Final report

Field testing NICE guideline on Oral health: local authority oral health improvement strategies

Report to: National Institute for Health and Care Excellence

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1 Executive summary

The Centre for Public Health at the National Institute for Health and Care Excellence (NICE) commissioned fieldwork to test the draft recommendations on 'Oral health: local authority oral health improvement strategies'.

The overall aim of the fieldwork was to capture participants' views of the guidance in terms of how clear, relevant and implementable they considered the recommendations.

The fieldwork was conducted among a wide range of people who hold professional roles that are identified in the draft guidance. These include oral and dental health experts, public health specialists, frontline health and social care professionals, teachers, school governors and representatives of agencies that support people whose social circumstances make them especially vulnerable to poor oral health.

The fieldwork involved ten group discussions of between 11-15 participants in London, Birmingham, Manchester and York, together with a number of individual interviews. Fieldwork was conducted in April 2014.

Key messages from the fieldwork

Key message 1 The guidance was widely welcomed as it was felt likely to focus attention and resources on an important area of public health that may be threatened by new requirements on local authorities to plan and deliver public health

The guidance was welcomed by all participants. There was widespread agreement that it would serve to raise the profile of an important area of public health. While many of the oral health promoting activities identified in the guidance were considered to be a bringing together of what was described as standard practice, there was also awareness that implementation of these actions was variable between geographical areas. The guidance was considered likely to help to make what should be standard practice more regular.

The timing of the guidance was also welcomed. It was seen as an opportunity for local authorities – many of which were felt to be struggling with the new responsibilities to plan and deliver public health set out in the Health and Social Care Act 2012 – to develop effective oral health promotion strategies and delivery plans. While participants offered suggestions for improving individual recommendations, the guidance was commended by most participants as being thorough and comprehensive, and advocating evidence based approaches. Participants also welcomed the stated intention to focus on the needs of the most socially disadvantaged. While most participants who described the guidance as 'comprehensive' did not explain what they meant by that term meant as regards how the guidance may be implemented, some participants explained that their interpretation of the comprehensiveness of the guidance meant that they would be able to 'pick and mix' from the document, as opposed to following it as an instruction manual. This may be of relevance to NICE in terms of how it intends the guidance to be implemented.

Key message 2 Concerns about the scope of the recommendations being individual based and 'one off' - over actions that may impact wider societal determinants, education and skills development

While many participants described the guidance as comprehensive, some were disappointed by what they felt was the limited scope and ambition of the recommendations. The main areas of disappointment concerned the following:

- A narrow focus on individual based interventions over actions that would impact broader social determinants of oral health
- The fact that most of the recommendations were felt unlikely to make a significant difference because most were described as already being standard practice in the majority of areas
- Some participants had expected the guidance would have included more innovative interventions based on recent large scale oral health programmes including Smile4Life in regions of England and Childsmile in Scotland and Designed to Smile in Wales

While most participants supported the inclusion of supervised tooth brushing schemes and fluoride varnish programmes for identified groups because they were aware that these were evidence based approaches that had shown positive oral health outcomes, some also expressed a concern that the emphasis in the guidance on such interventions had the potential to conflict with - and potentially to undermine - an important public health message, of encouraging self-reliance and of developing necessary skills and habits in relation to oral health. Fluoride varnish programmes were identified as having the potential to disempower the individual from learning to take responsibility for their oral health, thanks to the 'magic varnish' that would protect their teeth. Supervised tooth brushing schemes were similarly identified as potentially disempowering, because they were considered likely to teach the child and its parent(s) that their oral health needs would be taken care of by the school or other provider of the scheme, so undermining the notion of autonomy and self-reliance.

Key message 3 The needs of adults at higher risk of poor oral health were not addressed adequately

Participants welcomed the life course approach in the guidance and felt that – with the possible exception of neo-nates and very young infants - the needs of children had been carefully considered. However, when they reflected on the recommendations for adults – and particularly the needs of those at greater risk of poor oral health, including the groups mentioned in the preamble - participants felt that the guidance failed to consider these groups' needs in a similarly thorough way as the sections that related to children.

Beyond the good intentions identified in the preamble, participants felt that the guidance had little to say on social inequalities in oral health among adults. Those participants who work with vulnerable adults were disappointed not to see clear identification of groups and settings for action and targeting of recommendations in the guidance in the way that children's needs were considered. They felt that there were many missed opportunities to make this document 'speak to' key decision makers and practitioners who have the potential to make an important contribution to improving the oral health of large numbers of vulnerable adults. Participants wanted to know whether some important groups' needs would be covered by the guidance (including prisoners,

recently released prisoners, asylum seekers) because they found the guidance did not address them directly.

And while participants noted a goal of the guidance was to increase access to dental services, many identified a lack of attention within the guidance to improving access to NHS General Dental Practitioners among socially disadvantaged adults. This was felt to be a critical concern particularly among Healthwatch representatives - who identified access to NHS dental services as the top enquiry received by Healthwatch - and representatives of marginalised groups.

Key message 4 Training of frontline staff to deliver many of the recommendations not given sufficient priority

A major concern among all participants was the presumption in the guidance that frontline staff across a wide range of settings and sectors would be willing, able and ready to implement many of the recommendations. Participants asked continually, 'who will do this?', 'who is going to implement this?' Typically, participants felt that the goals of individual recommendations were good, but felt that they lacked any realistic hope of being implemented because of a lack of appropriately trained staff to deliver them. They felt that the guidance did not acknowledge this deficit nor the challenges involved in ensuring training across such a broad sweep of professional roles.

Where training requirements were identified in recommendations, they were understood as being of relatively low priority (because they were often put as the last bullet point) and insufficiently demanding to ensure they would be implemented. Most participants doubted the feasibility of wholesale training of staff in frontline services across different sectors in the way envisaged in the guidance. In part this was due to a concern that the main providers of oral health training – the community dentistry services – have in many areas been disbanded as a result of policy changes, and *no alternative has taken their place. Moreover, there was a concern that the guidance failed to provide information about how oral health promotion training might take place. Instead, some suggested alternatives that rely on dedicated public health staff providing periodic education in* relevant settings on oral health.

Key message 5 Aspects of the guidance were felt not to reflect the 'real world' arrangements of local authority planning and delivery of oral health promotion and this was felt likely to impede implementation

Participants felt that the guidance lacked an appreciation of how local authorities operate currently, and that this disconnect represented a barrier to implementation of the guidance. Key areas of concern related to the following:

- an assumption in the guidance that local authorities can/should easily include oral health within their health and wellbeing strategies
- local authorities' ability to access oral health expertise –including relationships with NHS England and Public Health England
- the contractual relationship between local authorities and oral health promotion practitioners
- the assumption that local authorities can rely on partner agencies (in health and education) to deliver oral health promotion at a time when all such agencies are experiencing high demand for services and a lack of resources.

