Public Health Guidance

ORAL HEALTH: LOCAL AUTHORITY STRATEGIES TO IMPROVE DENTAL HEALTH AMONG VULNERABLE GROUPS - Consultation on Draft Scope
Stakeholder Comments Table 29th October 2012 – 26th November 2012

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
British Association for the Study of Community Dentistry	General	0	BASCD as a registered stakeholder organisation are pleased to be able to comment on the draft scope and would welcome the opportunity to meet with NICE as detailed in the proposed schedule for the development of the guidance. BASCD is the UK's professional association for the science, philosophy and practice of promoting the oral health of populations and groups in society. There is considerable experience and expertise of international standard within BASCD council and the membership who could provide assistance with the development of this guidance.	Thank you for taking the time to read and comment on the draft scope.
British Association for the Study of Community Dentistry	General	0	Full references can be supplied if required	Thank you.
British Association for the Study of Community Dentistry	2 a, b		**Scope in relation to dental and oral health** The draft scope makes the distinction between oral and dental health and focuses the guidance on 'teeth and gums'. Local authorities have a duty under the Health and Social Care Act 2012 to improve the health including the oral health of their populations. Any guidance relating to local authorities strategies should therefore consider oral health (including oral cancer and trauma) particularly in relation to vulnerable groups. Limiting the scope to dental caries and periodontal disease is not appropriate and will not meet the needs of local authorities. The incidence of oral cancer is strongly related to social and economic deprivation. Cancer Research UK has recently stated that whilst overall, cancer death rates in the United Kingdom are predicted to fall by 17% by 2030; death rates from some cancers are predicted to rise. For oral cancer, it is set to rise by 22% from 2.9 to 3.5 per 100,000 people (BMJ 2012). It is suggested in the scope that further guidance will address oral health however both of these documents have a focus (dental practice and residential care homes settings) that means they will not reflect the wider partnership work necessary to address oral health improvement at a population level.	Thank you for your comments and helpful suggestions. We agree that the scope should be extended to wider oral health but it will not cover injury prevention. Multi-agency working will be considered by the committee when drafting their recommendations. We have revised and clarified the scope document.
British Association for the Study	2c		**Related Policy documents**	Thank you for your

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of Community Dentistry			GUIDANCE: Dental Screening (Inspection) in Schools and Consent for Undertaking Screening and Epidemiological Surveys Gateway Approval Reference Number: 7698 Choosing Better Oral Health (2009), Department of Health Valuing People's Oral Health (2007) Delivering Better Oral Health, (2009) (Links to these documents are included at the end of the submission)	comment and suggestions. We have amended the final scope and included some of these additional references. The scope is not intended to be a comprehensive review of policy documents, but thank you for the references.
British Association for the Study of Community Dentistry	2d		The list of who the guidance is aimed at should include Directors of Public Health, Consultants in Dental Public Health and their teams.	Thank you, noted. Lists are not intended to be exhaustive, but we agree your suggestion and have amended.
British Association for the Study of Community Dentistry	3 general		**<u>The economic Impact of oral disease</u>** Under 'the need for guidance' (section 3) it is important to note the economic impact of oral disease. Oral diseases remain a significant public health issue for many high-income countries, where expenditure on treatment often exceeds that for other diseases, including cancer, heart disease, stroke, and dementia. This is concerning, given that much of the oral disease burden in high-income countries is due to dental caries and its complications, and this is preventable through the use of fluoride and other cost-effective measures (Pitts et al. 2011). Savings in dental expenditure have been demonstrated in countries such as Denmark and Sweden, which have invested in the provision of preventive oral health services, and where positive trends have been noted in terms of reduction in the prevalence of oral disease (Wang et al. 1998).	Thank you for your comment and helpful suggestions. We agree the importance of economic impact of oral disease and this will be emphasised in the final guidance. The scope is intended to set out broadly what the guidance will and will not cover, the case for cost effectiveness will be made in the guidance

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				document. The reference is appreciated.
British Association for the Study of Community Dentistry	3a		**<u>Oral health and general health</u>** The scope emphasises the importance of oral health to general health this is very much welcomed and highlights the importance of partnership approaches to oral health improvement this needs to be reflected within the scope. It is also important to emphasise and highlight the impact of poor oral health on general health about which evidence is emerging. E.g. between periodontal disease and diabetes, cardiovascular disease, and pre-term and low birth weight babies.	Thank you for your comment. We have amended and clarified the final document appropriately. This section offers some background information it is not intended to be exhaustive. We have made reference to some of these relationships, but not all. Thank you for the suggestions.
British Association for the Study of Community Dentistry	3b		**<u>Risk factors for dental disease</u>** This paragraph is limited to dental caries only. It should focus on oral health. Oral health is an integral part of general health; dental diseases share common risk factors with other non-communicable diseases (NCD). A common risk factor approach to health promotion (Sheiham and Watt 2000) addresses risk factors to several NCD within the context of the wider determinants of health. Risk factors for oral health include poor diet, tobacco use and immoderate alcohol consumption, trauma and stress and these factors are also common to other NCD. The key concept to this approach is that by concentrating on a small number of risk factors which may impact on a number of diseases will result in greater efficiency than a disease specific approach. Common risk factors often cluster within the population. The prevalence of the five key risk factors for ill health (smoking, alcohol, diet, obesity, and physical activity) have been assessed, with almost the whole population having at least one risk factor, 55% three or more and 20% having four or all five. This clustering further reinforces the importance of the social environments within which people live and the influence of the wider determinants of health.	Thank you for your comment and suggestions. Please see previous responses. We have expanded this background information in this section to include some of your helpful suggestions.

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British Association for the Study of Community Dentistry	3c		**<u>Oral health inequalities in the context of wider determinants of health</u>.** Oral health inequalities can be observed in age, gender, socio-economic and education level within the UK. Caries still remains a major health problem for many groups of people in the UK, particularly for those from socio-economically deprived or vulnerable groups. The incidence of oral cancer and periodontal diseases is also strongly related to social and economic deprivation. It is unlikely that oral health can be improved at population level, or inequalities reduced if the only actions taken relate to individuals dental patients and their self care. Social and economic risk factors also need to be tackled and community and population level programmes are required. In any two year period 25% of children and over half of adults in England do not make any contact with an NHS dentist. Non-attendance may well be a feature of many vulnerable groups so general dental practice, clinically–based activities would not reach such people The Marmot review stated that *'In the UK health inequalities'* (including oral health inequalities)' *are a dominant feature nationally and across all regions. They are not inevitable they stem from inequalities in income, education, employment and neighbourhood circumstances throughout life and can be reduced. Avoidable inequalities are unfair and remedying them is a matter of social justice*.' *Reducing health inequalities will require action on six policy objectives:* • *Give every child the best start in life* • *Enable all children young people and adults to maximise their capabilities and have control over their lives* • *Create fair employment and good work for all* • *Ensure healthy standard of living for all* • *Create and develop healthy and sustainable places and communities*	Thank you for your comments on the draft scope. Your concerns are noted. We agree and have amended and clarified the final document When developing the scope of the work we have to take into account the time and resources available to complete the guidance to publication. Our aim is generally to try and ensure that we have a manageable piece of work, which may mean not covering a topic as comprehensively as stakeholders would wish. We are aware at first drafting we may need to adjust or amend the boundaries of the scope, which is why we publish a first draft and review in the light of comments or concerns from stakeholders.

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			• *Strengthen the role and impact of ill health prevention* Guidance for local authorities regarding strategies to improve oral health and address inequalities need to reflect these policy objectives.	We try to reconsider particular issues where we can. We hope you will continue to comment on the work as it develops. Further information about NICE public health guidance development process and methods are described in Methods for development of NICE public health guidance (third edition) (2012) and The NICE public health guidance development process (third edition) (2012).
British Association for the Study of Community Dentistry	3d,e		The NHS Dental Epidemiology programme data is described in paragraphs d and e. With regard to trend data it is important to note that from **May 2006 DH** issued new guidance regarding consent procedures with subsequent data collected under positive consent arrangements. This had considerable impact on results which meant that caveats should be used when using the data. http://www.nwph.net/dentalhealth. Prior to this change there had been little improvement in the dental health of 5 year olds over a twenty year period.	Noted, thank you, we have amended the scope and added this ref.
British Association for the Study of Community Dentistry	3f		Local authorities will be responsible for dental screening and should consider the guidance previously referred to from the UK National Screening committee regarding the screening of 6-9 year old school children.	Thank you for your comment. We have noted your point and will ensure final guidance is

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			Care should be taken to avoid confusion between the terms for screening (identification of individuals with a particular clinical need) and for examinations conducted for the purpose of epidemiological surveys.	clear. The scope broadly sets out what the guidance will and will not cover. The content of the guidance will be determined following NICE public health methods and process We have amended and clarified the final scope, thank you for pointing this out.
British Association for the Study of Community Dentistry	4.1.1		**The focus of the guidance should not be narrowed only to vulnerable groups indeed the Department of Health referral in Appendix A does not do so.** In order to successfully improve the oral health of their communities local authorities need guidance that addresses populations and communities whilst ensuring equity for vulnerable groups and addressing inequalities. Key messages from the Marmot review (below) reinforce the importance of a population approach addressing the needs of the most disadvantaged through 'proportionate *universalism'*. ▪ *There is a social gradient in health – the lower a person's social position, the worse his or her health therefore action should focus on reducing the gradient in health.* ▪ *Health inequalities result from social inequalities. Therefore action on health inequalities requires action across all the social determinants of health.* ▪ *Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage 'proportionate universalism'*	Thank you for your comment and suggestions. We have amended the scope to include all populations, but with a focus on those who are most vulnerable. Please see additional responses.

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British Association for the Study of Community Dentistry	4.2.1		**<u>Activities/measures that will be covered</u>** The measures (b-f) are very focused on individuals there is no reference to adopting population based health promotion using a common risk factor approach and partnerships to achieve this. The activities are focused on dental caries and periodontal disease and do not include oral cancer or trauma (e.g. alcohol use and facial trauma - action through safer communities partnerships). http://www.alcohollearningcentre.org.uk/_library/Cardiff_Model_-_violence_prevention1.pdf Several of the proposed activities are focused on those that would be delivered at an individual level in dental practices and would be within the remit of other guidance NICE will be producing – 'Oral health: guidance for dental health practitioners on promoting oral health, including making a visit to the dentist a positive experience'. This guidance should, instead, be focused on population level interventions, their effectiveness and cost effectiveness. For example Community level programmes to improve diet: • Support for breastfeeding • Actions to discourage use of sugared drinks in baby bottles, including sweetened milk • Actions to encourage use of trainer cups and beakers • Campaigns to stop babies, toddlers and young children being given bottles of sugar-containing drinks to have in bed • Support to replace sugar containing snacks with healthy ones that do not cause decay • Support for healthy settings- child care institutions, primary, secondary and special support schools to adopt healthy policies for food at school	Thank you. Your concerns have been noted and are addressed by clarifications and revisions to the final document. We have amended the scope so that it now focuses on community-based health promotion approaches and interventions, rather than individual level interventions conducted in the dental practice. Please also see Previous responses.

