Confidential Public Health Guidelines

ORAL HEALTH: LOCAL AUTHORITY ORAL HEALTH IMPROVEMENT STRATEGIES - Consultation on Draft Guideline Stakeholder Comments Table

Tuesday 1 April – Thursday 15 May 2014

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Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	00	0 What is the Guideline About?	1& 2	The population groups that the document focuses on who are at higher risk of poor oral health (e.g. lower SE group. homeless etc) - ? References should be included here for the evidence that the named groups are at higher risk of poor oral health.	Thank you for taking the time to read and comment on the draft guideline. Please refer to the scope document of this work for more information, also the context and considerations section of the guideline document.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	25	03 General sec 3		Consider including an additional recommendation in Section 3 (Early Years Services) : Considering commissioning a service in nurseries and Children's centres (most in-need areas) where a dentist visits to carry out a basic OH check on each child.	Thank you for your comment. Section 3 is about the context and does not contain recommendations.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	01	01 Section 1	4	Recommendation 1 –Include a representative from Children's Centres and education on the OH strategy and needs assessment group (as OH problems often manifest themselves in under 5s and school children)	Thank you for your suggestion. The committee considered your request and has amended recommendation 1 appropriately. If further representation is required there is sufficient flexibility to determine additions.
Birmingham Community Nutrition, St	02	01 Section 1	6	Recommendation 2 – Include guidance on the preferred type of evaluation required so plan can be put in place for effective evaluation from the start and not left as an afterthought (final point	Thank you for your comment and suggestions. Recommendation 3 now includes some information about the range of data sources and the type of data that may

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Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA				re monitoring and evaluating the effect of the local OH improvement programme as a whole) – e.g. formative? This links in with the point in recommendation 3 about cyclical OH needs assessment – regular monitoring of the status of OH will act as an effective evaluation of the OH strategy.	help inform a local oral health improvement strategy.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	06	01 Sec 1	6	Recommendation 4 - Bullet points 1 and 3 – Make clear the difference between these two bullet points by underlining or putting in bold the terms 'Local' and 'National'. Bullet point 5 – could include link to appropriate source of advice on survey design and collection, interpretation of epidemiological data?	Thank you for your comments and suggestions. We have amended and clarified where appropriate.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	07	01 Section 2	7	Recommendation 5 – Bullet point 2 – include common practices of some Black, Asian and Minority Ethnic groups such as the chewing of Khat, Betel Nut / Paan that are linked to mouth cancers and/or OH problems.	Thank you for your comment and suggestions. The recommendation has been amended. The final document refers to the latest version of DBOH 2014 document which sets out these examples and other advice relevant to your suggestions and describes the cup in more detail. Recommendations also include suggestions about advocacy.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate,	08	01	8	Recommendation 6 – include GP surgeries, health centres, pharmacies, churches, mosques, hospitals in here Recommendation 7 – include point about links between poor OH and lingering on the baby bottle or valved (non-spill) baby beaker for too long	Thank you for your comment and suggestions, the final document refers to health and social care professionals; the NICE community engagement guideline offers some direction about advice and settings relevant to each locality. Please see our previous responses.

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Birmingham, B12 0YA					
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	09	01 Rec9 –	9 Early years services (0-5 yrs)	Recommendation 8 – could examples be included here? For example: Midwives, Health visiting teams and Family Nurse Practitioners – include a prompt to ask families if they brush their children's teeth and take them to the dentist in Birth Visit checklist. Early Years services, children's centres and nurseries – include information about how to maintain good oral health in newsletters and displays	Thank you for your comment. The recommendations for these services have been amended and the list of examples expanded.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	09	01 Rec 9	9 Early Years Services (0-5yrs)	Recommendation 9 – bullet point 1 – include point about correct bottle to cup transition (i.e. babies off bottles and onto open cups by 12 months and avoid non-spill/valved beakers Bullet point 2 - include point about correct bottle to cup transition (i.e. babies off bottles and onto open cups by 12 months and avoid non-spill/valved beakers. Include point about supporting/assisting families that may otherwise struggle to register with a dentist by completing a registration request letter or form on their behalf? Include point re including education of the children via reading stories, using hand puppets etc.	Thank you for your comment and suggestions. Please see our previous responses.
Birmingham Community Nutrition, St	09	01 Section 3	9	Recommendation 9 Encouraging people to regularly visit the dentist from when a child gets their first tooth – we need to ensure that NHS dentists will	Thank you for your comment. This particular issue was also reflected by the experience of the committee and is discussed in the final guideline.

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Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA				consistently see children from 6months or first tooth. We have anecdotal reports of families with children under 5 being turned away from receiving treatment as their child is considered too young.	
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	10	01 Rec 10	10	Recommendation 10 – Bullet point 2 'Local Community Organisations' – include examples such as Churches, Mosques, Temples and GP practices (i.e. venues where 'hard to reach' groups may attend)	Thank you for your comment and suggestion. The term has not been altered as it is a broad term and lists of examples are often misinterpreted and taken to be exhaustive. However, the final document refers to NICE community engagement guideline which may be helpful.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	10	01 Sec 3	10	Recommendation 10 - Is there an option for community dentists to visit Early Years settings?	Thank you for your comment and suggestion. This is not an activity that would be excluded from the current recommendations if service commissioners were sufficiently well resourced. Unfortunately there was no evidence to support recommending this specific activity in the current guideline.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate,	11	01	10	Recommendation11 – Include 'Children's Centres' as well as nurseries in the title of this recommendation	Thank you, we have included this reference.

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Birmingham, B12 0YA					
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	11	01 Sec 3 early years Services (0-5s)	11	Recommendation 11 – might put people off to stipulate 'daily' schemes – more manageable / motivating to say 'supervised tooth brushing (daily if possible or weekly if more manageable)'. Daily tooth supervised tooth brushing in nurseries/ children's' centres (daycare) is ideal, but weekly still has an educational/awareness raising role to play? We have found that getting consent can be a barrier to setting up tooth brushing schemes as parents/carers often need lots of reminding/chasing to sign their forms – could this say 'getting informed consent' or 'signed opt-out forms if consent is difficult to collect' instead?	Thank you for your comment. Your suggestion was considered by the committee who decided on balance to keep the current wording. Re consent, thank you for raising, this is now included in the recommendation as one of the first activities to support collaborative working with parents.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	11	01 Sec 3	11 Early Years Services (0-5s)	Recommendation 11 – could put a link to the Scottish Child Smile website here? www.child-smile.org.uk	Thank you for your suggestion, childsmile is linked and referred to in the final guideline.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street,	14	01	12 Children in Primary Educatio	Recommendation 14 - Include point stating something like : Consider giving all primary schools a free oral health mouth model or hand puppet for use during tooth brushing demonstrations / lessons	Thank you for your suggestion, the committee believed there was sufficient flexibility in the guideline for local authorities to decide which activities they would wish to support, taking into account local capacity and resources.

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Highgate, Birmingham, B12 0YA			n		
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	14 (and 15)	01 Section 4 –	12 Children in Primary Educatio n	Recommendation 14/15 – Link in with new curriculum requirements to include cooking in Key Stage 1 & 2. Providing opportunities for children to make healthier dishes.	Thank you for your suggestion, which was considered by the committee. This would be up to local schools to implement if they wished.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	15	01 Section 4 –	12 Children in Primary educatio n	Recommendation 15 – include a point about assisting parents/carers to register with a dentist if they need it (e.g. support to complete registration letter or form or referral on their behalf)	Thank you for your suggestion, advocacy is mentioned in the final guideline.
Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	16	01 Section 4	12 Children in Primary educatio n	Recommendation 16 – include a point about assisting parents/carers to register with a dentist if they need it (e.g. support to complete registration letter or form)	Thank you for your suggestion, advocacy is mentioned in the final guideline.

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Birmingham Community Nutrition, St Patrick's Centre, Frank Street, Highgate, Birmingham, B12 0YA	17	06 Section 6	17 Providing Adult Services (was rec 24 now 9)	Include examples of 'frontline staff' (e.g. those working with homeless groups, those working with unemployed groups, those working in residential care homes for the elderly/those with disabilities)	Thank you for your suggestion, these examples are included where appropriate. Promoting oral health in residential care is the subject of a separate piece of work, more information is available on the NICE website. Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62
British Association for the Study of Community Dentistry (BASCD)	00	0 General		BASCD as a registered stakeholder organisation are pleased to be given the opportunity to comment on the draft guidance.	Thank you for taking the time to read and comment on the guideline.
British Association for the Study of Community Dentistry (BASCD)	0	0 General		There is no evidence of effectiveness or cost-effectiveness for some of these recommendations, e.g. displaying information in work premises. Recommendations should only be made if there is good quality evidence to support them. It is stated in the paragraph about selection criteria that studies from a non-OECD country were excluded, but the list of statements and evidence includes several studies undertaken in the US so the generalizability to the UK, with a nationalised health system, should be questioned.	Thank you for your comments and raising your concerns. The committee considered a range of evidence from systematic reviews, reports, fieldwork and expert testimony, as you will have read. The content of the recommendations reflects their deliberations and careful consideration of the best available evidence and stakeholder concerns. Recommendations have been worded to reflect the strength of the evidence available and some of the uncertainty. The committee have made their recommendations taking into account the best available evidence at the time of drafting and where they genuinely believed activities, interventions or approaches could benefit local communities.

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					The USA is an OECD, so the selection criteria was adhered to. With regard to research from OECD countries, all NICE committees carefully consider the relevance and applicability of any intervention, approach or activity from the country in question in the absence of direct evidence from England. This guideline was developed following the methods and processes set out in the NICE guideline development manuals available on the NICE website: 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
British Association for the Study of Community Dentistry (BASCD)	0	0 General		The lack of detail about who should be doing what is a major shortcoming at consultation stage. Ensuring the quality of delivery of many recommended actions is essential and there should be clear statements about the necessary skills, experience, knowledge and qualifications of providers. Many amateurs believe they can undertake oral health promotion or improvement, but the evidence base for the actions refers to professionally implemented interventions.	Thank you for your comment and raising your concerns, which are appreciated. Please see our previous responses. The committee considered a range of best available evidence, and identified a range of activities and professionals within the limitations of the available evidence. Unfortunately detailed evidence about the implementation and delivery of oral health community programmes is limited or poorly reported.
British Association for the Study of	0	0 What is	1	The list of oral health problems should include tooth surface loss as well as tooth loss.	Thank you for your comment. These are simply examples of oral health problems and

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Community Dentistry (BASCD)		this guideline about?			the list is not intended to be exhaustive.
British Association for the Study of Community Dentistry (BASCD)	0	0 What is this guideline about?	1	Although the guideline focuses on specific groups, there is a need for universal as well as targeted approach, as the Marmot review stated that "Universal action is needed to reduce the steepness of the social gradient of health inequalities, but with a scale and intensity that is proportionate to the level of disadvantage."	Thank you for your comment. The recommendations include both universal and targeted approaches, completely in keeping with the Marmot review.
British Association for the Study of Community Dentistry (BASCD)	1	01 Section 1: Rec 1	4	An 'oral health improvement group' might be a more appropriate name for such a group rather than an 'oral health strategy and needs assessment group'. The latter suggests a task oriented group that is time limited. This group should also be tasked with overseeing the implementation of the strategy and its impact on the target population.	Thank you for your suggestion. The committee considered stakeholder comments about how best to frame the group in this recommendation and decided to avoid a distinct title.
British Association for the Study of Community Dentistry (BASCD)	2	01 Section 1: Rec2	4,5	Recommendation 2 should come after recommendation 3. Development of an oral health strategy should follow on from an oral health needs assessment. In order to get oral health included in work of front line staff and part of life course pathways, it needs to be included in national specifications and in joint HWBs strategy.	Thank you for your comment, the order of the recommendations has been altered and clarified to refer to the JSNA and HWB.
British Association for the Study of Community Dentistry (BASCD)	3	01 Sec 1: Rec 3	5	As above recommendation 3 should be renumbered as recommendation 2. It is not sensible or possible to undertake a proper health needs assessment of all oral conditions, all treatment pathways for all populations groups simultaneously. Those who have not been trained in HNA may think they can undertake this and produce	Thank you for your comment. Your concerns and suggestions were noted by the committee. The order of the recommendations has been altered. There is no mention in the recommendations of undertaking an oral health needs assessment at local population level for all oral health conditions. There are

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				meaningful results in a rapid manner. The guideline should take the opportunity to advise on the need for greater focus on single conditions, specific population groups or specific reason for a HNA e.g. prior to a procurement process for contemporaneous services for a target population, care pathway development or service redesign, where there will be a need for detailed assessment of need, potential demand and other indicators to inform the development of a suitable service.	recommendations about ensuring oral health is a key health and wellbeing priority and suggestions for how a local authority might go about identifying and meeting the oral health needs of their local communities.
British Association for the Study of Community Dentistry (BASCD)	4	01 Sec1: Rec 4	6	Inclusion of the fifth bullet point 'consider seeking advice on survey design etc.' should be reconsidered as LAs have a statutory duty to participate in the national programme of surveys and these follow strict protocols as laid out by Public Health England. Additionally, consultants in dental public health will be able to provide advice on survey design and interpretation and analysis of epidemiological data and are part of the strategy group. There is no mention of use of dental service data, or of documenting available resources for the oral health needs assessment. The Knowledge and Intelligence teams should be mentioned as they can be a resource for pulling together data as well as providing specific data including data on oral cancer. There should also be a bullet point that states something like 'Undertake bespoke surveys if necessary to establish oral health needs where these cannot be gleaned or modelled from existing sources'.	Thank you for your comments and suggestions. The recommendations are not about participation in national survey data collection activities, which, as you rightly point out follow nationally agreed protocols. Your additional suggestions were considered by the committee and the recommendations have been amended and clarified within the remit of this work. Recommendations refer to collecting data from a range of surveys and data sources to inform local needs and using local dental health expertise (who would presumably understand the requirements and sources of reliable data including KIT, LDNs etc). If further representation for the group informing the OHNA is required, there is sufficient flexibility to determine additional input.
British Association	5	01	7	This should happen automatically if OHNA is used to inform the	Thank you for your comment.

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for the Study of Community Dentistry (BASCD)		Sec 2: Rec 5		JSNA and joint HWbS. All the points mentioned should be included as part of the joint HWbS using the common risk factor approach.	Please see our previous responses.
British Association for the Study of Community Dentistry (BASCD)	6	01 **Rec 6**	7	Although there is welcome recognition that the creation of environments that promote oral health is important in line with the Ottowa Charter, there would be benefit in strengthening this recommendation. For example, there is a recommendation that all public services encourage and support breastfeeding, but the environment is key here. Making water freely available is to be commended, but should this be strengthened to make water the only freely available drink in some settings, for example schools/ hospitals where 'coke machines' are much easier to find than a water fountain? Drinks that are 'low in sugar' are just as cariogenic as those with full sugar and should not be recommended in a statement about preventing decay. People could mistakenly think that they are choosing a safe option by drinking low sugar drinks and so drink them more often, in the belief that they do no harm to teeth. Recommendation 20 Secondary education may also require this correction.	Thank you for your comment and raising your concerns. The recommendations have been revised and amended within the remit of the work. The document refers to DBOH 2014 throughout which should help with the detail of oral health promotion Recommendations that refer to the local environment have been strengthened and amended within the remit of the work, including those that refer to the role diet plays in oral health.
British Association for the Study of Community Dentistry (BASCD)	7	01 Rec 7	8	We agree with the recommendation to ensure front line staff understand the importance of health' and are pleased to see this is beyond the core dental team into other health and social care front lines staff. The recommendation should go beyond staff awareness to staff training and action.	Thank you for your comment and raising your concerns. Staff training and monitoring has been included in the recommendations, which should help promote action.

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				The setting should also be expanded to all settings used by the vulnerable groups the guideline focuses on.	
British Association for the Study of Community Dentistry (BASCD)	8	01 Rec 8	8-9	No comment	Noted, thank you.
British Association for the Study of Community Dentistry (BASCD)	9	01 Rec 9	9	The list of oral health promotion principles given is good, however, there perhaps should also be information to address barriers to dental attendance e.g. there should be information available to give guidance to those who are anxious about attending dental services Front line staff should advise use of sugar-free over-the counter medicines, as well as requesting prescribed medicines are sugar free for all age groups.	Thank you for your comment and suggestions. References about increasing access to services have been strengthened through the recommendations within the limitations of the supporting evidence. Also included is reference to the latest DBOH 2014 which discusses sugar free medicine. Issues about information from dental practitioners to patients to promote oral health is the subject of another guideline. More information about this work can be found on the NICE website: Oral health: approaches for general dental practice teams on promoting oral health http://www.nice.org.uk/guidance/indevelopment/GID-PHG60
British Association for the Study of Community Dentistry (BASCD)	10	01 Rec 10	10	This recommendation concerning inequalities is welcomed; however, the Marmot review stated that “Universal action is needed to reduce the steepness of the social gradient of health inequalities, but with a scale and intensity that is proportionate to the level of disadvantage.” So it is important that not all resources should be aimed at the bottom 10%	Thank you for your comment and concerns which were noted by the committee. The recommendations include both universal and targeted approaches, completely in keeping with the Marmot report, and also include recommendations about training a range of staff, but the level of detail about training was not

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				Should local authorities and health and wellbeing commissioning partners be advised to commission appropriately trained people to deliver the actions bulleted?	available in the current evidence base with any degree of certainty to warrant specifying further detail in this guideline. If this evidence is available when the guideline is reviewed it will be considered.
British Association for the Study of Community Dentistry (BASCD)	11	01 Sec 3: Rec 11	10, 11	The first bullet point suggests that achieving good oral hygiene in young children is the important feature of tooth brushing. This is not the case. The two most important factors at this age are 1) the delivery of fluoride in toothpaste to prevent decay 2) the establishment of a twice daily habit. Effective removal of plaque is more relevant in older children and adults as it is important in the control of gum disease. This recommendation talks about supervised toothbrushing schemes but doesn't support toothbrushing packs as much as perhaps it should. Should the delivery of toothbrush packs not be an independent recommendation? Within Scotland toothbrush packs are given at birth, two at age 3, two at age 4, and one at age 5 years (see www.child-smile.org.uk). This relates to the evidence of their effectiveness (e.g. Davies et al Community Dental Health 2002 Sep; 19(3): 131-6).	Thank you for your comment and for raising. The recommendations have been amended to include tooth brushing packs. The content of local schemes will address the issues raised about key oral health activities aligned with the DBOH 2014 document. Childsmile is linked and referred to in the revised document. Please see our previous responses
British Association for the Study of Community Dentistry (BASCD)	12	01 Section 3: Rec 12	11	Use information from the health needs assessment to target nurseries in areas of higher risk and follow up children who may not visit the dentist regularly. This sentence implies that all children in higher risk areas don't visit the dentist. It might be considered to be condescending.	Thank you for your comment, your concern is noted.
British Association	13	01	11	No comment	Noted, thank you.

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for the Study of Community Dentistry (BASCD)		Sec 3: Rec13			
British Association for the Study of Community Dentistry (BASCD)	14	01 Rec 14	12	Should the first organisation mentioned be local authorities rather than local education authorities? NICE may want to consider what age groups it feels are most appropriate for this advice (e.g. age 5, age 12, every year?)	Thank you for raising, the committee shared your concern and debated this issue, which has been clarified in the final version within the remit of the work and the uncertainty of the evidence. There is still flexibility for local authorities to decide their actions based on local needs, capacity and resource.
British Association for the Study of Community Dentistry (BASCD)	15	01 Rec15	12	No comment	Noted, thank you.
British Association for the Study of Community Dentistry (BASCD)	16	01 Recommendation 16	12, 13	Should the first organisation mentioned be local authorities rather than local education authorities? Oral health promotion should be universal, not just to children in primary schools in areas at higher risk of poor oral health. Bullet points one and two-as previously stated oral health promotion should be provided at all primary schools and all staff should be trained to provide evidence-based, age appropriate advice and information.	Thank you for raising, we have amended. Please see our previous responses and note that the recommendations do refer to a whole school approach for all schools.
British Association for the Study of Community Dentistry (BASCD)	17	01 Recommendation 17	13	Should the first organisation mentioned be local authorities rather than local education authorities? The recommendation should include the points the scheme should include as laid out in Recommendation 11. The comments are the same as for recommendation 11. The use of targeted and timely provision of free toothbrushes and	Thank you for raising both these issues we have amended. Please also see our previous responses. Direct evidence of effectiveness and cost effectiveness about the use of postal delivery was mixed (please see

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				toothpaste (i.e. postal delivery or via Health visitors) has been shown to be effective but has not been included as a recommendation.	the supporting evidence statements and reviews), some studies showed little or no effect. The recommendations reflect the uncertainty of the evidence, the committee agreed to suggest local authorities consider free tooth brushing packs and recommendations refer to Childsmile for further examples. The final decision rests with local authorities and depends on local resource and capacity, but your concerns are noted.
British Association for the Study of Community Dentistry (BASCD)	18	01 Rec18	13	Should the first organisation mentioned be local authorities rather than local education authorities? If the scheme is to be provided by staff from General Dental Practice, then there may be a need to involve NHS England in discussions.	Thank you for raising we have amended, and NHS England are now referenced in the document.
British Association for the Study of Community Dentistry (BASCD)	19	01 Sec 4: Rec 19	14	Should the first organisation mentioned be local authorities rather than local education authorities?	Thank you, we have amended.
British Association for the Study of Community Dentistry (BASCD)	20	01 Rec 20	14	Should the first organisation mentioned be local authorities rather than local education authorities? Bullet point two -School nursing services should encourage use of toothpaste with appropriate fluoride levels. Bullet point three - Those at school as well as school leavers need advice given in this bullet point. Bullet point four - All staff in contact with children should receive training on oral health. This advice should be given to all secondary care children not just those at risk. The school nursing	Thank you for your comment and for raising your concerns, we have amended within the remit of the scope. The detail of oral health promotion is set out in the latest version of DBOH 2014, the NICE guideline refers to this document throughout Raising awareness of oral health is incorporated into recommendations about whole school approaches, which is aimed at all schools. If school nursing services are operational in a local area,

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				services should also be providing this advice if they have received training from suitably qualified personnel. Is this recommendation evidence based?	local authorities may wish to utilise them, but the committee were aware that the level and presence of this service varies across regions and localities. For information about the evidence please see supporting documents and reviews. All recommendations are informed by evidence, but this does not always provide direct evidence of effectiveness or cost effectiveness, nor provide the level of detail to inform implementation or delivery. Recommendations are affected by a number of variables including implementation and delivery, so evidence requires interpretation. The committee carefully consider the evidence and make recommendations they genuinely believe will help local authorities decide where they may wish to put their resources, taking into account local needs and local resource availability.
British Association for the Study of Community Dentistry (BASCD)	21	01 Rec 21	15	Is there any evidence that displaying national guidelines on oral health will be effective at improving oral health? The term “all premises” could be very difficult for a LA to implement and could lead to ridicule or criticism of the nanny state.	Thank you for your comment and for raising your concerns which are appreciated. There was limited evidence about the effectiveness of all community oral health programmes in general and initiatives in the workplace in particular, though there were a few studies as you will have read. The final revised recommendations take into account stakeholders comments and concerns, but recognise raising the profile of oral health in the workplace would be beneficial for many adults. The recommendations have been amended and the wording reflects the degree of uncertainty and where the committee genuinely believed such activity

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					would be beneficial. The final decision rests with local authorities.
British Association for the Study of Community Dentistry (BASCD)	22	01 Rec 22	15, 16	No evidence as to what works in improving oral health of adults at higher risk. Providing access to care, and oral hygiene aids still requires the individual to take action. There is limited evidence about the effectiveness of behaviour change interventions. Would be good to have some evidence-based approaches to inform this recommendation.	Thank you for your comment. Please see our previous responses. The document refers to NICE guidance on behaviour change which may be helpful. No specific oral health behaviour change evidence was identified during guideline development despite a call for evidence.
British Association for the Study of Community Dentistry (BASCD)	23	01 Rec 23	16	There should be a requirement for services dealing with vulnerable people to have a process in place to assess and maintain their oral health, as part of their responsibility to caring for their overall health. Service providers should be given targets which are monitored to ensure that every individual in their care has an oral health assessment and access to therapeutic and preventive care in order to attain optimum oral health. Local experience around the country has indicated difficulties with staff training in residential care homes around high staff turnover, literacy levels of care staff and relative importance allocated to caring for residents' oral health. Unless service providers are required to address these issues, there will not be any changes to the current system.	Thank you for your comment and raising your concerns. The recommendations have been revised and suggest a requirement to include oral health in service specifications, targeting setting is not within the remit of this current work. Residential care is the subject of a separate guideline project. More information can be found on the NICE website: Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62
British Association for the Study of Community Dentistry (BASCD)	24	01 Rec 24	16, 17	There is apparent confusion between the prevention of gum disease and decay as the messages in the sixth bullet point blend the two. It is important to separate and make clear the causes and prevention of caries, periodontal disease and erosion. Need to specify which "frontline staff" and how this training is to be	Thank you for raising this, this statement simply reflects associations such as periodontal disease and oral cancer, but we appreciate the point. We appreciate your concerns about staff training, which were reflected by the debate held in committee.

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				commissioned. There is a need to consider the difficulties with staff training such as literacy levels and areas where there may be a high staff turnover.	Unfortunately, no evidence provided the level of detail required to support the committee specifying which staff should deliver which interventions or the impact of levels of literacy on training.
British Association for the Study of Community Dentistry (BASCD)		03 Context	18	In the introduction paragraph it states that oral diseases are associated with coronary heart disease etc. It is only periodontal disease that has been shown to have these associations, no other conditions.	Thank you for raising. This section in the guideline mentions oral diseases and gives examples of a range of conditions associated with poor oral health, which include periodontal disease. If people require further detail the references are given. We appreciate the point though.
British Association for the Study of Community Dentistry (BASCD)		03	19 Context Oral health in England	The statements about 'better oral health' made in the first paragraph are based on self-assessment so should be described as 'claimed' or 'self-reported' not given as statements of fact unless as they are not based on a standardised clinical measure.	Thank you for raising. The reference is available should people wish to investigate further, the statement is clear it is based on survey data which usually implies results should be interpreted with caution. We do appreciate the point though.
British Association for the Study of Community Dentistry (BASCD)		03 Context	19	In the second paragraph there is an inaccuracy. The change to consent arrangements only affected the surveys of five year olds; it was not relevant to 12 year olds.	Thank you for raising. The reference to 12 year old children is about the NHS Dental Epidemiology programme and levels of disease in this age group. The second point is a general point about bias, using the example of children and consent, no age is given but the reference is available should people wish to look further. We appreciate the point though.
British Association for the Study of Community Dentistry (BASCD		03 Context	19	In the third paragraph it is stated that 33.4% reported having dental caries. This not correct – this proportion of volunteers were measured as having caries, it was not a self-reported measure.	Thank you for raising, the guideline has been amended.

