The issue of capacity to consent needs to be covered at some point in the guidance.	Thank you for your comment, your concern is noted. The issue of consent is common across many conditions and across a range of populations, and is already covered by existing national and international

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				guidelines and legislation. It is not within the remit of this guideline to address the broader issue of consent to care and treatment. Nevertheless, health and safety issues will be considered by the committee during guideline development, and recommendations will consider where person centred care should be highlighted.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	General		This is a very welcome and necessary start to guideline production. The population is living longer with more complex disease and treatments. In addition, those born with disabilities are surviving with increasingly complex disabilities. They have a greater burden of oral disease, but reflecting the improvement in oral health of the rest of the population, are maintaining their dentition more than has been the case in the past. Provision of dental treatment can be very challenging and individuals may be unable to advise if they are experiencing oral ill-health, so prevention is vital.	Thank you for taking the time to read and comment on the draft scope.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	2a	1	The Scottish Government supports an oral health promotion programme "Caring for Smiles" in each Health Board. http://www.healthscotland.com/uploads/documents/5751-CaringForSmilesCard.pdf	Thank you for your suggestion, we are aware of the programme and reference this in other oral health guidelines.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	2c	2	Other professionals providing care should be made aware including medical practitioners/ social work, given the significant impact oral health can have on an individual's health and well-being	Thank you for your comment, we note your concern and suggestion.

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Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	3	4	In addition to the impact on general health, provision of treatment of dental disease may be very challenging. Patients may be unable to comply due to a physical disability/ movement disorder; a learning disability; mental ill-health including dementia. They may require sedation or general anaesthesia for examination as well as treatment. This may not be possible due to their medical condition. Hence the consequences of their poor oral health (which may be preventable) are more severe. Thus the importance of prevention of disease is heightened.	Thank you for your helpful comments and suggestions, they are noted.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	3g	5	The impact of systemic disease and conditions is acknowledged here. Individuals who are PEG fed have particular oral health difficulties; patients who have had eg radiotherapy to the head and neck have particular difficulties. Due to medical advances, individuals with significant disease are surviving longer, and having to cope with the side effects of their medical and surgical treatments.	Thank you for your comment and suggestions.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	3g	5	The conflict between medical care and oral health needs to be acknowledged eg the need for high calorie supplements.	Thank you for your comment, your concern is noted and the committee will take this and other issues into consideration when developing the recommendations.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	3g	5	Consider addressing particular examples of challenges as mentioned above.	Thank you, noted..
Faculty of Dental Surgery, Royal College of Physicians and Surgeons	4.1.2 b	6	There is a need to draw a line in the sand, but the principles of oral health care for long stay residents of psychiatric hospitals will be the same.	Thank you for your comment, we agree and considered the issue of specific oral health care needs and

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of Glasgow				have clarified the final scope document and hope this is helpful. The aim of the work requested by the DH is to produce generic guidance about oral health for all adults delivered in care homes with or without nursing provision. We share your concerns about inadvertently excluding particular groups and have amended the scope, but this work will not develop specialised guidelines to manage oral health for specific health (including mental health) conditions. If you believe that NICE should consider developing other guidance about an issue, please see suggest a topic http://www.nice.org.uk/about/nice-communities/public-involvement
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	4.1.2c	6	The guidance will not include “young people”. Will it include those between 18 and 65? Older people have great need, however, younger people in nursing and residential care have significant needs and high oral disease risk.	Thank you for your comment. The scope has been amended appropriately and the population clarified to include adults in residential care with or without nursing provision (aged 18 and

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				over).
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	4.2.1a	7	It is important to recognise the potential difficulties of access, both physical and social.	Thank you for your comment, your suggestion is noted.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	"	7	Care home staff need to be aware of the need for and their responsibility to have available information regarding benefits and entitlements for those for whom they care	Thank you for your comment and helpful suggestion, the committee will take this and other issues into consideration when developing recommendations.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	"	7	Perhaps beyond the scope of this guidance, but can further consideration be given to extended duties dental nurses as in the Childsmile project in Scotland (Extended Duties Dental Nurses apply fluoride varnish to nursery and primary school children's teeth).	Thank you for your comment and suggestion. The committee will consider a range of information about activities that may be useful for this group when developing recommendations. FYI other oral health work developed by NICE may be found at: http://www.nice.org.uk/guidance/indevelopment/GID-PHG6 http://www.nice.org.uk/guidance/indevelopment/GID-PHG61