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			Programmes to increase availability of fluoride: • Provision of free toothpaste of correct concentration of fluoride for parents of young children to support commencement of twice daily, supervised toothbrushing before the first birthday • Supervised brushing with fluoride toothpaste at child care sites and schools • Facilitating schools being able to offer both plain and fluoridated milk for break time safe drinks • Biannual fluoride varnish applications to high risk young children's teeth in priority nurseries and schools by trained dental nurses Activities to encourage attendance at general dental practices form 6 months of age, alongside – Activities to incentivise and educate practices to provide key, correct, evidence-informed treatment and advice for all patients. See Delivering Better Oral Health, DH 2009, Second Edition	
British Association for the Study of Community Dentistry	4.2.1 g		**Multi-agency working** This section is key to achieving change and oral health improvement. It needs to address a broader agenda that focuses on the wider political, environmental, social and economic drivers that create oral health inequalities. A multi-strategy approach is needed that considers further measures such as legislation, fiscal policy and community development. Encouraging a cross-sectoral approach which incorporates health and social care to address the social determinants of oral health. This includes developing supportive oral health environments in local settings such as schools, colleges, hospitals, workplaces and care organisations. It should also address oral health and include reference to oral cancer and facial trauma.	Thank you for your comments, the final scope has been clarified and revised. The final content of the guidance will reflect the evidence and the expertise of the committee. Strategic approaches and effective multi-agency working are common central features in public health guidance and will be part of the focus of

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				this particular piece of work. Please see previous responses about the nature of the scope document.
British Association for the Study of Community Dentistry	4.2.1		This section should also include; **Developing the oral health improvement workforce:** ▪ Maximising the potential of the dental team (dentists, hygienists, therapists, nurses, technicians, oral health promoters and educators) to adopt and deliver proactive preventive approaches. ▪ Making Every Contact Count- describes a 'competence framework' that seeks to equip the whole workforce - with the skills and knowledge they need to identify and make the most of every opportunity to help people live healthier lives. Addressing risk factors such as cigarette smoking, poor diet, high alcohol consumption, and sedentary lifestyles. Disseminating all major research outcomes, best practice measures and learning experiences in oral health promotion would enhance the probability of building a systematic body of evidence.	Thank you for your comment. Your concerns are noted. Please also see previous responses. In order to keep the work manageable in terms of times and resources, it may not possible to comprehensively cover all issues raised by stakeholders. The final guidance may identify training needs, if the evidence indicates these are required. These activities may also be covered by future work. However, the final content of the guidance will be determined by the evidence and the considerations of the committee.

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British Association for the Study of Community Dentistry	4.3		Should be restated as oral rather than dental health and be focused at population level inter-sectoral interventions.	Please see previous responses.
British Association for the Study of Community Dentistry	4.3 Expected outcomes		The outcomes stated within the scope seem to be those expected should successful programmes be implemented. Should they not reflect the product of this process i.e. the outcomes of the guidance itself. These should include, • A review of population level interventions for oral health improvement, the level of evidence supporting them and their cost effectiveness. • Guidance regarding the conduct of oral health needs assessments and screening programmes • Guidance regarding improving the oral health of vulnerable groups and those most at risk of poor dental health.	Thank you for your comment. Historically, this section is intended to reflect the outcomes or results of the evidence identified to address the overarching scope questions, not the outcome of the guidance itself. The content of the final guidance will depend on the evidence and considerations of the committee.
British Association for the Study of Community Dentistry	4.2.1 h		Restate as oral health and include oral cancer and facial trauma	We have amended and clarified, thank you. Please see previous responses.
City of York Council	General	0	City of York Council are pleased to be able to comment on the draft scope and would welcome the opportunity to meet with NICE as detailed in the proposed schedule for the development of the guidance.	Thank you for taking the time to read and comment on the draft scope and for your offer. We hope you will be able to comment on the draft guidance when it is released for consultation next year.
City of York Council	2 a, b		**Scope in relation to dental and oral health**	Thank you for your

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			The draft scope makes the distinction between oral and dental health and focuses the guidance on 'teeth and gums'. Local authorities have a duty under the Health and Social Care Act 2012 to improve the health including the oral health of their populations. Any guidance relating to local authorities strategies should therefore consider oral health (including oral cancer and trauma) particularly in relation to vulnerable groups. Limiting the scope to dental caries and periodontal disease is not appropriate and will not meet the needs of local authorities. The incidence of oral cancer is strongly related to social and economic deprivation. Cancer Research UK has recently stated that whilst overall, cancer death rates in the United Kingdom are predicted to fall by 17% by 2030, death rates from some cancers are predicted to rise. For oral cancer, it is set to rise by 22% from 2.9 to 3.5 per 100,000 people (BMJ 2012). It is suggested in the scope that further guidance will address oral health however both of these documents have a focus (dental practice and residential care homes settings) that means they will not reflect the wider partnership work necessary to address oral health improvement at a population level.	comments and helpful suggestions. We agree that the scope should be extended to wider oral health but it will not cover injury prevention. Multi-agency working will be considered by the committee when drafting their recommendations. We have revised and clarified the scope document.
City of York Council	2 c		**<u>Related Policy documents which should be included:</u>** Guidance: Dental Screening (Inspection) in Schools and Consent for Undertaking Screening and Epidemiological Surveys Gateway Approval Reference Number: 7698 *Guidance: Valuing People's Oral Health: A good practice guide for improving the oral health of disabled children and adults:2007* *Delivering Better Oral Health An evidence-based toolkit for prevention - second edition; 2009* *Directions to Primary Care Trusts concerning the exercise of Dental Public Health functions: 2008* *Choosing better oral health: An oral health plan for England: 2005*	Thank you for your comment and suggestions. We have amended the final scope and included some of these additional references. The scope is not intended to be a comprehensive review of policy documents, but thank you for the references. .
City of York Council	2 d		The list of who the guidance is aimed at should include Directors of Public Health,	Thank you, noted. Lists

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			Consultants in Dental Public Health and their teams.	are not intended to be exhaustive, but we agree your suggestion and have amended.
City of York Council	3 general		**<u>The economic Impact of oral disease</u>** Under 'the need for guidance' (section 3) it is important to note the economic impact of oral disease. Oral diseases remain a significant public health issue for many high-income countries, where expenditure on treatment often exceeds that for other diseases, including cancer, heart disease, stroke, and dementia. This is concerning, given that much of the oral disease burden in high-income countries is due to dental caries and its complications, and this is preventable through the use of fluoride and other cost-effective measures (Pitts et al. 2011). Global data shows how oral conditions are the second-most expensive disease group to treat, just below cardiovascular disease. Dental conditions were found to be more expensive to treat than all cancers combined (Australian Institute of Health and Welfare 2010). In addition, studies have shown how in some industrialised countries, the mouth is the most expensive part of the body to treat (Schneider et al. 1998, Bauer et al. 2009). Savings in dental expenditure have been demonstrated in countries such as Denmark and Sweden, which have invested in the provision of preventative oral health services, and where positive trends have been noted in terms of reduction in the prevalence of oral disease (Wang et al. 1998).	Thank you for your comment and helpful suggestions. We agree the importance of economic impact of oral disease and this will be emphasised in the final guidance. The scope is intended to set out broadly what the guidance will and will not cover, the case for cost effectiveness will be made in the guidance document. The references are appreciated.
City of York Council	3a		**<u>Oral health and general health</u>** The scope emphasises the importance of oral health to general health this is very much welcomed and highlights the importance of partnership approaches to oral health improvement this needs to be reflected within the scope.	Thank you for your comment. We have amended and clarified the final document appropriately.

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			It is also important to emphasise and highlight the association between oral diseases and general health. Poorly controlled diabetes is a well-recognised risk factor for developing periodontal diseases (Seppälä 1993) with evidence indicating that people with both Type 1 and Type 2 diabetes experience gum disease, and, it is of greater severity than in the general population (Firlati 1997; Sandberg 2000). It is also recognised that there is a bidirectional relationship between diabetes and periodontal diseases, with recent research showing how chronic periodontitis has an adverse effect on the control of blood sugar and the incidence of diabetes complications (Grossi 1998; Stewart 2001; Taylor 2001). Gum diseases are also associated with rheumatoid arthritis (Ortiz 2009), adverse pregnancy outcomes (Xiong et al. 2006), and coronary heart disease (Mathews 2008, Humphrey et al. 2008), although causation has not been proven. A potential role for the human papilloma virus in oral cancer has been documented (Syrjänen et al. 2011).	This section offers some background information it is not intended to be exhaustive. We have made reference to some of these relationships, but not all. Thank you for the suggestions.
City of York Council	3b		**Risk factors for dental disease** This paragraph is limited to dental caries only. It should focus on oral health. Oral health is an integral part of general health; dental diseases share common risk factors with other non-communicable diseases (NCD). A common risk factor approach to health promotion (Sheiham and Watt 2000) addresses risk factors to several NCD within the context of the wider determinants of health. Risk factors for oral health include diet, tobacco and alcohol consumption, trauma and stress and these factors are also common to other NCD. The key concept to this approach is that by concentrating on a small number of risk factors which may impact on a number of diseases will result in greater efficiency than a disease specific approach. Common risk factors often cluster within the population. The prevalence of the five key risk factors for ill health (smoking, alcohol, diet, obesity, and physical activity) have been assessed, with almost the whole population having at least one risk factor, 55% three or more and 20% having four or all five. This clustering further reinforces the importance of the social	Thank you for your comment and suggestions. Please see previous responses. We have expanded this background information in this section to include some of your helpful suggestions.