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British Association for the Study of Community Dentistry (BASCD)		03 Context 04	19 24 Considerations	The risk factors should mention the actual direct causes of poor oral health, not just the social associations. These are too frequent intakes of sugars, infrequent exposure to fluoride, ineffective plaque removal, smoking and drinking alcohol over safe limits.	Thank you for your comment, the considerations section sets out issues the committee debated and considered during guideline development. These are not recommendations, but a broad outline of some of their concerns. There is insufficient space to set out the detail of the debates by the committee during guideline development.
British Association for the Study of Community Dentistry (BASCD)		04 Cons	24	4.4 The risk factors should be stated more accurately – a diet that is high in sugar, smoking, alcohol use above advices limits, inadequate plaque removal.	Thank you for your comment. Please see our previous response.
British Association for the Study of Community Dentistry (BASCD)		04 Cons	24/25	4.5 It should be specified that frequent intake of foods and drinks with high acidity can cause erosion. There should be clarity about the different causes and prevention methods of caries, periodontal disease and erosion.	Thank you for your comment. Please see our previous response.
British Association for the Study of Community Dentistry (BASCD)		04 Cons	25	4.7 In DBOH the use of alcohol is not given as a risk factor for periodontal disease.	Thank you for your comment. Please see our previous response.
British Association for the Study of Community Dentistry (BASCD)		04 Cons	26	4,12 The comment doesn't not seem to fit correctly here and does not include many other risks that children and adults with special needs have; frequent medication (often containing sugar) reduced saliva flow, aspiration risks so limited use of toothpaste is possible, compensation by parents and carers so sweets are often given…..	Thank you for your comment. Please see our previous response.
British Dental		0		1. The BDA supports the role of local authorities in	Thank you for your comments and suggestions, and for

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Association		General		identifying oral health need and providing dental public health support, guidance, early years' intervention and assessing availability of dental services. Our responses to the Government's consultations 'Equity and Excellence: liberating the NHS' and 'Increasing local democratic legitimacy in health' outline our hopes for how oral health would integrate with local authorities under the reformed NHS structure. Our 2009 report Independent Local Commissioning Working Group Report also sets out our position on ensuring that local services meet the needs of the population	taking the time to read and comment on the guideline. The latest guidelines on commissioning oral health are referenced in the final guideline.
British Dental Association		0 General		2. The recommendations within Oral health: local authority oral health improvement strategies are ambitious and generally supported. Detailed comments are outlined below, but we have concerns whether these recommendations will be sufficiently funded. A further issue is that most of these strategies will be delivered with the support of staff employed by Public Health England (PHE). It is essential that dental public health remains a significant priority for PHE and that this includes sufficient staff to support local authority activities. This guidance should complement routine dental care and must not lead to a loss of funding or emphasis on the provision of care in typical dental settings. The involvement of area teams is important but this should not lead to resources being diverted from dental practices to achieve these recommendations. Only in the long-term will preventive measures potentially reduce the need for traditional dental services.	Thank you for your comment and support, this is welcomed. The committee appreciated and noted your concerns. The final decision about funding activities to improve oral health rests with local authorities based on the needs of their local communities and available resource and capacity. NICE does not have control over funding allocations and we are unable to respond to comments or concerns directed to PHE.
British Dental Association		0 General		3. From recommendation 5 onwards, it would be appropriate to add, "in line with the needs identified by the oral	Thank you for your comment and helpful suggestion, the recommendations have been clarified and amended and

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				health strategy and needs assessment group" after "local authorities and other commissioners and providers of public services should:" and other similar statements	cross-refer to other recommendations in the guideline. We hope this works better.
British Dental Association	0	0 General		4. The provision of universal free school meals in primary schools can have a major impact on dietary education. It will also help exclude unhealthy food and drink from the school environment. Local authorities should consider the provision of free school meals for all children in nursery and primary schools were children are a higher risk of poor oral health.	Thank you for your comment, your concern is noted, but we are unable to respond to your recommendation to local authorities.
British Dental Association	0	0 General		5. Where reference is made to offering a choice of food, drinks and snacks that support oral health, we would support the exclusion of food, drinks and snacks that negatively impact on oral health and health in general	Thank you for your comment.
British Dental Association	0	0 General		6. Recommendations 10, 11, 12, 13, 16, 17, 18, 19, 22 and 23 use the terms, "high risk" and "higher risk". These are ambiguous. Is it for the oral health strategy and needs assessment group to determine whether this is relative to the local or national population? We recommend that this reworded to reference prevalence of risk factors, or that it is made relative to the rest of the UK population. Alternatively, NICE should work to compile an evidence based list of risk factors and thresholds.	Thank you for your helpful comment. The guidance has been amended and this issue clarified, a glossary definition and single term is now used throughout. We hope revisions are helpful.
British Dental Association	1	01 Recommendation 1		7. We support the proposed membership of the oral health strategy and needs assessment group. It is not clear, however, whether there are enough consultants in dental public health to provide the support required (insert number). It would be appropriate for the dental member of the group to be a	Thank you for your comment and your concern is noted. The supply of dental public health consultants was debated, but the committee recognise this is outside the scope of the current guideline to consider. The composition of the HWB is also outside the scope of this guideline.

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				member of the Health and Wellbeing Board as well	However, the committee considered stakeholder concerns and have amended recommendation 1 which is within their remit. If further representation is required there is sufficient flexibility to determine additions.
British Dental Association	7	01 Rec 7		8. Specific reference to providing accredited training to staff would be welcomed. In areas, such as social care, where there is a high turnover of staff, we consider that investing in training could reduce turnover and improve quality of life for residents.	Thank you for your comment. Staff training and monitoring has been included in the recommendations, as have references to a range of health and social care staff where appropriate
British Dental Association	8 (and 9,10)	01 Rec 8, 9, 10		9. Reference to early years and frontline staff encouraging families to attend the dentist and identifying services would be welcomed. Recommendation 10 should also make specific reference to ensuring that the first experience of dental care is positive to encourage re-attendance.	Thank you for your comment. We have amended and hope this works better.
British Dental Association	12	01 Rec 12		10. We support the provision of daily supervised tooth brushing which has been effectively used in Childsmile programme. Fluoride varnishes offer a clinically effective way to prevent caries but their use needs to be justified as cost-effective compared to other community interventions aimed to reach children most at risk of decay.	Thank you for your comment. The evidence of both effectiveness and cost effectiveness was mixed. The degree of uncertainty is reflected in the final wording of the recommendations, and based on the committees' careful consideration of the available evidence and where they genuinely believed activities may be helpful. The guideline only recommends considering fluoride varnish in schools in areas where the baseline prevalence is high, as the cost effectiveness analyses suggested this was likely to be cost effective. The final decision rests with the local authorities and their decisions on how to make best use of available resources to meet local need.
British Dental	13	01		11. Additional use of toothpaste with an elevated fluoride	Thank you for your comment.

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Association		Rec 13		content should be included.	The document links to the DBOH 2014 guideline which sets out fluoride content.
British Dental Association	16	01 Recommendation 16		12. Use should be made of specialist staff such as extended duties dental nurses where available. This would save money on training costs and normalise attendance by a dental care professional.	Thank you for your comment and suggestion. No evidence was identified about the impact of using specialist staff on the effectiveness and cost effectiveness of community oral health programmes to support a recommendation to local authorities, but this issue was considered by the committee.
British Dental Association	18 (and 19)	01 Rec 18 and 19		13. The cost-effectiveness of fluoride varnish should be considered compared to the alternative strategies for improving oral health. For older children an evaluation of the relative benefit of fluoride varnish and fissure sealants is currently in progress in Wales. It seems premature to choose between these two approaches before the study is completed.	Thank you for your comment. There was considerable debate in committee about these issues, and on balance the committee made decisions to recommend activities or approaches they genuinely believed would be helpful for local authorities. The committee discussed the need for an incremental comparison of interventions for the current guideline but this was not possible due to the lack of relevant data. However, the committee are aware of the research you have mentioned and when this evidence is in the public domain at a future date it can be considered for inclusion in any update of the guideline.
British Dental Association	20	01 Rec 20		14. Mention of potential impact of HPV infection and the importance of vaccination should be included as it relates to oral health	Thank you for your suggestion. The inclusion of this detail was debated by the committee, but the limitation to influence the content of any school curriculum was recognised. The decision was taken to focus on promoting oral health in general and to include in curricula activities related to a range of health matters, appropriate to age. The recommendations are sufficiently

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
					flexible to encourage schools to raise awareness of the links between oral health and other health issues if they wish.
British Dental Association	20	01 Rec 20		15. The second bullet point makes reference to school nursing services. We are concerned that these may not be as prevalent as they once were and that this recommendation represents a key need for a range of public health activities.	Thank you for your comment and raising your concern. If school nursing services are operational in a local area, local authorities may wish to utilise them, but the committee were aware that the level and presence of this service varies across regions and localities.
British Dental Association	20	01 Rec 20		14. Mention of potential impact of HPV infection and the importance of vaccination should be included as it relates to oral health	Thank you for your suggestion. The inclusion of this detail was debated by the committee, but the limitation to influence the content of any school curriculum was recognised. The decision was taken to focus on promoting oral health in general and to include in curricula activities related to a range of health matters, appropriate to age. The recommendations are sufficiently flexible to encourage schools to raise awareness of the links between oral health and other health issues if they wish.
British Dental Association		01 Rec 20		15. The second bullet point makes reference to school nursing services. We are concerned that these may not be as prevalent as they once were and that this recommendation represents a key need for a range of public health activities.	Thank you for your comment. If school nursing services are operational in a local area, local authorities may wish to utilise, the committee were aware that the level and presence of this service varies across regions and localities. These variations are reflected in the recommendations.
British Dental Association		01 Rec 23		16. The potential use of a multi-disciplinary approach to vulnerable groups where multiple health issues (including oral	Thank you for your comment and interesting suggestion. There was little or no evidence around the efficacy and

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				health) are addressed at a single visit. Infrequent interactions with healthcare mean that maximum advantage needs to be taken at each visit	cost effectiveness of this activity to support a recommendation, but this may be a fruitful area for research.
British Dental Association		01 Rec 23		17. Consider the development of methods to deliver oral health interventions in a community setting. The innovative use of atraumatic or alternative restorative techniques may provide treatment outside the surgery environment. In this case the provision of additional services in for example within a residential care home should be funded by local authorities or area teams from a budget which is separate from the general dental budget.	Thank you for your suggestion, we would encourage you to publish any peer reviewed evidence you may have on the effectiveness or cost effectiveness of these interventions. Research recommendations are suggested in the guideline. Residential care is the subject of a separate guideline project. More information can be found on the NICE website: Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62
British Dental Association		01 Rec 24		18. This recommendation should include raising awareness of the importance of integrated routine care.	Thank you for raising this, the recommendations have been revised and amended to include oral health in service specifications and care needs assessments.
British Dental Association		03 context	Page 22	19. The final box should make reference to other forms of tobacco use and other disease causing habits such as the use of khat, where this is relevant to the community.	Thank you for your comment. The examples in these tables are directly quoted from the latest DBOH guideline 2014 and are not intended to be exhaustive.
British Dental Association		03	Page 22	20. Undiagnosed diabetes should be included as an established risk factor for the development of poor oral health.	Thank you, examples are not intended to be exhaustive.
British Dental		03	Page 23	21. The final box should also include reference to substances	Thank you, noted. The examples in these tables are

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Association				such as khat	directly quoted from the latest DBOH guideline 2014 and are not intended to be exhaustive.
British Dental Association		04	Page 26	22. Paragraph 4.14. We recommend that the oral health needs assessment takes place as often as the Joint Strategic Needs Assessment and Health and Wellbeing Strategies are updated.	Thank you, the recommendations have been revised to suggest considering cyclical activities. This section is the considerations section which broadly sets out the issues and deliberations of the committee so are not recommendations.
British Dental Association		04	Page 26	23. Paragraph 4.15, a threshold for sugar intake should be set, in-line with recommendations from the World Health Organization.	Thank you for your suggestion.
British Dental Association		05 Sec 5	Page 30	24. Paragraph 5.1, the suggestion that more research is needed regarding the cost effectiveness of different intervention strategies. This research should include both the overall impact on oral health and the effectiveness of improving the oral health of those at highest risk	Thank you, this section has been revised and your suggestions would not be excluded.
British Dental Association		05	Page 30	25. Paragraph 5.4, the wider impacts of oral health initiatives should be considered particularly for their potential to elicit behaviour change in other family members. This should include changes to overall diet and relevant lifestyle choices including smoking and alcohol consumption.	Thank you for your suggestions, please see our previous response.
British Dental Health Foundation	0	0 General	1	Consider water fluoridation should be a key part of all local authority considerations of improving oral health.	Thank you for your comment, your concern and suggestion is noted. This is outside the scope of this work and was clarified very early on in the guideline development process.
British Dental Health Foundation	0	0 General	1	Worth mentioning oral systemic links where general health of patients suffering from diabetes, cardiovascular disease and pregnancy can be improved by improving their periodontal	Thank you, for your suggestion. The committee considered your suggestions and the recommendations have been amended where

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				condition (Jeffcoat 2014).	appropriate. Some of the detail you suggest has been included throughout the document, other suggestions are in the DBOH 2014 document, which the final guideline refers to throughout.
British Dental Health Foundation	1	01 1.1	4	Recommendation 1: This would read better as to include they all need to be involved.	Thank you for your comment, the recommendation has been amended.
British Dental Health Foundation	1	01 1.1	4	Recommendation 1: Appropriate input from national organisations with an interest in oral health e.g. British Dental Health Foundation	Thank you for your suggestion. The committee considered stakeholder concerns and suggestions around this recommendation. Recommendation 1 has been amended within the remit of this work, but if further representation is required, there is sufficient flexibility to determine additions.
British Dental Health Foundation	2	01 1.1	5	Recommendation 2: **Identify and work in partnership with people who are in a position to improve oral health in their communities, including those working in children's services, education and health …** and voluntary sector organisations	Thank you for your suggestion. The recommendations have been amended and clarified and highlight the potential contribution of the voluntary sector where appropriate. The recommendations also cross refer to other NICE guidelines about engaging with the local community.
British Dental Health Foundation	2	01 1.1	5	Recommendation 2: Is this the same as the strategy? Would the strategy be better referred to as an oral health improvement programme?	Thank you for your comment and suggestion, which was considered by the committee. It was decided to continue to refer to keep the original terms.
British Dental Health Foundation	6	01 1.2	7	***Recommendation 6: encouraging and supporting breastfeeding…*** Should certainly not be the first bullet point – would question whether it should even be on the list.	Thank you for your comment, noted, we have altered the order.

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British Dental Health Foundation	6	01 1.2	7	***Recommendation 6: offering a choice…*** Language is poor - offering a choice does not imply requirement to ensure that offering is good for oral health. Unhealthy choices should be reduced. This is about improving the health of all in the community not just those in public funded premises so consideration should be given to other areas and venues also. Residential care must be included here although it is to be dealt with in separate guidance.	Thank you for your comment. The wording for each recommendation reflects the direction and strength of the evidence base. The committee considered your concerns and others raised by stakeholders, and have clarified the document within the remit of the work and within the remit of local authorities and their partners. Residential care is outside the scope of this work, as you indicate. However, more information can be found on the NICE website: Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62
British Dental Health Foundation	6	01 1.2	7 & 8	*Recommendation 6: considering linking up with local…* Language is too weak – "consider" should be more concrete This section also needs separate bullet point for third sector organisations providing community services	Please see our previous response. References to linking with community groups, third sector organisations and specific guidance on community engagement have been included.
British Dental Health Foundation	7	01 1.2	8	*Recommendation 7* • ***Links between dietary habits and tooth decay…*** Frequent sugar consumption rather than dietary habits • ***Links between poor oral health and alcohol and tobacco use…*** Links between poor oral health and poor pregnancy outcomes, diabetes and cardio vascular disease (Jeffcoat 2014).	Thank you for your comment and suggestions. The committee considered your suggestions and the recommendations have been amended where appropriate. Some of the detail you suggest has been included and strengthened throughout the document, other suggestions are in the DBOH 2014 document, which the final version of the NICE guideline refers to throughout.

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British Dental Health Foundation	15	01 1.4	12	*Recommendation 15* • ***Providing a choice of food, drinks and snacks…*** This needs to be stronger with a requirement that foods and drinks provided are healthy and sugar free or low in sugar not just a choice. • ***Identify and link with relevant local partners…*** Also third sector organisations.	Thank you, please see our previous responses on these issues.
British Dental Health Foundation	17	01 1.4	13	*Recommendation 17* Why should this stop at age 7? The needs do not cease for older children in primary education.	Thank you for your comment, your concern is noted. There is sufficient flexibility in the recommendations for local authorities to extend any of the activities should they wish to do so.
British Dental Health Foundation	24	01 1.6	17	*Recommendation 24* • ***The consequences of poor oral health…*** What about respiratory infections from periodontal disease increasing deaths in the frail elderly?	Thank you for your comments. Examples are not intended to be exhaustive.
British Dental Health Foundation	0	0 General	17	Whilst being covered by other work, there is not enough mention of the elderly population both those in residential care and care in the community and at home. There is very little about the role of smoking and oral health tooth loss and gum disease and also with mouth cancer, of which rates in the UK have been steadily rising for decades.	Thank you for your comment. We have amended and strengthened the recommendations where these groups are mentioned, but residential care is the subject of a separate piece of NICE guidance currently in development (see note below). However, the guideline has to keep to the original scope boundaries, but we appreciate your concern. We note your comments about increasing references and discussion around smoking, tooth loss and gum disease and oral cancer and have strengthened the links with

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					other relevant guidelines. The aim of the guideline is to set out recommendations about activities, interventions or approaches to improve oral health through local authorities. Common risk factors to oral health and general health are mentioned in the appropriate sections. Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62
British Dental Health Foundation		03	18	***Poor oral and dental health can affect a person's ability to eat, speak and socialise normally*** …and also lead to increased medical costs (Jeffcoat 2014).	Thank you, noted, please see our previous responses.
British Dental Health Foundation		03	19	Needs a definition of what ADHS defined as better oral health.	Thank you for your suggestion. The reference is included should people wish to read further.
British Dental Health Foundation		03	19	***A significant number of children (72.1%) are free from obvious dental decay, with only 27.9% having at least 1 decayed, missing or filled tooth...*** Only implies this is good - this is in fact appalling for a preventable disease	Thank you for your comment, we have amended..
British Dental Health Foundation		03	20	***The 3rd edition of the toolkit is expected in May 2014…*** This text is now finalised and 3rd edition text should be included.	Please see previous responses. The DBOH 2014 guideline was not available at the time this document went to consultation.
British Dental Health Foundation		03	18	***Poor oral and dental health can affect a person's ability to eat, speak and socialise normally***	Thank you, noted, please see our previous responses.

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				…and also lead to increased medical costs (Jeffcoat 2014).	
British Dental Health Foundation		04 4.1	23	There is good evidence from other countries such as Child Smiles in Scotland why would this not be considered or included.	This work was considered in great detail (please see supporting documents, including the evidence reviews and the expert testimony reports)) and was debated by the committee, who also heard expert testimony from the Director of the programme, also in the supporting documents. The evidence of effectiveness and cost effectiveness was uncertain and the committee made recommendations based on careful consideration of the evidence and where they genuinely believed actions could help local authorities in their decision making.
British Dental Industry Association	0	0 General		The BDIA welcomes the opportunity to comment on these draft guidelines and fully supports the principle and recommendations contained in the guidelines on local authority oral health improvement strategies. The BDIA also supports the emphasis on vulnerable groups at risk of poor oral health and increasing access to dental services. It important to include goals and targets in the establishment of oral health improvement strategies.	Thank you for taking the time to read and comment on the guideline. We appreciate your concerns, but target setting is outside the remit of this work.
British Dental Industry Association	**1**	01 Rec 1.	4	We fully support the recommendation.	Thank you.
British Dental Industry Association	2	01 Rec 2**.**	5	We believe that it is an important part of these guidelines that oral health strategy and needs assessment groups set out clear strategies for local authorities and involve the right people to	Thank you for your comment.

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				promote oral health, particularly amongst vulnerable and disadvantaged groups.	
British Dental Industry Association	3	01 Rec 3.	5	Oral health needs assessments will be a critical part of the local strategies and should be ongoing, adequately resourced and co-ordinated between all relevant parties.	Thank you for your comment.
British Dental Industry Association	4	01 Rec4	6	As much relevant and robust data as possible should be used.	Thank you for your comment.
British Dental Industry Association	5	01 Rec 5	7	This is extremely important as advice and information are key to the success of local strategies and we agree in principle with the areas included.	Thank you for your comment.
British Dental Industry Association	6	01 Rec 6	7	Creation of an environment that is conducive to the promotion of oral health is an important factor in the facilitation of oral health improvement. We believe that it is very important that all public services are engaged in the promotion of oral health, especially amongst groups with particular and special needs, focussing on the simple messages as outlined in the guidelines and promoted widely through the public sector facilities outlined.	Thank you for your comment.
British Dental Industry Association	7	01 Rec 7.	8	We cannot emphasise enough the importance of the understanding and education of frontline staff. A successful strategy will be dependent on frontline staff being able to understand the importance of the strategy and correctly trained and educated to facilitate meaningful delivery and outcomes.	Thank you for your comment.
British Dental	8	01	8	It is critical that oral health messages can be promoted though	Thank you for your comment.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
Industry Association		Rec 8.		early years service specifications and activities.	
British Dental Industry Association	9	01 Rec 9.	9	It is an essential part of the strategy that oral hearth information and education can be provided through frontline staff.	Thank you for your comment.
British Dental Industry Association	10	01 Rec 10.	10	We fully support the emphasis of provision where there is a higher risk of poor oral health and this will be key in the effective and efficient targeting of local authority resources and achieving the goals of the strategy.	Thank you for your comment.
British Dental Industry Association	11	01 Rec 11.	10	Practical and simple interventions such as supervised tooth brushing, especially amongst higher risk groups should provide positive outcomes and is to be strongly encouraged.	Thank you for your comment.
British Dental Industry Association	12	01 Rec 12.	11	We fully support strategies that encompass flouride varnish programmes, particularly in areas of higher risk of poor oral health amongst young children and would encourage local authority funding being make available for these programmes.	Thank you for your comment.
British Dental Industry Association	13	01 Rec 13.	11	We urge local authorities to adopt this recommendation as widely as possible.	Thank you for your comment.
British Dental Industry Association	14	01 Rec 14.	12	We fully support any measures or activities that support the promotion of oral health care in the primary school curriculum	Thank you for your comment.
British Dental Industry Association	15	01 Rec 15.	12	A whole school approach to the promotion of oral health in primary education is very important and will help in the effective implementation of local oral health solutions.	Thank you for your comment.

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British Dental Industry Association	16	01 Recommendation 16.	12	This is a logical expansion of the recommendations.	Thank you.
British Dental Industry Association	17	01 Recommendation 17.	13	This sort of practical intervention should be encouraged wherever possible.	Thank you for your comment.
British Dental Industry Association	18	01 Rec 18.	13	We would fully endorse this recommendation, as per Recommendation 13.	Thank you for your comment.
British Dental Industry Association	19	01 Rec 19.	14	This is a logical extension to the previous recommendation and fully supported by the BDIA and would urge local authorities to make resources available.	Thank you for your comment.
British Dental Industry Association	20	01 Rec 20.	14	We believe that there is a very significant opportunity for the provision of oral health education and information within the secondary school environment and would encourage local authorities to strongly encourage this. It is important that school governors and teachers are aware of the opportunities to reinforce positive oral health messages amongst this age group as this is a critical stage in developing behaviours that will then be adopted throughout adult life.	Thank you for your comment.
British Dental Industry Association	21	01 Rec 21.	15	We strongly believe that there is a very significant opportunity to promote oral health in the workplace and that this could provide a very cost effective way of improving oral health as [part of the local authority strategy. We would support the commissioning of	Thank you for your comments.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				programmes, the widespread availability and encouragement to display materials and the displaying of material about the availability of local dental services.	
British Dental Industry Association	22	01 Rec 22.	15	We would urge all local authorities to fully adopt this recommendation.	Thank you for your comment and support.
British Dental Industry Association	23	01 Rec 23.	16	We fully support this recommendation	Thank you for your comment.
British Dental Industry Association	24	01 Rec 24.	16	Suitable training for all staff involved is a critical part of implementing the local authority improvement strategy.	Thank you for your comment.
British Dental Industry Association		02	17 Who should take action?	It is important that there is a clear understanding of who the guidelines are aimed at and who should be taking action.	Thank you for your comment.
British Dental Industry Association		02	18 Who should do what at a glance	We trust that this will be based upon 'Who should take action' and include responsibilities/tasks based upon implementing the details of the improvement strategy.	Yes, that is the intention.
Department of Health	0	0 General		Thank you for the opportunity to comment on the draft for the above Public Health guideline. **I wish to confirm that the Department of Health has no**	Thank you.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				substantive comments to make, regarding this consultation.	
Durham County Council	0	0 General		Background evidence limited and inconclusive for proposed interventions – supervised tooth brushing and fluoride varnish– the completion of robust evaluations should be recommended to contribute towards the evidence base	Thank you for your comment and raising your concerns. The committee carefully considered the best available evidence about these activities, and decided that on balance, the current evidence base would support recommendations for children at high risk of poor oral health. The wording of the recommendations reflects the strength of the evidence available at the time of drafting and requires that each local authority makes the decision based on their understanding of the needs of their local communities, and available resources. We note your concerns and your point about further research is reflected in the research recommendations in the final version of the guideline.
Durham County Council	0	0 General		Economic modelling uncertain for fluoride varnish and tooth brushing interventions at a community level – the completion of robust evaluations should be recommended to contribute towards the evidence base	Thank you for your comment, several of the research recommendations included in the guidance reflect the need for these types of evaluations.
Durham County Council	0	0 General		Moving away from individual level behaviour change to a focus on settings which require policy shift to reduce the availability of sugary snacks and drinks is crucial. It would be welcomed to have guidance which highlights the importance of reducing the availability of sugar (vending machines as well as general catering), in venues such as workplaces, leisure services, care provision and education. A reduction in the availability of sugary snacks and drinks should be a standalone	Thank you for your comment. The recommendations have been amended and references to the role diet plays in promoting oral health have been strengthened. We hope the amendments are helpful.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				recommendation as well as within many of the current recommendation. Its profile needs to be raised.	
Durham County Council	0	0 General		Brief and simple recommendations but funding within local authorities is very limited to implement/commission resource intensive interventions such as supervised tooth brushing/ fluoride varnish. Therefore the practical value may result in poor uptake of recommendations. However, NICE recommendations give strength to the argument to add to the evidence base.	Thank you for your comment and raising your concerns, which were also a concern for the committee and is reflected in the wording of the final version of the recommendations. The committee carefully considered the best available evidence of effectiveness and cost effectiveness about these and other activities, and decided that on balance, the current evidence base would support recommendations for children at high risk of poor oral health. The wording of the recommendations reflects the strength of the evidence available at the time of drafting and requires that each local authority makes the decision based on their understanding of the needs of their local communities, and available resources. We note your concerns and your point about further research is reflected in the research recommendations in the final version of the guideline.