An important consideration was the fact that many local authorities' planning and delivery processes cover 'clusters' of authorities, as opposed to every local authority acting autonomously. Related to this, participants questioned whether aspects of the guidance (planning, needs assessments, action planning) would better be directed at a regional or sub regional level. There were also some aspects of the guidance where participants felt the 'leverage' for change would be better directed at national agencies (for instance, making oral health outcomes a criterion for assessment by Ofsted).

Key message 6 Readability: the guidance was described as lacking impact, being difficult to navigate, repetitive in places and lacking directional information about how to implement recommendations. Some key terms and concepts were unclear

Several participants found the guidance difficult to navigate, repetitive in places and lacking a strong 'case making' statement at the beginning of the document that would encourage the intended audiences to take it seriously, including information on the relationship between oral health and general health and wellbeing and the common risk factor approach. There was also a concern that the document lacked clear guidance on how to ensure the recommendations would be implemented.

There were some specific issues over terminology that caused confusion:

- the use of the term 'low in sugar' alongside 'sugar-free' angered many participants. It was unclear whether this was intentional or an editing oversight, but the inclusion of the term, 'low in sugar' was widely criticised as inappropriate by oral health professionals.
- 'Higher risk' and 'very high risk': several recommendations include these terms without any contextual information about how to interpret their meaning. As a result, many participants were confused, and felt that NICE should make explicit its intention over how these terms should be understood.
- Hierarchies of interventions: some recommendations (especially those that relate to supervised tooth brushing schemes and fluoride varnish programmes) were understood to indicate some sense of hierarchy. The assumption was that there may be some differential evidence relating to the effectiveness and cost effectiveness of different interventions. Related to this, there was an assumption by participants of a gradient of what should be done in which situations. However, participants were unclear whether there WAS an intention to imply a hierarchy and if there was, on what grounds this was based. Many participants were uncomfortable with the idea of prioritising one form of intervention over the other. For these specific recommendations, there was a call for information to be included on effectiveness and cost effectiveness in an easy to read form.

2 Introduction

2.1 Background and scope

The Centre for Public Health at the National Institute for Health and Care Excellence (NICE) was asked by the Department of Health to develop guidelines for local authorities on oral health needs assessments and community oral health promotion programmes.

2.2 Overview and purpose of field testing

Word of Mouth Research was commissioned by the Centre for Public Health at NICE to field test the draft guidance.

The purpose of this fieldwork was to test the relevance, use, acceptability and ease of implementation of the draft recommendations among a broad range of professionals who have responsibility for commissioning and providing oral health needs assessments, commissioning and providing community oral health promotion programmes and professionals who represent the needs and interests of those who are at greater risk of poor oral health.

In this study, feedback was gathered from 132 relevant professionals working in England. To do so, participants were asked questions about the clarity, relevance, use, acceptability and ease of implementation of the recommendations on local authority oral health improvement strategies (see topic guide Appendix 1).

The views contained in this report and the conclusions derived from them are based entirely on the views expressed by the participants to whom we spoke. Word of Mouth Research would like to thank all the participants who committed their valuable time in order to give their feedback during this study.

3 Methodology

This section describes the aims and methodology used to carry out the fieldwork and analysis, including the fieldwork aims and objectives, recruitment strategies employed, and a description of the resulting sample. The data analysis techniques employed are also described in this section.

3.1 Aims and objectives of the fieldwork

The overall aim of the fieldwork was to capture participants' views on the recommendations in terms of how relevant, usable, acceptable, and implementable they thought they were.

Seven specific questions were set by NICE:

a. What are the views of those who have responsibility for commissioning and providing oral health needs assessments?

b. What are the views of those who commission, develop, manage and deliver community oral health promotion services?

c. What factors could either help or hinder the effective implementation and delivery of the recommendations, as part of current or future practice?

d. What are the potential consequences of the recommendations for improving oral health and tackling oral health inequalities?

e. What is the potential impact of the recommendations on current policy, service provision or practice?

f. Are the recommendations feasible and likely to make a difference to practice?

g. What would be the relative priority of each of the recommendations?

3.2 Sampling approach and achieved sample

Selection of regions and cities

The guidance applies to a wide range of policy makers, planners, commissioners and practitioners across England. A sampling framework was developed in order to give a robust picture of how diverse professionals, working in different settings responded to the draft guidance and recommendations developed by NICE. The framework was developed to include local authority areas that reflected:

- A geographical spread across the country
- Different sizes and types of areas in terms of demographics and physical characteristics
- Good balance between urban and rural areas
- A range of oral health disadvantage (using the Public Health Outcomes Framework Data Tool – indicator 'tooth decay in children aged 5').

The group discussions were held in early April 2014 in four locations:

- London (3 groups), Birmingham (2 groups), Manchester (3 groups) and York (2 groups)

3.3 Recruitment methods

A range of methods were used to contact and secure the involvement of the professionals in each of the four areas:

- An invitation to register interest in participating in the fieldwork was sent via the National Oral Health Promotion Group's emailed newsletter to all of its members (Appendix 2)
- Consultants in Dental Public Health, Commissioners based in NHS England and Directors of Public Health in a range of local authorities, Oral Health Promotion Leads as well as Chairs of Health and Wellbeing Boards were contacted by telephone and email, requesting assistance in identifying and recruiting other identified roles in each of the four geographical localities, taking account of the need to ensure representation from a range of types of area based on social deprivation indices
- Following a reply from interested parties, email and/or telephone contact was made with the relevant individuals, with details of job role and area recorded, to place participants into the appropriate groups
- Individuals who registered interest in participating were then sent a formal invitation and asked to reply to confirm attendance
- A reminder email with information about the time, date and venue along with a hyperlink to the draft guideline was sent to professionals ahead of the event.
- Paper copies of the draft recommendations were also provided at each of the discussion groups.
- Consent to note-taking was gained from professionals at the beginning of each discussion group as part of the sign-up process.

Overall we achieved a total sample of 132 participants, which was made up of 117 focus group participants, and 15 one to one telephone or face-to-face interviews.

AREA		**Participants**
London 4 April	3 Groups - 35 people	29
Birmingham 8 April	2 Groups - 27 People	26
Manchester 9 April	3 Groups - 37 people	37
York 10 April	2 Groups - 25 people	25
In depth Interviews	15 in depth interviews	15
TOTAL	10 groups and 15 depths	**132**

These participants came from the following professional groups and settings.