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			environments within which people live and the influence of the wider determinants of health.	
City of York Council	3 c		**<u>Oral health inequalities in the context of wider determinants of health</u>.** Oral health inequalities can be observed in age, gender, socio-economic and education level within the UK. Caries still remains a major health problem for many groups of people in the UK, particularly for those from socio-economically deprived or vulnerable groups. The incidence of oral cancer and periodontal diseases is also strongly related to social and economic deprivation. The Marmot review stated that *'In the UK health inequalities'* (including oral health inequalities)' *are a dominant feature nationally and across all regions. They are not inevitable they stem from inequalities in income, education, employment and neighbourhood circumstances throughout life and can be reduced. Avoidable inequalities are unfair and remedying them is a matter of social justice*.' *Reducing health inequalities will require action on six policy objectives:* • *Give every child the best start in life* • *Enable all children young people and adults to maximise their capabilities and have control over their lives* • *Create fair employment and good work for all* • *Ensure healthy standard of living for all* • *Create and develop healthy and sustainable places and communities* • *Strengthen the role and impact of ill health prevention* Guidance for local authorities regarding strategies to improve oral health and address inequalities need to reflect these policy objectives.	Thank you for your comments on the draft scope. Your concerns are noted. We agree and have amended and clarified the final document When developing the scope of the work we have to take into account the time and resources available to complete the guidance to publication. Our aim is generally to try and ensure that we have a manageable piece of work, which may mean not covering a topic as comprehensively as stakeholders would wish. We are aware at first drafting we may need to adjust or amend the boundaries of the scope, which is why we publish

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				a first draft and review in the light of comments or concerns from stakeholders. We try to reconsider particular issues where we can. We hope you will continue to comment on the work as it develops. Further information about NICE public health guidance development process and methods are described in Methods for development of NICE public health guidance (third edition) (2012) and The NICE public health guidance development process (third edition) (2012).
City of York Council	3 d, e		The NHS Dental Epidemiology programme data is described in paragraphs d and e. With regard to trend data it is important to note that from May 2006 DH issued new guidance regarding consent procedures with subsequent data collected under positive consent arrangements. Prior to this change there had been little improvement in the dental health of 5 year olds over a ten year period.	Thank you for your comment. We have amended and added this reference. Thank you.
City of York Council	3f		Local authorities will be responsible for dental screening and should consider the	Thank you for your

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			guidance previously referred to from the UK National Screening committee regarding the screening of 6-9 year old school children.	comment. Thank you for your comment. We have noted your point and will ensure final guidance is clear. This is the scope which sets out what the guidance will and will not cover, the content of the guidance will be determined following NICE public health methods and processes.
City of York Council	4.1.1		**The focus of the guidance should not be only to vulnerable groups indeed the Department of Health referral in Appendix a does not do so.** In order to successfully improve the oral health of their communities local authorities need guidance that addresses populations and communities whilst ensuring equity and for vulnerable groups and addressing inequalities. Key messages from the Marmot review (below) reinforce the importance of a population approach addressing the needs of the most disadvantaged through 'proportionate *universalism'*. ▪ *There is a social gradient in health – the lower a person's social position, the worse his or her health therefore action should focus on reducing the gradient in health.* ▪ *Health inequalities result from social inequalities. Therefore action on health inequalities requires action across all the social determinants of health.* ▪ *Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage 'proportionate universalism'*	Thank you for your comment and suggestions. We have amended the scope to include all populations, but with a focus on those who are most vulnerable. Please see additional responses.

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City of York Council	4.2.1		**Activities /measures that will be covered** The measures (b-f) are very focused on individuals there is no reference to adopting population based health promotion using a common risk factor approach and partnerships to achieve this. The activities are focused on dental caries and periodontal disease and do not include oral cancer or trauma (e.g. alcohol use and facial trauma - action through safer communities partnerships). http://www.alcohollearningcentre.org.uk/_library/Cardiff_Model_-_violence_prevention1.pdf Several of the proposed activities are focused on those that would be delivered at an individual level in dental practices and would be within the remit of other guidance NICE will be producing – 'Oral health: guidance for dental health practitioners on promoting oral health, including making a visit to the dentist a positive experience'. This guidance should be focused on population level interventions, their effectiveness and cost effectiveness. There is no reference within the guidance to population based programmes in the UK or indeed in other countries for example; Childsmile Programme, Scotland The Childsmile Programme (Childsmile 2012) operating in predominantly non-fluoridated Scotland incorporates: ▪ Oral health education and free daily supervised toothbrushing in all nurseries and priority schools ▪ Free dental packs with toothbrush and toothpaste, to support toothbrushing at home ▪ Advice and information for parents and carers to help them care for their child's	Thank you. Your concerns have been noted and are addressed by clarifications and revisions to the final document. We have amended the scope so that it now focuses on community-based health promotion approaches and interventions, rather than individual level interventions conducted in the dental practice. Please also see Previous responses. .

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			teeth ▪ Biannual fluoride varnish applications to high risk young children's teeth in priority nurseries and schools by trained dental nurses ▪ Additional home support and community interventions delivered by a range of partners ▪ An enhanced programme of care within Primary Care Dental Services Since implementation of the programme, children's dental health in this age-cohort across Scotland has shown a distinct improvement. Figures released in 2010 showed the highest ever percentage of children with no decay. In addition, the mean dmft score decreased from 1.86 in 2008, to 1.52 in 2010 (NDIP 2010).	
City of York Council	4.2.1 g		**<u>Multi-agency working</u>** This section is key to achieving change and oral health improvement. It needs to address a broader agenda that focuses on the wider political, environmental, social and economic drivers that create oral health inequalities. A multi-strategy approach is needed that considers further measures such as legislation, fiscal policy and community development. Encouraging a cross-sectoral approach which incorporates health and social care to address the social determinants of oral health. This includes developing supportive oral health environments in local settings such as schools, colleges, hospitals, workplaces and care organisations. It should also address oral health and include reference to oral cancer and facial trauma.	Thank you for your comments, the final scope has been clarified and revised. The final content of the guidance will reflect the evidence and the expertise of the committee. Strategic approaches and effective multi-agency working are common central features in public health guidance and will be part of the focus of this particular piece of work. Please see previous responses

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				about the nature of the scope document.
City of York Council	4.2.1 h		Restate as oral health and include oral cancer and facial trauma	We have amended and clarified, thank you. Please see previous responses.
City of York Council	4.2.1		This section should also include; **Developing the oral health improvement workforce:** ▪ Maximising the potential of the dental team (dentists, hygienists, therapists, nurses, technicians, oral health promoters and educators). ▪ Making Every Contact Count- describes a 'competence framework' that seeks to equip the whole workforce - with the skills and knowledge they need to identify and make the most of every opportunity to help people live healthier lives. Addressing risk factors such as cigarette smoking, poor diet, high alcohol consumption, and sedentary lifestyles. Disseminating all major research outcomes, best practice measures and learning experiences in oral health promotion to enhance probability of building a systematic body of evidence.	Thank you for your comment. Your concerns are noted. Please also see previous responses. In order to keep the work manageable in terms of times and resources, it may not possible to comprehensively cover all issues raised by stakeholders. The final guidance may identify training needs, if the evidence indicates these are required. These activities may also be covered by future work. However, the final content of the guidance will be determined by the evidence and the considerations of the

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				committee.
City of York Council	4.3		Should be restated as oral rather than dental health and be focused at population level inter-sectoral interventions.	Please see previous responses.
City of York Council	4.3 Expected outcomes		These should include, • A review of population level interventions for oral health improvement, the level of evidence supporting them and their cost effectiveness. • Guidance regarding the conduct of oral health needs assessments and screening programmes • Guidance regarding improving the oral health of vulnerable groups and those most at risk of poor dental health. •	Thank you for your comment. Historically, this section is intended to reflect the outcomes or results of the evidence identified to address the overarching scope questions, not the outcome of the guidance itself. The content of the final guidance will depend on the evidence and considerations of the committee.
NHS Sheffield	General	0	NHS Sheffield as a registered stakeholder organisation are pleased to be able to comment on the draft scope.	Thank you for taking the time to read and comment on the draft scope
NHS Sheffield	General	0	Full references can be supplied if required	Thank you.
NHS Sheffield	General	0	Choosing Better Oral Health 2009 – Department of Health, England. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251 Valuing People's Oral Health 2007	Thank you for these references. We have amended the final scope and included some of

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			http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080918 Delivering Better Oral Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102331	these additional references. The scope is not intended to be a comprehensive review of policy documents, but thank you for the references.
NHS Sheffield	General	0	There is no reference within the guidance to population based programmes in the UK or internationally for example, Childsmile, Scotland or Designed to Smile, Wales	Thank you for your comment on the draft scope. We have amended the document appropriately. We would not usually reference specific programmes in the scope document.
NHS Sheffield	2 a and b		**Scope in relation to dental and oral health** The draft scope makes the distinction between oral and dental health and focuses the guidance on 'teeth and gums'. Local authorities have a duty under the Health and Social Care Act 2012 to improve the health including the oral health of their populations. Any guidance relating to local authorities strategies should therefore consider oral health (including oral cancer and trauma) particularly in relation to vulnerable groups. Limiting the scope to dental caries and periodontal disease is not appropriate and will not meet the needs of local authorities or the needs of the local community. It is suggested in the scope that further guidance will address oral health however both of these documents have a focus (dental practice and residential care homes settings) that means they will not reflect the wider partnership work necessary to address oral health improvement at a population level.	Thank you for your comments and helpful suggestions. We agree that the scope should be extended to wider oral health but it will not cover injury prevention. Multi-agency working will be considered by the committee when drafting their recommendations. We have revised and

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				clarified the scope document.
NHS Sheffield	2c		**<u>Related Policy documents</u>** GUIDANCE: Dental Screening (Inspection) in Schools and Consent for Undertaking Screening and Epidemiological Surveys Gateway Approval Reference Number: 7698 Choosing Better Oral Health (2009), Department of Health Valuing People's Oral Health (2007) Department of Health Delivering Better Oral Health, (2009) Department of Health (Links to these documents are included at the end of the submission)	Thank you for your suggestions. We have amended the final scope and included some of these additional references. The scope is not intended to be a comprehensive review of policy documents, but thank you for the references.
NHS Sheffield	2d		The list of who the guidance is aimed at should include Directors of Public Health, Consultants in Dental Public Health and their teams.	Thank you for your comment. Examples are not intended to be exhaustive, but we have amended the final scope.
NHS Sheffield	3 general		<u>The economic Impact of oral disease</u> Under 'the need for guidance' (section 3) it is important to note the economic impact of oral disease. Oral diseases remain a significant public health issue for many high-income countries, where expenditure on treatment often exceeds that for other diseases, including cancer, heart disease, stroke, and dementia.	Thank you for your comment and helpful suggestions. We agree the importance of economic impact of oral disease and this will be emphasised in the final guidance. The scope is intended to set out

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				broadly what the guidance will and will not cover, the case for cost effectiveness will be made in the guidance document.
NHS Sheffield	3a		**<u>Oral health and general health</u>** The scope emphasises the importance of oral health to general health and highlights the importance of partnership approaches to oral health improvement. This needs to be reflected within the scope of the guidance. It is also important to emphasise and highlight the impact of poor oral health on general health about which evidence is emerging. E.g. between periodontal disease and diabetes, cardiovascular disease, and pre-term and low birth weight babies.	Thank you for your comment. We have amended and clarified the final document. The scope indicates what the guidance will and won't cover and the focus is oral health. This section offers some background information highlighting the importance of oral health to general health, which we have stated.
NHS Sheffield	3b		**<u>Risk factors for dental disease</u>** This paragraph is limited to dental caries only. It should focus on oral health. Oral diseases share common risk factors with other non-communicable diseases (NCD). A common risk factor approach to health promotion (Sheiham and Watt 2000) addresses risk factors to several NCD within the context of the wider determinants of health. Risk factors for oral health include poor diet, tobacco use and immoderate alcohol consumption, trauma and stress and these factors are also common to other NCD. The key concept to this approach is that by concentrating on a small number of risk factors that impact on a number of diseases will result in greater efficiency than a disease specific approach.	Thank you for your comment and suggestions. We have amended and clarified the scope, including the background information in section 3 to include some of your suggestions.