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Durham County Council	0	0 General		With the significant rise in the number of adults projected to suffer from Dementia it is vital that residential / care homes and carers understand the importance of oral health and the nutritional content of food/drinks provided to this vulnerable population. Whilst there are specific recommendations regarding vulnerable older people it would be of value to discuss specifically patients with dementia	Thank you for your comment. We would like to draw your attention to these two forthcoming pieces of NICE guidance, which we hope you will continue to read and comment upon. We appreciate your concern about people with dementia, and we do make reference to a range of people living in the community in the guideline where appropriate, but specific recommendations about oral health care for particular conditions is outside the scope of the current work, this type of work is usually undertaken by the Centre for Clinical Practice at NICE. More information about these relevant pieces of work can be found on the NICE website: Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62 Oral health: approaches for general dental practice teams on promoting oral health http://www.nice.org.uk/guidance/indevelopment/GID-PHG60
Durham County Council	2	01 rec 2	P5	"get all front line staff trained to promote oral health" This links to recommendation 7. More emphasis should be placed on 'making every contact count' as it links with the wider agenda of generic staff delivering a variety of brief intervention messages such as healthy eating,	Thank you for your comment. The recommendations have been clarified and amended to ensure oral health is promoted as an important part of general health and wellbeing.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				sensible drinking etc. It makes sense to not see oral health in isolation as a standalone message.	
Durham County Council	4	01 Sec 1	P6	Is recommendation 4 not just a subset of recommendation 3? Any good HNA would use a variety of robust data sources	Thank you for pointing this out, we have revised and combined these recommendations. The committee recognised that the quality of HNAs and OHNAs varied considerably across England.
Friends, Families and Travellers	2	01 1. Rec 2	4	Gypsies and Travellers should be included as a group "at higher risk of poor dental health" as Gypsies and Travellers experience severe inequalities with regard to oral and dental health. There are significant barriers to Gypsies and Travellers accessing dental services and there is a historic lack of outreach to Gypsy and Traveller communities resulting in a lack of knowledge regarding good oral health. Poor access to regular dental appointments leads to a lack of preventative treatment and an increased use of accident and emergency dental services.	Thank you for your comment and raising your concerns. Examples of groups are not intended to be exhaustive, we have amended and hope this is helpful.
Friends, Families and Travellers	8	01 3. Rec 8	8	Oral health interventions targeted at early years children's services are unlikely to reach Gypsy and Travellers due to a lack of access to mainstream services.	Thank you for your comment. We appreciate the point, but this appears to be a wider issue than oral health and is experienced by a range of groups out of touch with mainstream services, but we appreciate your concern.
Friends, Families and Travellers	10	01 3. Rec 10	10	Tailored oral health promotion is especially important for Gypsy Traveller communities due to a historical lack of access to dental services means that regular dental check- ups are not a cultural norm. Culturally appropriate oral health information for Gypsies and Travellers is necessary in order to increase health literacy and understanding of the need for good oral hygiene, diet, and regular	Thank you for your comment. Please see our previous response.

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				check- ups.	
Friends, Families and Travellers	21	01 6. Rec21	15	Workplace interventions are unlikely to reach Gypsy and Traveller communities as there is a strong culture of self-employment.	Thank you for your comment and raising your concerns. Being out of work or out of touch with health and social care services is reflected in the recommendations for a wide range of groups.
Friends, Families and Travellers	22	01 6. Rec 22	15	Oral health outreach services should be commissioned for Gypsy and Traveller communities. Community Oral Health advocates can support Gypsies and Travellers in registering at dentists and give oral health adice and promote good oral health practices by distributing free toothbrushes and toothpaste.	Thank you for your comment. Within the current commissioning structures it is up to local authorities to determine how they make best use of their resources to meet the needs of their local communities. The recommendations about the oral health needs assessment should help them identify local needs and prioritise.
Friends, Families and Travellers		03 Context	18	There is a higher prevalence of diabetes within Gypsy and Traveller communities but poor health literacy can lead to late diagnosis. Dental practitioners can play a role identification and good management of diabetes.	Thank you for your comment. This section of the guideline sets out the reflections and issues the committee considered during guideline development, these are not recommendations, but your point is noted.
Friends, Families and Travellers		04 Considerations 4.3	24	Gypsies and Travellers are at risk of poor dental health and should be included in provision for 'vulnerable' groups. It should be recognised that socioeconomic and cultural factors contribute to vulnerability to poor dental health.– From research conducted by FFT in conjunction with oral health promotion team in 3 Primary Care Trusts, the determinants of poor oral health were identified as: • Lack of accessible, culturally appropriate information. • Distrust and negative attitudes – both population and	Thank you for your comment, please see our previous responses. Your concern is appreciated and your observations welcomed however these apply to a range of vulnerable groups. This is reflected in the recommendations and the wording would not exclude any group from benefitting from the community oral health activities suggested.

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				professional. • A historical neglect of dental health services in reaching out to the Travelling community. • Raised levels of fear and anxiety about visiting the dentist. • A transient population.	
Friends, Families and Travellers		04 Cons 4.23	28	Community based health promotion targeted at Gypsies and Travellers proved highly effective in a pilot in conducted Jan 2009 – Dec 2010 in Brighton and Hove, East and West Sussex. The Gypsy Traveller Oral Health Outreach worker funded by the 3 PCTs provided information to 684 Irish, Romany and New Travellers and information she disseminated had a wider reach as it travelled through the community by word of mouth. In addition to providing oral health information the worker supported people into local Dentists, Emergency Dentists and Dental Hospital appointments for the most serious cases. The worker supported people to have full mouth extractions and oral replacements; Abscess treatment; Gum infections; Acid Erosion; Emergency care and follow up treatment as long as the Travellers were still in the area.	Thank you, please see our previous responses.
Friends, Families and Travellers		011	46 Gaps 11.2	Pilot studies should be funded to evaluate the effectiveness of community based oral health improvement programmes with Gypsy and Traveller communities.	Thank you, please see our previous responses. But note that this research would not be excluded from the current research recommendations.
Hampshire and Isle of Wight Local Dental Committee	0	0 General		Good quality surveillance data is very important to monitor oral health outcomes. The current dental survey data on children are not as useful as before due to the change from negative to	Thank you for your comment and helpful suggestions. Your points are well made and were considered by the committee, however it is outside the scope of this work to

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				positive consent which skews participation. Suggest using data on the number of children having dental extractions under general anaesthesia. There should be a national process to collect this as this is a good marker of oral health and oral health inequalities in children. Dental attendance data can also be used for monitoring inequalities in access. This is already available nationally on a quarterly basis from the Business Services Authority for both children and adults. This indicates inequalities in access to dental care.	make recommendations about collecting national data. The committee considered your suggestion to make specific reference to dental attendance data but believed there was sufficient indication of robust data sources in the current recommendations. The membership of the group with responsibility for the OHNA would be aware of relevant national data sets and could advise local authorities accordingly.
Hampshire and Isle of Wight Local Dental Committee	0	0 General		The guideline development group should include a Consultant in Dental Public Health who works at the frontline with LA commissioners and NHS England. This will provide the "frontline" view which is important as research initiatives do not always translate well in a "real-life" situation.	Thank you for your comment. Ideally all guideline development committees would have good representation from a range of stakeholders including all professionals involved in commissioning and delivering activities, approaches, or interventions identified in each guideline. The committee developing this guideline did include individuals from dental public health and others currently commissioning local oral health programmes. PHE's national lead for oral health improvement also gave expert testimony about the new commissioning and delivery landscape. NICE recruits to committees following an open and transparent process. Please see the NICE website for further information. http://www.nice.org.uk/
Hampshire and Isle of Wight Local Dental Committee	0	0 General		There is no evidence of effectiveness or cost-effectiveness for many of these recommendations. Recommendations should only be made if they are supported by good quality evidence for both of	Thank you for your comment. The committee considered a range of evidence from reviews, reports, fieldwork and expert testimony as you

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				these. LA and NHS England commissioners have limited budgets and competing priorities and need good quality information on which to base their decisions.	will have read. The content of the recommendations reflects their deliberations and careful consideration of all evidence, and stakeholder concerns. Please be aware that the status of NICE recommendations varies, recommendations for clinical practice and for local government for example, are always advisory. In this guideline the strength of the recommendations reflects the deliberations of the committee and where, on balance, they genuinely believed most benefit would be derived. The final decision to implement is up to local authorities taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process.
Hampshire and Isle of Wight Local Dental Committee	1	01 Section 1: Rec 1	4	It would not be possible to do an informative oral health needs assessment (OHNA) on every aspect of oral health. There can be some identification of key priorities for each local area. This can be picked up by the Local Dental Network (LDN) which includes local dental clinicians as well as NHS England commissioners and dental public health. This should feed the Joint Strategic Needs Assessment (JSNA) from which the Joint Health and Wellbeing Strategy (HWbS) is derived. The Public Health team and Health and Wellbeing Board should engage with the LDN as needed to ensure that oral health issues which impact on the local population's health and wellbeing are included in their recommendations.	Thank you for your comment. The committee considered stakeholder concerns and suggestions. Recommendations 1 and 2 have been amended within the remit of this work and representation to the groups responsible for the OHNA has been extended. If further representation for the OHNA is required, there is sufficient flexibility to determine additions

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Hampshire and Isle of Wight Local Dental Committee	2	01 Sec 1: Rec 2	4	The oral health strategy should be used to inform the joint HWbS so oral health is integrated into general health improvement programmes. Monitoring of oral health should be part of monitoring of health outcomes for all groups.	Thank you for your comment and suggestion. The recommendation has been amended to include mention of the HWB strategy.
Hampshire and Isle of Wight Local Dental Committee	2	01 Sec1: Rec 2	5: points 7&8	The only way to get oral health included in the work of frontline staff and part of lifecourse pathways, is to include it in the joint HWbS as that is the only document which carries weight locally. The discussions should use the LDN as a source of expert clinical advice.	Thank you for your suggestion. The recommendations have been amended to include reference to the HWB strategy and the LDN.
Hampshire and Isle of Wight Local Dental Committee	3	01 Sec1: Rec 3	5	It would be impossible to assess the oral health needs of every group in the community. It would be possible to carry out a very high-level assessment of oral health as part of the JSNA and link in with the information used in the JSNA (for e.g. population demographics) to avoid duplication. This information can then be included in the JSNA and inform the joint HWbS. This can only be a very high-level identification of the most important oral health priorities and will also depend on the priorities that are identified in the JSNA for e.g. most LAs will prioritise improving health for children as part of "Giving Every Child the Best Start in Life". In this case, one aspect of the OHNA should be about the oral health of young children.	Thank you for your comment. Your concerns and suggestions were noted by the committee. There is no mention in the recommendations of undertaking an oral health needs assessment at local population level for all oral health conditions. There are recommendations about ensuring oral health is a key health and wellbeing priority and suggestions for how a local authority might go about doing this to meet the oral health needs of their local communities, which will include children and young people.
Hampshire and Isle of Wight Local Dental Committee	3	01 Sec 1: Rec 3	6: last point	It is only worth doing a detailed OHNA if there is a particular reason for e.g. procurement process for contemporaneous services for a target population, care pathway development of service redesign, where there will be a need for detailed assessment of need, potential demand and other indicators to inform the development of a suitable service.	Thank you for your comment. Your concerns and suggestions were noted by the committee. There is no mention in the recommendations of undertaking an oral health needs assessment at local population level for all oral health conditions. There are

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					recommendations about ensuring oral health is a key health and wellbeing priority and suggestions for how a local authority might go about doing this to meet the oral health needs of their local communities.
Hampshire and Isle of Wight Local Dental Committee	5	01 Sec 2: Rec 5	7	This should happen automatically with the OHNA informing the JSNA and the joint HWbS. All the points mentioned should be included as part of the joint HWbS using the common risk factor approach.	Thank you for your comment. Please see our previous response. The committee were aware of the variable quality of OHNAs currently produced.
Hampshire and Isle of Wight Local Dental Committee	6	01 Sec 2: Rec 6	7	Environments which promote oral health also promote general health, so a holistic approach should be recommended. Oral health should not be considered separately from general health.	Thank you for your comment. The document has been amended appropriately and the links between oral health and general health strengthened.
Hampshire and Isle of Wight Local Dental Committee	6	01 Sec 2: Rec 6	8: Last point	Drinks that are promoted as sugar-free or low in sugar are still cariogenic as they would contain acids. These acids cause dental erosion making teeth more vulnerable to decay. Sweet drinks also encourage the development of a “sweet tooth” which then encourages people to choose sweet drinks over water. This will have an impact on oral health as well as weight. For e.g. Coca Cola promotes Coke Zero has a “healthy” option to encourage those who drink it to develop a taste for Coca Cola. Only water and milk are “safe” for teeth and have no negative effects on general health. There is no evidence that working with commercial food outlets produces positive health choices and therefore outcomes. Commercial food outlets are businesses which promote their own products, whether or not they are safe for health. There should be regulations to control their marketing practices in terms of the	Thank you for your comment. The recommendations have been revised and strengthened to reflect the role diet plays in oral health. The committee considered a range of evidence from reviews, reports, fieldwork and expert testimony as you will have read. The content of the recommendations reflects their deliberations and careful consideration of all evidence and stakeholder concerns. Please be aware that the status of NICE recommendations varies, recommendations for clinical practice and for local government for example, are always advisory. In this guideline the strength of the recommendations reflects the deliberations of the committee and where, on balance, they genuinely believed most benefit would be derived. There are suggestions to consider planning

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				foods they promote as "healthy".	policies and other levers within local authority control, also reference to other NICE guidance which has reviewed different evidence but reached similar conclusions. The final decision to implement is up to local authorities taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process.
Hampshire and Isle of Wight Local Dental Committee	7	01 Sec 2: Rec 7	8	To make this happen, there needs to be a directive to include it in local service specifications. This could come as a national steer but it is important that it is included in the local HWbS. Oral health should not be tackled in isolation, but as an integrated part of general health outcomes for children.	Thank you for your comment. The document has been amended and this referred to where appropriate. Please also see our previous responses.
Hampshire and Isle of Wight Local Dental Committee	7	01 Sec 3: Rec 8	8	See recommendation above for recommendation 7.	Noted, thank you.
Hampshire and Isle of Wight Local Dental Committee	9	01 Sec 3; Rec 9	9	The most important intervention for young children, in addition to good dietary practice, is to use toothpaste with (correct amount of) fluoride twice a day. There needs to be a national directive to include oral health in local service specifications. This could come as a national steer and from the local HWbS. Oral health should not be tackled in isolation, but as part of health outcomes for children.	Thank you for your comment. Please see our previous responses about the oral health needs assessment and health and wellbeing strategy. We have referred to local service specifications where appropriate in the recommendations.
Hampshire and Isle of Wight Local Dental Committee	10	01 Sec 3: Rec 10	10	Information should be available for all children in Early Years settings. There is no way of identifying with accuracy whether a child will get dental decay so need to target all children so using a "high-risk approach is inappropriate. This is in accordance with the Marmot approach.	Thank you for your comment. The recommendations include both universal and targeted approaches and a range of groups, including children, are at greater risk of poor oral health than others, completely in keeping with the Marmot review.

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				(Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries prevention strategy for populations". BMC 2006, 6:3)	
Hampshire and Isle of Wight Local Dental Committee	11	01 Sec 3: Rec11	10	Supervised toothbrushing programmes should be implemented at all school settings as there is no way of identifying, with any accuracy, which child will get dental decay. This is in accordance with the Marmot Review recommendations in combining universal and targeted approach. (Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries prevention strategy for populations". BMC 2006, 6:3) There needs to be promotion of the use of fluoride toothpaste as part of this intervention and encouragement of toothbrushing with fluoride toothpaste at home. For optimum results, the child needs to develop and maintain toothbrushing with a fluoride toothpaste twice a day. The evidence review includes the Childsmile programme which combines universal and targeted approaches.	Thank you for your comment. Your concern is noted. The recommendations include both universal and targeted approaches as a range of groups, including children, are at greater risk of poor oral health than others, completely in keeping with the Marmot review. The content of the schemes will address key oral health activities and the guideline refers to the latest version of DBOH 2014 to help with this. The evidence review did include data from the Childsmile programme, and the committee also heard from the director of this programme. Their decision was to suggest local authorities consider these activities due to the uncertainty of a range of evidence. Information about delivery and implementation was often missing or poorly reported and secular changes in were often not accounted for in the statistical analysis. The recommendations do provide a link to childsmile.
Hampshire and Isle of Wight Local Dental Committee	12	01 Sec 3: Rec 12	11	The evidence base for community fluoride varnish applications is mixed as indicated by the evidence review. A Cochrane review indicates that this intervention is effective. However, children will need to be consented into the programme and children from more deprived groups will be less likely to be consented, which risks increasing inequalities. There is no data	Thank you for your comment, please see our previous response. The guideline only recommends considering fluoride varnish in schools in areas where the baseline prevalence is high, as the cost effectiveness analyses suggested this was likely to be cost effective.

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				on cost-effectiveness for what is a very resource-intensive approach to carry out in a community setting. If this is to be implemented, it needs to include a strategy which will enable this intervention to successfully reach all children. This strategy should be part of a holistic programme which supports and encourages twice daily toothbrushing with a fluoride toothpaste and a healthy diet. The Scottish Childsmile programme has faced similar difficulties. A 2012 presentations indicated that only 29% of targeted 3-5 year olds and 47% of 6&7 year-olds got the 2 planned applications in the last year. (Reference: Conway D. Delivering Childsmile: Progress Report. Conference presentation Sep 2012. *www.child-smile.org.uk/*)	
Hampshire and Isle of Wight Local Dental Committee	13	01 Sec 3: Rec 13	11	See comments in both boxes above for Recommendations 11 and 12.	Thank you, please see our previous responses.
Hampshire and Isle of Wight Local Dental Committee	15	01 Sec 4: Rec 15	12	Good to have whole school approach but oral health should be included as part of general health improvement measures for e.g. dietary advice is also important for healthy weight. Drinks that are promoted as sugar-free or low in sugar are still cariogenic as they would contain acids, which damage teeth through dental erosion. They also encourage the development of a "sweet tooth" which then encourages people to choose sweet drinks over water. This will have an impact on oral health as well as weight.	Thank you please see our previous responses on these issues.
Hampshire and Isle	16	01	12	Should be done for all primary school children as there is there is	Thank you for your comment, please see previous

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of Wight Local Dental Committee		Section 4: Recommendation 16		no way of identifying, with any accuracy, which child will get dental decay. This is in accordance with the Marmot approach. Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries prevention strategy for populations". BMC 2006, 6:3	responses.
Hampshire and Isle of Wight Local Dental Committee	17	01 Section 4: Recommendation 17	13	Supervised toothbrushing programmes should be implemented at all school settings as there is no way of identifying, with any accuracy, which child will get dental decay. This is in accordance with the recommendations in the Marmot review. (Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries prevention strategy for populations". BMC 2006, 6:3) There needs to be promotion of the use of fluoride toothpaste as part of this intervention and encouragement of toothbrushing with fluoride toothpaste at home. For optimum results, the child needs to develop and maintain toothbrushing with a fluoride toothpaste twice a day. Parents should brush their children's teeth until the child is able to that for him/her self.	Please see our previous responses.
Hampshire and Isle of Wight Local Dental Committee	18	01 Sec 4: Rec 18	13	See comments above for Recommendation 12.	Thank you, please see our previous responses.
Hampshire and Isle of Wight Local Dental Committee	19	01 Sec 4: Rec 19	14	See comments for Recommendation 17 and 18 above	Noted, please see our previous response
Hampshire and Isle	21	01	15	There is no evidence to support the effectiveness of displaying	Thank you for your comment and for raising your concerns

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of Wight Local Dental Committee		Sec 6: Rec 21		information in improving any aspect of health, including oral health. If LAs are to invest, then there should be good evidence to support effectiveness. Displaying information on "all premises" is resource-intensive and may increase inequalities as it impacts on literacy (e.g. what some staff find useful may not be understood by others) and does not address barriers to access. It would not be possible to provide dental services in workplaces, other than a limited service through a mobile dental service. Many workplaces may also be within reach of a local dental practice. Increasing access to care does not necessarily improve oral health. This is just one aspect. There would still need to be a commitment to good oral hygiene practices including toothbrushing with a fluoride toothpaste and eating a health diet. There is no evidence that making a service available, even at a workplace, would encourage everyone to access dental care. It may increase inequalities as those who already attend may use it as an alternative to attending their dental practice, and those who do not attend may not use it. It would be logistically very difficult and very resource-intensive for LAs to provide free oral hygiene aids regularly to all their employees indefinitely, this cannot be a one-off distribution. How would the LA manage this process? What if there was a high staff turnover? Would this include employees from companies who are sub-contracted to provide services and what happens if the service provider used different staff at different times?	which are appreciated. There was limited evidence about the effectiveness of all community oral health programmes in general and initiatives in the workplace in particular, though there were a few as you will have read. The final revised recommendations take into account stakeholders comments, but recognise raising the profile of oral health in the workplace would be beneficial for many adults. The recommendations have been amended and the wording reflects the degree of uncertainty and where the committee genuinely believed such activity would be beneficial.
Hampshire and Isle	22	01	15	No evidence as to what works in improving oral health of adults at	Thank you for your comment.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
of Wight Local Dental Committee		Section 6: Recommendation 22		higher risk. Providing access to care, and oral hygiene aids still requires the individual to take action. There is limited evidence about the effectiveness of behaviour change interventions. Would be good to have some evidence-based approaches to inform this recommendation.	The document refers to NICE guidance on behaviour change which may be helpful. No specific oral health behaviour change evidence was identified during guideline development despite a call for evidence.
Hampshire and Isle of Wight Local Dental Committee	23	01 Sec 6: rec 23	16	There should be a requirement for services dealing with vulnerable people to have a process in place to assess and maintain their oral health, as part of their responsibility to caring for their overall health. Service providers should be given targets which are monitored to ensure that every individual in their care has an oral health assessment and access to therapeutic and preventive care in order to attain optimum oral health. Experience of dental services around the country delivering this type of intervention has indicated difficulties with staff training in residential care homes around high staff turnover, literacy levels of care staff and relative importance allocated to caring for residents' oral health. Unless service providers are required to address these issues, there will not be any changes to the current system.	Thank you for your comment. The recommendations have been revised and suggest a requirement to include oral health in service specifications, targeting setting is not within the remit of this current work. We note your concerns, but residential care is outside the scope of this current work and is the subject of a separate guideline project, we hope you will continue to comment on this work. More information can be found on the NICE website: Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62
Hampshire and Isle of Wight Local Dental Committee	24	01 Sec 6: Rec 24	17	It would be most important to involve other healthcare professionals such as GPs, practice nurses, community nurses and others who come into contact with these adults to include oral health issues in their advice. Everyone should work to promote all aspects of health, including oral health. They should check with them about access to dental care and encourage and support them to seek dental care, if they have not already done so.	Thank you for your comment and suggestions, which are noted. We appreciate your concerns about raising awareness with other healthcare professionals which also reflect the debates held in committee. Recommendations have been strengthened in the final guideline and also reflect the links between oral health and general health.

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Hampshire and Isle of Wight Local Dental Committee		04 Sec 4.4 04 Cons	24	Using the common risk factor approach means that general medical teams and staff involved in maternal and child nutrition, breastfeeding and smoking cessation should include mention of oral health advice when they talk to their patients/ clients. They can encourage and support people to access dental care regularly such as signposting them to a local practice and following up to see if they have attended.	Thank you for your comment. Please note this section of the guideline broadly sets out the deliberations and issues the committee considered during guideline development, so are not recommendations in themselves.
Hampshire and Isle of Wight Local Dental Committee		04 Sec 4.5 Cons	24	Fruit juices are high in sugar as well as acids which contribute to weight management issues as well as poor dental decay. They should not be promoted as “healthy” as this provides a mixed message, particularly to parents. There should be recommended limits on how much fruit juice should be consumed per day to avoid children/adults substituting fruit juice for water. There should also be restrictions on the marketing of these drinks. Water and milk should be the drink of choice for everyone.	Thank you for your comment.
Hampshire and Isle of Wight Local Dental Committee		04 Sec 4.7 Cons	25	Smoking cessation services work should encourage and support their clients to access dental care, including signposting and following up to ensure they attend. Helping smokers get their mouths clean and healthy may further encourage them to quit. This is relevant to all but may be more effective for certain groups for e.g. young smokers.	Thank you for your comment.
Hampshire and Isle of Wight Local Dental Committee		04 Section 4.10 Cons	25	All targeted health improvement interventions are very resource-intensive. Those in the highest needs groups are the ones who are least likely to engage. There is little evidence of effective interventions and even less evidence on cost-effectiveness (as indicated by the evidence review). A high-level OHNA can be	Thank you for your comment. Please see our previous responses and the nature of the evidence.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				used to inform the JSNA regarding appropriate integrated strategies as a holistic approach, but more detailed needs assessments may be needed to identify interventions needed for targeted groups.	
Hampshire and Isle of Wight Local Dental Committee		04 Section 4.15 Cons	27	Health visitors, midwives and general medical practice teams are more likely to be in touch with new parents than dental practitioners. All healthcare professionals, including those names here should support and encourage parents to take the child to a dentist by the age of 12 months (recommendation of the American Academy of Paediatric Dentistry (AAPD), American Dental Association (ADA) and the American Academy of Paediatrics: "Get it Done in Year One"), and then take the children at least once every 6 months to facilitate delivery of fluoride varnish applications, fissure sealants and other preventive care.	Thank you for your comments and suggestions, recommendations have been revised and strengthened around encouraging visits to the dentists at a very early stage. With regard to fissure sealants, committee discussed the need for an incremental comparison of interventions for the current guideline but this was not possible due to the lack of relevant data. However, the committee are aware of the research you have mentioned and when this evidence is in the public domain at a future date it can be considered for inclusion in any update of the guideline.
Hampshire and Isle of Wight Local Dental Committee		04 Section 4.16 Consid	27	The focus at parenting programmes should be about encouraging good habits for health overall. That would include toothbrushing twice a day with a fluoride toothpaste and taking the child regularly to the dentist (with the first visit by the age of 12 months). That would result in development of good oral health which will enable the child to eat a healthy and varied diet which is good for health.	Thank you for your comment.
Hampshire and Isle of Wight Local Dental Committee		04 Section 4.18 Consid	27	The evidence for this is mixed and "some evidence" is not sufficient to invest in what is a very resource-intensive intervention. Unless there is a strategy to include all children, including children from high-risk groups, this will not be effective.	Thank you for your comment. Please see our previous responses about the evidence.