PROFESSIONAL GROUP OR SETTING	Focus Group	In depth	Total
Consultants in dental public health	13		13
NHS England commissioner of local dental services	8		8
Local authority public health representative (Directors of public health/ Medical director/ Oral health lead/manager/Head of Oral Health)	14		14
Representative from a local professional dental network	4	2	6
Representative from children's and adult social care services	4	2	6
Senior local government representative to lead on and act as advocate for oral health (Health and Wellbeing Board member or relevant officer)	6		6
Oral health promotion manager/senior staff member	15		15
Community dentistry services manager/senior staff member	8	1	9
Frontline staff working in early years services (including health visitors, school nurses, midwives, family nurse practitioners, early years services, children's centres and nurseries)	13		13
Local education authority representative, school governors, senior teaching staff	6	2	8
Frontline staff working in relevant primary care services: e.g. .NHS Stop smoking services, alcohol services, dieticians etc.	11		11
Representative from local Healthwatch	4	1	5
Third sector: homeless and rough sleepers organisations, primary care outreach teams (e.g. Crisis, London Street Outreach), mobile outreach services, substance abuse services	7	5	12
Regional leads, local authority public health analysts/information analysts, local authority health and wellbeing board and scrutiny board members	4	2	6
Total	**117**	**15**	**132**

NICE guidance on undertaking fieldwork was followed throughout the data collection stage.

- We undertook 3 groups in Manchester, 3 groups in London, 2 groups in York and 2 groups in Birmingham with key professional groups identified by NICE as relevant to the guidance
- We gave participants information in advance of the discussion groups about the draft recommendations and the structure of the consultations
- We ensured that each discussion group was led by an experienced facilitator
- We audio-recorded all group discussion and transcribed the recordings verbatim following the groups

Discussion groups (timed to take 2 ½ hours) were structured in line with NICE guidance http://www.nice.org.uk/guidelinesmanual

The discussion group template can be seen at Appendix 1.

3.4 Research methods

All focus groups and in depth interviews were moderated by experienced researchers. By way of introduction researchers set out the 'ground rules' for the research – namely that in order for the research to be of value to NICE, we would seek to elicit views and opinions from a wide range of practitioners, all of whom have an interest in the guidance, and that we wanted to hear alternate and conflicting views – if and where these existed.

Ensuring that participants have read the text of recommendations

Our experience of conducting fieldwork for NICE on other public health topics – and of conducting similar studies for other organisations – is that no matter how much advance preparation is done (for example sending the draft recommendations to participants ahead of the discussion groups, or providing time in the groups for participants to refresh their memories), some participants will fail to read the recommendations ahead of the discussion group or interview.

To ensure that every respondent is familiar with the content of the recommendations, and is not disadvantaged by not having read them in advance – or not recalling the detail, the moderator reads through each recommendation or gives the respondents the opportunity to read through each recommendation before discussing each in detail.

The moderator then proceeds to work through the topic guidance prompts for each recommendation (see appendix 1)

During the group discussions the moderator challenges opinions, and invites participants with different professional experience to agree or challenge others' views and the moderator teases out nuances of interpretation and understanding that may have relevance to individual recommendations and to the guidance overall.

Within the group and individual interviews the moderator summarises the debate/discussion on each recommendation and seeks confirmation from respondent(s) on what appear to be areas of consensus or points of contention.

3.5 The in-depth interviews

The ten focus group interviews were supplemented by 15 in-depth interviews. The selection strategy was based on two factors;

a) In the final focus group sample we achieved more than sufficient representation from all the professional categories. However, if prior to the group discussion it was clear that certain professional groups were under-represented we would seek to secure an in-depth interviewer, usually by telephone, with members of that professional group. For example, at the sampling stage it was difficult to secure sufficient numbers of people working in the third sector, e.g. people working with the people who are homeless, who are rough sleepers, and people who work with adults and children with learning difficulties. We addressed this shortfall by recruiting five more people from the third sector to take part in an in-depth interview.

b) Another factor that warranted an in-depth interview was if a respondent could not attend the focus group offered in their area. Initially they were offered the possibility of attending another focus in a different area. If they were unable to attend any of the focus groups but were still keen to make a contribution we offered an in-depth interview.

The choice of recommendations to discuss in the interviews

Within each in depth interview we had 30-60 minutes, depending on the time offered by the respondent. The choice of recommendations for each interview was dictated by the population group they primarily served. For example, for a third sector respondent dealing with adults, the majority of the interview would explore the recommendations directed at adults - i.e. sections 6 to start with - and then move on to sections 1 and 2. If the respondents worked with disadvantaged children we would focus on the children's recommendations first and if time permitted cover other recommendations.

3.6 Analysis

Each focus group discussion was moderated by the authors (AC, DM and LW). RC attended one group (London) as an observer. NICE staff members attended two groups (London and Manchester) as observers. Both group discussions and telephone interviews were audio-recorded and written up soon after completion. Write ups for focus groups and interviews were structured by the individual recommendations, supported by stakeholder quotes, and themed according to the fieldwork aims and objectives, (see Section 2.1).

Once all the focus groups and interviews were completed, analysis took place using a content analysis approach. Using the fieldwork's key aim and objectives, the researchers identified core themes emerging from the data, defining concepts, providing explanations and finding associations and key differences between the views of different groups of participants.

The analysis process is based on the Framework analysis method developed by the National Centre for Social Research (Natcen). It involves a series of key steps and a constant critical and reflexive approach to identify relevant themes and explanations for observations. The steps include:

- Familiarisation with the data: from each recording a description and summary of salient themes is produced and descriptive quotes are identified for potential inclusion in the report.
- Listing of themes: once all interviews have been summarised, a list of emerging themes is compiled
- Construction of the analytical grid: a matrix is constructed from the themes identified, to enable cross referencing (or mapping) of substantive points with explanatory variables
- The grid is populated with data
- Analysis of the grid: the connections between substantive themes and explanatory variables become apparent, and issues are sifted and prioritised by importance/salience from the large volume of data on the grid

Regular briefing and debriefing sessions took place throughout the analysis process to agree themes and ensure that analysis was carried out in a robust manner.

3.7 Reporting style and terminology

The use of terms "most/majority"

In the group setting opinions are initially expressed by one or two people within the group and these views are either endorsed immediately by the majority of the group or a discussion ensues and usually the majority endorse the point or a variation of it. This will be reported as *"most participants believed ..*" or a *"majority of participants thought...."*. Where we state that *"participants believed .."* this should be understood to mean that a "majority" or "most" participants held the reported view.

Where findings are reported they should be interpreted as the majority view unless the text states otherwise.

"Some /several/minority"

Occasionally we report minority views which were not expressed or endorsed by the majority but which were strongly felt by a *substantial* minority and resulted in a valuable discussion or observation worthy of inclusion in the report. This is usually stated in the report as "*some respondents believed ..."* or *"several respondents thought*...."