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			Common risk factors often cluster within the population. The prevalence of the five key risk factors for ill health (smoking, alcohol, diet, obesity, and physical activity) have been assessed, with almost the whole population having at least one risk factor, 55% three or more and 20% having four or all five. This clustering further reinforces the importance of the social environments within which people live and the influence of the wider determinants of health.	
NHS Sheffield	3c		**Oral health inequalities in the context of wider determinants of health.** Oral health inequalities can be observed by age, gender, socio-economic and education level within the UK. Dental caries still remain a major health problem for many groups of people in the UK, particularly for those from socio-economically deprived or vulnerable groups. The incidence of oral cancer and periodontal diseases is also strongly related to social and economic deprivation. It is unlikely that oral health can be improved at population level or inequalities reduced if the only actions taken relate to individuals dental patients and their self care. Social and economic risk factors also need to be tackled and community and population level programmes are required.	Thank you for your comments on the draft scope. Your concerns are noted. We agree and have amended and clarified the final document When developing the scope of the work we have to take into account the time and resources available to complete the guidance to publication. Our aim is generally to try and ensure that we have a manageable piece of work, which may mean not covering a topic as comprehensively as stakeholders would

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				wish. We are aware at first drafting we may need to adjust or amend the boundaries of the scope, which is why we publish a first draft and review in the light of comments or concerns from stakeholders. We try to reconsider particular issues where we can. We hope you will continue to comment on the work as it develops. Further information about NICE public health guidance development process and methods are described in Methods for development of NICE public health guidance (third edition) (2012) and The NICE public health guidance development process (third edition) (2012).

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NHS Sheffield	3d,e		The NHS Dental Epidemiology programme data are described in paragraphs d and e. With regard to trend data it is important to note that from May 2006 DH issued new guidance regarding consent procedures with subsequent data collected under positive consent arrangements. This had considerable impact on results which meant that caveats should be used when using the data. http://www.nwph.net/dentalhealth. Prior to this change there had been little improvement in the dental health of 5 year olds over a twenty year period.	Noted, thank you, we have amended and added this ref.
NHS Sheffield	3f		Local authorities will be responsible for dental screening and should consider the guidance previously referred to from the UK National Screening committee regarding the screening of 6-9 year old school children. Care should be taken to avoid confusion between the terms for screening (identification of individuals with a particular clinical need) and for examinations conducted for the purpose of epidemiological surveys.	Thank you for your comment. We have noted your point and will ensure final guidance is clear. This is the scope which sets out what the guidance will and will not cover, the content of the guidance will be determined following NICE public health methods and process. Further information about the public health guidance development process and methods are described in Methods for development of NICE public health guidance (third edition) (2012) and The NICE public health guidance development

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				process (third edition) (2012). We have amended and clarified the final scope, thank you for pointing this out.
NHS Sheffield	4.1.1		**The focus of the guidance should not be narrowed only to vulnerable groups indeed the Department of Health referral in Appendix A does not do so.** In order to improve the oral health of their communities local authorities need guidance that addresses populations and communities whilst ensuring equity for vulnerable groups and addressing inequalities. Key messages from the Marmot review reinforce the importance of a population approach addressing the needs of the most disadvantaged through 'proportionate universalism'.	Thank you for your comment and suggestions. We have amended the scope to include all populations, but with a focus on those who are most vulnerable. Please see additional responses.
NHS Sheffield	4.2.1		**Activities/measures that will be covered** The measures (b-f) are very focused on individuals and there is no reference to adopting population based health promotion using a common risk factor approach and partnerships to achieve this. The activities are focused solely on dental caries and periodontal disease and do not include oral cancer or trauma (e.g. alcohol use and facial trauma - action through safer communities partnerships). http://www.alcohollearningcentre.org.uk/_library/Cardiff_Model_-_violence_prevention1.pdf Several of the proposed activities are focused at an individual level in dental practices and would be within the remit of other guidance NICE will be producing – 'Oral health: guidance for dental health practitioners on promoting oral health, including making a	Thank you. Your concerns have been noted and are addressed by clarifications and revisions to the final document. We have amended the scope so that it now focuses on community-based health promotion approaches and interventions, rather than individual level interventions conducted

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			visit to the dentist a positive experience'. This guidance should, instead, be focused on population level interventions, their effectiveness and cost effectiveness: Community level programmes to improve diet: • Support for breastfeeding • Actions to discourage use of sugared drinks in baby bottles, including sweetened milk • Actions to encourage use of trainer cups and beakers • Campaigns to stop babies, toddlers and young children being given bottles of sugar-containing drinks to have in bed • Support to replace sugar containing snacks with healthy ones that do not cause decay • Support for child settings to adopt healthy policies including child care institutions, primary, secondary and special support schools Programmes to increase availability of fluoride: • Provision of free toothpaste of correct concentration of fluoride for parents of young children to support commencement of twice daily, supervised toothbrushing before the first birthday • Supervised brushing with fluoride toothpaste at child care sites and schools • Fluoridated milk programmes • Biannual fluoride varnish applications to high risk young children's teeth in priority nurseries and schools by trained dental nurses • Activities to encourage attendance at general dental practices from 6 months of age alongside activities to incentivise and educate practices to provide key, correct, evidence-informed treatment and advice for all patients. See Delivering Better Oral Health, DH 2009, Second Edition	in the dental practice. Please also see Previous responses.

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NHS Sheffield	4.2.1 g		**<u>Multi-agency working</u>** This section is key to achieving change and oral health improvement. It needs to address a broader agenda that focuses on the wider political, environmental, social and economic drivers that create oral health inequalities. A multi-strategy approach is needed that considers further measures such as legislation, fiscal policy and community development. A cross-sectoral approach that incorporates health and social care to address the social determinants of oral health is needed. This includes developing supportive oral health environments in local settings such as schools, colleges, hospitals, workplaces and care organisations. It should also address oral health and include reference to oral cancer and facial trauma.	Thank you for your comments, the final scope has been clarified and revised. The final content of the guidance will reflect the evidence and the expertise of the committee. Strategic approaches and effective multi-agency working are common central features in public health guidance and will be part of the focus of this particular piece of work. Please see previous responses about the nature of the scope document.
NHS Sheffield	4.2.1 h		Restate as oral health and include oral cancer and facial trauma	We have amended and clarified, thank you. Please see previous responses.
NHS Sheffield	4.2.1		This section should also include: **Developing the oral health improvement workforce:** ▪ Maximising the potential of the dental team (dentists, hygienists, therapists, nurses, technicians, oral health promoters and educators) to adopt and deliver proactive preventive approaches.	Thank you for your comment. Your concerns are noted. Please also see previous responses. In order to keep the work manageable in terms of

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			▪ Making Every Contact Count, which describes a competence framework that seeks to equip the whole workforce with the skills and knowledge they need to identify and make the most of every opportunity to help people live healthier lives, for example through addressing risk factors such as cigarette smoking, poor diet, high alcohol consumption and sedentary lifestyles. Disseminating all major research outcomes, best practice measures and learning experiences in oral health promotion would enhance the probability of building a systematic body of evidence.	times and resources, it may not possible to comprehensively cover all issues raised by stakeholders. The final guidance may identify training needs, if the evidence indicates these are required. These activities may also be covered by future work. However, the final content of the guidance will be determined by the evidence and the considerations of the committee.
NHS Sheffield	4.3		Should be restated as oral rather than dental health and be focused at population level inter-sectoral interventions.	Please see previous responses.
NHS Sheffield	4.3		The outcomes stated within the scope seem to be those expected should successful programmes be implemented. Should they not reflect the product of this process i.e. the outcomes of the guidance itself through inclusion of: • A review of population level interventions for oral health improvement, the level of evidence supporting them and their cost effectiveness. • Guidance regarding the conduct of oral health needs assessments and screening programmes • Guidance regarding improving the oral health of vulnerable groups and those most at risk of poor dental health.	Thank you for your comment. Historically, this section is intended to reflect the outcomes or results of the evidence identified to address the overarching scope questions, not the outcome of the guidance itself. The content of the final guidance will

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
				depend on the evidence and considerations of the committee.
North Yorkshire County Council/ North Yorkshire and York PCT	General	0	As the Director of Public Health for North Yorkshire I am pleased to be able to comment on the draft scope and would welcome the opportunity to meet with NICE as detailed in the proposed schedule for the development of the guidance.	Thank you for taking the time to read and comment on the draft scope, and for your offer.
North Yorkshire County Council/ North Yorkshire and York PCT	2a, b		**Scope in relation to dental and oral health** The draft scope makes the distinction between oral and dental health and focuses the guidance on 'teeth and gums'. Local authorities have a duty under the Health and Social Care Act 2012 to improve the health including the oral health of their populations. Any guidance relating to local authorities strategies should therefore consider oral health (including oral cancer and trauma) particularly in relation to vulnerable groups. Limiting the scope to dental caries and periodontal disease is not appropriate and will not meet the needs of local authorities. The incidence of oral cancer is strongly related to social and economic deprivation. Cancer Research UK has recently stated that whilst overall, cancer death rates in the United Kingdom are predicted to fall by 17% by 2030, death rates from some cancers are predicted to rise. For oral cancer, it is set to rise by 22% from 2.9 to 3.5 per 100,000 people (BMJ 2012). It is suggested in the scope that further guidance will address oral health however both of these documents have a focus (dental practice and residential care homes settings) that means they will not reflect the wider partnership work necessary to address oral health improvement at a population level.	Thank you for your comments and helpful suggestions. We agree that the scope should be extended to wider oral health but it will not cover injury prevention. Multi-agency working will be considered by the committee when drafting their recommendations. We have revised and clarified the scope document.
North Yorkshire County Council/ North Yorkshire and York PCT	2c		**Related Policy documents which should be included:** Guidance: Dental Screening (Inspection) in Schools and Consent for Undertaking Screening and Epidemiological Surveys Gateway Approval Reference Number: 7698 *Guidance: Valuing People's Oral Health: A good practice guide for improving the oral*	Thank you for your comment and suggestions. We have amended the final scope and included some of

Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			health of disabled children and adults:2007 *Delivering Better Oral Health An evidence-based toolkit for prevention - second edition; 2009* *Directions to Primary Care Trusts concerning the exercise of Dental Public Health functions: 2008* *Choosing better oral health: An oral health plan for England: 2005*	these additional references. The scope is not intended to be a comprehensive review of policy documents, but thank you for the references.
North Yorkshire County Council/ North Yorkshire and York PCT	2d		The list of who the guidance is aimed at should include Directors of Public Health, Consultants in Dental Public Health and their teams.	Thank you for your comment. Examples are not intended to be exhaustive, but we have amended the final scope.
North Yorkshire County Council/ North Yorkshire and York PCT	3 general		<u>The economic Impact of oral disease</u> Under 'the need for guidance' (section 3) it is important to note the economic impact of oral disease. Oral diseases remain a significant public health issue for many high-income countries, where expenditure on treatment often exceeds that for other diseases, including cancer, heart disease, stroke, and dementia. This is concerning, given that much of the oral disease burden in high-income countries is due to dental caries and its complications, and this is preventable through the use of fluoride and other cost-effective measures (Pitts et al. 2011). Global data shows how oral conditions are the second-most expensive disease group to treat, just below cardiovascular disease. Dental conditions were found to be more expensive to treat than all cancers combined (Australian Institute of Health and Welfare 2010). In addition, studies have shown how in some industrialised countries, the mouth is the most expensive part of the body to treat (Schneider et al. 1998, Bauer et al. 2009). Savings in dental expenditure have been demonstrated in countries such as Denmark and Sweden, which have invested in the provision of preventative oral health services,	Thank you for your comment and helpful suggestions. We agree the importance of economic impact of oral disease and this will be emphasised in the final guidance. The scope is intended to set out broadly what the guidance will and will not cover, the case for cost effectiveness will be made in the guidance document. The references are appreciated.

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			and where positive trends have been noted in terms of reduction in the prevalence of oral disease (Wang et al. 1998).	
North Yorkshire County Council/ North Yorkshire and York PCT	3a		**Oral health and general health** The scope emphasises the importance of oral health to general health this is very much welcomed and highlights the importance of partnership approaches to oral health improvement this needs to be reflected within the scope. It is also important to emphasise and highlight the association between oral diseases and general health. Poorly controlled diabetes is a well-recognised risk factor for developing periodontal diseases (Seppälä 1993) with evidence indicating that people with both Type 1 and Type 2 diabetes experience gum disease, and, it is of greater severity than in the general population (Firlati 1997; Sandberg 2000). It is also recognised that there is a bidirectional relationship between diabetes and periodontal diseases, with recent research showing how chronic periodontitis has an adverse effect on the control of blood sugar and the incidence of diabetes complications (Grossi 1998; Stewart 2001; Taylor 2001). Gum diseases are also associated with rheumatoid arthritis (Ortiz 2009), adverse pregnancy outcomes (Xiong et al. 2006), and coronary heart disease (Mathews 2008, Humphrey et al. 2008), although causation has not been proven. A potential role for the human papilloma virus in oral cancer has been documented (Syrjänen et al. 2011).	Thank you for your comment. We have amended and clarified the final document appropriately. This section offers some background information it is not intended to be exhaustive. We have made reference to some of these relationships, but not all. Thank you for the suggestions.
North Yorkshire County Council/ North Yorkshire and York PCT	3b		**Risk factors for dental disease** This paragraph is limited to dental caries only. It should focus on oral health. Oral health is an integral part of general health; dental diseases share common risk factors with other non-communicable diseases (NCD). A common risk factor approach to health promotion (Sheiham and Watt 2000) addresses risk factors to several NCD within the context of the wider determinants of health. Risk factors for oral health	Thank you for your comment and suggestions. Please see previous responses. We have expanded this background information

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			include diet, tobacco and alcohol consumption, trauma and stress and these factors are also common to other NCD. The key concept to this approach is that by concentrating on a small number of risk factors which may impact on a number of diseases will result in greater efficiency than a disease specific approach.Common risk factors often cluster within the population. The prevalence of the five key risk factors for ill health (smoking, alcohol, diet, obesity, and physical activity) have been assessed, with almost the whole population having at least one risk factor, 55% three or more and 20% having four or all five. This clustering further reinforces the importance of the social environments within which people live and the influence of the wider determinants of health.	in this section to include some of your helpful suggestions.
North Yorkshire County Council/ North Yorkshire and York PCT	3c		**Oral health inequalities in the context of wider determinants of health.** Oral health inequalities can be observed in age, gender, socio-economic and education level within the UK. Caries still remains a major health problem for many groups of people in the UK, particularly for those from socio-economically deprived or vulnerable groups. The incidence of oral cancer and periodontal diseases is also strongly related to social and economic deprivation. The Marmot review stated that *'In the UK health inequalities'* (including oral health inequalities)' *are a dominant feature nationally and across all regions. They are not inevitable they stem from inequalities in income, education, employment and neighbourhood circumstances throughout life and can be reduced. Avoidable inequalities are unfair and remedying them is a matter of social justice*.' *Reducing health inequalities will require action on six policy objectives:* • *Give every child the best start in life* • *Enable all children young people and adults to maximise their capabilities and have control over their lives* • *Create fair employment and good work for all* • *Ensure healthy standard of living for all* • *Create and develop healthy and sustainable places and communities* • *Strengthen the role and impact of ill health prevention*	Thank you for your comments on the draft scope. Your concerns are noted. We agree and have amended and clarified the final document When developing the scope of the work we have to take into account the time and resources available to complete the guidance to publication. Our aim is generally to try and ensure that we have a manageable piece of work, which may mean not covering a topic as comprehensively as stakeholders would wish.

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			Guidance for local authorities regarding strategies to improve oral health and address inequalities need to reflect these policy objectives.	We are aware at first drafting we may need to adjust or amend the boundaries of the scope, which is why we publish a first draft and review in the light of comments or concerns from stakeholders. We try to reconsider particular issues where we can. We hope you will continue to comment on the work as it develops.
North Yorkshire County Council/ North Yorkshire and York PCT	3d, e		The NHS Dental Epidemiology programme data is described in paragraphs d and e. With regard to trend data it is important to note that from May 2006 DH issued new guidance regarding consent procedures with subsequent data collected under positive consent arrangements. Prior to this change there had been little improvement in the dental health of 5 year olds over a ten year period.	Noted, thank you, we have amended the scope and added this ref.
North Yorkshire County Council/ North Yorkshire and York PCT	3f		Local authorities will be responsible for dental screening and should consider the guidance previously referred to from the UK National Screening committee regarding the screening of 6-9 year old school children.	Thank you for your comment. We have noted your point and will ensure final guidance is clear. This is the scope which sets out what the guidance will and will not cover, the content of the guidance will be determined following NICE public health

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				methods and process. Further information about the public health guidance development process and methods are described in Methods for development of NICE public health guidance (third edition) (2012) and The NICE public health guidance development process (third edition) (2012).
North Yorkshire County Council/ North Yorkshire and York PCT	4.1.1		The focus of the guidance should not be narrowed only to vulnerable groups indeed the Department of Health referral in Appendix a does not do so. In order to successfully improve the oral health of their communities local authorities need guidance that addresses populations and communities whilst ensuring equity and for vulnerable groups and addressing inequalities. Key messages from the Marmot review (below) reinforce the importance of a population approach addressing the needs of the most disadvantaged through 'proportionate *universalism'*. ▪ *There is a social gradient in health – the lower a person's social position, the worse his or her health therefore action should focus on reducing the gradient in health.* ▪ *Health inequalities result from social inequalities. Therefore action on health inequalities requires action across all the social determinants of health.* ▪ *Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage 'proportionate universalism'*	Thank you for your comment and suggestions. We have amended the scope to include all populations, but with a focus on those who are most vulnerable. Please see additional responses.

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North Yorkshire County Council/ North Yorkshire and York PCT	4.2.1		**Activities/measures that will be covered** The measures (b-f) are very focused on individuals there is no reference to adopting population based health promotion using a common risk factor approach and partnerships to achieve this. The activities are focused on dental caries and periodontal disease and do not include oral cancer or trauma (e.g. alcohol use and facial trauma - action through safer communities partnerships). http://www.alcohollearningcentre.org.uk/_library/Cardiff_Model_-_violence_prevention1.pdf Several of the proposed activities are focused on those that would be delivered at an individual level in dental practices and would be within the remit of other guidance NICE will be producing – 'Oral health: guidance for dental health practitioners on promoting oral health, including making a visit to the dentist a positive experience'. This guidance should be focused on population level interventions, their effectiveness and cost effectiveness. There is no reference within the guidance to population based programmes in the UK or indeed in other countries for example; Childsmile Programme, Scotland The Childsmile Programme (Childsmile 2012) operating in predominantly non-fluoridated Scotland incorporates: ▪ Oral health education and free daily supervised toothbrushing in all nurseries and priority schools ▪ Free dental packs with toothbrush and toothpaste, to support toothbrushing at home ▪ Advice and information for parents and carers to help them care for their child's teeth	Thank you. Your concerns have been noted and are addressed by clarifications and revisions to the final document. We have amended the scope so that it now focuses on community-based health promotion approaches and interventions, rather than individual level interventions conducted in the dental practice. Please also see Previous responses.