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Hampshire and Isle of Wight Local Dental Committee		04 Section 4.22 04 Consi	28	What evidence is there for this statement? It is logistically difficult to reach and influence young adults who are not in education, employment or training to change any aspect of their lifestyle. Any recommendation should come with evidence-based strategies.	Thank you for your comment, please note this is a consideration not a recommendation.
Hampshire and Isle of Wight Local Dental Committee		04 Section 4.25 Cons	29	There is no evidence to support the first sentence in this point.	Thank you for your comment, please see our previous response about the purpose of this section.
Hampshire and Isle of Wight Local Dental Committee		05 Sec 5 Rec for Research	30	Research needs to conducted in "real-life" settings. Interventions conducted in research settings are not always successful in practice. An example of this is the Cochrane review on fluoride varnish which does not work well in practice due to issues with reaching everyone in the target population. What is the impact of poor oral health on a child's quality of life and development? Is there any association with social class (which would indicate inequality)? What impact do dental problems have on school attendance and is there any association with social class (which would indicate inequality)? What is the cost impact of dental disease in children and adults to the economy in the short-term and long-term? Dental care is expensive.	Thank you for your comment, please note this is a consideration not a recommendation, the research recommendations will not exclude investigation in real life settings, nor any of your suggestions.

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Hampshire County Council	0	0 General		Good quality surveillance data is very important to monitor oral health (OH) outcomes. Dental epidemiology data on 5-year-olds currently in PHOF is not high-quality due to positive consent process which skews participation, and it is only available every 2-3 years. Suggest using data from dental extractions for children which are done under general anaesthesia. There should be national process to collect this regularly. This should be included in the online Local Authority profile data and updated regularly. Dental attendance data can also be used for monitoring inequalities in access. This is already available nationally on a quarterly basis from the Business Services Authority for both children and adults. This can also be included in the Local Authority profiles.	Thank you for your comment. Your points are well made and were considered by the committee, however it is outside the scope of this work to make recommendations about collecting national data. The committee considered your suggestion to make specific reference to dental attendance data but believed there was sufficient indication of robust data sources in the current recommendations. The membership of the group with responsibility for the OHNA would be aware of relevant national data sets and could advise local authorities accordingly.
Hampshire County Council	0	0 General		The guideline development group should include a Consultant in Dental Public Health who works at a PHE Centre on the frontline and not just research academics who are not directly involved in the commissioning process. This will provide the "frontline" view which is important as research initiatives do not always translate well in a "real-life" situation.	Thank you for your comment. Ideally all guideline development committees would have good representation from a range of stakeholders including all professionals involved in commissioning and delivering activities, approaches, or interventions identified in each guideline. NICE recruits to committees following a transparent process. Unfortunately, representation is limited by individual's availability and commitment to what is an intense and lengthy process. The committee did include individuals currently commissioning oral health programmes in local authorities. However, in order to account for any perceived gaps in expertise, NICE sometimes commissions fieldwork, which

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					conducts interviews with a range of health and social care professionals. Please see the supporting documentation for detailed information about the fieldwork supporting the recommendations in this guideline. It is also the case that not all regions have access to CDPH, which has been identified by other stakeholders as a potential difficulty and partly informs the identification of contributors to the OHNA. We appreciate your concern and hope this addresses some of your points.
Hampshire County Council	0	0 General		There is no evidence of effectiveness or cost-effectiveness for many of these recommendations. Recommendations should only be made if they are supported by good quality evidence for both of these. LA and NHS England commissioners have limited budgets and competing priorities and need good quality information on which to base their decisions.	Thank you for your comment. The committee considered a range of evidence from reviews, reports, fieldwork and expert testimony as you will have read. The content of the recommendations reflects their deliberations and careful consideration of all evidence and stakeholder concerns. Please be aware that the status of NICE recommendations varies, recommendations for clinical practice and for local government for example, are always advisory. In this guideline the strength of the recommendations reflects the deliberations of the committee and where, on balance, they genuinely believed most benefit would be derived. The final decision to implement is up to local authorities taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process.
Hampshire County		04	24	Using common risk factor approach means that general medical	Thank you for your comment and suggestions.

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Council		Section 4.4 Cons		teams and staff involved in maternal and child nutrition, breastfeeding and smoking cessation should include mention of oral health advice when they talk to their patients/ clients. They can encourage and support people to access dental care regularly such as signposting them to a local practice and following up to see if they have attended.	Please note this section of the guideline broadly sets out the deliberations and issues the committee considered during guideline development, so are not recommendations in themselves.
Hampshire County Council		04 Section 4.5 Cons	24	Fruit juices are high in sugar as well as acids which contribute to weight management issues as well as poor dental decay. They should not be promoted as "healthy" as this provides a mixed message, particularly to parents. Suggest that there be recommended limits on how much fruit juice is consumed per day to avoid children/adults substituting fruit juice for water.	Thank you for your comment and suggestions. Please see our previous response.
Hampshire County Council		04 Section 4.7 Cons	25	Services involved in tobacco work should encourage and support their clients to access dental care, including signposting and following up to ensure they attend. Helping smokers get their mouths clean and healthy may further encourage them to quit. This is relevant to all buy may be particularly applicable to young smokers in relation to looking presentable for job interviews, meeting people socially etc…	Thank you for your comment and suggestions. Please see our previous responses.
Hampshire County Council		04 Section 4.10 Considerations	25	All targeted health improvement interventions are very resource-intensive. Those in the highest needs groups are the ones who are least likely to engage. There is little evidence of effective interventions and even less evidence on cost-effectiveness (as indicated by the evidence review). A high-level OH needs	Thank you for your comment and suggestions. Please see our previous responses.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				assessment can be used to inform the JSNA regarding appropriate integrated strategies as a holistic approach, but more detailed needs assessments may be needed to identify interventions needed for targeted groups.	
Hampshire County Council		04 Section 4.15 Considerations	27	Health visitors, midwives and general medical practice teams are more likely to be in touch with new parents than dental practitioners. All healthcare professionals, including those names here should support and encourage parents to take the child to a dentist by the age of 12 months (recommendation of the American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA) and the American Academy of Pediatrics: "Get it Done in Year One"). There should be an indicator in the national "Healthy Child Programme" which specifically measures dental attendance annually during the first 5 years.	Thank you for your comment and suggestions. Please see our previous responses.
Hampshire County Council		04 Section 4.16 Considerations	27	The focus at parenting programmes should be about encouraging good habits for health overall. That would include toothbrushing twice a day with a fluoride toothpaste and taking the child regularly to the dentist (with the first visit by the age of 12 months). That would result in development of good oral health which will enable the child to eat a healthy and varied diet which is good for health.	Thank you for your comment and suggestions. Please see our previous responses.
Hampshire County Council		04 Section 4.18 Cons	27	The evidence for this is mixed and "some evidence" is not sufficient to invest in what is a very resource-intensive intervention. Unless there is a strategy to include all children, including children from high-risk groups, this will not be effective.	Thank you for your comment and suggestions. Please see our previous responses.

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Hampshire County Council		04 Section 4.22 Cons	28	What evidence is there for this statement? It is logistically difficult to reach and influence young adults who are not in education, employment or training to change any aspect of their lifestyle. Any recommendation should come with evidence-based strategies.	Thank you for your comment and suggestions. Please see our previous responses.
Hampshire County Council		04 Section 4.25 Cons	29	There is no evidence to support the first sentence in this point.	Thank you for your comment and suggestions. Please see our previous responses.
Hampshire County Council		05 Section 5 Recommendations for Research	30	Research needs to conducted in “real-life” settings. Research conducted in controlled settings in order to meet research guidance protocols do not always translate to real-life practice. An example of this is the Cochrane review on fluoride varnish which does not work well in practice due to issues with reaching everyone in the target population. What is the impact of poor oral health on a child’s quality of life and development? Is there any association with social class (which would indicate inequality)? What impact do dental problems have on school attendance and is there any association with social class (which would indicate inequality)? What is the cost impact of dental disease in children and adults to the health economy in the short-term and long-term?	Thank you for your suggestion. The research recommendations have been amended and would not exclude your suggestions.
Hampshire County Council	1	01 Section	4	It would not be possible to do an informative oral health needs assessment (OHNA) on every aspect of oral health. There can be	Thank you for your comments and suggestions. The committee considered stakeholder concerns and

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		1: Rec 1		some identification of key priorities for each local area. This can be picked up by the Local Dental Network (LDN). This should feed the Joint Strategic Needs Assessment (JSNA) from which the Joint Health and Wellbeing Strategy (HWbS) is derived. The Public Health team and Health and Wellbeing Board should engage with the Local Dental Network consultant in dental public health to ensure that the key OH issues which impact on the local population's health and wellbeing are considered in their recommendations.	suggestions. Recommendations 1 and 2 have been amended within the remit of this work. If further representation for the OHNA is required, there is sufficient flexibility to determine additions
Hampshire County Council	2	01 Sec 1: Rec 2	4	The OH strategy can only be a high-level document which discussed the key interventions needed and the evidence to support them. It should be used to inform the joint HWbS so OH is integrated into general health improvement programmes. Monitoring of OH should be part of monitoring of health outcomes for all groups.	Thank you for your comment and suggestions, your concerns are noted. The recommendations have been amended to include reference to the HWB strategy and the LDN.
Hampshire County Council	2	01 Sec 1: Recommendation 2	5: points 7&8	The only way to get OH included in the work of frontline staff and part of lifecourse pathways, is to include it in national specifications and in the joint HWbS.	Thank you for your comment and suggestions, your concerns are noted. The recommendations have been amended within the remit of the work and include reference to the HWB strategy and local service specifications.
Hampshire County Council	3	01 Sec 1: Rec 3	6: last point	It is only worth doing a detailed OHNA if there is a particular reason for e.g. procurement process for contemporaneous services for a target population, care pathway development of service redesign, where there will be a need for detailed assessment of need, potential demand and other indicators to inform the development of a suitable service.	Thank you for your comment. Your concerns and suggestions were noted by the committee. There is no mention in the recommendations of undertaking an oral health needs assessment at local population level for all oral health conditions. There are recommendations about ensuring oral health is a key

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					health and wellbeing priority and suggestions for how a local authority might identify and meet the oral health needs of their local communities, within local resources available.
Hampshire County Council	4	01 Sec1: Rec 4	6	This list of information includes much of what is included in JSNAs. If a high-level assessment of oral health is done alongside the JSNA, the same information can be used for both avoiding duplication.	Thank you for your comment and suggestion. Please also see our previous responses.
Hampshire County Council	6	01 Sec 2: Rec 6	7	Environments which promote OH also promote general health. An integrated approach should be promoted but also needs to be based on good quality evidence for effectiveness and cost-effectiveness.	Thank you for your comment. The committee considered a range of evidence from reviews, reports, fieldwork and expert testimony as you will have read. The content of the recommendations reflects their deliberations and careful consideration of all evidence and stakeholder concerns. Please be aware that the status of NICE recommendations varies, recommendations for clinical practice and for local government for example, are always advisory. In this guideline the strength of the recommendations reflects the deliberations of the committee and where, on balance, they genuinely believed most benefit would be derived. The final decision to implement is up to local authorities taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process.
Hampshire County Council	6	01 Sec 2:	8: Last point	Drinks that are promoted as sugar-free or low in sugar are still cariogenic as they would contain acids. They also encourage the	Thank you for your comment, the recommendations have been amended within the remit of the work.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
		Rec 6		development of a "sweet tooth" which then encourages people to choose sweet drinks over water. This will have an impact on oral health as well as weight. For e.g. Coca Cola promotes Coke Zero has a "healthy" option to encourage those who drink it, particularly teenagers, to develop a taste for Coca Cola. This encourages them to choose CoCa Cola instead of water. It would be useful to have some evidence or precedence for the positive impact of working with other sectors, including commercial food outlets, before including it as a recommendation. For e.g. is there any evidence that working with a food outlet has contributed to changes in dietary choices?	There are suggestions to consider planning policies and other levers within local authority control, also reference to other NICE guidance which has reviewed different evidence but reached similar conclusions. The final decision to implement is up to local authorities taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process.
Hampshire County Council	7	01 Sec 2: Rec 7	8	To make this happen, there needs to be a directive to include it in local service specifications. This could come as a national steer and/ from the local HWbS. OH should not be tackled in isolation, but as an integrated part of general health outcomes for children.	Thank you for your comment. The document has been amended and local service specifications referred to where appropriate. Please also see our previous responses.
Hampshire County Council	8	01 Sec 3: Rec 8	8	To make this happen, there needs to be a directive to include it in local service specifications. This could come as a national steer and/ from the local HWbS. OH should not be tackled in isolation, but as an integrated part of general health outcomes for children.	Thank you for your comment. Please see our previous responses.
Hampshire County Council	9	01 Sec 3; Rec 9	9	The most important intervention for young children, in addition to good dietary practice, is to use toothpaste with (correct amount of) fluoride twice a day. For settings to provide OH information, there needs to be a directive to include it in local service specifications, including for school nursing, health visiting ec... This could come as a national	Thank you for your comment. Please see our previous responses about the oral health needs assessment and health and wellbeing strategy.

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				steer and from the local HWbS. OH should not be tackled in isolation, but as an integrated part of general health outcomes for all children.	
Hampshire County Council	10	01 Sec 3: Rec 10	10	Information should be available for all children in Early Years settings where feasible. There is no way of identifying with accuracy whether a child will get dental decay so need to target all children so using a "high-risk approach is inappropriate. This is in accordance with the Marmot approach. (Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries prevention strategy for populations". BMC 2006, 6:3)	Thank you for your comment. The recommendations include both universal and targeted approaches as a range of groups, including children, are at greater risk of poor oral health than others, completely in keeping with the Marmot review.
Hampshire County Council	11	01 Section 3: Rec 11	10	Whilst settings with a higher level of poor oral health should be a priority, supervised toothbrushing programmes should be considered for implementation in all school settings as there is no way of identifying, with any accuracy, which child will get dental decay. This is in accordance with the Marmot approach. (Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries prevention strategy for populations". BMC 2006, 6:3) There needs to be promotion of the use of fluoride toothpaste as part of this intervention and encouragement of toothbrushing with fluoride toothpaste at home. For optimum results, the child needs to develop and maintain toothbrushing with a fluoride toothpaste twice a day. The evidence review includes the Childsmile programme which includes a description of this intervention. The supervised	Thank you for your comment. Your concern is noted. The recommendations include both universal and targeted approaches as a range of groups, including children, are at greater risk of poor oral health than others, completely in keeping with the Marmot review. The content of the schemes will address key oral health activities, and the recommendations refer to the DBOH guideline throughout to help wit this. Direct evidence of effectiveness and cost effectiveness about the use of postal delivery was mixed (please see the supporting evidence statements and reviews), some studies showed little or no effect. The recommendations reflect the uncertainty of the evidence, the committee agreed to suggest local authorities consider free tooth

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				toothbrushing programme is supplemented with a postal scheme where toothbrushes and toothpaste are posted out regularly to all young children.	brushing packs and recommendations refer to Childsmile for further examples. The final decision rests with local authorities and depends on local resource and capacity, but your concerns are noted.
Hampshire County Council	12	01 Section 3: Recommendation 12	11	The evidence base for community fluoride varnish applications is mixed as indicated by the evidence review. A Cochrane review indicates that this intervention is effective. However, there is also evidence that this is not effective in practice, as children from more deprived groups are less likely to participate. There is no data on cost-effectiveness for what is a very resource-intensive approach to carry out in a community setting. If this is to be implemented, it needs to include a strategy which will enable this intervention to successfully reach all children. References: A cluster-randomized controlled trial: fluoride varnish in school children. Milsom KM et al. J Dent Res. 2011 Nov;90(11):1306-11 Recruitment and participation in pre-school and school-based fluoride varnish pilots – the South Central experience. Buckingham S and John JH. *BDJ 2013; 215:E8* This strategy should be part of a holistic programme which supports and encourages twice daily toothbrushing with a fluoride toothpaste and a healthy diet. The Scottish Childsmile programme has faced similar difficulties. A 2012 presentations indicated that only 29% of targeted 3-5 year olds and 47% of 6&7 year-olds got the 2 planned applications in the last year.	Thank you for your comment. All recommendations are informed by evidence, but this does not always provide direct evidence of effectiveness or cost effectiveness and the impact on community oral health activities as your comment reflects. The guideline only recommends considering fluoride varnish in schools in areas where the baseline prevalence is high, as the cost effectiveness analyses suggested this was likely to be cost effective. Recommendations are affected by a number of variables in the documented evidence including the impact on implementation and delivery, all evidence requires careful interpretation over multiple meetings. The committee carefully considered the evidence and made recommendations they genuinely believed would help local authorities decide where they may wish to put their resources, taking into account local needs and local resource availability. The Childsmile programme is linked and referenced in the guideline.

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				(Reference: Conway D. Delivering Childsmile: Progress Report. Conference presentation Sep 2012. *www.child-smile.org.uk/*)	
Hampshire County Council	13	01 Sec 3: Rec 13	11	See comments in both boxes above for Recommendations 11 and 12.	Thank you, please see our previous responses
Hampshire County Council	15	01 Sec 4: Rec 15	12	Good to have whole school approach but oral health should be included as part of general health improvement measures for e.g. dietary advice is also important for healthy weight. Drinks that are promoted as sugar-free or low in sugar are still cariogenic as they would contain acids. They also encourage the development of a "sweet tooth" which then encourages people to choose sweet drinks over water. This will have an impact on oral health as well as weight.	Thank you, please see our previous responses on the role of diet and drinks, and the common risk factor approach. The detail of oral health promotion is provided in the DBOH 2014 guideline which is also referenced throughout in this document.
Hampshire County Council	16	01 Section 4: Recommendation 16	12	Should be done for all primary school children as there is there is no way of identifying, with any accuracy, which child will get dental decay but should be integrated into existing approaches e.g. Healthier Schools Standard. This is in accordance with the Marmot approach. Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries prevention strategy for populations". BMC 2006, 6:3	Thank you for your comment, please see previous responses.
Hampshire County Council	17	01 Sec 4: Rec 17	13	There needs to be promotion of the use of fluoride toothpaste as part of this intervention and encouragement of toothbrushing with fluoride toothpaste at home. For optimum results, the child needs to develop and maintain toothbrushing with a fluoride toothpaste twice a day. The evidence review includes the Childsmile programme which	Please see our previous responses.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				includes a description of this intervention. The supervised toothbrushing programme is supplemented with a postal scheme where toothbrushes and toothpaste are posted out regularly to all young children.	
Hampshire County Council	18	01 Sec 4: Rec 18	13	The evidence base for community fluoride varnish applications is mixed as indicated by the evidence review. A Cochrane review indicates that this intervention is effective. However, there is also evidence that this is not effective in practice, as children from more deprived groups are less likely to participate. There is no data on cost-effectiveness for what is a very resource-intensive approach to carry out in a community setting. If this is to be implemented, it needs to include a strategy which will enable this intervention to successfully reach all children. References: A cluster-randomized controlled trial: fluoride varnish in school children. Milsom KM et al. J Dent Res. 2011 Nov;90(11):1306-11 Recruitment and participation in pre-school and school-based fluoride varnish pilots – the South Central experience. Buckingham S and John JH. *BDJ 2013; 215:E8* This strategy should be part of a holistic programme which supports and encourages twice daily toothbrushing with a fluoride toothpaste and a healthy diet. The Scottish Childsmile programme has faced similar difficulties. A 2012 presentations indicated that only 29% of targeted 3-5 year olds and 47% of 6&7 year-olds got the 2 planned applications in the last year.	Thank you, please see our previous responses.

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				(Reference: Conway D. Delivering Childsmile: Progress Report. Conference presentation Sep 2012. *www.child-smile.org.uk/*)	
Hampshire County Council	19	01 Sec 4: Rec19	14	See comments for Recommendation 17 and 18 above	Noted, please see our previous response
Hampshire County Council	21	01 Sec 6: Rec 21	15	There is no evidence to support the effectiveness of displaying information in improving any aspect of health, including oral health. If LAs are to invest, then there should be good evidence to support effectiveness. Displaying information on "all premises" is resource-intensive and may increase inequalities as it impacts on literacy (e.g. what some staff find useful may not be understood by others) and does not address barriers to access. It would not be possible to provide dental services in workplaces, other than a limited service through a mobile dental service. Many workplaces may also be within reach of a local dental practice. Increasing access to care does not necessarily improve oral health. This is just one aspect. There would still need to be a commitment to good oral hygiene practices including toothbrushing with a fluoride toothpaste and eating a health diet. There is no evidence that making a service available, even at a workplace, would encourage everyone to access dental care. It may increase inequalities as those who already attend may use it as an alternative to attending their dental practice, and those who do not attend may not use it. It would be logistically very difficult and very resource-intensive for LAs to provide free oral hygiene aids regularly to all their	Thank you for your comment and for raising your concerns which are appreciated. There was limited evidence about the effectiveness of all community oral health programmes in general and initiatives in the workplace in particular, though there were a few as you will have read. The final revised recommendations take into account stakeholders comments, but recognise raising the profile of oral health in the workplace would be beneficial for many adults. The recommendations have been amended and the final wording reflects the degree of uncertainty and where the committee genuinely believed such activity would be beneficial.

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				employees indefinitely, this cannot be a one-off distribution. How would the LA manage this process? What if there was a high staff turnover? Would this include employees from companies who are sub-contracted to provide services and what happens if the service provider used different staff at different times?	
Hampshire County Council	22	01 Section 6: Recommendation 22	15	No evidence as to what works in improving oral health of adults at higher risk. Providing access to care, and oral hygiene aids still requires the individual to take action. There is limited evidence about the effectiveness of behaviour change interventions. Would be good to have some evidence-based approaches to inform this recommendation.	Thank you for your comment. The document refers to NICE guidance on behaviour change which may be helpful. But as you point out, no specific oral health behaviour change evidence was identified during guideline development despite a call for evidence.
Hampshire County Council	23	01 Sec 6: rec 23	16	There should be a requirement for services dealing with vulnerable people to have a process in place to assess and maintain their oral health, as part of their responsibility to caring for their overall health. Service providers should be given targets which are monitored to ensure that every individual in their care has an oral health assessment and access to therapeutic and preventive care in order to attain optimum oral health. Local experience around the country has indicated difficulties with staff training in residential care homes around high staff turnover, literacy levels of care staff and relative importance allocated to caring for residents' oral health. Unless service providers are required to address these issues, there will not be any changes to the current system.	Thank you for your comment. The recommendations have been revised and suggest a requirement to include oral health in local service specifications, targeting setting is not within the remit of this current work. We note your concerns, but residential care is outside the scope of this current work and is the subject of a separate guideline project, we hope you will continue to comment on this work. More information about this work can be found on the NICE website: Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62

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Hampshire County Council	24	01 Sec 6: Rec 24	17	Need to specify which "frontline staff" and how this training is to be commissioned. There is a need to consider the difficulties with staff training such as literacy levels and areas where there may be a high staff turnover. A key group would be other healthcare professionals such as GPs, practice nurses, community nurses and others who come into contact with these adults. They should check with them about access to dental care and encourage and support them to seek dental care, if they have not already done so.	Thank you for raising this, we have amended within the remit of the work. We appreciate your concerns about frontline staff and staff training, which were reflected by the debate held in committee. Unfortunately, no evidence provided the level of detail required to support specifying which staff should deliver which interventions or the impact of levels of literacy on training. We appreciate your concerns about raising awareness with other healthcare professionals which also reflect the debate held in committee. The final guideline reflects the links between oral health and general health.
Health Improvement Service - SWYPFT	0	0 general		Having looked at this draft guidance we feel the recommendations in the guidance are very broad and cover all aspects of promoting good oral health across all communities and especially vulnerable groups or individuals. Our small Oral Health Team are very happy with the recommendations and feel our community based programmes and activities reflect within these draft guidelines. Where we have gaps, hopefully in the future we can expand our work. We hope this document will form a very good basis for the future of oral health and inform Public Health Teams and others who make decisions when planning locally. In our area we do not have the benefit of a Consultant in Dental Public Health and it is our knowledge and experience which drives us to be passionate to	Thank you for your comments, we appreciate you taking the time to read and comment on the document. The committee were also concerned about the lack of DPH and other oral health expertise. Please be aware we have two more pieces of oral health work in development. We hope you will continue to read and comment on NICE work, it is appreciated.

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				improve the oral health of our community.	
Leeds City Council	0	0 General		It is essential that promoting attendance at the dentist from the age of the first eruption or 6 months of age should be included in the recommendations.	Thank you for your comment. This activity is supported in the revised recommendations.
Leeds City Council	0	0 General		The recommendations should include holistic approaches for very young children such as HENRY (Health, Exercise, and Nutrition for the Really Young).	Thank you for your comment and helpful suggestion. This activity did not emerge during the development of the evidence reviews about community oral health or at the call for evidence, if you know of peer reviewed research or good practice examples on this approach to improve community oral health, we would be pleased to hear about it. However, the recommendations in this guideline would not exclude this type of activity to promote oral health if local practitioners were already using it and found it useful.
Leeds City Council	0	0 General		Dental injury through trauma is not adequately covered, including reference to injury prevention and effectiveness of interventions such as (appropriate) gum shields for sports.	Thank you for your comment. This particular issue is outside the scope of the current guideline.
Leeds City Council	0	0 General		It is useful to see that the evidence does not dental milk schemes, but it would be helpful to have a firmer statement about whether these should be continued given the many practical issues which make these schemes difficult to deliver and assure,	Thank you for your comment and for raising your concerns. The issue of fluoridated milk was debated in committee and this review was considered, but the decision to make a specific recommendation to disinvest was not taken. The issues debated by the committee around fluoridated milk are mentioned in the considerations section.