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Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	"	7	Is there a funding stream for provision of free oral care items?	Thank you for your comment. This is not a question about the draft scope of the work, so we are unable to answer, but again this is just an example of an intervention that could be considered if supported by evidence. The content of the recommendations will consider evidence of effectiveness and cost effectiveness.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	"	7	Oral health education needs to include awareness of soft tissue disease at a basic level ie oral cancer, oral dryness, ulceration	Thank you for your comment and suggestion, your suggestion is noted.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	4.2.2	8	The duty of care to those for whom they care needs to be emphasised. The point is made that staff are more willing to deal with incontinence than oral health. It is recognised that individuals may be less compliant for oral healthcare, and whilst it is beyond the scope of this guidance to suggest management strategies, the issue needs to be addressed. See British Society for Disability and Oral health Guidance document: http://www.bsdh.org.uk/userfiles/file/guidelines/longstay.pdf	Thank you for your comment and suggestion, we will send any references to our review team and will cross refer to relevant guidelines in the final NICE guideline. The committee will consider these issues when developing recommendations.
Faculty of Dental Surgery, Royal College of	4.3 Expected outcomes	9	A desirable outcome would be the mentioned change in attitude of all staff and professionals to include an improved recognition of the impact of poor oral health	Thank you for your comment. We agree, but the draft scope only

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Physicians and Surgeons of Glasgow			on systemic health and general well-being and the potential catastrophic effects of poor oral health.	offers examples of outcomes and activities, they are not intended to be exhaustive. We have considered your suggestion but as this outcome would not be excluded by the current wording in the scope, we have not changed the current text.
Faculty of Dental Surgery, Royal College of Physicians and Surgeons of Glasgow	General		Great news that this is being addressed. Important to remember	Thank you for your comments and very helpful suggestions. We hope you will comment on the draft guideline when it is released for consultation.
Royal Pharmaceutical Society	Section 4.2.1	7	Pharmacists provide a number of services to residential and nursing homes, such as medicines use reviews, flu vaccinations, as well as supplying medicines. Some community pharmacists provide an enhanced service, advising and supporting residents and care home staff, "*to ensure the proper and effective ordering of drugs and appliances and their clinical and cost effective use, their safe storage, supply and administration and proper record keeping*". Further information can be found on the Pharmaceutical Negotiating Committee's website at: http://psnc.org.uk/services-commissioning/locally-commissioned-services/service-specifications-and-resources/en5-care-homes/.	Thank you for taking the time to read and comment on the draft scope, and for your helpful suggestions.
Royal Pharmaceutical Society			RPS Scotland has also published guidance on *Improving Pharmaceutical Care in Care Homes*, highlighting the important contributions pharmacists make to residents, patients and staff in care homes:	Thank you for your comment, helpful suggestions and references which we will pass to our review team.

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			http://www.rpharms.com/promoting-pharmacy-pdfs/rpscarehomereportfinalmarch2012.pdf. Pharmacists providing care home services have ample opportunities to speak to patients about their oral health and provide advice on how to maintain good oral health. We would like to see dental health services being joined up with pharmacy services, and recommend that appropriate wording to explain this is added to this section of the draft scope.	The committee will consider a range of information and evidence during guideline development and will consider the issues you raise. We hope you will comment on the draft guideline when it is released for consultation.
Scottish Consultants in Dental Public Health and Chief Administrative Dental Officers Group	General		Our main concern is over the exclusion criteria in the draft scope, in particular: 1. Excluding 'residences offering end of life care' in 'Groups that will not be covered' 2. Excluding 'specific techniques for carer to help people with their oral hygiene' in 'Activities that will not be covered'. 3. Excluding 'Interventions to manage behaviours associated with resisting care or treatment' in 'Activities that will not be covered'. See below for more detail.	Thank you for taking the time to read and comment on the draft scope and for raising these important points. We have amended and clarified the final scope document where appropriate and responded to your concerns below. Please see our responses to the specific concerns raised: <u>FYI Consent</u> Any relevant issues concerning the health and safety of residents will be considered in relation to promoting person centred care and

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				cross referring to relevant guidance and legislation. The issue of consent is common across many health conditions, and is already covered by existing national and international guidelines and legislation. If you think that NICE should consider developing clinical practice guidance about oral health for these groups please see: Suggest a topic http://www.nice.org.uk/about/nice-communities/public-involvement For further information about NICE public health methods and process please see: PH Methods manual http://www.nice.org.uk/article/PMG4/chapter/1%20Introduction PH Process Manual http://www.nice.org.uk/article/PMG5/chapter/1%20Introduction

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				We hope this helps.
Scottish Consultants in Dental Public Health and Chief Administrative Dental Officers Group			1. Many care homes for older people provide palliative and end-of-life care. Effective mouth care informed by 'best practice' at this stage is crucial. Not covering 'residences offering end-of-life care' pg 6, 4.1.2, b) in the scope risks developing a guideline which fails to incorporate this essential aspect carried out by many care home staff . Palliative and end-of-life guidelines on mouth care exist, but by not incorporating such guidance in a document for adults in care homes this may result in staff remaining uninformed of the special care requirements of care home residents at end of life.	Thank you for your comments and raising your concerns about this important issue. We agree and it was never the intention to exclude these populations from this public health guidance, The aim of this work is to produce generic public health guidance about oral health for all adults, delivered in care homes with or without nursing provision. We share your concerns about inadvertently excluding particular groups and have clarified this issue in the final scope document, but this work will not develop specialised guidelines to manage specific oral health care needs for specific health (including mental health) conditions. We have carefully considered your suggestions and amended the scope appropriately. We hope this helps.