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			▪ Biannual fluoride varnish applications to high risk young children's teeth in priority nurseries and schools by trained dental nurses ▪ Additional home support and community interventions delivered by a range of partners ▪ An enhanced programme of care within Primary Care Dental Services Since implementation of the programme, children's dental health in this age-cohort across Scotland has shown a distinct improvement. Figures released in 2010 showed the highest ever percentage of children with no decay. In addition, the mean dmft score decreased from 1.86 in 2008, to 1.52 in 2010 (NDIP 2010).	
North Yorkshire County Council/ North Yorkshire and York PCT	4.2.1 g		**Multi-agency working** This section is key to achieving change and oral health improvement. It needs to address a broader agenda that focuses on the wider political, environmental, social and economic drivers that create oral health inequalities. A multi-strategy approach is needed that considers further measures such as legislation, fiscal policy and community development. Encouraging a cross-sectoral approach which incorporates health and social care to address the social determinants of oral health. This includes developing supportive oral health environments in local settings such as schools, colleges, hospitals, workplaces and care organisations. It should also address oral health and include reference to oral cancer and facial trauma.	Thank you for your comments, the final scope has been clarified and revised. The final content of the guidance will reflect the evidence and the expertise of the committee. Strategic approaches and effective multi-agency working are common central features in public health guidance and will be part of the focus of this particular piece of work. Please see previous responses

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				about the nature of the scope document.
North Yorkshire County Council/ North Yorkshire and York PCT	4.2.1 h		Restate as oral health and include oral cancer and facial trauma	We have amended and clarified, thank you. Please see previous responses.
North Yorkshire County Council/ North Yorkshire and York PCT	4.2.1		This section should also include; **Developing the oral health improvement workforce**: ▪ Maximising the potential of the dental team (dentists, hygienists, therapists, nurses, technicians, oral health promoters and educators). ▪ Making Every Contact Count- describes a 'competence framework' that seeks to equip the whole workforce - with the skills and knowledge they need to identify and make the most of every opportunity to help people live healthier lives. Addressing risk factors such as cigarette smoking, poor diet, high alcohol consumption, and sedentary lifestyles. Disseminating all major research outcomes, best practice measures and learning experiences in oral health promotion to enhance probability of building a systematic body of evidence.	Thank you for your comment. Your concerns are noted. Please also see previous responses. In order to keep the work manageable in terms of times and resources, it may not possible to comprehensively cover all issues raised by stakeholders. The final guidance may identify training needs, if the evidence indicates these are required. These activities may also be covered by future work. However, the final content of the guidance will be determined by the evidence and the considerations of the

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				committee.
North Yorkshire County Council/ North Yorkshire and York PCT	4.3		Should be restated as oral rather than dental health and be focused at population level inter-sectoral interventions.	Please see previous responses.
North Yorkshire County Council/ North Yorkshire and York PCT	4.3		These should include, • A review of population level interventions for oral health improvement, the level of evidence supporting them and their cost effectiveness. • Guidance regarding the conduct of oral health needs assessments and screening programmes • Guidance regarding improving the oral health of vulnerable groups and those most at risk of poor dental health.	Thank you. Please see previous responses.
British Dental Association	General	0	There is no mention of the important role of Consultants in Dental Public Health (CsDPH) in the guidance and it is essential that this is remedied. CsDPH will be located in Public Health England (PHE) and will provide leadership in the development of oral health improvement strategies across England.	Thank you for your comment. This is the scope document which sets out what the final guidance will and will not cover. Lists are not intended to be exhaustive, but we have amended the document.
British Dental Association	2c	2	We recommend that the supporting policy documents include the Department of Health's *Delivering Better Oral Health*	Thank you for your suggestion. We agree and have amended and clarified the final scope.
British Dental Association	4.3	7	Building on comments above, we believe that the questions outlined in this section must link back to the work that will be undertaken at strategic and local level by PHE. The advantage of the new NHS architecture is the single operating model and	Thank you for your comment. NICE develops guidance in response to referrals from Ministers. The aim

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			commissioning structure (all dental services will be commissioned by the NHS Commissioning Board) and emerging links with Health Education England and PHE will enable efficiencies in the provision of dental public health advice. We believe strongly that those tasks which can be done once and applied nationally should only be done once, with best practice examples shared nationally with local flexibility. We would not welcome guidance which conflicted with the national approach to strategy, planning and delivery, and forced local areas to invest resource in duplicating work. PHE has a significant opportunity to facilitate the sharing of best practice, and we believe this should be communicated in the guidance. Question 2, for example, can be answered simply by placing a duty on local authorities to work with their local PHE office to understand their populations. This will occur as part of the drafting of Joint Strategic Needs Assessments, but it is vital that the roles of PHE and CsDPH are central in this guidance.	is for guidance to demonstrate efficacy based on best available, current evidence and on the discussions of the public health advisory committee. NICE guidance for public health and clinical practice are not mandatory, it is up to local authorities to decide where to focus their spending depending on local needs.
Cardiff University	General	0	Information and comments below based on ongoing study being carried out with colleagues in Northumbria LHB	Thank you. Please see our response to this comment and suggestion below.
Cardiff University	4.1.2.		Information in study mapping phase supports the need for a better pathway for young people who recently left care.	Thank you for your comment on the draft scope, this group are included in this work. The scope document sets out what the guidance will and will not cover. The content of the final guidance will be

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				informed by the best available evidence and the considerations of the committee. We hope you will continue to comment on the work as it develops.
Cardiff University	4.1.2.		Study suggests that children in residential care have trouble accessing care and in using offered treatment when it can be found, raises questions as to why they are excluded.	Thank you for your comment. Children in residential care are part of a separate piece of work under the other referrals from the Department of Health. These other referrals are listed in the document (see section 2b).
Cardiff University	4.3		Study suggests… assessment and treatment must be available to all LAC quickly as they come into care And that services must Have the time and resources to respond to the often complex needs of LAC who often need more time than usual to be introduced to dental care and overcome any anxieties before treatment begins Be acceptable and usable by both LAC and the carers Ensure LAC who fail to attend appointments are quickly identified and followed up Good practice includes establishing a network of : the child, all relevant health and social professionals, the child's carer and if possible the child's biological parent would ned to be consulted to help local authorities identify the needs and severity of dental health problems in Looked After Children. Information can be collected through surveys and interviews with the above	Thank you for your comments. Please see our previous responses.
Cardiff University	4,3		Study results suggest an effective pathway using the CDS to provide treatment has	Thank you for your

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			been identified. This pathway runs from the first medical assessment as children come into care, and keeps all involved in the child's care fully informed.	comment, please see our previous responses.
Central London Community Healthcare NHS Trust	4.1.2	5	Feel that the client group should not be left out of this guidance-there is evidence that patients who often enter residential care with adequate oral hygiene experience a rapid deterioration due to a lack of support/knowledge from staff in these institutions-inclusion of details of resident's regular dentist/arranging a dental assessment on admission to residential care would help greatly	Thank you for taking the time to read and comment on the draft scope. This group are not excluded, but are the subject of a separate piece of work to be conducted at a future date. We hope you will comment on this work as it develops and during the consultation periods.
CHX Technologies Europe Ltd	General	0	Any new policy must treat the cause of dental caries, not the outcome of this chronic disease. While it is a multifactorial disease, caries is primarily a low-grade bacterial infection which existing methods such as dental restoration and fluoride do not address. One new and MHRA-approved product does reduce this bacterial infection causing dental caries. It is called Prevora, has a unique base of evidence for preventing caries in high risk adults, and should therefore be the focus of any new policy and programming addressing high risk patients. Indeed, it is the only approved preventive treatment for these patients.	Thank you for your comment. This is the draft scope to inform the development of NICE public health guidance, following public consultation a final scope will be published on the NICE website. Medicines and treatments are evaluated by the health technologies appraisals programme at NICE and are outside the remit of this piece of public health work.

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Department of Health	General	0	I have been played in to the response sent by the British Association for the Study of Community Dentistry, which is the specialist organisation representing the specialty of dental public health, of which I am a member. I whole heartedly agree with that response, which has been very carefully considered and covers most of my own points.	Thank you. Please see our responses to BASCD.
Department of Health	2c		I would suggest an additional related policy document Delivering Better Oral Health, an evidence based toolkit for prevention, 2nd edition DH2009	Thank you for your suggestion, we have amended and added this reference.
Department of Health	2d		Could we include NHS commissioners in the list of who this is aimed at?	Thank you, yes and we have amended.
Department of Health	3c		There is a factual error; the proportion of adults without natural teeth was found to be 6% in the 2009 Adult Dental Health Survey, not 22%	Thank you. Noted and amended.
Department of Health	4.2.2 b		I am surprised that strategies and approaches to promoting positive oral health behaviour, including dental health messages for the public are explicitly excluded from the scope as these would form part of a population approach.	Thank you for your comment. We agree that the scope should be extended to wider oral health and will cover community based health-promotion including for example local information and education campaigns about toothbrushing.
Department of Health	4.3		Questions should describe oral health not just dental health.	Thank you, noted. We have amended the final document.
East Cheshire NHS Trust	3 b	3	Include with the risk factors: - Children and adults with chronic medical conditions. Reference: DH 284832/Valuing People's Oral Health: A good practice guide for improving oral health of disabled children and adults	Thank you for your comment on the draft scope, and for your suggestion. The purpose of the scope is

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				to set out what the guidance will and will not cover, lists of examples are not intended to be exhaustive.
East Cheshire NHS Trust	4.1.1	5	Include in this section those with mobility difficulties and/or learning disability who live in the community and get staff support that is commissioned by the local authority.	Thank you for your suggestion. This group would not be excluded from benefitting from the guidance when it is developed.
Health Improvement Service, South West Yorkshire Partnership NHS Foundation Trust	3f	4	Our small team have been part of a Community Dental Service for many years providing Oral Health Promotion/Education and having transferred into the Health Improvement Service (HIS) four years ago provide several programmes locally which are commissioned at the moment by the PCT. (The team all have a dental background & have worked in a clinical environment but have gained additional qualifications over the years to enable us to move into the field of prevention) With the changes about to take place we are concerned that the new arrangements include our team in future developments as we are the main providers for schools, children centres, other early years practitioners, care homes etc and have a wide range of networks to help raise awareness of problems locally. This will be a concern nationally I am sure.	Thank you for taking the time to read and comment on the draft scope. Your concerns are noted. We hope you will continue to comment as the work develops and when the draft guidance will be available during the public consultation.
Health Improvement Service, South West Yorkshire Partnership NHS Foundation Trust	4.2.1	6	We are pleased to see the activities/measures which will be covered. This enhances what we are already doing within our programmes. Being part of HIS helps us in our endeavour for multi-agency working and to take a holistic approach.	Thank you for your comment.
NHS Greater Manchester. NHS Tameside and Glossop	2b	1	Although the scope stated here is for the range of diseases the focus seems to be on caries and periodontal disease. The inclusion of oral cancers and dental injuries could be more explicit throughout and in outcomes.	Thank you for your comment on the draft scope, We agree that the scope should be