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Leeds City Council	0	0 General		Oral Health Promotion during pregnancy should be covered in the recommendations.	Thank you for your comment and suggestion, the final guideline has been amended and refers to oral health and pregnant women and also to the DBOH document.
Leeds City Council	1	01 Recommendation 1	p.4	Health and Well-being Boards should be at liberty to prioritise particular aspects of oral health to address at any given time. Children's oral health should be advised as an early priority.	Thank you for comment, they are at liberty to do so, there is no mention in the guideline that this is not the case. The aim of the guideline is to help local authorities makes decisions about identifying and meeting local needs within local resources and capacity available.
Leeds City Council	1	01 Recommendation 1	p.4	Understanding the causes of poor oral health is complex. Third sector organisations who work with children and young people are well placed and provide excellent engagement opportunities to understand the issues causing oral health inequalities.	Thank you for your comments, which are noted. The guideline refers to community groups and to NICE guidance on community engagement which also refers to third sector organisations.
Leeds City Council	2	01 Rec 2	p.4	This section needs to have a focus on how discussions and information is provided. For example a collaborative approach is the most effective way of engaging withcgroups 'at risk' of oral health inequalities.	Thank you for your comment. Recommendations have been amended and clarified, and cross refers to specific NICE guidance about community engagement.
Leeds City Council	3	01 Rec 3	p.5	Include some insight research to further understand all stakeholders' perceptions and views.	Thank you for your comment and helpful suggestion which is reflected in the final version of the recommendations (see also NICE guidance about community engagement).
Leeds City Council	4	01 Rec 4	p.6	This is a narrow reflection of the possible scope of a health needs assessment.	Thank you for your comment. The intention of the committee was to help inform the development of an oral health needs assessment as part of the health and wellbeing strategy, and to ensure oral health was included as an important component of general health and wellbeing.
Leeds City Council	6	01 Rec 6	p.7	Public services should be stronger at modelling healthy practices in eg. Leisure centres. However choice is important. It is vital that	Thank you for your comment and helpful suggestions. The recommendations have been amended to reflect this

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				the key message regarding sugar is that the number of exposures to sugar needs to be reduced.	issue within the remit of the work.
Leeds City Council	7	01 Rec 7	p.8	Frontline staff need to be able to understand the information. It is important that they are supported to increase the public's understanding of the information and ability to act on the information rather than to deliver advice to the public.	Thank you for your comment, your concern is noted.
Leeds City Council	8	01 Rec 8	p.8	This should be directed to Early Years providers as well as commissioners, recognising that some early year's services (eg children's centres) may be directly provided by local authorities, rather than commissioned. It should also recognise that private child care services are not commissioned and cannot be managed via service specifications. The Family nurse Partnership programme is licensed and written in a manual format- so it is inappropriate to frame recommendation about its content. Health visiting and FNP are currently commissioned by NHS England on a national DH service specification, so recommendations about these services should be directed to the DH, not local health and wellbeing commissioning partners.	Thank you for your comment and for raising these issues. The recommendations have been revised and strengthened where early years services are mentioned. Your point about the FNP has been considered and the wording of this recommendation clarified to avoid any confusion, we hope the revisions are helpful.
Leeds City Council	9	01 Recommendation 9	p.9	It is unrealistic and impractical to suggest that all frontline staff should have annual training in oral health.	Thank you for your comment. This has been amended to 'regular'.
Leeds City Council	10	01 Rec 10	p.10	This intervention will only be successful if the behaviours of the community are understood before interventions are planned.	Thank you for your comment. The guideline refers to specific NICE guidance about Community Engagement which addressed this issue.
Leeds City Council	11	01	p.10	These schemes are a good idea. However the parents are the key	Thank you for your comment, your concern is noted and

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		Rec 11		people who need to support the young people to brush their teeth. The schemes need to engage the parents so they learn how to brush effectively and regularly.	was also a concern for the committee. Collaborative working between schools and parents was included in the revised recommendations. Thank you.
Leeds City Council	12	01 Rec 12	p.11	It would be helpful to see recommendations about providing specific payment and incentives for GDPs to encourage attendance by young children, give oral health promotion advice, fluoride varnishes and fissure sealing.	Thank you for your comment and helpful suggestion, but this activity is out of scope for this guideline as it is about preventative advice and treatment by high street dentists.
Leeds City Council	14	01 Rec 14	p.12	It is important to engage parents in a fun and relevant way. Whole family behaviour change approach is important.	Noted, thank you for your suggestion.
Leeds City Council	16	01 Recommendation 16	p.12	Information is just a small part of bringing about behaviour change. Consider using readiness to change models and different methodologies depending on the needs of the population.	Thank you, the document refers to NICE guidance on behaviour change, which may be helpful.
Leeds City Council	20	01 Rec 20	p.14	This should be addressed to local authorities – not to local education authorities. It should be recognised that school nursing is commissioned by wider parts of the local authority than the education section.	Thank you for your comment, we have amended where feasible within the scope of this work and the available evidence, and your point is noted.
Leeds City Council	20	01 Rec 20	p.14	This should be addressed to local authorities – not to local education authorities. It should be recognised that school nursing is commissioned by wider parts of the local authority than the education section.	Thank you for your comment, your point is noted thank you. we have amended,
Manchester Mental Health and Social Care Trust	0	0 General		While the recommendations within the document are generally acceptable consideration must be given to the cost of implementation.	Thank you for your comment. There is a separate costing statement on the nice website which considers the cost implications of implementing the recommendations. In this guideline the strength of the recommendations reflects the deliberations of the committee and where, on

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					balance, they genuinely believed most benefit would be derived. The final decision to implement is up to local authorities taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process.
Manchester Mental Health and Social Care Trust	2 (and 3)	01 Section 1	4 5	A member of a commissioned oral health team must have an input to develop an oral health needs assessment and subsequent oral health strategy. Recommendation 3 must be listed before recommendation 2	Thank you for your comment. The committee considered stakeholder concerns and suggestions. Recommendations have been amended within the remit of this work. If further representation for the OHNA is required, there is sufficient flexibility to determine additions. The order of the recommendations has been altered.
Manchester Mental Health and Social Care Trust	7 (12,20,21, 22)	01 Sec 2, 3 and sec 4	7 12, 20, 21,22	Recommendation 5, 6, 9 and 12. Examples are offered such as 'low sugar' this is incorrect because it can be just as cariogenic as full sugar. Throughout the document and stated in these recommendations ''advice should be in-line with Delivering Better Oral Health''. This document provides the evidence based guidance but does not provide the science behind it, for example, recommendation 9 states ''frontline staff should explain that tooth decay is preventable and how fluoride can prevent it''. It is vital the training and supervision should be coordinated and delivered by those with the necessary skills, knowledge and qualifications to ensure quality and accuracy.	Thank you for your comment, we have amended the document and clarified in relation to the role of diet and oral health. Recommendations about training have been clarified and amended appropriately within the remit of this work. We appreciate your concern, but NICE guidance does not provide scientific detail, in this case, the detail to promote oral health should be provided by the DBOH 2014 document, which is referenced throughout.
Manchester Mental Health and Social Care Trust	10 (and	01 Sec 3	10,11	All the recommendations in this section would need to be implemented by professionals as the evidence base indicates professionally implemented interventions. This section and others	Thank you for your comment. The guideline has been amended within the limitations of the evidence, which frequently did not specify the skills

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	11)			need more clarity especially when ‘‘access to dental support and guidance’’ is stated.	and training requirements needed, nor the required information to set out the detail you request.
NOHPG National Oral Health Promotion Group	8	01 Sec 3 Rec 8	8	It would a low cost prevention aid if at all Health Visitor/frontline services weaning age visits or appointments parents were given a mini open cup and advised on usage and health benefits.	Thank you for your comment and suggestion. There was no evidence of the impact on the effectiveness or cost effectiveness of this activity on community oral health, but the DBOH 2014 guideline supports advice on this particular issue.
NOHPG National Oral Health Promotion Group	8	01 Box 1	21	Please make the cup description more specific in order to explain this should be an open cup. Cup can easily be interpreted as a valved, spouted cup, the likes of which have the potential to contribute to poor oral health.	Thank you for your comment and suggestion, we have amended. The recommendation that includes this reference now links to the latest DBOH 2014 document which discusses this in more detail.
Pennine Care Foundation Trust Health Improvement Oral Health team		04 Overarching strategy	25	**General comment - Life course approach** - • Consider schemes to promote uptake and safe use of family fluoride toothpaste at ***6 months of age***? • Consider setting up sustainable cost effective fluoride distribution schemes that can be delivered to those children who are hard to reach and do not attend an early years establishments? • More emphasis on the importance of establishing good oral health habits right from the start. • *More research required on fluoride distribution schemes targeted at 6 months old*.	Thank you for your comment, your suggestions were considered and the recommendations have been strengthened within the limits of the available evidence and reflect many of the points you raise here.
Pennine Care Foundation Trust Health Improvement		04 Sec 4	12 &13	**General comment –** What goes on at home from birth onwards in preparation for school readiness is paramount. There does not seem to be much emphasis on engaging with parents and carers	Thank you for your comment and suggestions. The recommendations have been revised and strengthened within the remit of the work and the current

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Oral Health team				whilst attending these establishments about what they should be being reinforced and encouraged to do at home? For example safe and effective use of fluoride toothpaste and introducing routine early brushing soon as teeth appear and regular attendance at the dentist for advice and fluoride applications where appropriate. A lot stated is 'doing to' whilst in these establishments and appears to be taking away parents and carers responsibility. How sustainable is it for early years and school environments to carry this out? How sustainable is it for Health Improvement workers / oral health workers to support and facilitate these schemes? Maybe *make it clearer* to *teams* they need to use 'Common Risk' capacity building model to train and update school nurses and their teams to deliver holistic health and wellbeing session that include oral health. Some teams may (still) interpret this as they themselves as 'Oral Health Educators' should go into establishments and still continue to 'do talks' to children delivering oral health in isolation.	evidence base. Attending the dentist regularly from an early age is also encouraged. Where appropriate the committee were concerned that recommendations also encourage working in collaboration with parents and carers. In addition the document refers to the latest version of the DBOH 2014 which sets out the detail you highlight to be important.
Pennine Care Foundation Trust Health Improvement Oral Health team	4	01 Sec 1	6	Recommendation 4 - add the need to engage with the local community to collect feedback, (qualitative evaluation) to ensure the initiatives and services provided are acceptable to those using them.	Thank you for your comment. The recommendations have been amended, and suggest using a variety of sources to collect data that reflects local need. The document refers to community groups, voluntary agencies and refers to NICE guidance about engaging with local communities.
Pennine Care Foundation Trust Health Improvement Oral Health team	6	01 Section 2	8	Recommendation 6 – add hospitals to the list	Thank you for your suggestion, this setting is outside the scope of this current piece of work.

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Pennine Care Foundation Trust Health Improvement Oral Health team	8	01 Sec 3	9	**Recommendation 8** – Last bullet point add and in and accessing appropriate local NHS dental services	Thank you for your comment and suggestion, the guideline has been amended. Increasing access to appropriate NHS dental services has been referenced throughout the recommendations where appropriate.
Pennine Care Foundation Trust Health Improvement Oral Health team	11	01 Sec 3	11	**Recommendation 11** – Collect evaluation from parents and carers	Thank you for your comment. Collaborative working with parents is encouraged in the revised recommendations.
Pennine Care Foundation Trust Health Improvement Oral Health team	12	01 Sec 3	11	**Recommendation 12** - for children at higher risk of poorer oral health fluoride varnish should be applied 4 times a year not 2 as stated	Thank you, we have revised the recommendation which suggests 'at least' twice a year within the limits of the available evidence. If local authorities are in a position to fund more frequent applications they may wish to do so.
Pennine Care Foundation Trust Health Improvement Oral Health team	12 (?)	01 Sec 3	11	**General comment** – Another bullet point to consider recommending encouraging families with young children to *attend the dentist* for application of fluoride varnish	Thank you for your comment, the recommendations have been revised and strengthened where feasible. This activity is mentioned throughout appropriate recommendations.
Pennine Care Foundation Trust Health Improvement Oral Health team	15	01 Section 4	12	**Recommendation 15** - last bullet point – Identify and link with relevant local partners to promote a whole school approach to *health and Wellbeing embedding oral health throughout.*	Thank you for your comment and suggestion. The focus throughout the guideline is on health and wellbeing and oral health. Recommendations to schools include adopting a whole school approach to oral health and making the links to general health and wellbeing.
Pennine Care Foundation Trust Health Improvement Oral Health team	16	01 Section 4	13	**Recommendation 16** – Last bullet point there should be some mention of the benefits of regular dental attendance and fluoride application.	Thank you for your comment. The recommendations have been revised and amended to encourage these activities where appropriate and the document also refers to the latest DBOH document throughout which provides further detail.

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Pennine Care Foundation Trust Health Improvement Oral Health team	16	01 Section 4	13	**Recommendation 16** – last bullet point should include - Engaging with parents opportunistically to discuss all aspect of their child's health and wellbeing to include relevant oral health advice and information including the benefits of attending the dentist for advice information and fluoride application as well as discussing school food policy development.	Thank you for your comment. The recommendations have been revised and encourage collaborative working with parents and carers. The activities you suggest are also highlighted.
Pennine Care Foundation Trust Health Improvement Oral Health team	19	01 Sec 4	14	**Recommendation 19** – add in a bullet point to engage with parents to collect feedback.	Noted, please see our previous response.
Pennine Care Foundation Trust Health Improvement Oral Health team	20	01 Sec 5	14	**General comment - Recommendation 20** – Ensure school nursing service encourage good health and oral health – school nurse service workforce should be used to deliver key oral health messages early on in the curriculum too i.e. reception and year 1.	Thank you for your comment and suggestions. If school nursing services are operational in a local area, local authorities may wish to utilise them, but the committee were aware that the level and presence of this service varies across regions and localities. The whole school approach to promoting oral health encourages a range of activities across age groups, but it is up to schools to decide the content of their curricula.
Public Health England	0	0 General		PHE, as a registered stakeholder organisation, are pleased to be given the opportunity to comment on the draft guidance. The guidance will be extremely useful to local authorities in their oral health improvement role and is very welcome and timely.	Thank you for your comment and for taking the time to read the document. FYI The final version now makes clear reference throughout to the latest versions of the DBOH 2014 and PHE commissioning guide.
Public Health England	0	0 General		Within the structure of the guidance there is confusion re sections and chapters. As the recommendations are split into sections, do	Thank you for your comment. The final version of the guideline has been revised and will

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				the chapter numbers refer to chapters rather than sections?	not include sections. We hope you find the amended version clearer. Generally guideline structure follows a NICE style and is aligned to be best viewed on the website or via NICE pathways.
Public Health England	0	0 General		There is a lack of detail within the recommendations regarding who should be taking action. Ensuring quality of delivery is important and statements regarding the necessary skills and experience of providers would be helpful.	Thank you for your comment. We appreciate your concern. There was little available evidence specifying the effectiveness or cost effectiveness of deploying particular staff with particular skills, and their impact on delivering a community oral health programme. The committee made recommendations taking into account the uncertainty of the available evidence, and where they genuinely believed activities would help local authorities in their decision making.
Public Health England	0	0 General		The scope for the guidance focuses clearly upon vulnerable groups as stated on page 1. However, local authorities will be developing oral health improvement strategies involving a whole population approach, which includes these groups, so this is a somewhat artificial position. Within the recommendations many of those included would be population based approaches with perhaps a greater intensity within these groups. It is important that this is made clear as the conflict between universal and targeted approaches occurs several times throughout the recommendations.	Thank you for your comment and highlighting this potential confusion. The referral was to develop guidance for local authorities to conduct an oral health needs assessment with a particular focus on vulnerable groups. The recommendations set out these activities and a range of approaches that meet the remit of the work. The final guideline has been amended and is hopefully clearer.
Public Health England		02 Sec 2	7	***Promoting oral health for everyone***- the heading for this section is at odds with the scope of the guideline which focuses on	Thank you for your comment. The guideline has been revised and the emphasis on

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				vulnerable groups. The section is very important as to tackle inequalities effectively the principle of proportionate universalism should be followed involving, therefore a combination of universal and targeted interventions. This should be explicitly referred to and acknowledged in this section.	promoting oral health for all has been strengthened.
Public Health England		02	17 Who should take action	This should specifically mention NHS England Area Team commissioners as they are key commissioning partners, also Health Education England	Thank you, we have amended.
Public Health England		03 Context	18	In the introduction the second sentence refers to associations with other diseases and includes all oral diseases. To be accurate this should only refer to periodontal disease. Although this is important the order of the statements re context seems counter intuitive i.e. poor oral health and its impact including financial impact before links with general health. It needs to emphasise that these are associations, with the strongest evidence of an association between periodontal disease and diabetes. These **associations** need further explanation to avoid misinterpretation.	Thank you for raising. This section in the guideline mentions oral diseases and gives examples of a range of conditions associated with poor oral health, of which periodontal disease one. If people require further detail the references are given.
Public Health England		03 Oral health in England	19	The statement at the top of Page 19 needs to be clarified. With regards to 'better oral health' this is from ADHS survey data, if from the questionnaire should be 'reported 'or 'claimed' The changes re consent process only apply to the 5 year old survey not the 12 year old as stated. The statement that '33.4% reported having dental caries' is incorrect. This was a clinical measurement i.e. the actual proportion of children found to have dental caries.	Thank you for raising, we have amended. The reference to 12 year old children is about the NHS Dental Epidemiology programme and levels of disease in this age group. The second point is a general point about bias, using the example of children and consent, no age is given but the reference is available should people wish to look further. The list of risk factors are examples only, not intended to

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				Improving the oral health of local populations The list of risk factors does not mention the direct causes i.e. increased amount and frequency of sugar intake, sub optimal exposure to fluoride, ineffective plaque removal, smoking and alcohol misuse	be exhaustive.
Public Health England		03 context	20	The role of LAs in improving oral health This should state that the roles are statutory and the relevant statutory instruments SI 3094 and SI301 re water fluoridation. Although water fluoridation is out with your scope this is a role that is a LA responsibility with regard to improving oral health. This paragraph should commence with the overarching statutory role of LAs allocated to them under the Health and Social Care Act to improve health, and this includes oral health.	Thank you for your comment.
Public Health England		04 Cons	24	4.2 and 4.4 – Again, risk factors focusing on social associations	Thank you for your comment. This is the considerations section which broadly sets out some of the issues and deliberations of the committee.
Public Health England		04	24 &25	4.5 - The statements regarding fruit juice should be discussed in the context of pathological tooth wear or erosion as this is not clear and may confuse the reader with dental decay.	Thank you for your comment. Please see our previous response.
Public Health England		04	25	4.6 – This seems to be considering inadequate labelling, however this is not made explicit. Labelling has both mandatory and voluntary aspects (re the traffic light systems employed by various supermarkets). Is NICE going to make any recommendations regarding labelling of sugar sweetened beverages?	Thank you for your comment. Food labelling is outside the remit of this scope of work.
Public Health England		04	25	4.7 - The final sentence includes both oral cancer (two main risk factors are smoking and alcohol with potentiating effects) and periodontal disease (main risk factors poor oral hygiene, smoking,	Please see our previous responses.

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				systemic disease e.g. diabetes). These need to be clarified, as the current statement is misleading.	
Public Health England		04	25	4.9 - There is an inherent conflict in the document with regard to targeted and universal approaches as the scope is focusing on vulnerable groups for which most interventions will be targeted. It therefore needs addressing as these groups will also benefit from universal approaches such as the recommendations 1-7.	Please see our previous responses.
Public Health England		04	26	4.12 - This does not seem to fit naturally within this section on overarching strategy.	Thank you for your comment, the document has been revised.
Public Health England		04	26	4.13 - Quality of life measures are included in the National Child Dental Health Survey and in the 2009/10 survey of 12 year olds. The PHAC seem to have only considered one style of oral health needs assessment. HNA may include specific groups or to inform specific commissions. There is not a 'one size fits all' contents or method.	Thank you for your comment. Please see our response about the purpose of this section, which only sets our broadly what was debated and discussed in committee.
Public Health England		04	27	4.15 – Midwives, health visitors and GPs are more likely to have regular contact with new parents than dental teams 4.16 - The PHAC discussed the incorporation of tooth brushing within parenting programmes and this would seem appropriate. There is also an opportunity to refer to the oral health input mentioned in the national service specification for the HCP. This should be more specific in terms of timing and content. It should coincide with the life course event of the first tooth erupting at approximately 6 months and follow the advice from DBOH as stated for 0-3 years on page 21 and parents should be	Thank you for your comments and suggestions which are noted. The final document has been revised and many of your helpful points have been taken into account.

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				encouraged to take the child to the dentist regularly. 4.18 - The recommendation regarding both targeted fluoride varnish programmes and tooth brushing programmes in areas where children are at very high risk of dental caries misses the point that there needs to be a combination of universal and targeted interventions in LA areas and upstream policy and place schemes to support such interventions. Fluoride interventions need to be considered in the context of wider strategy and local policy development	
Public Health England		04	28	4.22 There is a statement in brackets here (Oral hygiene includes regular dental check-ups) which does not make sense. The statement regarding young adults not in education employment or training - is there any evidence to support the statement regarding their oral health needs? They are a particularly difficult group to engage.	Thank you for your comment, your concerns are noted.
Public Health England		04	29	4.25 Is there evidence to support the statement that most new *incidences* of dental decay are now in the adult population?	Please see our previous response about the purpose of this section.
Public Health England		04	29	The document notes the concerns of PHAC members re the robustness of the economic modelling. However the cost effectiveness of programmes is key information for commissioners. There is a pressing need to build a consensus regarding the type of information needed within future recommended programmes that can begin to develop this evidence.	Thank you for your comment, the priority of developing robust cost effectiveness data is reflected in the research recommendations section.

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Public Health England		06 Sec 6	32 Related NICE gdnce	Mini/micro screw implantation for orthodontic anchorage- how is this related to the current guidance or indeed the extraction of wisdom teeth?	Your concern is noted.
Public Health England		07 Section 7	32 Glossary	Fluoride varnish can be white or clear depending upon brand. However only one brand is licensed for caries control in the UK and that varnish is golden coloured.	Thank you for raising, we have amended.
Public Health England		09 Sec 9	36 reviewing the evidence	Studies were excluded if they were conducted in a non – OECD country, yet the list of statements and evidence includes several studies undertaken in in the US so it is debatable whether the conclusions of these studies can necessarily be applied to the UK.	OECD countries include the USA, the applicability of any studies conducted outside England are routinely and systematically taken into account during guideline development.
Public Health England		03 context	19&20	Improving the oral health of local populations The list of risk factors does not mention the direct causes of poor oral health (i.e. increased amount and frequency of sugar intake, sub optimal exposure to fluoride, ineffective plaque removal, smoking, alcohol misuse) , but focuses on social associations only.	Please see our previous responses,
Public Health England		05 Section 5 Rec for research	30&31	It would seem from the review that there is little robust or applicable evidence of cost effectiveness. The long list of recommendations for research should be prioritised and simplified. The key question for commissioners will be “what is the most cost effective way to improve oral health for various population groups?” 5.5 - It should be noted that a wide range of factors impact on the number and proportion of children admitted to hospital for treatment.	Thank you, these have been revised and your suggestions would not be excluded from the recommended areas for further research.
Public Health	1	01	4	PHE would support this recommendation however it could be	Thank you for your comment and helpful suggestion.

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England		Section 1: Recommendation 1		strengthened to say that oral health should be a core component of both the joint health and wellbeing strategy and the underpinning Joint Strategic Needs Assessment (JSNA). An oral health strategy and needs assessment group suggests a task oriented group that is time limited. An oral health improvement group might be a more appropriate name for such a group, which would also oversee implementation of a strategy and its impacts. The membership of this group should therefore also include a local authority commissioner and a local NHS England commissioner.	The committee considered your suggestions and that of other stakeholders and have amended and clarified this recommendation. We hope this is helpful.
Public Health England	2	01 Sec 1: 012 Rec 2	4	Recommendation 2 should come after recommendation 3.	Thank you for your comment. The order of the recommendations has been altered.
Public Health England	2	01 Sec 1: Rec 2	5: points 7&8	We would suggest that in order to ensure oral health is promoted by all frontline staff (and routinely as part of life course pathways) it should be included in national and local service specifications and in the joint Health and Wellbeing Boards (HWBs). PHE consultants in dental public health and NHS England's Local Dental Networks should provide local sources of expert advice.	Thank you for your comment. The committee considered stakeholder concerns and suggestions. Recommendations have been amended within the remit of this work and refer to local service specifications. These groups you suggest have been included, if further representation for the OHNA is required, there is sufficient flexibility to determine additional input, but we hope this is clearer.
Public Health England	3	01 Sec 1: Rec 3	5	Recommendation 3 should be renumbered as recommendation as the oral health needs assessment should be carried out before strategy development.	Thank you for your comment. The order of the recommendations has been altered.
Public Health England	3	01 Sec 1:	6: last point	It is not appropriate to assess the oral health needs of every population group for every oral condition, for all treatment	Thank you for your comment. Your concerns and suggestions were noted by the

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
		Rec 3		pathways. It would be possible to carry out a very high level assessment of oral health as part of the JSNA and linking to the HWBs. It is only worth doing a detailed Oral Health Needs Assessment (OHNA) if there is a particular reason, e.g. procurement process for services for a target population, care pathway development or service redesign, where there will be a need for detailed assessment of need, potential demand and other indicators to inform the development of a suitable service.	committee and the recommendations have been revised. The committee heard evidence that the quality of current OHNAs undertaken varies quite considerably across England. There are recommendations about ensuring oral health is a key health and wellbeing priority and suggestions for how a local authority might go about achieving this to meet the oral health needs of their local communities. There is no mention in the recommendations of undertaking an oral health needs assessment at local population level for all oral health conditions.
Public Health England	4	01 Sec1: Rec 4	6	Inclusion of the fifth bullet point 'consider seeking advice on survey design etc.' , should be clarified as LAs have a statutory duty to participate in the national programme of surveys, which follow strict protocols laid out by Public Health England. Additionally, consultants in dental public health, within the strategy group, will be able to provide advice on survey design and interpretation and analysis of epidemiological data. Should further bespoke surveys or larger samples of specific subgroups be required to provide local information, the local consultant in dental public health could provide appropriate advice.	Thank you for your comment. The recommendations are not about participation in national survey data collection activities, which follow nationally agreed protocols as you point out. Your suggestions were considered by the committee and the recommendations have been amended and clarified within the remit of this work. Recommendations refer to collecting data from a range of surveys and data sources to inform local needs. One of the difficulties the committee heard was the limited availability of DPH consultants, which was raised on a number of occasions. The expertise they offer is valuable.
Public Health England	4	01 Sec 1: Rec 4	6	In recommendation 4 there is no mention of using dental service or oral health improvement activity data, or indeed of documenting available resources, all of which are necessary to complete a needs assessment.	Thank you for your comment. Please see our previous response.