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Scottish Consultants in Dental Public Health and Chief Administrative Dental Officers Group			2. Page 7, 4.2.1 (Activities that will be covered), 5th bullet, states that techniques for brushing teeth and maintaining healthy dentures will be included, while page. 8, 4.2.2, d) states that specific techniques 'for carers to help' will be excluded. This implies that the guidelines will focus on individuals who retain the capacity to self-care. Promoting self-care techniques to those who remain able is beneficial - however, people generally come into care due to decreasing ability, and we feel guidelines which focus on those most in need, i.e. those dependent on others to provide the care, are required. Increasing knowledge about the importance of oral health of staff is necessary but not sufficient. The stated 'reluctance of a proportion of frontline staff to carry out activities related to oral health' can be a lack of confidence rather than an assumed distaste for the task.(1) The challenges inherent in providing effective intra-oral care are often underestimated, although the scope does highlight an 'extra layer of complexity' brought about by poor oral health, treatments for chronic medical conditions, including dementia. Interventions which incorporate practical skills training for care staff detailing specific techniques (such as approach and	Thank you for your comments, your concerns and suggestions are noted. Please see our previous responses. The current guideline is intended to cover a heterogeneous population with a range of abilities and conditions, including those who are more able. As you rightly point out, people come into residential care for a variety of reasons, for varying lengths of time, with different conditions and co-morbidities. This is a complex population with a range of varied oral health care needs which will be taken into consideration by the committee as the work progresses. Training needs are not excluded from this work, but it would not be possible to cover the content of such training needed to cover this

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			holding positions for people with dementia, how to remove, clean and reinsert dentures, care procedures for natural teeth and soft tissues), are necessary and this should be reflected in any guidelines. The 'reduced manual dexterity' of many residents, noted on pg 5, 3.g) also suggest the need for specific techniques for carers to be included. Excluding techniques appears to be in contradiction with a number of aspects stated in section 3. 'The need for guidance'	complex group. The final guideline will cross refer to the appropriate current national guidelines such as 'Delivering better oral health' PHE 2014 or any other relevant guideline or legislation. We hope this helps and that you will continue to comment on the draft guideline when it is available. If you believe that NICE should produce separate guidance on these issues please see Suggest a topic http://www.nice.org.uk/about/nice-communities/public-involvement
Scottish Consultants in Dental Public Health and Chief Administrative Dental Officers Group			3. Although there is evidence that the oral health status of residents in long-term care is generally poor, there is substantial evidence that it is those residents with dementia who will have the poorest oral health status,(2)(3)(4)(5)(6)(7)and that this will likely deteriorate further in line with progression of dementia. The draft scope suggests	Thank you for your comments, please see our previous responses. We would agree that practitioner experience suggests the rates of observed dementia are higher than the AGE UK data would suggest. It has proved difficult to get

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			the percentage of adults with dementia in care homes to be around 43%. In Scotland, 52% of residents had a formal diagnosis of dementia in 2013.(8) However, taking account of acknowledged high rates of undiagnosed dementia, the UK's Alzheimer's Society estimate this to be closer to 80%. Research suggests that a key causal factor of poor oral health and continued deterioration in oral health evident in care home population is resistance to care.(3) Care-resistance is relatively rare in people with no or mild cognitive impairment, but increases proportionally with the progression of the impairment, resulting in the highest prevalence in those with severe impairment.(9) Another deleterious influence on the oral health of people with dementia is often the inability to communicate oral or dental pain to care staff. Without adequate guidance and training on care-resistance strategies, staff may be less effective in providing necessary oral care for this group most vulnerable to poor oral health. There is increasing recognition that the invasive nature of oral care, especially for the increasing numbers of older people retaining natural dentition, requires strategies specific to oral care. (3)(10)	accurate national data for England to give an informed picture of this particular group of people living in residential care. If you or colleagues have any current reliable data for England we would be delighted to receive it. However, this will not affect the scope or content of the current piece of work. Techniques and legislation to safely provide health and care related treatments or interventions, already exist and compliance is a legal requirement and is common across a range of physical and mental health conditions. Whilst we share your concern, we do not believe it appropriate to alter the current scope of work. The committee will carefully consider any care and safety issues during guideline development, but it is not within the remit of this guideline to address the broader issue of consent to care and treatment.