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				extended to wider oral health but it will not cover injury prevention. We have amended and clarified the final scope.
NHS Greater Manchester. NHS Tameside and Glossop	2d	2	The guidance will also be of interest to local authority policy makers and providers of services – particularly for vulnerable groups such as early years, frail elderly and substance misusers. Also public health and health improvement commissioners and providers.	Thank you for your comment. We hope you will to continue to comment as the work develops.
NHS Greater Manchester. NHS Tameside and Glossop	3d, e	3-4	NB we can't make socio-economic or ethnicity comparisons for child dental health and this requirement should be picked up in this guidance.	Thank you for your comment on the draft scope, your concern is noted.
NHS Greater Manchester. NHS Tameside and Glossop	3a	3	It is worth including the effect on children's school attendance and hence attainment, and also on attendance at work as these are of more consequence to local authorities than treatment of dental disease.	Thank you for your comment. Although this is an interesting point, we are unable to use this particular example with no published reference to support this information. If you have a reference, the NICE team would be delighted to receive it. We hope you will continue to comment on the work as it progresses.
NHS Greater Manchester. NHS Tameside and Glossop	3b	3	Substance misuse is a risk factor, particularly not exclusively methadone use.	Thank you for your comment, noted. Lists of

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				examples in the scope are not intended to be exhaustive.
NHS Greater Manchester. NHS Tameside and Glossop	3f	4	A structured approach to needs assessment can include the following[1,2 3]: -Reasons that this is a public health issue – national prevalence and trends, contribution to morbidity and chronic illness. -Local caries and other dental disease prevalence and trends, benchmarked against the national and regional data. - Socio-dental indicators for example from health surveys reporting difficulties eating, speaking, pain etc. -Vulnerable groups and how they are represented locally – segmenting the needs of different sub-groups of the population -Evidence for effective intervention – for whole population and for particular sub-groups, based on literature reviews or policy guidance. -Relevant results of local and national consultations with communities, patients and staff. -Overview of services currently in place and identification of gaps in service -Draft conclusions based on the findings of each section. -Review findings and conclusions with a wide range of stakeholders including service users and formulate recommendations in partnership. Consultants in dental public health in PHE will also have a role in supporting local authorities through oral health needs assessments as they have the required technical skills.	Thank you for your comment on the draft scope and suggestions for the final guidance. The content of the final guidance will depend on the evidence and the considerations of the committee. Although we appreciate your suggestions, these seem to apply to the content of recommendations in the final work. We hope you will comment on the draft guidance during the next consultation (Spring 2014).

[11] Health needs assessment a practical guide: National Institute of Clincal Excellence. London; 2005
[2] Stevens A, Raferty J, Health Care Needs Assessment. Radcliffe; 2004
[3] Pencheon D, Oxford Book of Public Health Practice. Oxford University Press; 2003

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NHS Greater Manchester. NHS Tameside and Glossop	3f	4	Important to distinguish between screening and epidemiology – local authorities also responsible for commissioning surveys of dental health. Maintaining and improving the commissioning of epidemiological data is fundamental to oral health needs assessment. The scope should therefore include looking at the requirements of this function, commissioning of surveys, commissioning for high compliance to ensure data quality, collection of home postcode and ethnicity (schools have both of these) to enable analysis by socio-economic deprivation and ethnicity, commissioning separate sample sizes. May also be in scope to look at the potential for LAs to devolve this responsibility to ensure comparability across areas.	Thank you for your comment. Please see our previous responses. We agree and have clarified and amended the scope. We will ensure the final guidance is clear on the issue of screening and epidemiology, thank you for pointing this out.
NHS Greater Manchester. NHS Tameside and Glossop	4.1.1.	5	Other groups to include: specific needs of school aged children with other risk factors (eg chronic sickness, disability, or from areas of low income/ socio-economic deprivation); frail elderly living in the community; substance misusers.	Thank you for your suggestions, your concerns are noted, all these groups would be covered by the 3 guidance referrals. Lists of examples are not intended to be exhaustive.
NHS Greater Manchester. NHS Tameside and Glossop	4.2.1a	6	See previous note for section 3f page 4 setting out the structure of a comprehensive needs assessment.	Thank you, noted. Please see previous response.
NHS Greater Manchester. NHS Tameside and Glossop	4.2.1b	6	In order to cover the potential considerations set out in Appendix B it is important to consider the relative effectiveness of targeted and population strategies and the evidence for progressive universalism set out by Marmot.	Please see previous response about approaches and scope development.

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			Proportional universalism: focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.[4]	Further information about public health guidance development process and methods are described in Methods for development of NICE public health guidance (third edition) (2012) and The NICE public health guidance development process (third edition) (2012).
NHS Greater Manchester. NHS Tameside and Glossop	4.2.1e	6	Effective oral health activities also include working with other agencies and communities to embed healthy snacks and eating policies, breastfeeding policy, ensuring access to affordable brushes and paste etc.	Thank you, your concerns are noted. The final content of the guidance will depend on the evidence and considerations of the committee. Effective multi-agency working will be considered by the committee when it is drafting recommendations. We hope you will continue to comment on the work as it develops. .

[4] Fair society: healthy lives. The Marmot Review. Published by the Marmot Review 2010.

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NHS Greater Manchester. NHS Tameside and Glossop	4.2.1f	6	As above, improvements in diet achieved by settings approach for example healthy snacks in pre-school settings and in schools and access to healthy snacks and drinks especially for low income communities. 4.2.1.f might need to be more precisely phrased looking at role of sugar-containing foods and drinks in reducing decay and the importance of substituting healthy and nutritious foods and drinks including fruit, bread and milk. Links to wider nutrition policy and healthy eating messages are very important.	Thank you for your comment and suggestions. Please see previous responses.
NHS Greater Manchester. NHS Tameside and Glossop	4.2.1.g	6	Importance of consistent scientifically based advice. Also **multi-agency role** in promoting better oral health eg through improving access to healthier foods and drinks as much more effective in reaching vulnerable groups and reducing variations in health.	Thank you, please see previous response. The committee will consider effective multi-agency working when it is drafting recommendations.
NHS Greater Manchester. NHS Tameside and Glossop	4.2.1.h	6	Structured approach to monitoring and evaluation – process, impact and health outcomes: evaluation of process – material and staff resources invested, what's delivered, satisfaction of staff and communities with the process; evaluation of impact – changes in oral health behaviours, changes in policies eg food policies in schools and pre-school establishments and their implementation through healthy environments; evaluation of outcomes – improved oral health measured through epidemiology or through socio-dental indicators.	Thank you for your comment. Please see our previous responses.
NHS Greater Manchester. NHS Tameside and Glossop	4.2.1.	6	Include additional section - life course model [5]:- developmental environment, skills and knowledge, work, expertise and experience, parental support and early years education, education, employment and professional development, services for wellbeing, health prevention and care, secure, safe and supportive environment in line with CMOs report.	Thank you for your comment, we have clarified and revised the final document following this consultation. Please see our previous responses about scope

[5] Annual report of the Chief Medical Officer. Volume 1. DH 2012

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				development. Thank you.
NHS Greater Manchester. NHS Tameside and Glossop	4.2.1.	6	Include further additional section: family focus: children and young people are part of families and so all efforts to improve to reduce sugar in the diet – in the context of a healthy diet and the prevention of obesity - and introduce other oral health related behaviours should take a family focus.	Thank you for your comment, some of your helpful suggestions are covered in the clarified and revised final document.
NHS Greater Manchester. NHS Tameside and Glossop	4.3 question 1	7	The scope of this question needs to include the relative effectiveness and cost-effectiveness of population and high risk strategies as set out in response to 4.2.1b. Also important to consider that it is most cost-effective to make maximum use of existing staff to promote oral health.	Thank you for your suggestions. These issues will be considered during the work undertaken to determine the cost effectiveness of activities to promote oral health.
NHS Greater Manchester. NHS Tameside and Glossop	4.3 question 1	7	Cost-effectiveness needs to ask the questions as to where do the benefits fall and this is an issue for oral health where much of the benefit may fall to NHSCBA as commissioners of dental services rather than to the local authority. There is therefore scope for investment agreements so that those agencies that benefit may support prevention.	Thank you for your helpful suggestions. These issues will be considered during the work undertaken to determine the cost effectiveness of activities to promote oral health.
NHS Greater Manchester. NHS Tameside and Glossop	4.3. question 2	7	See response to 3.f page 4 setting out the requirements of a dental epidemiology programme providing valid data which can be broken down by subgroup to inform a needs assessment.	Thank you for your comment, this analysis will be undertaken during the review of evidence and included in the final guidance, if there is sufficient

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				evidence on the populations of interest.
NHS Greater Manchester. NHS Tameside and Glossop	4.3. question 2	7	See response to 3f page 4 which set out the structure of an oral health needs assessment. The types of additional information which will support this are collection of socio dental indicators from surveys, focus groups with particular groups of the community. Also data on service use eg on urgent and routine care by locality. As already stated PHE should support this activity.	Thank you for your suggestion. The aim of the scope is to broadly set out what the guidance will and will not cover. The second phase of guidance development will be to collect, appraise and interpret the evidence and present to the public health advisory committee to make recommendations to local authorities. As you rightly point out.
NHS Greater Manchester. NHS Tameside and Glossop	4.3. question 3	7	The scope of this should consider culturally appropriate activities, use of outreach, integrated oral health into successful existing targeted services such as children's centres, community groups, voluntary agencies, drug and alcohol services. – in order to maximise effectiveness and cost-effectiveness.	Thank you for your comment. We agree and that was the intention. The aim of the scope is to broadly set out what the guidance will and will not cover. We have clarified and revised the scope appropriately. Lists of examples are not intended to be exhaustive.