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Public Health England	5	01 Sec 2: Rec 5	7	This should happen automatically if OHNA is used to inform the JSNA and joint HWBs. All the points mentioned should be included as part of the joint HWBs using the common risk factor approach.	Thank you for your comment. Please see our previous response about the variability of the quality of OHNAs.
Public Health England	6	01 Rec 6	7-8	Many local authorities have already used planning policy to ensure that fast food outlets and other unhealthy food outlets e.g. ice cream vans are not located near to schools. This should be recommended/supported and referenced within this section. Healthy eating policies supporting healthy environments should be developed and supported by LAs. LAs could also use policies in order to commend and provide support (through publicity or through raising awareness among their own staff) food outlets serving healthy foods within their areas.	Thank you for your comments and suggestions. The recommendations have been amended and clarified to incorporate many of the points you raise. These include suggestions to consider planning policies and other levers within local authority control, also reference to other NICE guidance which has reviewed different evidence but reached similar conclusions. The final decision to implement is up to local authorities taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process. Please also see our previous responses.
Public Health England	6	01 Recommendation 6	7	While it is welcomed that there is recognition that the creation of environments that promote oral health is important in line with the Ottawa Charter, this recommendation could be strengthened. For example there is a recommendation that all public services encourage and support breastfeeding, but the environment is key here. Local authorities and health services will need to do more than just encourage breastfeeding and truly create an environment that supports this. Where would a mother breastfeed in a busy shopping area? Or even at a hospital if they were a visitor? We	Thank you for your comment. The committee noted your concerns and have amended and strengthened the recommendations within the status (advisory not mandatory guidelines) and remit of this work. Recommendations that refer to the role of diet and the availability of drinking water in relation to oral health have been clarified. Local authorities have the final decision about how best to promote the oral health in their local community and the committee has recommended activities or approaches

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				need to go beyond encouraging mothers to breastfeed and ensure that they have a safe and appropriate place to feed their baby. Likewise, making water freely available is to be commended, but should this be strengthened to make water the only freely available drink in some settings, for example schools/ hospitals where 'coke machines' are much easier to find than a water fountain? Low sugar drinks are still cariogenic and therefore should not be recommended to improve oral health.	they hope will be helpful.
Public Health England	7	01 Rec 7	8	'Ensure front line staff understand the importance of health' is a commendable recommendation and it is pleasing to see this goes beyond the core dental team and involves other health and social care front line staff. These other players are key, however the recommendation should go beyond staff awareness to staff action. For example, care home staff may be aware that it is important for residents to clean their teeth/dentures, but they may not be trained or have incentive to offer help and support with this. To ensure implementation and action, training and support should be offered and action required within local service specifications and care plans. The large cohort of family members who are carers for elderly or disabled relatives may only become aware of the importance of oral health and mouth cleanliness when it is too late. Perhaps we need ambition beyond 'staff' to <u>all those who have responsibilities as carers.</u>	Thank you for your comment, we have amended the document and clarified in relation to the role of diet and oral health. Recommendations about training, including for all carers, have been clarified and amended appropriately within the remit of this work, and encourage training and advice to be given to all carers. However it is up to local authorities to determine local needs and available resources. Oral health improvement in care homes is the subject of a separate piece of guidance from NICE. We hope you will continue to comment on all NICE work about oral health.
Public Health England	8	01 Rec 8	8-9	This recommendation is welcome. Oral health should be included within the national and local service specification for 0-5 years.	Thank you for your comment. Please see our previous responses.

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Public Health England	9	01 Rec 9	9	The lists contained within the first two bullet points do not seem to explain the overarching statements they are supposed to illustrate. Key oral health practices for young children are good dietary practice and commencing brushing with fluoride toothpaste of appropriate fluoride concentration as soon as the first tooth erupts and establishing a twice daily brushing habit.	Thank you for your comment. The recommendations for early years services have been clarified and amended and refer to the latest version of DBOH 2014 (by PHE) which set out more detail and priorities.
Public Health England	10	01 Rec 10	10	This recommendation concerning inequalities is welcomed, however, the Marmot review stated that "Universal action is needed to reduce the steepness of the social gradient of health inequalities, but with a scale and intensity that is proportionate to the level of disadvantage." The recommendation should therefore be within the context of a universal approach.	Thank you for your comment. The recommendations include both universal and targeted approaches as a range of groups, including children, are at greater risk of poor oral health than others, completely in keeping with the Marmot review.
Public Health England	11	01 Sec 3: Rec 11	10	It would be helpful if NICE would consider placing the evidence of effectiveness alongside the recommendation i.e. Link it specifically to the Cochrane reviews on each of the recommendations; e.g. Link to Marinho's review http://summaries.cochrane.org/CD002278/fluoride-toothpastes-for-preventing-dental-caries-in-children-and-adolescents This recommendation (11) talks about supervised tooth brushing schemes in nurseries however it does not include distribution of packs that go home to support brushing with a fluoride toothpaste. NICE reference the Childsmile programme in the evidence review however within the programme toothbrush packs are given at birth, two at age 3, two at age 4, and one at age 5 years (see www.childsmile.org.uk). Should the distribution of packs not be a separate recommendation?	Thank you for your comment. NICE guidelines follow a uniform structure and editing style across all guideline products, and within each guideline document there are the lists of the evidence statements supporting each recommendation. The supporting documents also set out copies of all the evidence reviews, reports, economic modelling and expert testimony the committee considered. Each recommendation is made taking into account a range of data sources as well as the judgement of the committee, so to reference a single data source would make the document unwieldy. The recommendations have been amended to include tooth brushing packs. The content of the schemes will

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				This relates to the evidence of their effectiveness (e.g. Davies, Worthington et. al. Community Dent Health. 19, 2002, 131-136.) The suggestion of a lead person is a good idea- it works well in many health promotion programmes where the public health team is reliant on working with an establishment. The final bullet point recommends '*Performance monitoring at least once every term against a checklist drawn up and agreed with the oral health strategy and needs assessment group (see recommendation 2',* SIGN guidance often includes a sample checklist as an appendix- or online link – would NICE consider this?	address the issues raised about key oral health activities. Thank you for your helpful suggestion about a sample checklist which the implementation team at NICE will explore following publication. The recommendations also suggest working with the local group feeding into the OHNA which will likely be relevant to local needs.
Public Health England	12	01 Sec 3: Rec 12	11	See Recommendation 11- consider linking this directly to the evidence- to enable LA practitioners to easily find the evidence they need to support their desire to take up this recommendation. The guidance recommends tooth brushing schemes in preference within a recommendation promoting the use of fluoride varnish, some explanation of the circumstances when to commission fluoride varnish would be helpful. Effectiveness requires targeting of high risk populations, high rates of consent, compliance and retention. Successful delivery depends on engaging with parents, schools and early years settings. Good links with dental practices are needed to ensure that they are informed if their patients have received fluoride varnish. There may be high cost due to the need for clinical personnel. Use of skill mix may help to reduce costs (e.g. using	Thank you for your comment. Please see our previous response about linking to evidence, but the considerations sections sets out the reasoning behind these activities. The committee considered your suggestion about adding detail around commissioning, but also considered that the commissioning context varies considerably across localities and local authorities. However the final document makes reference to the latest guidelines about commissioning which may help local authorities in their decision making. The focus on STBs is set out in the considerations section of the guideline. NICE guidelines follow a uniform structure and NICE editing style across all guideline products. To include references for all recommendations, across clinical, public health, social care and technology appraisals would create

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				dental nurses rather than dentists). Such programmes need to be sustained to be effective The evidence base relates to children within two year programmes with at least twice yearly applications. Ad-hoc or short-term applications are not effective in achieving long-term benefits. Clinical governance requirements are considerable and careful planning is needed. Effectiveness is also dependent upon parental involvement with advice support and homecare. Community based studies that have not been found to be effective have not included parental involvement, have been carried out in areas with low caries levels and involved children of inappropriate ages with low risk of developing dental disease on the teeth included.	unwieldy documents. For further information about NICE processes and guideline production please go to the NICE website. Thank you for your suggestions, the recommendations have been revised and reflect many of the helpful points raised here.
Public Health England	13	01 Sec 3: Rec 13	11	No comment	Noted, thank you.
Public Health England	14	01 Rec 14		In section 4 the term local education authority is used on several occasions we would suggest this is replaced with local authority. NICE may want to consider what age groups it feels are most appropriate for this advice (e.g. age 5, age 12, every year?)	Thank you for raising, we have clarified this, and the points about age, in the final version.
Public Health England	15	01 Section 4: Recn 15	12	'Low sugar' options are cariogenic and should not therefore be included within healthier options. This recommendation could also include recording details of children's dentist on school entry in addition to details of GMP	Thank you, please see our previous responses on the role of diet and drinks, and the common risk factor approach.
Public Health England	16	01 Section 4: Rec 16	12	Oral health promotion should be universal, not just involving children in primary schools in areas at higher risk of poor oral health.	Please see our previous responses. There was very little or no evidence on the impact of training all school staff to promote oral health at

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				All staff should be trained to provide evidence-based, age appropriate advice and information.	community level. If further evidence of effectiveness and cost effectiveness does emerge this may be considered during the guideline review.
Public Health England	17	01 Sec 4: Rec 17	13	This recommendation should also include – 'the points the scheme should include' as laid out in Recommendation 11. The comments are the same as for recommendation 11. The use of targeted and timely provision of free toothbrushes and toothpaste (i.e. postal delivery or via Health visitors) has been shown to be effective but has not been included as a recommendation.	Thank you for your comment. Please also see our previous responses. The recommendations have been revised, thank you. However, direct evidence of effectiveness and cost effectiveness about the use of postal delivery was mixed (please see the supporting evidence statements and reviews), some studies showed little or no effect. The recommendations reflect the uncertainty of the evidence, the committee agreed to suggest local authorities consider free tooth brushing packs and recommendations refer to Childsmile for further examples. The final decision rests with local authorities and depends on local resource and capacity, but your concerns are noted.
Public Health England	18	01 Sec 4: Rec 18	13	If the scheme is to be provided by staff from General Dental Practice, then there may be a need to consider collaborative commissioning approaches involving NHS England.	Noted, please see our previous response.
Public Health England	19	01 Sec 4: Rec 19	14	See comments for recommendation 17 and 18 above	Noted, please see our previous response

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Public Health England	20	01 Sec 5: Rec 20	14	Bullet point two -School nursing services should encourage use of toothpaste with appropriate fluoride levels, at least twice daily brushing and spit don't rinse. Bullet point three - Those at school as well as school leavers need advice given in this bullet point. Bullet point four - All staff in contact with children should receive training on oral health. This advice should be given to all secondary care children not just those at risk. The school nursing services should also be providing this advice.	Thank you for your comment. The detail of oral health promotion is set out in the latest version of DBOH 2014 the NICE guideline refers to this document throughout Raising awareness of oral health is incorporated into recommendations about whole school approaches, which is aimed at all schools. If school nursing services are operational in a local area, local authorities may wish to utilise them, but the committee were aware that the level and presence of this service varies across regions and localities.
Public Health England	20	01 Sec 5: Rec 20	14	Bullet point two -School nursing services should encourage use of toothpaste with appropriate fluoride levels, at least twice daily brushing and spit don't rinse. Bullet point three - Those at school as well as school leavers need advice given in this bullet point. Bullet point four - All staff in contact with children should receive training on oral health. This advice should be given to all secondary care children not just those at risk. The school nursing services should also be providing this advice.	Thank you for your comment. Raising awareness of oral health is incorporated into recommendations about whole school approaches, which is aimed at all schools. If school nursing services are operational in a local area, local authorities may wish to utilise them, but the committee were aware that the level and presence of this service varies across regions and localities. The detail of oral health promotion is set out in the latest version of DBOH 2014 the NICE guideline refers to this document throughout.
Public Health England	21	01 Sec 6: Rec 21	15	There is no evidence to support the effectiveness of displaying information in improving any aspect of health, including oral health. If LAs are to invest, then there should be good evidence to support effectiveness. Displaying information on "all premises" is	Thank you for your comment and for raising your concerns which are appreciated. There was limited evidence about the effectiveness of all community oral health programmes in general and

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				resource-intensive and may increase inequalities as it impacts on literacy (e.g. what some staff find useful may not be understood by others) and does not address barriers to access. The last bullet point suggests providing dental care services (it is not clear if this is directly or as a benefit) however it would be difficult and often inappropriate to provide dental services in workplaces, other than a limited service through a mobile dental service. Many workplaces may also be within reach of a local dental practice. Increasing access to care does not necessarily improve oral health. This is just one aspect. There would still need to be a commitment to self-care practices including tooth brushing with fluoride toothpaste and eating a healthier diet. There is no evidence that making a service available, even at a workplace, would encourage everyone to access dental care. It may increase inequalities as those who already attend may use it as an alternative to attending their dental practice, and those who do not attend may not use it. It would be logistically very difficult and very resource-intensive for LAs to provide free oral hygiene aids regularly to all their employees indefinitely, this cannot be a one-off distribution. How would the LA manage this process? What if there was a high staff turnover? Would this include employees from companies who are sub-contracted to provide services and what happens if the service provider used different staff at different times?	initiatives in the workplace in particular, though there were a few as you will have read. The final revised recommendations take into account stakeholders concerns, but recognise raising the profile of oral health in the workplace would be beneficial for many adults. The recommendations have been amended and the wording reflects the degree of uncertainty and where the committee genuinely believed such activity would be beneficial.

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Public Health England	22	01 Sec 6: Rec 22	15	There is only limited evidence as to what is or is not effective in improving oral health of adults at higher risk. Providing access to care, and oral hygiene aids still requires the individual to take action. There is limited evidence about the effectiveness of behaviour change interventions. This recommendation would benefit from being informed by some evidence-based approaches.	Thank you for your comment. The document refers to NICE guidance on behaviour change which may be helpful. No specific oral health behaviour change evidence was identified during guideline development despite a call for evidence.
Public Health England	23	01 Sec 6: 01 Rec 23	16	PHE welcomes this recommendation that service specifications for vulnerable adults should include the requirement to promote oral health, assess oral health needs and ensure provision. However there should also be a requirement for services dealing with vulnerable people to have a process in place to assess and maintain their oral health, as part of their responsibility of caring for their overall health. Service providers should be given targets which are monitored to ensure that every individual in their care has an oral health assessment and access to therapeutic and preventive care in order to attain optimum oral health. Local experience around the country has indicated difficulties with regard to staff training in residential care homes, with high staff turnover, literacy levels of care staff and relative importance allocated to caring for resident's oral health. Unless service providers are required to address these issues, it is unlikely there will be any changes to the current system.	Thank you for your comment. The recommendations have been revised and suggest a requirement to include oral health in service specifications, targeting setting is not within the remit of this current work. We note your concerns, but residential care is outside the scope of this current work and is the subject of a separate guideline project, we hope you will continue to comment on this work. More information about this work can be found on the NICE website: Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62
Public Health England	24	01 Sec 6:	17	This recommendation is helpful however there is a need to specify which "frontline staff" this recommendation includes and how this	Thank you for your comment. We appreciate your concerns about frontline staff and staff

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		Rec 24		training is to be commissioned. There is a need to consider the difficulties that may be encountered with regard to staff training such as literacy levels and areas where there may be a high staff turnover. A key group would be other healthcare professionals such as GPs, practice nurses, community nurses and others who come into contact with these adults. Bullet 6 – this statement confuses the prevention of gum disease and decay as this message is a blend of the two. It is important to clarify the prevention of caries, periodontal disease and erosion.	training, which were also reflected by the debate held in committee. Unfortunately, no evidence provided the level of detail required to support specifying which staff should deliver which interventions or the impact of levels of staff literacy on training. We appreciate your concerns about raising awareness with other healthcare professionals which also reflect the debate held in committee. The final guideline reflects the links between oral health and general health. Bullet 6 - Thank you for pointing this out, we have amended,
Royal College of Paediatrics and Child Health	0	0 General		Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Oral health: local authority oral health improvement strategies consultation. We have not received any responses for this consultation.	Thank you for taking the time to comment on the guideline.
Solent NHS Trust Dental service	0	0 General		Good quality surveillance data is very important to monitor oral health outcomecheck repeated response see earlier one.s. The quality of the dental epidemiology data on children dropped when the consent process changed from negative to positive in 2006. Solent Dental Service carry out many dental extractions for children which are under general anaesthesia. We collect this data locally and it has been included in oral health needs assessment as a marker of child oral health. There should be	Thank you for your comment. Your points are well made and were considered by the committee however it is outside the scope of this work to make recommendations about collecting national data. Recommendations refer to collecting data from a range of surveys and data sources to inform local needs and using local dental health expertise (who would presumably understand the requirements and sources of reliable data including those raised here). If further representation for

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				national process to collect this regularly, so we can compare this across the country. This can be updated every quarter. Dental attendance data can also be used for monitoring inequalities in access. This is already available nationally on a quarterly basis from the Business Services Authority for both children and adults.	the group informing the OHNA is required, there is sufficient flexibility to determine additional input.
Solent NHS Trust Dental service	0	0 General		The guideline development group should include frontline dental staff such as a Centre Consultant in Dental Public Health and Oral Health Promotion lead. Research initiatives do not always translate well into a "real-life" intervention and this should be taken account of in these recommendations.	Thank you for your comment. Ideally all guideline development committees would have good representation from a range of stakeholders including all professionals involved in commissioning and delivering activities, approaches, or interventions identified in each guideline. The committee developing this guideline did include individuals from dental public health and others currently commissioning local oral health programmes. PHE's national lead for oral health improvement also gave expert testimony about the new commissioning and delivery landscape. NICE recruits to committees following an open and transparent process. Please see the NICE website for further information. http://www.nice.org.uk/
Solent NHS Trust Dental service	0	0 General		There is no evidence of effectiveness or cost-effectiveness for many of these recommendations. Recommendations should only be made if they are supported by good quality evidence for both of these. LA and NHS England commissioners have limited budgets and	Thank you for your comment. The committee considered a range of evidence about the effectiveness and cost effectiveness of activities to promote community oral health. Reviews, reports, fieldwork and expert testimony are set out on the website,

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				competing priorities and need good quality information on which to base their decisions. Community Dental Services also need information on the costs of interventions so that we can justify the level of investment needed to the Trust we are working within and to commissioners. This will avoid unrealistic expectations of the cost of developing and managing a programme.	as you will have seen. The content of the recommendations reflects their deliberations and careful consideration of all evidence, including the uncertainty of results and a range of limitations. Please be aware that the status of NICE recommendations varies, recommendations for clinical practice and for local government for example, are always advisory. In this guideline the strength of the recommendations reflects the deliberations of the committee and where, on balance, they genuinely believed most benefit would be derived. The final decision to implement is up to local authorities taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process.
Solent NHS Trust Dental service	1	01 Section 1: Recommendation 1	4	It would not be possible to do an informative oral health needs assessment (OHNA) on every aspect of oral health. There can be some identification of key priorities for each local area. This advice should come from the Local Dental Network (LDN). The LDN's priorities should feed the Joint Strategic Needs Assessment (JSNA) from which the Joint Health and Wellbeing Strategy (HWbS) is derived.	Thank you for your comment. The recommendations do not suggest conducting an oral health needs assessment on every aspect of oral health. The committee considered stakeholder concerns and suggestions, and recommendations 1 and 2 have been amended and clarified within the remit of this work and incorporate many stakeholder suggestions. If further representation for the OHNA is required, there is sufficient flexibility to determine additions We hope this is helpful.
Solent NHS Trust Dental service	2	01 Sec 1:	4	The oral health strategy can only be a high-level document which discussed the key interventions needed and the evidence to	The committee considered stakeholder concerns and suggestions around this recommendation and others.

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		Rec 2		support them. It should be used to inform the joint HWbS so oral health is integrated into general health improvement programmes. Monitoring of oral health should be part of monitoring of health outcomes for all groups.	Recommendation 1 and others have been amended within the remit of this work and incorporate many stakeholder suggestions. If further representation is required, there is sufficient flexibility to determine additions. The recommendations have also been amended to include reference to the HWB strategy and local service specifications.
Solent NHS Trust Dental service	2	01 Sec 1: Rec 2	5: points 7&8	Oral health issues should be included in the joint HWbS and any links with other interventions and life course pathways laid out in that document.	Thank you for your comment. The recommendations have been amended to include reference to the HWB strategy and local service specifications, and strengthen references to the importance to overall health and wellbeing.
Solent NHS Trust Dental service	3	01 Sec 1: Rec 3	5	The oral health needs assessment should link with the JSNA as the same information is needed for both (for e.g. population demographics). It should identify key oral health priorities which link in with the JSNA priorities. For e.g. most LAs will prioritise improving health for children as part of "Giving Every Child the Best Start in Life". In this case, the OHNA should focus on young children.	Thank you for your comment. The recommendations suggest linking with the JSNA and have since been amended to include reference to the HWB strategy and local service specifications, and strengthen references to the importance to overall health and wellbeing. There are also recommendations about ensuring oral health is a key health and wellbeing priority and suggestions for how a local authority might go about doing this to meet the oral health needs of their local communities, which will include children and young people.
Solent NHS Trust Dental service	3	01 Section 1: Recommendation	6: last point	It is only worth doing a detailed OHNA if there is a particular reason for e.g. procurement process for contemporaneous services for a target population, care pathway development of service redesign, where there will be a need for detailed assessment of need, potential demand and other indicators to	Thank you for your comment. Your concerns and suggestions were noted by the committee. There is no mention in the recommendations of undertaking an oral health needs assessment at local

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
		3		inform the development of a suitable service.	population level for all oral health conditions. There are recommendations about ensuring oral health is a key health and wellbeing priority and suggestions for how a local authority might go about doing this to meet the oral health needs of their local communities.
Solent NHS Trust Dental service	4	01 Sec 1: Rec 4	6	This list of information includes much of what is included in JSNAs. If an oral health needs assessment is done alongside the JSNA, the same information can be used for both avoiding duplication.	Thank you for your comment. Please see our previous response.
Solent NHS Trust Dental service	5	01 Sec 2: Rec 5	7	This should happen automatically if OHNA is used to inform the JSNA and joint HWbS. All the points mentioned should be included as part of the joint HWbS using the common risk factor approach.	Thank you for your comment. Please see our previous response.
Solent NHS Trust Dental service	6	01 Sec 2: Rec 6	7	An integrated approach for all aspects of health should be advocated as environments which promote oral health also promote general health.	Thank you for your comment. The recommendations have been amended and clarified, and the role of oral health and general health has been reinforced throughout.
Solent NHS Trust Dental service	6	01 Sec 2: Rec 6	8: Last point	Drinks that are promoted as sugar-free or low in sugar are still cariogenic as they would contain acids. They also encourage the development of a "sweet tooth" which then encourages people to choose sweet drinks over water. This will have an impact on oral health as well as weight. For e.g. many of our patients believe that fruit juice is healthy and use it as a substitute for water. However fruit juices are high in sugar which is a risk factor for dental decay and obesity.	Thank you for your comment and raising your concerns, the recommendations have been revised. Recommendations that refer to the role of diet and the availability of drinking water in relation to oral health have been clarified within the scope of the work and the evidence available. There are suggestions to consider planning policies and other levers within local authority control, also references

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				We are not aware of any examples where working with a commercial food outlet has yielded positive outcomes. This recommendation would need to come with evidence for e.g. case studies.	to other NICE guidance which has reviewed different evidence but reached similar conclusions.
Solent NHS Trust Dental service	7	01 Sec 2: Rec 7	8	To make this happen, there needs to be a directive to include it in local service specifications. This could come as a national steer as well as from the local HWbS. Oral health should not be tackled in isolation, but as an integrated part of general health outcomes for children but all healthcare professionals are stretched and not always keen to support issues which are not included in their service specification. Foe e.g. local general medical practitioners will not even ask their patients if they have a dentist.	Thank you for your comment. The guideline has been amended and reference is made to local specifications. Please see our previous responses.
Solent NHS Trust Dental service	8	01 Sec 3: Rec 8	8	Please see comments above for recommendation 7.	Thank you, noted.
Solent NHS Trust Dental service	9	01 Sec 3; Rec 9	9	The most important intervention for young children, in addition to eating healthy food and visiting a dentist regularly for preventive care, is to use toothpaste with (correct amount of) fluoride twice a day. There should be a national directive for all settings to provide oral health information as part of health information.	Thank you for your comment. The recommendations for early years services have been clarified and amended, and refer to the latest version of DBOH published by Public Health England 2014.
Solent NHS Trust Dental service	10	01 Sec 3: Rec 10	10	Information should be available for all children in Early Years settings. There is no way of identifying with accuracy whether a child will get dental decay so interventions need to include all children. There can be additional targeted approaches. Just using a “high-risk approach is inappropriate. This is in accordance with the Marmot approach.	Thank you for your comment. The recommendations include both universal and targeted approaches as a range of groups, including children, are at greater risk of poor oral health than others, completely in keeping with the Marmot review.