Differences between professional groups

When stating *"most participants said ...."* or *"several participants stated...."* this means that the view was expressed across most professional groups and that there was no discernible professional difference in the response.

Where there were important differences in response between professional groups these have been stated in the text.

4 Feedback on the guidance overall

4.1 The guidance was welcomed by all participants

Important and timely

All participants welcomed the guidance because it was felt likely to focus attention on an important area of public health.

The timing of the guidance was also welcomed. Many participants reported that the transition of responsibilities for public health from the NHS to local authorities, as set out in the Health and Social Care Act 2012, had led to challenges for the prioritisation of oral health, and that this guidance would serve to help those seeking to advocate for oral health promotion within local authorities.

> 'I thought it was really positive – local authorities have been handed the baton and this is helpful in telling them what to do.' *Public Health Specialist, Birmingham*

> 'The first problem is engaging with local authorities to get them to accept their responsibilities in this area… Some of them are focused on the 3 or 4 key national priorities and don't see oral health as a priority – others are very good – but you need resources, funding and people – and trying to get these resources out of local authorities at a time like this is challenging.' *Consultant in Dental Public Health, London*

> 'This will help give us clout when we go to higher people – it all comes down to finance and resources.' *Oral Health Promotion Lead, Manchester*

Comprehensive and evidence based

Most participants' initial response was that the guidance appeared to be thorough, comprehensive and that it urged actions that were supported by a solid evidence base.

> 'From a public health perspective it has all the underlying bases you'd want to see – strategy, needs assessment, using a range of data. Also, it does push the evidence base.' *NHS England Commissioner 1, Birmingham*

> 'Really encouraging – we're a frontline service not in dental health – this is really helpful. Pleased to see it.' *Homeless People's Charity Manager, Birmingham*

Importantly however, the notion of comprehensiveness was understood by some participants to mean that the guidance offered the opportunity to 'pick and mix' from the 'menu', rather than to follow the guidance in a systematic manner.

> 'What is also good is that it's comprehensive – this means that you don't have to do everything – you can do what is appropriate and possible in your area.' *Consultant in Dental Public Health, London*

The life course approach and the focus on socially disadvantaged groups were welcomed

There was appreciation of the structure of the guidance taking a life course approach, beginning with children and young people – and the settings in which they may be reached for oral health promotion – and moving through the age groups to adults.

There was also support for the stated intention of the guidance to address the needs of the most socially disadvantaged and marginalised groups, and for the community based actions identified in the recommendations.

> 'I'm very encouraged that customers that are marginalised in our services are recognised and supported – people who wouldn't have had their oral health needs met.' *Community Dentistry Services Manager, Birmingham*

> 'I like the community focus – it's taking it away from the surgery and into every contact which we know is important, because most people won't get inside a surgery or a hospital.' *Healthwatch Representative, London*

4.2 Overall concerns

While the majority of participants were enthusiastic to see the publication of NICE guidance on this topic, this positive response was mixed with some critical comments.

Individual focused and limited scope, concern about 'one off' interventions, and some 'missing' issues and groups

Some participants – mainly oral health or dental experts and senior professionals, as opposed to frontline staff – felt that the scope of the guidance was more limited than they had expected, and regretted that it did not include a broader range of recommendations. Several participants discussed large regional oral health programmes including Smile4Life in the North West, Child Smile in Scotland and Designed to Smile in Wales as types of programme that they would have expected to have seen referenced.

Most welcomed the inclusion of supervised tooth brushing schemes and fluoride varnish programmes for identified groups. Some questioned what they felt was an over-reliance in the guidance on 'one off' interventions, over the education of skills and habits that would be life-long.

Both fluoride varnish programmes and supervised tooth brushing schemes were discussed as having the potential to undermine individuals' sense of responsibility for their own oral health needs – in the case of the former by giving the message that the 'magic varnish' would permit the child to feel that it was acceptable to drink or eat whatever they like and not take care of their teeth. In the latter case, it was felt that tooth brushing schemes, while ostensibly aimed at teaching lifelong skills, may for some people give the impression that the child's oral health needs are 'taken care of' by the school or providing agency, instead of re-enforcing the message of the importance of children and parents needing to take care of tooth brushing in the home environment.

They also felt that key groups – including parents of young children - were not given sufficient profile in the guidance.

> 'It is narrower than what we expected in terms of what would have been done. And there is a reliance on fluoride varnish programmes – and there is clear evidence in support of this approach. But it is not without risks – not to the individual – but in terms of encouraging beliefs that all is fine because they have got this 'magic' varnish on, and they can eat and drink what they like. And parents don't have to do anything for them because they're being dealt with elsewhere.' *Consultant in Dental Public Health 1, Manchester*

> 'There is a lot in there on supervised tooth brushing schemes but not enough on education for parents – this could take away control and responsibility from parents. There's nothing in there about pre-birth and preparing them for what to expect. That would be best for their own oral health care and the baby.' *Oral Health Promotion Lead, Manchester*

There was a tension between participants' enthusiasm for three key aspects of the guidance whose philosophical roots appeared to be mutually conflicting. These were:

a) 'NICE approved' and evidence based interventions that are 'done to' people – in particular, supervised tooth brushing schemes and fluoride varnish programmes

b) The potential for such interventions to conflict with - and to undermine - important public health goals of developing self-reliance and life-long skills and habits in relation to oral health, because they are likely to shift the 'locus of control' of responsibility for oral health from parents and children to the body/authority that provides these interventions
c) The perception of a conflict between individual based interventions in general - including education about oral health - and an awareness that social inequalities in oral health are unlikely to be addressed by such an approach

Several participants expressed discomfort with the guidance overall, because while they supported the approach of interventions in groups a) and b) above, they felt the claimed ambition of the guidance (to address the oral health needs of socially disadvantaged groups) was unlikely to be achieved without a programme of action that sought to tackle the social determinants of inequalities in oral health.

The needs of adults (and distinct socially disadvantaged groups) are not addressed adequately

Participants appreciated the life-course approach of the guidance but were concerned that while the needs of children appeared to have been clearly identified and this age group carefully segmented by age and setting and risk group, the needs of adults appeared to be almost completely undifferentiated. As a result, it was felt that the guidance would not succeed in its aim of helping to address the needs of those whose circumstances place them at higher risk of poor oral health.

Several participants – especially those working with socially disadvantaged groups - felt that the needs of adults appeared to have been lumped together as single group, while children had been more carefully segmented by age group and setting. Participants felt that if groups of adults were identified in a similar fashion to children, key decision makers and practitioners who work with vulnerable adults would be able to understand where and how the guidance would be of relevance to them and their client groups.