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NHS Greater Manchester. NHS Tameside and Glossop	4.3.	7	Measures of oral health: caries prevalence and severity (av dmft) by populations and subgroups; trends; prevalence of other oral disease or trauma including perio, dento-facial injuries, oral cancer. Socio-dental indicators. Also relevance of breast-feeding levels and childhood obesity. Measures of impact: development of policies on healthy snacks in schools and pre-school. Reported behaviour on consumption of sugary snacks and drinks. Consumption fresh fruit. Oral hygiene practices. Fluoride supplements in high risk groups only. Data on urgent and routine dental visiting. In relation to return on investment – this will need a cost-benefit analysis that measures both investment by different agencies and where benefit fall. This will give potential for investment agreements to ensure that those agencies that benefit (eg NHSCBA) will also be encouraged to support local authority investment.	Thank you for your helpful suggestions and comments. Please see previous responses.
Northamptonshire Healthcare NHS Foundation Trust	2 b	1	'Oral health: guidance for nursing and residential care homes on promoting oral health, preventing dental health problems and ensuring access to dental treatment'. **We cannot ensure access merely enable/facilitate or assure that it is available. The phrase used implies a lack of choice which I am sure is not the intention**	Thank you for taking the time to read and comment on the draft scope. The phrase you have selected is not part of this guidance development, but is a separate referral for another piece of work. This work will be developed at a later date. We hope you will be able to comment on this work when it is undertaken.
Northamptonshire Healthcare NHS Foundation Trust	4.1.2	5	Groups that will not be covered **This is a serious error as the young and adult in disadvantaged groups (residential care is included in this section) have the most to benefit from oral**	Thank you for your comment, however, we disagree. Disadvantaged groups living in the

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			health promotion and prevention as not only will oral health improve but this will have an impact on general health, well-being and self-esteem.	community are covered by this piece of work and those in residential care are the subject of a separate piece of work to be conducted at a future date (see section 2b).
Northamptonshire Healthcare NHS Foundation Trust	4.2.1	6	The committee will also take reasonable steps to identify ineffective measures and approaches **Whilst we keep surveying and screening we waste valuable time and financial resources. The factor that improve oral health are already known and proven. We do not need any more surveys when synthetic modelling would give us the answers we seek. The resources should be aimed at delivering targeted interventions to the high risk groups, including the development of social; care workforce, as opposed to more surveys and discussion** **We are making this more complicated than it needs to be** **1. Fluoride (paste/varnish/water)** **2. Diet** **3. Oral hygiene**	Thank you for your comment your concerns are noted. This is the draft scope, which sets out what the guidance will and will not cover. The final scope has been amended and clarified. Recommendations in the final guidance will be based on best available evidence and the considerations of the Public Health Advisory Committee. We hope you will continue to comment on the work as it develops. Further information about the public health guidance development process

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				and methods are described in Methods for development of NICE public health guidance (third edition) (2012) and The NICE public health guidance development process (third edition) (2012).
Nottinghamshire Healthcare NHS Trust	General	0	30.10.12 The Nottinghamshire Oral Health Team have created many exciting resources that compliment the new guidelines. We are happy to share these documents, templates and resources to encourage other areas to maintain the importance of the oral health messages. Please do not hesitate to contact me if you wish to pursue further.	Thank you for your comments and suggestions. We are still in the scoping phase which is a very early stage of guidance development. If there is a call for evidence on these types of resources, and they have been evaluated, we would be pleased to receive them. A call for evidence, if required, will be made on the NICE website as the work progresses.
Nottinghamshire Healthcare NHS Trust	General	1	Should the word 'dental' be replaced with 'Oral' as the document is titled "Oral" and the word oral covers all the mouth rather than just dentition. Also link to the World Health Organisation definition of oral health.	Thank you for your comment on the draft scope, we agree and

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				have amended the final document.
Nottinghamshire Healthcare NHS Trust	3 c,d,e	Page 3	Should a sentence be added regarding local data? This would encourage local areas to find out their regional scores and compare to national information.	Thank you for your comment. This document is the draft scope and broadly sets out what the final guidance will and will not cover. The final guidance may make specific reference to local data as the issues around local authority oral health needs assessments will be examined as guidance develops.
Nottinghamshire Healthcare NHS Trust	4.1.1	Page 5	Does this refer to national vulnerable groups as locally our vulnerable groups differ? We cover young children; young people (5 – 18years as the dmft/DMFT scores show poor scores) plus special school children are not named but are extremely vulnerable.	Thank you for your comment. This document is the draft scope and sets out, broadly what the final guidance will and will not cover. The final guidance, when it is developed, is intended to be applied to meet local needs. It will be up to each local area to apply the

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				recommendations as suits local needs.
Nottinghamshire Healthcare NHS Trust	4.2.1	Page 6	Are templates, samples, examples of good practice and contacts going to be included?	Thank you for your comment. If activities have been evaluated, demonstrated effective and are available in the public domain, it would be possible for the public health advisory committee to consider them as evidence to inform national guidance. There may be a call for evidence where this type of information may be required, it is not clear yet. A notification will appear on the website if this is the case and the type of information required will be clarified. The difficulty is sometimes in extrapolating from high quality local practice to national level guidance. It may be of interest to look at our methods and processes manuals to see how guidance is

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				developed. The public health guidance development process and methods are described in Methods for development of NICE public health guidance (third edition) (2012) and The NICE public health guidance development process (third edition) (2012).
Nottinghamshire Healthcare NHS Trust	4.2.1 E	Page 6	National campaign on "Spit do not rinse" is this being adopted nationally?	Thank you for your comment. This is not a question we can answer, we would suggest you contact the Department of Health who may have more information.
Nottinghamshire Healthcare NHS Trust	4 Question 1	Page 7	To increase knowledge to change behaviour. Increase knowledge to ensure a better quality choice. Increase access to resources and dental access. Reduce costs to increase access.	Thank you for your helpful suggestions. The scope sets out broadly what the guidance will and will not cover. These issues would be covered in the reviews of the evidence.
Nottinghamshire Healthcare NHS Trust	4 Question 2	Page 7	Epidemiology surveys. Dental Access data/Surveys Health Needs Assessments	Thank you for your helpful suggestions. The final document has been clarified and

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				revised appropriately. These issues would be included in the evidence reviews.
Nottinghamshire Healthcare NHS Trust	4 Question 3	Page 7	Increasing Knowledge Promoting Dental Access Evidence Based Activities Promote Fluoridated water.	Thank you for your helpful suggestions. The final document has been clarified and revised appropriately. Some of these activities would be covered in the evidence reviews, however this guidance work is not covering water fluoridation.
RCGP	General	0	The way in which dentists are paid in the UK , i.e. item for service provides a perverse incentive to treat rather than to prevent dental disease. A capitation system, at least for vulnerable groups so that time spent with the dental team was acknowledged and where advice on diet, oral hygiene, use of fluoride by pregnant women and children to the age of twelve could be provided should be trialled. The dental team would provide an annual report on the dental health of each patient, the activities and treatments offered, accepted and accomplished. There would be the opportunity to develop the epidemiology data base and to review progress against different dental strategies.	Thank you for your comment. This is the scope which broadly sets out what the guidance will and will not cover. Your suggestion is noted and should any evidence of the effectiveness of this activity relevant to the scope of work, it would be reviewed and considered by the public health advisory committee during guidance development.

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				Recommendations to address gaps in research are included in the final guidance. We hope you will continue to comment on the work as it develops.
RCGP	General	0	Refined carbohydrates, sweet eating, are critical in providing a cariogenic environment in the dental plaque. Controlled sugar use is possible and desirable on other health grounds e.g. obesity There is work to be done with manufacturers and advertisers. Simple measures like chewing gum to increase salivary flow, to try to contain sweet eating to the immediate post meal period	Thank you for your comment. The final content of the guidance will be based on the best available evidence and the consideration of the committee.
RCGP	General	0	In the 1960's Dental auxiliaries were trained to provide a dental service for children. They were effective and cost efficient. Unfortunately their role in dental treatment was abandoned. It is reasonable, given the problems of demand and supply for dental care and the real problems of providing NHS care for all for a similar option to be reconsidered	Thank you for your comment. If evidence of the efficacy of these activities emerges during guidance development they will be considered by the public health advisory committee.
Royal College of Nursing	General	0 General	The Royal College of Nursing welcomes proposals to develop this public health guidance. It is timely.	Thank you for taking the time to read and comment on the draft scope.
Royal College of Nursing	General	0 General	There is still a "fear" of dental care often passed down through the generations, sometimes rational and sometimes not. If the children are to be reached and dental care improved, parents need reassurance and support too.	Thank you for your comment. Your concerns are noted. Fearful avoidance of

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			Continuity of care and the chance to build a rapport with the dentist is important if trust is to be gained.	dental treatments is to be covered in a separate piece of work. Please see section 2b of the final scope document. We hope you will comment on this work when it commences.
Royal College of Nursing	4 Question 1	7	Many NHS dental facilities have been lost to communities, especially in rural areas where Gypsy families are located. To improve and maintain dental health and to be effective and cost-effective these services need to be reinstated.	Thank you for your comment. However, directives to reinstate of services are outside the terms of reference of the Institute.
Royal College of Nursing	4 Question 2	7	Dental health needs cannot and should not be viewed in isolation. A holistic approach needs to be taken for hard to reach groups or vulnerable children. We already know how difficult it is to include such children in immunisation programmes so a more unified approach is necessary.	Thank you for your comment. Your concern is noted and the committee will take into consideration the needs of vulnerable groups within the remit of the scope of work.
Royal College of Nursing	4 Question 3	7	Use the Primary Care, Social Care and schools systems where possible. Obstetric care too can be used as a platform to reach parents. These are best placed to identify the issues and offer support.	Thank you for your comment and your helpful suggestions are noted. The document you have commented upon is the draft scope which sets out what the guidance will and will not

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				cover and informs the final scope. Should the evidence indicate that these settings are an effective and cost effective platform, they will be considered by the committee for specific mention in guidance recommendations.
Sheffield Health and Social Care Trust	4.2.1		Effective use of behavioural interventions to improve anxious patients access to oral health care.(Not health promotion).	Thank you for your comment. This topic is the subject of a separate piece of work to be conducted at a future date. We hope you will comment on this future work.
Sheffield Health and Social Care Trust	4.1.1	5	Those patients who suffer with severe anxiety and phobia appear to a group excluded. They are a significant number whose oral health is directly affected by their inability to manage their fears and anxieties. They have been in the past identified by the Department of Health as a group at risk (DOH 2000 A Conscious Decision), whose present treatment/management either leads to avoidance or the use of sedation with its accompanied health risks as identified by the DOH 2000.	Thank you for your comment and for taking the time to read and comment on the draft scope. This group is the subject of a separate piece of work to be conducted at a future date (see section 2b). We hope you will comment on this future work.
Sheffield Teaching Hospitals	4.1.1	5	Need to emphasise that within the scope of clients covered 'those with a mental health	Thank you for your

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NHS Foundation Trust			diagnosis' should include those with diagnosis of memory loss/ early diagnosis of Alzheimer's disease. It is much easier to try and ensure such people are dentally fit while they still live in community and can accept dental care, than when their condition is so severe they are in residential care.	comment. Your concerns are noted. The scope of work broadly sets out what the guidance will and will not cover. These groups would not be excluded from the guidance. Lists of examples are not intended to be exhaustive.
UK National Screening Committee	4.2.1		This in combination means that you will in effect be screening a demographic group. The UKNSC not that long ago stopped screening all children for decay focussing instead on prevention. So you could either take that section out and focus on preventative activities etc or refer the question of identifying disease for the purpose of treatment to the UKNSC.	Thank you for your comment on the draft scope and for pointing this out, we have clarified and amended the final version where appropriate.
UK National Screening Committee	4.1.1	5	I see that you are intending to use children under 5 as an at risk group for the purposes of ……	Thank you. Please see previous comment.
UK National Screening Committee	4.2.1	6	Identifying, treating and offering care	Thank you, noted. Please see previous comment.

[i] Fair society: healthy lives. The Marmot Review. Published by the Marmot Review 2010.