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Solent NHS Trust Dental service	11	01 Sec 3: Rec 11	10	Supervised toothbrushing programmes should be implemented at all school settings as there is a Cochrane review which indicates that brushing with a fluoride toothpaste twice a day significantly reduces the risk of dental decay. Toothbrushing with a fluoride toothpaste at home should be promoted as part of this intervention. Free toothbrushes and toothpaste may aid this intervention. The evidence review includes the Childsmile programme where the supervised toothbrushing programme is supplemented with a postal scheme where toothbrushes and toothpaste are posted out regularly to all young children.	Thank you for your comment and raising your concerns. The committee considered that the difficulties lie in the implementation and delivery of such schemes not the use of fluoride toothpaste twice a day, the evidence does not address implementation with a sufficient degree of certainty. The recommendations have been amended to include tooth brushing packs where appropriate, but direct evidence of effectiveness and cost effectiveness about the use of postal delivery was mixed (please see the supporting evidence statements and reviews), some studies showed little or no effect.
Solent NHS Trust Dental service	12	01 Sec 3: Rec 12	11	The evidence base for community fluoride varnish applications is mixed as indicated by the evidence review. A Cochrane review indicates that this intervention is effective. However, our local experience and that of our colleagues elsewhere in the country is that this is not effective in practice, as children from more deprived groups are less likely to participate. For maximum impact, this will need to be provided *ad infinitum* to all children aged between 3 and 16 years (see DH document *"Delivering Better Oral Health"*) There is no data on cost-effectiveness for what is a very resource-intensive approach to carry out in a community setting. If this is to be implemented, it needs to include a strategy which will enable this intervention to successfully reach all children. Information on costs is vital so that both commissioners and providers are clear	Thank you for your suggestions, the recommendations have been revised and reflect many of the points raised here. Please also see our previous responses to your comments. DBOH 2014 and Child smile are referenced throughout the document. All recommendations are informed by evidence, but this does not always provide direct evidence of effectiveness or cost effectiveness nor offer help in terms of specifying implementation or delivery as your comment reflects. Recommendations are affected by a number of variables in documented evidence including lack of detail on implementation and delivery, so evidence requires careful

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				about the investment needed and that this is for the long-term. This strategy should be part of a holistic programme which supports and encourages twice daily toothbrushing with a fluoride toothpaste and a healthy diet. The Scottish Childsmile programme has faced similar difficulties. A 2012 presentations indicated that only 29% of targeted 3-5 year olds and 47% of 6&7 year-olds got the 2 planned applications in the last year. (Reference: Conway D. Delivering Childsmile: Progress Report. Conference presentation Sep 2012. *www.child-smile.org.uk/*)	consideration and interpretation over multiple meetings. The committee carefully considered the evidence and made recommendations they genuinely believed would help local authorities decide where they may wish to put their resources, taking into account local needs and local resource availability. There are recommendations that promote a whole school approach and if local authorities have the resources and decide to incorporate other recommendations the guideline does not exclude their doing so. The Childsmile programme is linked and referenced in the guideline.
Solent NHS Trust Dental service	13	01 Sec 3: Rec 13	11	See comments in both boxes above for Recommendations 11 and 12.	Thank you, please see our previous responses
Solent NHS Trust Dental service	15	01 Section 4: Recommendation 15	12	It is good to engage the whole school but oral health should be included as part of general health improvement measures for e.g. dietary advice is also important for healthy weight. Drinks that are promoted as sugar-free or low in sugar are still cariogenic as they would contain acids. They also encourage the development of a "sweet tooth" which then encourages people to choose sweet drinks over water. This will have an impact on oral health as well as weight.	Thank you for your comment, the recommendations have been revised and strengthened on the role of diet and drinks,
Solent NHS Trust Dental service	16	01 Sec 4: Rec 16	12	This should be available as a universal intervention for all primary school children as there is there is no way of identifying, with any accuracy, which child will get dental decay.	Please see our previous responses.

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Solent NHS Trust Dental service	17 (see 11)	01 Sec 4: Rec 17	13	Supervised toothbrushing programmes should be implemented at all school settings. Please see comments for Recommendation 11.	Please see our previous responses.
Solent NHS Trust Dental service	18 (see 12)	01 Sec 4: Rec 18	13	Please see comments for Recommendation 12.	Noted, please see our previous response
Solent NHS Trust Dental service	19 (see 11, 12)	01 Sect 4: Rec 19	14	Please see comments for Recommendation 11 and 12.	Noted, please see our previous response
Solent NHS Trust Dental service	21	01 Sec 6: Rec 21	15	There is no evidence to support the effectiveness of displaying information in improving any aspect of health, including oral health. It would not be possible to provide dental services in workplaces, other than a limited service through a mobile dental service. Many workplaces may also be within reach of a local dental practice. Increasing access to care does not necessarily mean that people will use it or that it will improve their oral health. This is just one aspect. There would still need to be a commitment to good oral hygiene practices including toothbrushing with a fluoride toothpaste and eating a healthy diet.	Thank you for your comment and for raising your concerns which are appreciated. There was limited evidence about the effectiveness of all community oral health programmes in general and initiatives in the workplace in particular, though there were a few as you will have read. The final revised recommendations take into account stakeholders comments, but recognise raising the profile of oral health in the workplace would be beneficial for many adults. The recommendations have been amended and the wording reflects the degree of uncertainty and where the committee genuinely believed such activity would be beneficial.
Solent NHS Trust Dental service	22	01 Sec 6: Rec 22	15	There is no evidence as to what works in improving oral health of adults at higher risk. Providing access to care, and oral hygiene aids still requires the individual to take action. There is limited evidence about the effectiveness of behaviour change	Thank you for your comment. The document refers to NICE guidance on behaviour change which may be helpful. No specific oral health behaviour change evidence was identified during

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				interventions. More research on what works in these situations would be very helpful.	guideline development despite a call for evidence.
Solent NHS Trust Dental service	23	01 Sec 6: rec 23	16	There should be a requirement for services dealing with vulnerable people to have a process in place to assess and maintain their oral health, as part of their responsibility to caring for their overall health. Solent Dental Service provides care to many vulnerable patient groups. It would be helpful to services like ours if service providers should be given targets which are monitored to ensure that every individual in their care has an oral health assessment and access to therapeutic and preventive care in order to attain optimum oral health. Out local experience has raised many issues with staff training in residential care homes around high staff turnover, literacy levels of care staff and relative importance allocated to caring for residents' oral health. Unless service providers are required to address these issues, it will be difficult for us to continue prioritising that service within the limited resources available.	The recommendations have been revised and suggest a requirement to include oral health in service specifications, national targeting setting is not within the remit of this current work. We note your concerns, but residential care is outside the scope of this current work and is the subject of a separate guideline project, we hope you will continue to comment on this work. More information about this work can be found on the NICE website: Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62
Solent NHS Trust Dental service	24	01 Sec 6: Rec 24	17	A key group of "frontline" staff would be other healthcare professionals such as GPs, practice nurses, community nurses and others who come into contact with these adults. They should check with them about access to dental care and encourage and support them to seek dental care, if they have not already done so. These groups will not do anything that is not included in their contracts/ service specifications. So, there needs to be a national directive to include the	Thank you for your comment and suggestions. We appreciate your concerns about raising awareness with other healthcare professionals which also reflect the debate held in committee. The final guideline reflects the links between oral health and general health and the revised recommendations reflect these points within the scope of the work and limitations of the evidence. Please see previous responses which may be relevant.

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				requirement for them to adopt a more holistic approach, including considering oral health issues.	
Solent NHS Trust Dental service	24	01 Sec 6: Rec 24	17	A key group of "frontline" staff would be other healthcare professionals such as GPs, practice nurses, community nurses and others who come into contact with these adults. They should check with them about access to dental care and encourage and support them to seek dental care, if they have not already done so. These groups will not do anything that is not included in their contracts/ service specifications. So, there needs to be a national directive to include the requirement for them to adopt a more holistic approach, including considering oral health issues.	Please see our previous responses.
Solent NHS Trust Dental service	26	04 Section 4.4 Cons	24	Using common risk factor approach means that general medical teams and all staff involved in maternal and child nutrition, breastfeeding and smoking cessation should include mention of oral health advice when they talk to their patients/ clients. They can encourage and support people to access dental care regularly such as signposting them to a local practice and following up to see if they have attended.	Thank you for your comment. This is the considerations section (not recommendations) which broadly sets out some of the issues and deliberations of the committee during guideline development.
Solent NHS Trust Dental service	26	04 Sec 4.5 Con	24	Fruit juices are high in sugar as well as acids which contribute to weight management issues as well as poor dental decay. They should not be promoted as "healthy" as this provides a mixed message, particularly to parents. National recommended limits on how much fruit juice is consumed per day would be helpful to avoid children/adults substituting fruit juice for water.	Thank you for your comment.
Solent NHS Trust Dental service	26	04 Section	25	Services involved in tobacco work should encourage and support their clients to access dental care, including signposting and	Thank you for your comment.

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		4.7 Con		following up to ensure they attend. Helping smokers get their mouths clean and healthy may further encourage them to quit. This is relevant to all buy may be particularly applicable to young smokers in relation to looking presentable for job interviews, meeting people socially etc…	
Solent NHS Trust Dental service	26	04 Section 4.10 Cons	25	All targeted health improvement interventions are very resource-intensive. Those in the highest needs groups are the ones who are least likely to engage. There is little evidence of effective interventions and even less evidence on cost-effectiveness (as indicated by the evidence review). More research evidence is needed on effectiveness and cost-effectiveness.	Thank you for your comment, please see our previous responses which may be relevant.
Solent NHS Trust Dental service	26	04 Section 4.15 Cons	27	Health visitors, midwives and general medical practice teams are more likely to be in touch with new parents than dental practitioners. All healthcare professionals, including those names here should support and encourage parents to take the child to a dentist by the age of 12 months (recommendation of the American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA) and the American Academy of Pediatrics: “Get it Done in Year One”). There should be an indicator in the national “Healthy Child Programme” which specifically measures dental attendance annually during the first 5 years. That would encourage school health nurses and health visitors to include this within their discussions with new parents.	Thank you for your comment, please see our previous responses which may be relevant.
Solent NHS Trust Dental service	26	04 Section 4.16	27	The focus at parenting programmes should be about encouraging good habits for health overall. That would include toothbrushing twice a day with a fluoride toothpaste and taking the child regularly	Thank you for your comment, please see our previous responses which may be relevant.

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		Cons		to the dentist (with the first visit by the age of 12 months). That would result in development of good oral health which will enable the child to eat a healthy and varied diet which is good for overall health and wellbeing.	
Solent NHS Trust Dental service	26	04 Section 4.18 Cons	27	The evidence for this is mixed and "some evidence" is not sufficient to invest in what is a very resource-intensive intervention. Unless there is an evidence-based strategy which will reach all children, including children from high-risk groups, this will not be effective.	Thank you for your comment, please see our previous responses which may be relevant.
Solent NHS Trust Dental service	26	04 Section 4.22 Cons	28	What evidence is there for this statement? It is logistically difficult to reach and influence young adults who are not in education, employment or training to change any aspect of their lifestyle. Any recommendation should come with evidence-based strategies.	Thank you for your comment, please see our previous responses about the purpose of this section.
Solent NHS Trust Dental service	26	04 Section 4.22 Cons	28	What evidence is there for this statement? It is logistically difficult to reach and influence young adults who are not in education, employment or training to change any aspect of their lifestyle. Any recommendation should come with evidence-based strategies.	Thank you for your comment, please see our previous responses about the purpose of this section.
Solent NHS Trust Dental service	26	04 Section 4.25 Cons	29	There is no evidence to support the first sentence in this point – that most new decay is in adults. Statements made should be evidence-based	Thank you for your comment, please see our previous responses about the purpose of this section.
Solent NHS Trust Dental service	27	05 Section 5 Rec for Research	30	Research needs to conducted in "real-life" settings. Research conducted in controlled settings in order to meet research guidance protocols do not always translate to real-life practice. An example of this is the Cochrane review on fluoride varnish which	Thank you for your comment. The research recommendations do not exclude your suggestions, but thank you for raising.

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				does not work well in practice due to issues with reaching everyone in the target population. What is the impact of poor oral health on a child's quality of life and development? Is there any association with social class (which would indicate inequality)? What strategies would be effective in engaging with children from more deprived backgrounds who are less likely to be consented into health improvement interventions? How can parents be encouraged/ incentive to take their children to the dentist regularly? How can we ensure that all children are taken to the dentist for their first visit by the age of 12 months? What impact do dental problems have on school attendance and is there any association with social class (which would indicate inequality)?	
Southampton City Council	0	0 General		Good quality surveillance data is very important to monitor oral health (oral health) outcomes. The dental epidemiology survey data on 5-year-olds currently in PHOF is not high-quality due to positive consent process which skews participation, and it is only available every 2-3 years. We have often used local data from dental extractions for children which are done under general anaesthesia as an indicator of local oral health. There should be national process to collect this regularly from all areas so there can be national comparison. This should be included in the online Local Authority profile data and	Thank you for your comment. Your points are well made and were considered by the committee, however it is outside the scope of this work to make recommendations about collecting national data. The committee considered your suggestion to make specific reference to dental attendance data but believed there was sufficient indication of robust data sources in the current recommendations. The membership of the group with responsibility for the OHNA would be aware of relevant national data sets and could advise local

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				updated regularly.	authorities accordingly.
Southampton City Council	0	0 General		The guideline development group should include someone who advises LAs such as a PHE Centre Consultant in Dental Public Health. This will provide the "frontline" view which is important as research initiatives do not always translate well in a "real-life" situation.	Thank you for your comment. Ideally all guideline development committees would have good representation from a range of stakeholders including all professionals involved in commissioning and delivering activities, approaches, or interventions identified in each guideline. The committee developing this guideline did include individuals from dental public health and others currently commissioning local oral health programmes. PHE's national lead for oral health improvement also gave expert testimony about the new commissioning and delivery landscape. NICE recruits to committees following an open and transparent process. Please see the NICE website for further information. http://www.nice.org.uk/Get-Involved
Southampton City Council	0	0 General		There is no evidence of effectiveness or cost-effectiveness for many of these recommendations. Recommendations should only be made if they are supported by good quality evidence for both of these. LA commissioners have limited budgets and competing priorities and need good quality information on which to base their recommendations to Cabinet colleagues.	Thank you for your comment. The committee considered a range of evidence from reviews, reports, fieldwork and expert testimony as you will have read. The content of the recommendations reflects their deliberations and careful consideration of all evidence and stakeholder concerns. Please be aware that the status of NICE recommendations varies, recommendations for clinical practice and for local government for example, are always advisory. In this guideline the strength of the recommendations

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					reflects the deliberations of the committee and where, on balance, they genuinely believed most benefit would be derived. The final decision to implement is up to local authorities taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process.
Southampton City Council	1	01 Section 1: Rec 1	4	It would not be possible to do an informative oral health needs assessment (OHNA) on every aspect of oral health. There can be some identification of key priorities for each local area. We would get this information from the local PHE Centre Consultant in Dental Public Health. The oral health priorities should be included in the Joint Strategic Needs Assessment (JSNA) from which the Joint Health and Wellbeing Strategy is derived. The Public Health team and Health and Wellbeing Board should engage with the consultant in dental public health and the Local Dental Network as needed to ensure that the key oral health issues which impact on the local population's health and wellbeing are considered in their recommendations.	Thank you for your comment. The recommendations do not suggest conducting an oral health needs assessment on every aspect of oral health. The committee considered stakeholder concerns and suggestions around this recommendation and others. Recommendation 1 has been amended within the remit of this work. If further representation is required, there is sufficient flexibility to determine additions We hope this is helpful.
Southampton City Council	2	01 Sec 1: Rec2	4	The oral health strategy should be used to inform the joint Health and Wellbeing Strategy so oral health is integrated into general health improvement programmes. Monitoring of oral health should be part of monitoring of health outcomes for all groups.	Thank you for your comment. The recommendations have been amended to include reference to the HWB strategy and local service specifications, and strengthen references to the importance to overall health and wellbeing.
Southampton City Council	2	01 Sec 1:	5: points 7&8	The only way to get oral health included in the work of frontline staff and part of lifecourse pathways, is to include it in the joint	Thank you for your comment. The recommendations have been amended to include

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		Rec 2		Health and Wellbeing Strategy which is produced locally and used to inform local interventions.	reference to the HWB strategy and local service specifications.
Southampton City Council	3	01 Section 1: Recommendation 3	5	It would be impossible to assess the oral health needs of every group in the community. It would be possible to carry out a very high-level assessment of oral health as part of the JSNA and link in with the information used in the JSNA (for e.g. population demographics) to avoid duplication. This information can then be included in the JSNA and inform the joint Health and Wellbeing Strategy. Oral health priorities should be considered in the priorities which are identified in the JSNA for e.g. most LAs will prioritise improving health for children as part of "Giving Every Child the Best Start in Life", and the oral health of young children should be a part of interventions developed to improve the health and wellbeing of young children.	Thank you for your comment. The final decision rests with local authorities and resource availability. There is no mention in the recommendations of undertaking an oral health needs assessment at local population level for all oral health conditions. There are recommendations about ensuring oral health is a key health and wellbeing priority and suggestions for how a local authority might go about doing this to meet the oral health needs of their local communities which include children and young people.
Southampton City Council	3	01 Sec 1: Rec 3	6: last point	It is only worth doing a detailed OHNA if there is a particular reason for e.g. procurement of an oral health improvement service for a particular group, where there will be a need for detailed assessment of need, potential demand and other indicators.	Thank you for your comment. Your concerns and suggestions were noted by the committee, please see our previous response.
Southampton City Council	4	01 Sec1: Rec 4	6	This list of information includes much of what is included in JSNAs. If an assessment of oral health is done alongside the JSNA, the same information can be used for both avoiding duplication.	Thank you for your comment. Please see our previous response.
Southampton City Council	5	01 Sec 2: Rec 5	7	This should happen automatically if OHNA is used to inform the JSNA and joint Health and Wellbeing Strategy. A common risk factor approach, which considers the oral health impact as well as	Thank you for your comment. Please see our previous response.

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				general health impact of interventions, should be used to maximise health gain.	
Southampton City Council	6	01 Sec2: Rec6	7	Environments which promote oral health also promote general health. An integrated approach should be advocated.	Thank you for your comment. The recommendations have been amended and clarified, and the role of oral health and general health has been reinforced throughout.
Southampton City Council	6	01 Sec 2: Rec 6	8: Last point	Drinks that are promoted as sugar-free or low in sugar are still cariogenic as they would contain acids. They also encourage the development of a "sweet tooth" which then encourages people to choose sweet drinks over water. This will have an impact on oral health as well as weight. For e.g. fruit smoothies are marketed as "healthy" but they are high in sugar and the healthy fibre is lost in the preparation process. It would be useful to have some evidence or precedence for the positive impact of working with other sectors, such as commercial food outlets, before including it as a recommendation. For e.g. is there any evidence that working with a food outlet has contributed to changes in dietary choices? Are there any case studies to demonstrate how this has worked?	Thank you for your comment. The committee noted your concerns and have amended and strengthened the recommendations within the status (advisory not mandatory guidelines) and remit of this work. Recommendations that refer to the role of diet and the availability of drinking water in relation to oral health have been clarified. There was limited evidence about the effectiveness and cost effectiveness of all community oral health programmes in general. The recommendations have been amended and the wording reflects the degree of uncertainty and where the committee genuinely believed recommended activities would be beneficial. Reference to using local planning policies to promote oral health is also mentioned.
Southampton City Council	7	01 Sec 2: Rec 7	8	To make this happen, there needs to be a directive to include it in local service specifications. This could come from a national steer. Oral health should not be tackled in isolation, but as an integrated part of general health outcomes for children.	Thank you for your comment. Please see our previous responses.
Southampton City Council	8	01 Sec 3:	8	Please see comments above for Recommendation 7.	Thank you, noted.

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		Rec 8			
Southampton City Council	9	01 Sec 3; Rec 9	9	The most important intervention for young children, in addition to good dietary practice, is to use toothpaste with (correct amount of) fluoride twice a day. For settings to provide oral health information, there needs to be a directive to include it in local service specifications. This should come from a national steer. But oral health should not be tackled in isolation, but as an integrated part of maximising health outcomes for children.	Thank you for your comment. The recommendations for early years services have been clarified and amended and refer to the latest version of DBOH published by Public Health England, reference has also been made to local service specifications.
Southampton City Council	10	01 Sec 3: Rec10	10 reoeat	Information should be available for all children in Early Years settings. There is no way of identifying with accuracy whether a child will get dental decay so need to target all children so using a "high-risk approach is inappropriate. This is in accordance with the Marmot concept of "proportionate universalism". (Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries prevention strategy for populations". BMC 2006, 6:3)	Thank you for your comment. The recommendations include both universal and targeted approaches as a range of groups, including children, are at greater risk of poor oral health than others, completely in keeping with the Marmot review.
Southampton City Council	11	01 Sec 3: Rec 11	10	Supervised toothbrushing programmes should be implemented at all school settings in accordance with the Marmot concept of "proportionate universalism". There needs to be promotion of the use of fluoride toothpaste as part of this intervention and encouragement of toothbrushing with fluoride toothpaste at home. For optimum results, the child needs to develop and maintain toothbrushing with a fluoride toothpaste twice a day (*Delivering Better Oral Health, DH 2009*).	Thank you for your comment. Your concern is noted. The recommendations include both universal and targeted approaches completely in keeping with the Marmot report. The content of the schemes will address key oral health activities and the DBOH guideline is referenced to help with this. The recommendations have been amended to include tooth brushing packs. The content of the schemes will address the issues raised about key oral health activities

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Southampton City Council	12	01 Sec 3: Rec 12	11	The evidence base for community fluoride varnish applications is mixed as indicated by the evidence review. A Cochrane review indicates that this intervention is effective. However, our local experience is that this is not effective in practice, as children from more deprived groups are less likely to participate. *(*Buckingham and John. Recruitment and participation in pre-school and school-based fluoride varnish pilots – the South Central experience. *BDJ Sep 13* ***215****, E8 (2013))* There is no data on cost-effectiveness for what is a very resource-intensive approach to carry out in a community setting. If this is to be implemented, it needs to include a strategy which will enable this intervention to successfully reach all children.	Thank you for your suggestions, the recommendations have been revised and reflect many of the points raised here. All recommendations are informed by evidence, but this does not always provide direct evidence of effectiveness or cost effectiveness as your comment reflects. Recommendations are affected by a number of variables including implementation and delivery, so evidence requires interpretation. The guideline only recommends considering fluoride varnish in schools in areas where the baseline prevalence is high, as the cost effectiveness analyses suggested this was likely to be cost effective. The committee carefully considered the evidence and made recommendations they genuinely believed would help local authorities decide where they may wish to put their resources, taking into account local needs and local resource availability. There are recommendations that promote a whole school approach and if local authorities have the resources and decide to incorporate other recommendations the guideline does not exclude their doing so. The Childsmile programme is linked and referenced in the guideline. The committee considered that the delivery or implementation of community oral health programmes is where the degree of uncertainty is greatest and the evidence weakest DBOH 2014 is referenced throughout the document where

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					relevant, links to childsmile are also provided.
Southampton City Council	12	01 Sec 3: Rec 12 (continued from previous)	11	This strategy should be part of a holistic programme which supports and encourages twice daily toothbrushing with a fluoride toothpaste and a healthy diet. The Scottish Childsmile programme has faced similar difficulties. A 2012 presentations indicated that only 29% of targeted 3-5 year olds and 47% of 6&7 year-olds got the 2 planned applications in the last year. (Reference: Conway D. Delivering Childsmile: Progress Report. Conference presentation Sep 2012. *www.child-smile.org.uk/*)	Thank you for your comment. Please see our previous responses.
Southampton City Council	13	01 Sec 3: Rec13	11	See comments in both boxes above for Recommendations 11 and 12.	Thank you, please see our previous responses
Southampton City Council	15	01 Sec 4: Rec 15	12	It is good to have a whole school approach but oral health should be included as part of general health improvement measures for e.g. dietary advice is also important for healthy weight. Drinks that are promoted as sugar-free or low in sugar are still cariogenic as they would contain acids. They also encourage the development of a "sweet tooth" which then encourages people to choose sweet drinks over water. This will have an impact on oral health as well as weight.	Thank you for your comment. Please see our previous responses on the role of diet and drinks, and the common risk factor approach
Southampton City Council	16	01 Sec 4: Rec16	12	This strategy should include all primary school children as there is there is no way of identifying, with any accuracy, which child will get dental decay. This is in accordance with the Marmot approach of proportionate universalism. (Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries	Please see our previous responses.

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				prevention strategy for populations*". BMC 2006, 6:3*)	
Southampton City Council	17	01 Section 4 Rec 17	13	Supervised toothbrushing programmes should be implemented at all school settings as there is no way of identifying, with any accuracy, which child will get dental decay. This is in accordance with the Marmot concept of "proportionate universalism". (Reference: Batchelor and Sheiham. "The distribution of burden of dental caries in schoolchildren: a critique of the high-risk caries prevention strategy for populations". *BMC 2006, 6:3*) There needs to be promotion of the use of fluoride toothpaste as part of this intervention and encouragement of toothbrushing with fluoride toothpaste at home. For optimum results, the child needs to develop and maintain toothbrushing with a fluoride toothpaste twice a day.	Please see our previous responses.
Southampton City Council	17	01 Sec 4: Rec 17	13 (continued from previous)	The evidence review includes the Childsmile programme which includes a description of this intervention. The supervised toothbrushing programme is targeted at all nursery children and this was supplemented with a postal scheme where toothbrushes and toothpaste are posted out regularly to all young children.	Your concern is noted Direct evidence of effectiveness and cost effectiveness about the use of postal delivery was mixed (please see the supporting evidence statements and reviews), some studies showed little or no effect. The recommendations reflect the uncertainty of the evidence, the committee agreed to suggest local authorities consider free tooth brushing packs and recommendations refer to Childsmile for further examples. The final decision rests with local authorities and depends on local resource and capacity, but your concerns are noted.
Southampton City Council	18	01 Sec 4: Rec 18	13	The evidence base for community fluoride varnish applications is mixed as indicated by the evidence review. A Cochrane review indicates that this intervention is effective. However, there is also	Thank you for your comment. All recommendations are informed by evidence, but this does not always provide direct evidence of effectiveness

Stakeholder Organisation	Recs	Sec No	Page No	Comments Please insert each new comment in a new row.	Response
				evidence that this is not effective in practice, as children from more deprived groups are less likely to participate. There is no data on cost-effectiveness for what is a very resource-intensive approach to carry out in a community setting. If this is to be implemented, it needs to include a strategy which will enable this intervention to successfully reach all children. This strategy should be part of a holistic programme which supports and encourages twice daily toothbrushing with a fluoride toothpaste and a healthy diet.	or cost effectiveness as your comment reflects. Recommendations are affected by a number of variables including implementation and delivery, so evidence requires interpretation. The committee carefully considered the evidence and made recommendations they genuinely believed would help local authorities decide where they may wish to put their resources, taking into account local needs and local resource availability. The Childsmile programme is linked and referenced in the guideline.
Southampton City Council	18	01 Sec 4: Rec 18	13(continued from previous)	The Scottish Childsmile programme has faced similar difficulties. A 2012 presentations indicated that only 29% of targeted 3-5 year olds and 47% of 6&7 year-olds got the 2 planned applications in the last year. (Reference: Conway D. Delivering Childsmile: Progress Report. Conference presentation Sep 2012. *www.child-smile.org.uk/*)	Noted, please see our previous response
Southampton City Council	19	01 Sec 4: Rec 19	14	See comments for Recommendation 17 and 18 above	Noted, please see our previous response
Southampton City Council	21	01 Sec 6: Rec 21	15	There is no evidence to support the effectiveness of displaying information in improving any aspect of health, including oral health. If LAs are to invest, then there should be good evidence to support effectiveness. Displaying information on "all premises" is resource-intensive and may increase inequalities as it impacts on literacy (e.g. what some staff find useful may not be understood by others) and does not address barriers to access.	Thank you for your comment and for raising your concerns which are appreciated, the recommendations have been revised. There was limited evidence about the effectiveness and cost effectiveness of many activities to promote community oral health in general and initiatives in the workplace in particular, though there were a few as you will have read. The final revised recommendations take

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					into account stakeholders comments, but recognise raising the profile of oral health in the workplace would be beneficial for many adults. The recommendations have been amended and the wording reflects the degree of uncertainty and where the committee genuinely believed such activity would be beneficial.
Southampton City Council	21	01 Sec 6: Rec 21	15 (continued from previous)	It would not be possible to provide dental services in workplaces, other than a limited service through a mobile dental service. It would be difficult for LAs or NHS England to justify this strategy. Many workplaces may also be within reach of a local dental practice anyway. There is no evidence that making a service available, even at a workplace, would encourage everyone to access dental care. It may increase inequalities as those who already attend may use it as an alternative to attending their dental practice, and those who do not attend may not use it.	Please see our previous response.
Southampton City Council	21	01 Sect 6: Rec 21	15(continued from previous)	Increasing access to care does not necessarily improve oral health. There would still need to be a commitment to good oral hygiene practices including toothbrushing with a fluoride toothpaste and eating a healthy diet. It would be logistically very difficult and very resource-intensive for LAs to provide free oral hygiene aids regularly to all their employees indefinitely. This would have to continue indefinitely to achieve long-term benefits, it would be pointless doing this as a one-off distribution. How would the LA manage this process? What if there was a high staff turnover? Would this include employees from companies who are sub-contracted to provide services and what happens if the service provider used different	Please see our previous responses.