> 'Really, it's about having those trigger words that make you think – 'this is for me'.'
> *Substance Misuse Services Manager, Birmingham*

There was also a strong call for the guidance to be more directive about the need to include oral health outcomes in service specifications and 'contracts let by local authorities' with agencies that work with identified groups. This was felt to be a relatively simple and easy means of focusing attention and ensuring action.

Prisoners, people in custody and recently released prisoners

While participants were aware of the scope of the guidance – and in particular the fact that the guidance does not cover people in residential settings - a small number asked whether the guidance would apply to prisoners, people in custody and recently released prisoners. They were unclear about the applicability of the guidance to these groups and felt that there should be clarification on this point.

Access to NHS dental services

While participants were aware that this guidance was aimed at local authorities and was focused on oral health promotion and not dentistry services, there was discussion in all groups – mainly led by non oral health and dental professionals – about the importance of improving access to NHS dentists, particularly among socially disadvantaged groups.

'The number one enquiry that we get – by far – is about access to dental services. It's way ahead of any other issue. Maybe it's about dentists' unwillingness to take on patients, but it's a major barrier to good oral health.' *Healthwatch Representative, Manchester*

Other missing groups

Finally, some participants felt that there was insufficient attention in the guidance to the needs of pregnant women and weaning infants, and considered this a missed opportunity to educate and inform parents at this crucial time in the life course. Some participants also felt that more attention should be given to the need to engage with parents of children in the various settings across the age ranges of childhood.

> 'I would say that when I first read this I thought, 'Oh, this is very limited'. I was a bit disappointed when I read it. I was expecting more detail on the first year of life – moving from bottle to cup – some rationale, some information about age, which professionals should be involved in giving advice.' *Public Health Specialist, Manchester*

'Nothing new'

Other criticisms focused on a sense that the guidance was – in the view of those who expressed this view –pulling together and recommending what was felt to be common practice in most areas of the country, but not saying anything original.

> 'My initial view is that there's nothing particularly new in there. We are doing most of this already.' *Community Dentistry Services Manager, Birmingham*

> 'I thought it was good – but a lot of it is already happening – there's nothing really new here.' *Oral Health Promotion Lead, London*

However, even where this view was accepted, participants agreed that the value of the guidance – which was felt to lie in supporting the planning function within local authorities – was more important than the fact that the contents of the recommendation were not original.

> 'I suspect that a lot of front line services are doing most of this already, but for public health commissioning teams in local authorities – there are lots of places where there isn't anybody who's taking charge of oral health. So it's really helpful to have something aimed at local authorities.' *NHS England Commissioner 1, Birmingham*

Readability concerns: 'unwieldy', 'difficult to navigate', 'repetitive' and 'lacking impact'

Several participants expressed a concern that the guidance could be organised better to engage key audiences. Most criticisms included the view that the document was unwieldy, repetitive in parts (e.g. recommendations 11-13 and 17-19), that some recommendations were not in the correct order (recommendation 2 should come after a combined recommendation 3 and 4), that it lacked a 'case making' statement in the introduction that would engage readers, and that key audiences would find it difficult to navigate.

> 'I think it's positive to see something out there. My only negative comment is that it is quite repetitive and doesn't come across as short and snappy as it could to get the message out there.' *NHS England Commissioner 1, Birmingham*

> 'In terms of the way it's structured at the moment you have to go right to the end before you find out what the real issues are with oral health. It talks about the impact on people's ability to eat and smile – which is known – but it doesn't have the hard figures around oral health. They come much later. But I thought that if they came up front, people would be much more likely to read the document and think, 'Oh, this is a real issue in my area – I'll carry on reading.' *Public Health Specialist, Birmingham*

> 'I think there's an issue with the size of the document and a question about its utility. There's also an ordering thing in section one where it talks about the strategy and the needs assessment..' *Consultant in Dental Public Health 1, Manchester*

> 'It's really about attracting or advertising it to the key people you want to take action. So you could start with some key facts, impacts, broader health impacts and costs up front.' *NHS England Commissioner 2, Birmingham*

> 'I think some sections are too long and basically repeat information with very minor changes.' *Consultant in Dental Public Health, London*

4.3 Participants' views of the barriers to implementation of the guidance

The main barriers to the implementation of the guidance were acknowledged to be familiar concerns to people who work in public health. They related to - in the first instance - ensuring that oral health was prioritised by local authorities (and other relevant partner agencies) as a concern that requires attention and investment. Following from this, other worries included a concern that even with local authority prioritisation of oral health, there is likely to be a lack of resources (funding and personnel) to deliver the recommendations.

> 'The biggest challenge is prioritisation – there are so many other directives and guidelines for local authorities. The personnel are often not there. If they don't engage with the appropriate expertise, there is always a danger that oral health will be dismissed as 'Oral Health - it's just teeth – let it go'. In the circumstances we have at the moment it's very easy for local authorities to say, 'we can't be bothered with that – we are choosing what are mandatory activities and focusing on other things''. *Consultant in Dental Public Health 3, Manchester*

> 'This year local authorities will receive two pieces of guidance on oral health but it will be irrelevant if they don't have it on their health and wellbeing board and JSNA. So they might say partner up with others. The documents are there to help those that want to. How we work to help those who don't want to – to change their minds – I don't know. I don't know how you deal with those areas where their ears are shut.' *Public Health Specialist, Manchester*

The transfer of public health responsibilities from PCTs to local authorities was identified as a new and unknown factor that could potentially hinder implementation of NICE guidance. Some participants recalled that in the past, PCTs would be charged with monitoring progress of implementation of NICE guidance, but with the new arrangements, it was unclear whether – and to what extent – the implementation of NICE guidance would be monitored at local authority level.

> 'Where it works well – say in XXX - we have a Director of Public Health who is very supportive of oral health. We have a Health and Wellbeing board that is very excited. We have the CCGs and Healthwatch involved. Where you have senior buy-in, then things happen. In other boroughs it's not so good. If there are reporting mechanisms that also helps. In the old PCT days, people had to make an effort to show that they were implementing NICE guidelines – but I don't know if that is happening in local authorities.' *Consultant in Dental Public Health, London*

4.4 Suggestions for overcoming barriers

Participants identified a range of actions that could be included by NICE within the guidance to help ensure that the recommendations are acted upon.

Clearer direction about making oral health part of service specifications

Several participants suggested the need to provide more direction within the guidance about the importance of including measurable oral health outcomes as part of local authorities' service level agreements with internal services, and as part of commissioned service specifications and contracts.

