NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC HEALTH GUIDANCE

SCOPE

1 Guidance title

Oral health: local authority strategies to improve oral health particularly among vulnerable groups

1.1 Short title

Oral health: local authority oral health improvement strategies

2 Background

a) The National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health (DH) to develop public health guidance for local authorities on oral health needs assessments and community oral health promotion programmes, in particular, for vulnerable groups at risk of poor oral health.

b) The DH has also asked NICE to produce 2 additional pieces of NICE guidance on oral health:

- Guidance for dental health practitioners on effective approaches to promoting positive oral health behaviour, including a positive patient experience of attendance at the dentist and reducing any anxiety among ‘dental phobics’.

- Guidance for carers working in health and social residential care settings (including nursing homes, residential care homes) on effective approaches to promoting oral health, preventing dental health problems and ensuring access to dental treatment when required.

c) The World Health Organization (2013) defines oral health as being free from diseases and disorders that affect the oral cavity. This includes: chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss.

d) This guidance will support a number of related policy documents including:

- 'Delivering better oral health: An evidence based toolkit for prevention' (DH 2009)
- 'Dental quality and outcomes framework' (DH 2011)
- 'Healthy lives, healthy people: our strategy for public health in England' (DH 2010a)
- 'Healthy lives, healthy people: transparency in outcomes, proposals for a public health outcomes framework' (DH 2010b)
- 'Improving oral health and dental outcomes: developing the dental public health workforce in England' (DH 2010c)
- 'The NHS outcomes framework' (DH 2010d)
- 'Valuing people's oral health. A good practice guide for improving the oral health of disabled children and adults' (DH 2007).

e) This guidance is aimed at local health and wellbeing boards, directors of public health, consultants in dental public health and commissioners in local authorities and the NHS. It will also be of interest to dentists, other dental care professionals, nutritionists, social care professionals and others with a responsibility for promoting oral health. In addition, it may be of interest to members of the public.

f) The guidance will complement NICE guidance on dental recall. For further details see section 6.

This guidance will be developed using the NICE public health guidance process and methods guides.

3 The need for guidance

a) Oral health is important to general health and wellbeing. Poor oral and dental health can affect someone’s ability to eat, speak and socialise normally (DH 2011). In addition, oral diseases are associated with coronary heart disease (Humphrey et al. 2008; Mathews 2008); diabetes complications (Grossi and Genco1998; Stewart et al. 2001; Taylor 2001); rheumatoid arthritis (Ortiz et al. 2009); and adverse pregnancy outcomes (Xiong et al. 2006). Tooth decay (dental caries) and gum disease (periodontal disease) are the most common dental problems in the UK. They can be painful, expensive to treat and can seriously damage health if left unchecked (DH 2011). However, they are largely preventable (Levine and Stillman-Lowe 2009).

b) Risk factors for poor oral health include: diet, tobacco and alcohol consumption, trauma and stress (Sheiham and Watt 2000). Risk factors for severe dental caries include: living in a deprived area; being from a lower socioeconomic group or living with a family in receipt of income support; belonging to a family of Asian origin; or living with a Muslim family where the mother speaks little English (Rayner et al. 2003). Other risk factors include substance misuse or having a chronic medical condition (DH 2007).

c) Overall, oral health in England has improved significantly over recent decades. However, marked inequalities persist. The ‘Adult dental health survey 2009’ reports that the proportion of adults in England without natural teeth has fallen over the last 30 years from 28% to 6% (The Health and Social Care Information Centre 2011). However, the survey also shows a clear socioeconomic gradient. For example, people from managerial and professional occupation households have better oral health (91%) when compared to people from routine and manual occupation households (79%).

d) The NHS dental epidemiology programme for England oral health survey of children aged 12 shows that levels of dental disease among this group are decreasing, in line with previous survey years[1]. Data collected between 2008 and 2009 show 66.6% of them were free from visually obvious dental decay. However, 33.4% reported having dental caries (with 1 or more teeth severely decayed, extracted or filled). The same survey reports a higher prevalence and severity of oral disease among those living in the north, compared with those in the midlands and south west. Specifically, it was higher in the areas covered by strategic health authorities in Yorkshire and the Humber, the North West and North East. The lowest levels of disease were reported in the south and east (North West Public Health Observatory 2010).

e) The NHS dental epidemiology programme for England oral health survey of children aged 5 years indicates wide variations in dental health across the general population. A significant number of children (69.1%) are free from obvious dental decay, with only 30.9% having at least 1 decayed, missing or filled tooth. However, at primary care trust-level, the prevalence of dental caries ranges from 17.7% for the East Riding of Yorkshire to 53.4% for Middlesbrough Primary Care Trust (North West Public Health Observatory 2009).

f) From April 2013, oral health needs assessments will inform joint strategic needs assessments. NHS England (previously the NHS Commissioning Board) will '…work with local authorities and Public Health England to develop and deliver oral health improvement strategies and commissioning plans specific to the needs of local populations' (NHS Commissioning Board 2012). Local authorities will be responsible for commissioning surveys of dental health, dental screening and improving the oral health of their populations.