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				staff at different times?	
Southampton City Council	22	01 Sec 6: Rec 22	15	There is no evidence as to what works in improving oral health of adults at higher risk. Providing access to care, and oral hygiene aids still requires the individual to take action. There is limited evidence about the effectiveness of behaviour change interventions. Evidence-based approaches to inform this recommendation.	Thank you for your comment. The document refers to NICE guidance on behaviour change which may be helpful. No specific, oral health behaviour change evidence was identified during guideline development despite a call for evidence.
Southampton City Council	23	01 Sec 6: rec 23	16	There should be a requirement for services dealing with vulnerable people to have a process in place to assess and maintain their oral health, as part of their responsibility to caring for their overall health. Service providers should be given targets which are monitored to ensure that every individual in their care has an oral health assessment and access to therapeutic and preventive care in order to attain optimum oral health. Local experience around the country has indicated difficulties with staff training in residential care homes around high staff turnover, literacy levels of care staff and relative importance allocated to caring for residents' oral health. Unless service providers are required to address these issues, there will not be any changes to the current system.	Thank you for your comment and suggestion. The recommendations have been revised and suggest a requirement to include oral health in service specifications, targeting setting is not within the remit of this current work. We note your concerns, but residential care is outside the scope of this current work. Residential care is the subject of a separate guideline project and more information can be found on the NICE website: Oral health: guidance for nursing and residential care homes http://www.nice.org.uk/guidance/indevelopment/GID-PHG62
Southampton City Council	24	01 Sec 6: Rec 24	17	There should be specification as to which "frontline staff" this recommendation refers to and what and how training should be commissioned. There is a need to consider the difficulties with staff training such as literacy levels and areas where there may be a high staff turnover. A key group would be other healthcare professionals such as	Thank you for raising this, this statement simply reflects associations such as periodontal disease and oral cancer, but we appreciate the point. We appreciate your concerns about staff training, which were reflected by the debate held in committee. Unfortunately, no evidence provided the level of detail

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				GPs, practice nurses, community nurses and others who come into contact with these adults. They should check with their patients, particularly parents of young children, about access to dental care and encourage and support them to seek dental care, if they have not already done so.	required to support the committee specifying which staff should deliver which interventions or the impact of levels of literacy on training. Recommendations have been strengthened where appropriate and suggest collaborative working with parents.
Southampton City Council	26	04 Section 4.4 Cons	24	Using the common risk factor approach means that general medical teams and staff involved in maternal and child nutrition, breastfeeding and smoking cessation should include mention of oral health advice when they talk to their patients/ clients. They can encourage and support people to access dental care regularly such as signposting them to a local practice and following up to see if they have attended.	Thank you for your comment.
Southampton City Council	26	04 Sec 4.5 Cons	24	Fruit juices are high in sugar as well as acids which contribute to weight management issues as well as poor dental decay. They should not be promoted as “healthy” as this provides a mixed message, particularly to parents. There be recommended limits on how much fruit juice is consumed per day to avoid children/adults substituting fruit juice for water.	Thank you for your comment.
Southampton City Council	26	04 Sec 4.7 Con	25	Services involved in tobacco work should encourage and support their clients to access dental care, including signposting and following up to ensure they attend. Helping smokers get their mouths clean and healthy may further encourage them to quit. This is relevant to all buy may be particularly applicable to young smokers in relation to how they look.	Thank you for your comment.

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Southampton City Council	26	04 Section 4.10 Considerations	25	All targeted health improvement interventions are very resource-intensive. Those in the highest needs groups are the ones who are least likely to engage. There is little evidence of effective interventions and even less evidence on cost-effectiveness (as indicated by the evidence review).	Thank you for your comment.
Southampton City Council	26	04 Sec 4.15 Cons	27	Health visitors, midwives and general medical practice teams are more likely to be in touch with new parents than dental practitioners. All healthcare professionals, including those named here should support and encourage parents to take the child to a dentist by the age of 12 months (recommendation of the American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA) and the American Academy of Pediatrics: “Get it Done in Year One”). There should be an indicator in the national “Healthy Child Programme” which specifically measures dental attendance annually during the first 5 years.	Thank you for your comment.
Southampton City Council	26	04 Section 4.16 Cons	27	The focus at parenting programmes should be about encouraging good habits for health overall. That would include toothbrushing twice a day with a fluoride toothpaste and taking the child regularly to the dentist (with the first visit by the age of 12 months). That would result in development of good oral health which will enable the child to eat a healthy and varied diet which is good for overall health and wellbeing.	Thank you for your comment.
Southampton City	26	04	27	The evidence for this is mixed and “some evidence” is not	Thank you for your comment.

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Council		Section 4.18 Cons		sufficient to invest in what is a very resource-intensive intervention. Unless there is a strategy to include all children, including children from high-risk groups, this will not be effective.	As you point out there is limited evidence on the effectiveness and cost effectiveness of many community based oral health promotions activities. Please see our previous responses.
Southampton City Council	26	04 Section 4.22 Cons	28	What evidence is there that NEETS young adults are any more at risk than other young adults? It is logistically difficult to reach and influence young adults to change any aspect of their lifestyle. Any recommendation should come with evidence-based strategies about how this can be achieved.	Thank you for your comment. This is the considerations section which broadly sets out the issues and deliberations of the committee, these are not recommendations.
Southampton City Council	26	04 Section 4.25 Cons	29	There is no evidence to support the first sentence in this point.	Please see our previous response.
Southampton City Council	26	05 Section 5 Rec for Research	30	Research needs to be conducted in “real-life” settings. Research conducted in controlled settings according to strict research protocols do not always translate to real-life practice. An example of this is the Cochrane review on fluoride varnish which does not work well in practice due to issues with reaching everyone in the target population. All recommendations should be informed by evidence, not just on effectiveness, but also on cost-effectiveness and achieving value-for-money. LAs have limited budgets and competing priorities and need good quality information to advise councillors who are the decision-makers locally.	Thank you for your comment, the research recommendations have been revised and would not exclude these activities. Please see our previous responses about the limitations of the evidence base.
Southampton City Council	27	05 Section 5 Rec for	30 (continued from	What is the impact of poor oral health on a child’s quality of life and development? Is there any association with social class (which would indicate inequality)?	Please see our previous responses.

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		Research	previous)	What impact do dental problems have on school attendance and is there any association with social class (which would indicate inequality)? What is the cost impact of dental disease in children and adults to the local economy in the short-term and long-term? What is the cost impact of preventing dental disease?	
University of Leeds, Bradford District Care Trust, CLAHRC YH	0	0 General	general	In summary, I very much welcome the document. I work as a dental academic with most of my clinical care undertaken as a consultant in Paediatric Dentistry in Bradford Community Dental Service. In Bradford, an area of high dental needs, I have seen first hand the benefits of joined up oral health policies with proactive community based public health interventions. I have witnessed the benefits of **recommendations 8-20** and fully support them. I agree the evidence for such interventions are in their infancy and require long-term studies to demonstrate their benefit. The process of increasing public awareness of oral health and improving oral health behaviours is a gradual process.	Thank you for taking the time to read and comment on the document.
University of Leeds, Bradford District Care Trust, CLAHRC YH	0	0 General	general	I feel the document reads very much as an isolated document and fails to identify that this strategy should sit as part of a wider engagement with dental services already provided in a local area. A joined up approach which encourages participation from primary and secondary dental care providers will only help to ensure an appropriate and tailored strategy is developed for each local authority. For example improving access to dental care or provision of fissure sealants (section 4.20) requires engagement with general dental services.	Thank you for your comment. The committee considered your suggestion and concerns, recommendation 1 has been revised and the list of organisations expanded. Hopefully this makes clearer reference to wider engagement with local dental services at community and secondary care level. With regard to Fissure sealants, the committee discussed the need for an incremental comparison of interventions for the current guideline but this was not possible due to the lack of

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					relevant data. However, the committee are aware of the research you have mentioned and when this evidence is in the public domain at a future date it can be considered for inclusion for the review update.
University of Leeds, Bradford District Care Trust, CLAHRC YH	0	0 General	1	The document is aimed at individuals at high risk of dental disease, especially dental decay. While many of the groups are identified the largest vulnerable group is children. This is a missed opportunity as children are a vulnerable group in their own right. For example, recommendations 8-19 are aimed at young children who may or may not fit some of the other vulnerable categories as well. Another vulnerable group at increased risk of dental diseases are children with child protections plans or in foster care.	Thank you for your comment. Examples of vulnerable groups are not intended to be exhaustive. The decision to implement all recommendations or only some, rests with each local authority and will naturally depend on their resource and capacity, and the oral health needs of their local communities which include children and young people.
University of Leeds, Bradford District Care Trust, CLAHRC YH	0	0 General	4	Many of these vulnerable groups, including young children are seen within specialist services in either primary care through the Community Dental Service or in secondary care. The commission framework (as indicated in the Department of Health's Care Pathway for Paediatric Dentistry) will ensure consultants and specialists in paediatric dentistry and adult special care dentistry will lead these networks and provide quality assurance of care for a local area/ authority. I would therefore strongly advocate that both these local leads are invited to participate in the "oral health strategy and needs assessment group". They can therefore bring to the group their clinical experience and provide feedback on local oral healthcare issues. They will also support the appropriate design and interpretation of local oral health surveys.	Thank you for your comment and suggestions. The committee considered your proposals and those of other stakeholders. The revised list of suggested representation for this group is now in the final guideline On balance it was felt that the revisions allow sufficient flexibility to include the particular professional groups you suggest, if they are available and if required.
University of Leeds,		03	19	Oral health surveys will only identify obvious dental caries.	Thank you for your comment and raising your concern.

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Bradford District Care Trust, CLAHRC YH		Sec 3		Consequently the data is an under estimation of the dental needs in the population owing to the methodology used in the surveys. Last complete paragraph – For children with dental caries, the number of carious teeth is an average of over three and consequently this is why young children are a vulnerable group as providing dental care for one tooth or one quadrant is different to providing dental care over multiple visits often requiring local anaesthetic and or extractions.	The limitations of national oral health surveys were considered by the committee, suggestions about local data collection may help provide relevant local information to inform local needs.
University of Leeds, Bradford District Care Trust, CLAHRC YH		04 cons	25, Section 4.8	I welcome the adoption of a "lifecourse approach".	Thank you.
University of Leeds, Bradford District Care Trust, CLAHRC YH		04 cons	28, Section 4.20	Lifecourse approach – I fully support this approach. While section 4.25 identifies that caries continues to develop in adulthood, studies show that the high-risk adults are the same population as high-risk children. Consequently improving oral health for young children (recommendations 8-20) will have long-term benefits.	Thank you for your comment.
University of Leeds, Bradford District Care Trust, CLAHRC YH		04 cons	29, section 4.29	This section seems to dismiss the importance and value of child report outcomes or for very young children parent reported outcomes. Although challenges are present with identifying the impact of dental caries in children, a number of validated quality of life scales have been used and these demonstrate a significant impact of dental caries in this population.	Thank you for your comment. This is not the case. This section broadly sets out the issues and deliberations of the committee, these are not recommendations. There is insufficient space to relate all the detail of the concerns of the committee, self-reported, qualitative data (including proxy reporting) was something the committee wished to support, as is evidenced in the recommendations around the OHNA.
University of Leeds,	6	01	Section	I would fully support the need to work with and ensure all health	Thank you for your comment and suggestions.

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Bradford District Care Trust, CLAHRC YH		Rec 6?	2, P7	care professionals give a uniform oral health message. In this engagement it is important opportunity to highlight the potential for safeguarding issues in these vulnerable groups. Dental neglect and failure to attend appointments can trigger safeguarding concerns. Consequently the dental team often will work with health visitors, school nurses, support and social workers to encourage and support attendance. This message and the need for their support to work with these vulnerable groups should be highlighted. This is a two way communication process and the dental team may also be able to provide further evidence of neglectful attendance or attitudes if wider safeguarding concerns have been raised.	Your concern is noted and the guideline has been amended where possible. The issue of safeguarding and neglect is mentioned in this document where feasible but not in detail as this is an important issue which requires action that has to follow national protocols and legislation, as such outside the scope of this current work. If school nursing services are operational in a local area, local authorities may wish to utilise them, but the committee were aware that the level and presence of this service varies across regions and localities.
University of Portsmouth Dental Academy	0	0 General		Good quality surveillance data is very important to monitor oral health (OH) outcomes. Dental epidemiology survey data on children is no longer useful since the consent process changed from negative to positive consent. Participation is skewed towards children less likely to have decay. We suggest using data from dental extractions done under general anaesthesia and dental attendance data, both of which are available and can be updated quarterly.	Thank you for your comment. Your points are well made and were considered by the committee however it is outside the scope of this work to make recommendations about collecting national data. The committee considered your suggestion to make specific reference to dental attendance data but believed there was sufficient indication of robust data sources in the current recommendations. The membership of the group with responsibility for the OHNA would be aware of relevant national data sets and could advise local authorities accordingly.
University of Portsmouth Dental Academy	0	0 General		The guideline development group should include someone who has experience of commissioning OH improvement programmes at the frontline such as a Consultant in Dental Public Health who	Thank you for your comment. Ideally all guideline development committees would have good representation from a range of stakeholders

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				works at a PHE Centre, to be able to understand the issues.	including all professionals involved in commissioning and delivering activities, approaches, or interventions identified in each guideline. The committee developing this guideline did include individuals from dental public health and others currently commissioning local oral health programmes. PHE's national lead for oral health improvement also gave expert testimony about the new commissioning and delivery landscape. NICE recruits to committees following an open and transparent process. Please see the NICE website for further information. http://www.nice.org.uk/
University of Portsmouth Dental Academy		04 Sec 4.4	24	Using the common risk factor approach, staff involved in maternal and child nutrition, breastfeeding and smoking cessation should include mention of oral health advice when they talk to their patients/ clients. They can encourage people to access dental care regularly and signpost them to a local practice.	Thank you for your comment. This is the considerations section which broadly sets out the issues and deliberations of the committee, these are not recommendations.
University of Portsmouth Dental Academy		04 Sec 4.5	24	Fruit juices are high in sugar as well as acids which contribute to weight management issues as well as poor dental decay. They also encourage development of a "sweet tooth" which then encourages a poor diet.	Thank you for your comment. Please see previous responses.
University of Portsmouth Dental Academy		04 Sec 4.7	25	Services involved in smoking cessation and alcohol reduction should encourage their clients to access dental care. Getting their mouths clean and healthy may further encourage them to change their habits. This is relevant to all but may be particularly applicable to young smokers in relation to looking presentable for job interviews, meeting people socially etc…	Thank you for your comment. Please see previous responses.

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University of Portsmouth Dental Academy		04 Sec 4.10	25	All targeted health improvement interventions are very resource-intensive. Those in the highest needs groups are the ones who are least likely to engage and much resource is spend getting consent. Information on evidence-based interventions, particularly effectiveness and cost-effectiveness are needed.	Thank you for your comment. Please see previous responses.
University of Portsmouth Dental Academy		04 Sec 4.15	27	Health visitors/ midwives who are in touch with new parents should encourage them to take the child to a dentist by the age of 12 months (recommendation of the American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA) and the American Academy of Pediatrics: “Get it Done in Year One”).	Thank you for your comment. Please see previous responses.
University of Portsmouth Dental Academy		04 Sec 4.16	27	The focus at parenting programmes should be about encouraging good habits for health overall. That would include toothbrushing with a fluoride toothpaste and taking the child regularly to the dentist. That would result in development of good oral health through provision of preventive dental care and advice which will enable the child to eat a healthy and varied diet which is good for health.	Thank you for your comment. Please see previous responses.
University of Portsmouth Dental Academy		04 Sec 4.18	27	See comments for Recommendation 12 Page 11. Not supported by evidence.	Thank you for your comment. Please see previous responses.
University of Portsmouth Dental Academy		04 Sec 4.22	28	Our local experience is that it is difficult to reach and retain young adults, particularly those who are from vulnerable backgrounds, in health improvement programmes. A holistic approach and evidence-based effective interventions are needed.	Thank you for your comment. Please see previous responses.
University of Portsmouth Dental		04 Sec 4.25	29	The best indicator of dental decay in permanent teeth is decay in primary teeth. If we can keep the child decay-free through their	Thank you for your comment. Please see previous responses.

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Academy				childhood, there is a much greater chance that they will have no or low decay levels as an adult. Once a child has dental decay, there is usually a downward spiral of extractions and fillings.	
University of Portsmouth Dental Academy		05 Section 5	30	Additional recommendation: What is the impact of poor oral health on a young child's quality of life and development?	Thank you for your suggestion. The research recommendations have been revised and would not exclude your suggestion.
University of Portsmouth Dental Academy	1	01 Section 1: Rec 1	4	The oral health needs assessment (OHNA) can be picked up by the Local Dental Network (LDN). This should feed the Joint Strategic Needs Assessment (JSNA) from which the Joint Health and Wellbeing Strategy (HWbS) is derived. The JSNA team should engage with the Local Dental Network as needed to ensure that OH issues are included.	Thank you for your comment. The committee considered stakeholder concerns and suggestions around this recommendation and others and revised. Recommendation 1 and others have been amended within the remit of this work. If further representation is required, there is sufficient flexibility to determine additions Please see our previous responses which may also be relevant.
University of Portsmouth Dental Academy	2	01 Sec 1: Rec 2	4	The OH strategy should be used to inform the joint HWbS so OH is integrated into general health improvement programmes.	Thank you for your comment. The recommendations have been amended to include reference to the HWB strategy and local service specifications, and strengthen references to the importance to overall health and wellbeing.
University of Portsmouth Dental Academy	2	01 Section 1: Rec 2	5: points 7&8	The only way to do this is for LAs to include OH in the joint HWbS as that is the only document which carries weight locally. A local OHNA should be used to inform the HWbS and suggest how it can be included within life course pathways.	Thank you for your comment. The recommendations have been amended to include reference to the HWB strategy and local service specifications, and strengthen references to the importance to overall health and wellbeing.
University of	3	01	5	The OHNA should link in with the information used in the JSNA	Thank you for your comment and suggestion.

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Portsmouth Dental Academy		Sec 1: Rec3		(for e.g. population demographics)	This is included in the revised recommendations.
University of Portsmouth Dental Academy	3	01 Sec 1: Rec 3	6: last point	OHNAs can be done when needed for a particular reason for e.g. commissioning/ changing a service or care pathway.	Thank you for your comment, your suggestions were noted by the committee.
University of Portsmouth Dental Academy	4	01 Sec1: Rec 4	6	This list of information includes much of what is included in JSNAs. If OHNA is done alongside the JSNA, the same information can be used for both avoiding duplication.	Thank you for your comment. Please see our previous response.
University of Portsmouth Dental Academy	5	01 Sec 2: Rec 5	7	This should happen automatically if OHNA is used to inform the JSNA and joint HWbS. All the points mentioned should be included as part of the joint HWbS using the common risk factor approach.	Thank you for your comment. Please see our previous response.
University of Portsmouth Dental Academy	6	01 Sec 2: Rec 6	7	An integrated approach should be adopted as environments which promote OH also promote general health.	Thank you for your comment. The recommendations have been amended and clarified, and the role of oral health and link to general health has been reinforced throughout.
University of Portsmouth Dental Academy	6	01 Sec 2: Rec 6	8: Last point	It would be useful to have some evidence or precedence for the positive impact of working with other sectors, such as commercial food outlets, before including it as a recommendation.	Thank you for your comment. Recommendations that refer to the role of diet and the availability of drinking water in relation to oral health have been clarified. There are suggestions to consider planning policies and other levers within local authority control, also reference to other NICE guidance which has reviewed different evidence but reached similar conclusions. The final decision to implement is up to local authorities

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					taking into account local resources and the needs of their local communities. The committee were hopeful this guideline would assist in that decision making process.
University of Portsmouth Dental Academy	7	01 Sec 2: Rec 7	8	To make this happen, there needs to be a directive to include it in local service specifications. This could come as a national steer and/ from the local HWbS. OH should not be tackled in isolation, but as integrated part of general health outcomes for children.	Thank you for your comment. Please see our previous responses.
University of Portsmouth Dental Academy	8	01 Sec 3: Rec 8	8	See recommendation above for Section2: Recommendation 7	Thank you, noted.
University of Portsmouth Dental Academy	9	01 Sec 3; Rec 9	9	See recommendation above for Section2: Recommendation 7	Thank you for your comment, please see our previous responses.
University of Portsmouth Dental Academy	10	01 Sec 3: Rec 10	10	Information should be available for all children in Early Years settings. There is no way of identifying with accuracy whether a child will get dental decay so need to target all children.	Thank you for your comment. Your concern is noted. The recommendations include both universal and targeted approaches as a range of groups, including children, are at greater risk of poor oral health than others, completely in keeping with the Marmot review.
University of Portsmouth Dental Academy	11	01 Sec 3: Rec 11	10	Supervised toothbrushing programmes should be implemented at all school settings as there is no way of identifying, with any accuracy, which child will get dental decay. The Scottish Childsmile programme attributes improvements in children's dental health to their universal supervised toothbrushing programme for all 3-5 year-olds and 20% of Primary school children (*www.chlid-smile.org.uk*).	Thank you for your comment. Your concern is noted. The recommendations include both universal and targeted approaches completely in keeping with the Marmot report. The committee considered a range of evidence from systematic reviews, reports, fieldwork and expert testimony, as you will have read. The content of the recommendations reflects their deliberations and careful

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					consideration of the best available evidence and stakeholder concerns. Recommendations have been worded to reflect the strength of the evidence available and some of the uncertainty. The committee have made their recommendations taking into account the best available evidence at the time of drafting and where they genuinely believed activities, interventions or approaches could benefit local communities. The final decision rests with the local authorities and their decisions on how to make best use of available resources to meet local need.
University of Portsmouth Dental Academy	12	01 Sec 3: Rec 12	11	The evidence base for community fluoride varnish applications indicates this is not effective in practice, as children from more deprived groups are less likely to participate. The evidence based listed indicated that there is difficulty with recruiting the target population. The Scottish Childsmile programme has also faced similar drop-outs. A 2012 presentation indicated that only 29% of targeted 3-5 year olds and 47% of 6&7 year-olds got the 2 planned applications in the last year (*www.child-smile.org.uk*).	Thank you for your comment. The evidence of both effectiveness and cost effectiveness for many community oral health activities was mixed. The guideline only recommends considering fluoride varnish in schools in areas where the baseline prevalence is high, as the cost effectiveness analyses suggested this was likely to be cost effective. The degree of uncertainty is reflected in the final wording of the recommendations, and based on the committees' careful consideration of the available evidence. The final decision rests with the local authorities and their decisions on how to make best use of available resources to meet local need. Please see our previous responses.
University of Portsmouth Dental	13	01 Sec 3:	11	See comments in both boxes above for Recommendations 11 and 12.	Thank you, please see our previous responses

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Academy		Rec 13			
University of Portsmouth Dental Academy	15	01 Sec 4: Rec 15	12	The "whole school" approach is good but oral health should be included as part of general health improvement measures for e.g. dietary advice is also important for healthy weight.	Thank you for your comment, the recommendations about oral health and general health have been strengthened.
University of Portsmouth Dental Academy	16	01 Section 4: Rec 16	12	All primary school children should be included as there is there is no way of identifying, with any accuracy, which child will get dental decay.	Please see our previous responses.
University of Portsmouth Dental Academy	17 (see 10)	01 Sec 4: Rec 17	13	See comments for Recommendation 10 above.	Please see our previous responses.
University of Portsmouth Dental Academy	18 (see 11)	01 Sec 4: Rec 18	13	See comments for Recommendation 11 above.	Noted, please see our previous response
University of Portsmouth Dental Academy	19 (See 11,12)	01 Sec 4: Rec 19	14	See comments for Recommendation 11 and 12 above	Noted, please see our previous response
University of Portsmouth Dental Academy	22	01 Sec 6: Rec 22	15	There is no evidence as to what works in improving oral health of adults at higher risk. Providing access to care, and oral hygiene aids still requires the individual to take action, but there is limited evidence of the effectiveness of behaviour change interventions. Evidence is needed before a recommendation can be made.	Thank you for your comment. The document refers to NICE guidance on behaviour change which contains evidence based recommendations about behaviour change which may be helpful. No specific oral health behaviour change evidence was

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					identified during guideline development despite a call for evidence.