> 'I think it will happen much quicker if our commissioners are telling us to report on it. So it would be very easy to add oral health in as a KPI [key performance indicator] and then very quickly everyone we work with would be registered with a dentist. I'm not saying we don't do this already but there are merits to making it a requirement.' *Substance Misuse Charity, Birmingham*

> 'You do need to ensure that it is embedded in everyday practice, and to do that you need to have your commissioners on board - and have it written into service specifications – otherwise it won't happen. If you have a KPI to deliver on oral health, then you will get funding to deliver that and you can embed that into your service.' *Public Health Specialist, London*

Training

Participants felt that the guidance under-estimated the training needs required to implement many of the recommendations. Throughout the fieldwork, participants pointed to the fact that many of the recommendations identified many worthwhile goals and actions that would help to improve oral health of the key groups identified. However, time and again, participants asked, 'who's going to deliver this?' and felt that either individual recommendations should include a training requirement, or that training should be more clearly signalled as a stand-alone recommendation.

> 'As a school nurse this is all new to me. What I want is up to date evidence based information that we as school nurses – can give the correct messages and ensure we're all singing from the same hymn sheet. I haven't seen anything like this before.' *School Nurse, Birmingham*

Where training needs were identified, participants felt that the guidance failed to give them adequate priority within recommendations. This was due to the fact that a fully trained workforce was assumed to be in place to deliver the recommendations (e.g. recommendation 20) or that training was included at the end of a recommendation as a final bullet point (e.g. recommendation 9).

The single stand-alone training recommendation (24) was welcomed for its intention but was unclear how such training would take place. There was particular concern in this regard because of the contextual concern that key specialist oral health training agencies (Community Dentistry Services) have been abolished or fallen by the wayside as a result of recent (last 2-3 years) policy

changes at the national level. As a result, participants reported that they would struggle to identify who could provide the kind of training envisaged in the guidance.

Finally on this point, some participants felt that the guidance failed to consider innovative means of providing and delivering training. The guidance was generally unspecific about how training should be provided, and as a result participants assumed a traditional face to face/classroom model – which many felt was impractical. Instead, they felt that there should be suggestions for online or and other digital media training. The issue of frequency of training was also not felt to have been addressed adequately.

Clearer links to related strategies and delivery mechanisms

Another suggestion was to emphasise an aspect of the guidance that some participants felt was underplayed – that oral health improvement should be clearly signalled as part of general health and wellbeing strategies and of related implementation programmes, including the Healthy Child Programme. Participants identified the importance of integrating policy and service delivery and called for the guidance to be clear about where such links exist.

> 'I think any areas where you can link it back to cost savings – broader health impacts – links between oral health and general health and how that may impact on costs and savings has got to give you a better chance of it being taken notice of.' *NHS England Commissioner 1, Birmingham*

> 'Looking at where you have staff already working – so we have school nurses, health visitors already contracted under the Healthy Child programme to do certain things. It's about having an eye to what's already commissioned that is relevant to oral health – health weight services – maximising the whole.' *Public Health Specialist, London*

> 'I think the key is enhancing what's already there – I know something we face a lot is public health departments saying they haven't got any money for oral health. But it's not about having a separate pot of money for oral health. It is about linking to wider programmes and ensuring that the obesity agenda encompasses oral health messages, and that front line staff have the resources to do it.' *NHS England Commissioner 2, Birmingham*

However, other participants questioned how feasible such reliance on partners and related health and wellbeing strategies and policies would be in practice. While acknowledging the importance of these related programmes and the professional groups who work with identified population groups (including for example health visitors and school nurses), there was recognition that there were limits to partnership working.

> 'Where I work, the tension I see is that the partnership organisations that we're so reliant on - the demands on them are so high – and I can see that there are other agendas that you could say could stretch a bit – but the problem is that those agendas are already fully stretched.' *Public Health Specialist, Manchester*

5 Feedback on the recommendations

This section provides detailed description of the views expressed for each recommendation.

5.1 Section 1 Oral health strategy and oral health needs assessment

Recommendation 1 Make oral health a core component of the joint health and wellbeing strategy

Health and wellbeing boards and directors of public health should:

- Make oral health a core component of the joint health and wellbeing strategy.
- Set up an oral health strategy and needs assessment group with input from several organisations, including:
  - a consultant in dental public health
  - a local authority public health representative
  - an NHS England commissioner of local dental services
  - a representative from a local professional dental network
  - representatives from children and adult social care services
  - a local healthwatch representative
  - a senior local government representative to lead on, and act as an advocate for, oral health
  - representatives from relevant community groups.

Summary

Participants felt that the first section was a vital first step in ensuring that local authorities acknowledge their responsibility and plan actions to improve oral health. However, there were some important considerations identified by participants that may impact the implementation of the section. The section was felt to be built on certain assumptions about local authority planning processes, which were not reflected in reality. In particular, the assumption that oral health promotion can/should easily be included as a priority on the health and wellbeing strategy was not accepted by all participants. In particular staff employed by local authorities as oral health promoters and public health specialists questioned this assumption.

Another assumption that was not reflected in reality was the notion that each local authority should develop its own oral health promotion strategy and needs assessment. Many participants revealed that these considerations are currently undertaken at a 'cluster' level of groups of local authorities. Some participants felt that identifying, linking and working with sub-regional and regional strategies should be included in the recommendation.

A key omission from this recommendation was the importance of requiring local authorities to identify a suitably qualified and experienced Lead for Oral Health. Many participants felt that the

lack of such a role was a considerable barrier to the development of plans and action to improve oral health.

Clarity

The recommendation was clear and understandable to all participants.

Relevance

For the vast majority of participants, the recommendation to make oral health a core component of the joint health and wellbeing strategy was seen as an appropriate and uncontroversial first step in ensuring that the subject received the appropriate priority within local authorities.

> 'It's clear and I'd've thought very much supported. It's a key recommendation.' *Healthwatch Representative, Manchester*

> 'I very much welcome the input into the strategy.' *Consultant in Dental Public Health 1, Manchester*

The recommendation does not reflect the real world experience

Several participants across different group discussions felt that this recommendation did not reflect the real world experience of local authorities – and their planning arrangements for developing strategic plans and delivering oral health promotion.

While they welcomed the intention of the recommendation, to ensure that oral health was accorded priority at the local authority level, several participants across the various group discussions and individual interviews commented that in practice, decisions about what to do and how to deliver oral health promotion services are planned in concert with other neighbouring authorities, and that the key experts (in Public Health England and in NHS England) are also 'geared up' to provide expert advice and support at 'cluster level' rather than at individual local authority level.