[1] From May 2006, data has only been collected on children if written information and consent has been provided. Previously, consent was assumed if a letter was sent to the parents or guardians and no objection was received. These consent arrangements suggest a bias towards participation of those who are less likely to have tooth decay (Davies et al 2011).

4 The guidance

Public health guidance will be developed according to NICE processes and methods. For details see section 5.

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

4.1 Who is the focus?

4.1.1 Groups that will be covered

The local population, but with a particular focus on those whose social circumstances or lifestyle place them at greater risk of poor oral health or make it difficult for them to access dental services. For example, this may include:

- children aged 5 and under
- people on a low income
- older people
- people who are homeless or who frequently change the location where they live (for example, traveller communities)
- people from some black and minority ethnic groups (for example, those of South Asian origin)
- people who chew tobacco
- people with mobility difficulties or a learning disability and who live independently in the community.

4.1.2 Groups that will not be covered

Children, young people and adults living in residential care.

4.2 Activities

4.2.1 Activities that will be covered

The guidance will focus on the following activities:

a) Approaches to conducting oral health needs assessments.

b) Community-based oral health promotion programmes and interventions that aim to:

- Increase access to fluoride. For example, by providing children with free fluoride toothpaste, providing fluoridated milk and fluoride drops in schools, or by dental nurses offering fluoride varnish applications in schools.
- Improve oral hygiene. For example, by offering supervised tooth brushing with fluoride toothpaste at childcare sites and schools, or running information and education campaigns about tooth-brushing.
- Improve diet. For example, by providing support to adopt a healthy diet or by offering nutritious food and drink in schools and workplaces.
- Increase access to dentists. For example through better coordination of dental health services with community health initiatives.

c) Monitoring and evaluation of community-based programmes and interventions.

The committee will also take reasonable steps to identify ineffective activities.

4.2.2 Activities that will not be covered

a) Water fluoridation.

b) Preventive information, advice and treatment provided by dental health practitioners to their patients.

c) Oral health promotion and access to dental treatment in residential or care settings (including nursing and residential care homes for children, young people and adults).

4.3 Key questions and outcomes

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

Question 1: What are the most effective and cost-effective programmes and interventions to promote, improve and maintain the oral health of a local community? In particular, what are the most effective and cost-effective approaches for groups of people who are disadvantaged and at high risk of poor oral health?

Question 2: What methods and sources of information will help local authorities identify the oral health needs and severity of oral health problems in their local community?

Expected outcomes include:

- Changes in oral health. For example, changes in the incidence and prevalence of oral cancers, dental caries and periodontal disease.
- Changes in modifiable risk factors, including the use of fluoride supplements, oral hygiene practices and frequency of visits to the dentist.

4.4 Status of this document

This is the final scope, incorporating comments from a 4-week consultation.

5 Further information

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).

6 Related NICE guidance

Published

Dental recall. NICE clinical guideline 19 (2004)

Under development

Oral health – the patient experience (publication date to be advised)

Oral health – in nursing and residential care (publication date to be advised)

Appendix A Referral from the Department of Health

The Department of Health asked NICE to:

'Develop public health guidance for local authorities on needs assessment and commissioning of community dental health programmes to promote the oral health of their communities, particularly vulnerable groups at risk of poor dental health. Epidemiological surveys would contribute to needs assessment'.

Appendix B Potential considerations

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

- The role of people and organisations in developing oral health needs assessments
- The activities needed to ensure local oral health needs are identified, especially the needs of vulnerable groups at risk of poor oral health.
- Whether activities or approaches are based on an underlying theory or conceptual model.
- Whether activities or approaches are effective and cost effective and represent good value for money.
- Critical elements. For example, whether effectiveness and cost effectiveness varies according to the diversity of the population (for example, in terms of the person's age, gender or ethnicity).
- Any trade-offs between equity and efficiency.
- Any factors that prevent – or support – effective implementation.
- Any adverse or unintended effects.
- Current practice.
- Availability and accessibility for different groups.

Appendix C References

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