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Scottish Consultants in Dental Public Health and Chief Administrative Dental Officers Group			3. Continued Stakeholders have been invited to comment on whether this scope could be changed to better promote equality of opportunity. We assume this is incorporates equal rights to good oral health and quality of life for those dependent on others to provide this. Excluding interventions to manage behaviours associated with resisting care or treatment (pg 8. 4.2.2. e) in a guideline aimed at improving the oral health of care home residents is unlikely to tackle a key factor contributing to poor oral health in this population.	Thank you for your comment and for raising this important concern. We would refer to our previous responses which clarify the intended scope of the work and how it will address the needs of the populations identified. If needed the final guideline will refer to existing national and international guidelines and legislation to support good practice and person centred care.
Scottish Consultants in Dental Public Health and Chief Administrative Dental Officers Group	General		All staff in Care Homes need comprehensive training in Oral Health Care and the Caring for Smiles model is an excellent basis on which to develop such a strategy. Further information available at http://www.nes.scot.nhs.uk/education-and-training/by-discipline/dentistry/areas-of-education/oral-health-improvement-caring-for-smiles.aspx	Thank you for your suggestions.
Scottish Consultants in Dental Public Health and Chief Administrative	General		Early Assessments of Oral Health status and oral health risks need to be done within a very short time after admission. Daily recording	Thank you for your suggestions. Please see our previous responses about the purpose and status of

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Dental Officers Group			of oral health care provision is necessary. The importance of this should be highlighted to all Managers of Care Homes. This was highlighted in the Fatal Accident Inquiry determination in the case of Elizabeth McGaw http://www.scotcourts.gov.uk/search-judgments/judgment?id=d2aa8aa6-8980-69d2-b500-ff0000d74aa7	this scope document.
Scottish Consultants in Dental Public Health and Chief Administrative Dental Officers Group	4.2.1 a) bullet 4 4.2.2 d)	7 8	This states that increasing access to fluoride will be covered. This states content of fluoride toothpastes etc will not be covered. If fluoride is to be covered, then highlighting the content difference between what is available over the counter versus what can be prescribed is information that would be helpful to staff.	Thank you for your comment. Please see previous responses. The final guideline will cross refer to appropriate national guidance about the content of fluoride products (e.g. Delivering better oral health 2014). The concentration of fluoride in fluoride products is outside the scope of this current guideline.
Scottish Consultants in Dental Public Health and Chief Administrative Dental Officers Group		9	The section detailing the expected outcomes only notes changes in policies or procedures, knowledge and attitudes of managers and staff. We would suggest including 'change in practice' as a critical outcome.	Thank you for your comment. This is the draft scope and the example of activities or outcomes are not intended to be exhaustive.
Scottish Consultants in Dental Public Health and	4	6	This section notes that the scope (what will and will not be examined) is based on the referral from the Department of Health.	Thank you for your comment. Please see our previous

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Chief Administrative Dental Officers Group			The minimal information given on page 11 relating to the scope does not suggest that the exclusions are based on the DofH requirements as stated.	responses. The referral has been interpreted taking into account the focus of NICE public health guidance and the resources available.
Welsh Government	2b	1	Delivering Better Oral Health : an evidence based toolkit for prevention. The link is not working. It connects to version 2. Version 3 was published by PHE in June 2014	Thank you for your comment. The latest version was not available at the time of going to press, this has been amended.
Welsh Government	2b	2	There are 2 additional publications which would be useful to add for colleagues in Wales- Fundamentals of Care www.wales.nhs.uk/documents/ACF1153.pdf National Minimum Standards for Care Homes for older people, CSSIW http://cssiw.org.uk/providingacareservice/regs-nms/adult-services/?lang=en	Thank you for your comment and suggestions. The scope has been amended, but these documents are outside the current scope of work. NICE Guidance is adapted for use in Wales and Scotland separately by the appropriate national bodies.
Welsh Government	2c	2	4th Bullet point – please add Care and Social Services Inspectorate Wales after “Care Quality Commission”	Thank you, please see our previous response.
Welsh Government	4.2.1a	7	Suggest 2 additional activities-	Thank you for your suggestions, the activities and outcomes are

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			Care homes need a straightforward policy on oral and dental care After "conducting assessments…..", an additional bullet point that delivery of individual care plans must follow the assessment	intended to be examples only. The committee will consider these issues you highlight during guidance development.
Welsh Government	General		A great deal of work is already underway in Wales and Scotland to address the issue of oral and dental care for care home residents. It will be essential to capture the breadth of this work as part of your information gathering.	Thank you for your comment.