> 'Can I ask a stupid question? Is each local authority expected to develop its own oral health strategy – or would it be say one oral health strategy for the North West? It looks like each local authority has to report to its own Health and Wellbeing board, but there is an opportunity here to work at a combined level – which is how a lot of us do - and that should be reflected in this document.' *Oral Health Promotion Lead, Manchester*

> 'This is a function that is often shared between several local authorities and this model assumes that local authorities operate at an individual level, whereas in many instances they operate as a cluster – and this recommendation doesn't take account of that. It will vary from place to place – and it's not just the local authorities – it's also the dental services the community dental services – they often cover a number of geographical patches and that's part of the challenge of consistency.' *NHS England Commissioner, Birmingham*

Concern that the recommendation fails to appreciate how the joint health and wellbeing strategy is understood by some local authorities

Furthermore, there was discussion over whether this would be a relatively simple and straightforward recommendation to implement. It was argued that the purpose of Health and Wellbeing strategies was not to be a repository for every health concern, but instead to serve as a focal point to tackle key local priorities. In this context, it was possible that oral health may not be regarded as a sufficiently important concern warranting inclusion in the Health and Wellbeing strategy.

> 'It's absolutely right for there to be senior level support and championing of oral health promotion – I don't disagree with that. But for me the recommendation displays a lack of understanding of what the Health and Wellbeing strategy is for. The assumption here is that a Health and Wellbeing strategy should include every health area, whereas in fact the purpose of them is to identify the maybe half a dozen top priorities in the area. Otherwise they just become too big and unmanageable. It would be like the Epilepsy Society coming along and saying 'you've got to have epilepsy on the Health and Wellbeing strategy' – that's not what it's about.' *Health Improvement Manager, Manchester*

> 'Health and wellbeing boards have a huge agenda – is oral health a priority?' *Dentist, York.*

However, regardless of participants' views about the ease/difficulty of achieving this goal, there was a consensus that this recommendation was essential, if oral health was to have any hope of being prioritised by local authorities.

> 'The important thing is that there's a real emphasis on the Health and Wellbeing Board's responsibility - which is different from the direct commissioning responsibility of the local authority, but also some of the NHS England responsibilities. Having somewhere that can hold HWB responsibilities... there needs to be a place where different organisations and structures come together. Integration of agendas of local authorities and NHS England and PHE – all of these need to be closely aligned.' *Consultant in Dental Public Health 3, Manchester*

> 'If you look at the intention of shifting responsibility in the reforms, it was about improving local democratic accountability for what happens in any given area – whether that is clinical commissioned services or health improvement, the intention is better outcomes for the local population and that's the responsibility of the local authority and the local health and wellbeing board. For me, there is an opportunity here to get the one and only combined joint strategy that deals with all of those elements under the eyesight of the health and wellbeing board locally and that is what the policy intention was.' *Consultant in Dental Public Health 4, Manchester*

Questions about the list of professionals identified to be represented on the oral health and needs assessment group

Participants welcomed the inclusion of a list of suggested professionals to be involved on the group but felt that this list should be presented as a *possible* or *suggested* list of roles rather than a required list of professional representatives. Several participants felt that it was both unrealistic and

unnecessary to involve all of the identified roles, and also that the inclusion of a very long list of roles would make any group unworkable.

> ‘Perhaps it could be a suggested list – in case people think they can’t get all of them. Not all areas have a Consultant in Dental Public Health – it’s a shared function.’ *Public Health Specialist, Birmingham*

> 'In my experience, you have to get the lead councillor on health in each local authority.’ *Oral Health Promotion Manager, York.*

> ‘I don’t think you can make it that prescriptive because everywhere has a different structure and a different way of working. We have a County council, a district council – we cover 2500 square miles. What works in Barrow doesn’t work in Langdale. It’s fine as a guide but it doesn’t need to be so prescriptive.’ *Public Health Specialist, Manchester*

> ‘There is a pragmatic point that there’s a risk of making this group too big and too inclusive that nothing will get done.’ *Consultant in Dental Public Health 4, Manchester*

There were however, other participants who felt that key roles had been omitted from the proposed list, and who felt that they should be included on a longer list from which to draw. The main roles that were identified in several groups were Oral Health Promotion Leads, and representatives from children’s services and early years settings and schools.

> ‘There doesn’t seem to be any representation of children’s services, health visiting, school nurses, schools – I would have through they are fairly vital. It’s both frontline staff from NHS and local education authorities. It could be the NHS Head of Services for children and young people– that would cover health visitors and School Nurses.’ *Public Health Specialist, London*

> 'We’re missing the medical representative, because people go to GPs with all their health issues, and get referred.’ *Dentist, York*

Identify a named Oral Health Lead as part of this group

Importantly, and reflecting what was identified as a deficit in many local authorities at the present time, participants felt that the recommendation should include a requirement to have a named Oral Health Lead on the group from the local authority – and recommended that this role should be of sufficient seniority that the representative would both command respect from others on the group and also ensure that strategic decisions were enacted.

> ‘Oral health is delegated down and down until it sits with someone who has no power or control and they are not really a representative. It needs to be a public health representative ‘with some clout’ otherwise they just become a mouthpiece and we can’t get the message back up. It could be a public health consultant. I think anything under that is going to be difficult to get any priority for this subject.’ *Consultant in Dental Public Health 2, Manchester*

> ‘It would be helpful to identify a named Oral Health Lead – because we don’t know who to link to. The automatic link is the Director of Public Health, but they are often not the right person. But having an identified person within the Public Health team would be helpful. It could be the Obesity Lead for instance.’ *NHS Commissioner 1, Birmingham*

Identify a convenor for the group

Most participants also felt that the recommendation should identify who should convene/chair the strategy group. Without an identified role, participants worried that no one would take ownership of the matter.

> 'Somebody needs to convene it – it needs someone identified who should do that. Otherwise there's no guarantee it will happen. It should be the local authority. It could be a nominated person from the local authority. It has to be someone very senior.' *Oral Health Promotion Lead, Manchester*

> 'The 'relevant community groups' can be represented by Healthwatch – that's their job.... but you have to make sure they are representing your target groups.' *CCG Member, York*

> 'You have to make sure you get decision-makers round the table; you need a level of seniority.' *Director of Public Health, York*

Recommendation 2 Develop an oral health strategy

The oral health strategy and needs assessment group (see recommendation 1) should:

- Develop an oral health strategy. This should set out how the local authority and its health and wellbeing commissioning partners will:
  - Address the oral health needs of the local population including groups at higher risk of poor oral health (see recommendations 3–4).
  - Address any oral health inequalities within and between the local population and the rest of England.
  - Determine which oral health interventions should be commissioned for the general population and which should be commissioned for people at higher risk of oral health problems.
  - Identify and work in partnership with people who are in a position to improve oral health in their communities, including those working in children's services, education and health.
  - Set out the additional support that those working with groups at higher risk of poor oral health will be given, including training or resources. (See NICE guidance on community engagement.)
  - Use formative evaluation to determine what works for whom and in what circumstances.
  - Get all frontline staff in health, children and adult services to use every opportunity to promote oral health and emphasise the links with general health and wellbeing.
  - Ensure there are clear pathways across the life course (that is, for lifetime care) involving primary and secondary prevention of oral disease. (The former involves preventing disease in the first place, the latter prevention of a recurrence or progression of disease.) These pathways should also provide access to high quality dental care when needed.
  - Monitor and evaluate the effect of the local oral health improvement programme as a whole.

Summary

A recommendation to develop an oral health strategy was viewed as essential by all participants. The actions identified in the recommendation were broadly considered to be appropriate. An important concern of some participants – mainly dental health and oral health professionals - was the assumption that this recommendation would be interpreted as favouring 'one off' and individual based interventions over those that could address life-long skills and the broader social determinants of oral health.

It was also the view of all participants that the ordering of this recommendation should be changed to follow the planning and execution of an oral health needs assessment.

Relevance

The main comments on this recommendation were first, that it was in the wrong place in the order of recommendations, and second that its scope was narrowly focused on 'one off' interventions, whereas participants felt that it should take a broader view of the determinants of oral health.

Participants in all groups felt that the task of developing an oral health strategy should follow the needs assessment (recommendations 3 and 4).

> 'I would expect to have an oral health needs assessment before the strategy is developed because how else can you know what the local population needs. That information then needs to be interpreted and the 'so what's?' filled in so that the strategy is informed.' *Consultant in Dental Public Health 1, Manchester*

> 'The order should be '1,3,4,2, with 3 and 4 combined. You definitely need the needs assessment before developing the strategy.' *Oral Health Promotion Lead, Manchester*

> 'There is another pragmatic point here – you end up with reports that have multiple recommendations and guidance. People say, 'how can we possibly implement all of these..?' Well here you have an opportunity – because recommendation 4 is a subset of 3 – it's a way of doing it - you could amend the heading to say, 'carry out a needs assessment using appropriate data sources.' *Consultant in Dental Public Health 2, Manchester*

Questions arose regarding the 'frontline staff'; how these would be identified and how much information they should be giving.

> 'Frontline staff'? Could we say, 'anyone who comes into contact with people'?' *Health and Wellbeing Board Member, York.*

> 'Staff' should include pharmacists?' *Oral Health Promotion Manager, Sheffield*

> 'Workers' would be a better word than 'staff'.' *Dentist, York.*

> 'Could we have a 'brief intervention' model for oral health, for all frontline workers?' Social *Enterprise Manager, York.*

Focus of the recommendation for strategy development was described as too narrow

Accepting that this recommendation should follow the carrying out of an oral health needs assessment, most participants were disappointed by the lack of ambition of this recommendation. They described it as being predominantly individual focused and reliant on 'one off' interventions to improve oral health, while they felt that such guidance should advocate a more holistic approach that would link it to a broader social determinants of health agenda.

Given the powers at the disposal of local authorities, participants felt that explicit reference should be made to other relevant policies, including planning and enforcement.

> 'I think that this recommendation is helpful in setting aims and objectives. But I think on point 3 we need to be really clear what we mean by 'oral health interventions'. With the wider health agenda we need to be clear about what we mean. This recommendation lends itself to 'a programme' or 'a campaign' or 'an intervention'. It should really be broader than that.' *Consultant in Dental Public Health 1, Manchester*

> 'Any strategy should be wider than just individual behaviour change based interventions – it should cover policies and service level agreements. For instance planning – local authorities are responsible for planning of things like fast food outlets. There's also healthy schools and whole school food policies and so on.' *Public Health Specialist 1, London*

> 'The trouble with this is that they'll put an intervention in place to do tooth brushing schemes instead of looking at the wider determinants of health and how they impact on oral health – I think this is quite narrow.' *NHS England Commissioner 1, Birmingham*

Lacks information about what to do and how to do it

Other participants commented on the fact that this recommendation was too 'broad brush' and lacked sufficient detail to really assist the commissioning process. They were concerned that the recommendation should either contain more directive instructional type information, and/or link and signpost to tools and examples of how to do the kinds of things required.

> 'It's very broad brush, but there is a lot of information elsewhere on the internet about how to do needs assessments and the like – so for this document I think that's ok. But I think It could signpost better to other tools.' Public *Health Specialist, Manchester*

> 'On the first bullet point: 'Develop' should be 'implement'. Saying 'develop' is far too vague – you can be developing something forever!' *Oral Health Promotion Manager, Sheffield*

> 'I don't know whether there is enough there because the people I worked with in the North East didn't have the knowledge and I don't think this document would help. They would need more support on how to commission.' *Dental Health Specialist, Manchester*

Ensuring the oral health strategy goals are reflected in commissioned service contracts

Participants restated the importance of having a mechanism for delivery of the strategic priorities both by local authority run services and by commissioned partners. Several participants expressed a concern that this recommendation should provide clearer guidance to local authorities about the

need to ensure that service level agreements and contracts with third parties, include requirements to deliver oral health promotion activities and that these are monitored as part of the performance management framework.

> 'The issue of direct responsibility where local authorities have direct responsibility for certain services, and contracted out activities – such as children's centres possibly – the point is the importance of getting policies or standards – about these wider or common risk factor things into those agreements and commissions with organisations that run these services – making sure that their contracts include these standards when they go out to commission.' *Consultant in Dental Public Health 3, Manchester*

Recommendation 3 Carry out an oral health needs assessment

The oral health strategy and needs assessment group (see recommendation 1) should:

- Define the scope of an oral health needs assessment for the local population. This should include:
  - What the assessment will and will not cover, for example, access to services for groups at higher risk of poor oral health, certain age groups or in certain settings (see recommendation 4).
  - The responsibilities of each partner organisation and how they will work together to make best use of resources (for example, detailing how data could be collected across organisations).
  - The need to include recommendations and outcomes from any previous oral health needs assessment (if available).
- Ensure the oral health needs assessment is an integral part of the joint strategic needs assessment and clearly linked to strategies on general health and wellbeing.
- Conduct the oral health needs assessment as part of a cyclical planning process geared towards improving oral health and reducing health inequalities. It should not be a one-off exercise that simply describes the target population.

Summary

All participants felt that a recommendation to carry out an oral health needs assessment was essential. Most comments on this recommendation concerned suggestions for strengthening the contents by: making explicit the need to seek professional expertise in the design and execution of the needs assessment, linking the needs assessment to other related health issues, requiring an action plan to be developed from the needs assessment. There was also widespread agreement that the recommendation should be combined with Recommendation 4 because the latter was seen as integral to the former, and be re-ordered to come before the development of an oral health strategy.

Seek professional expertise in the planning and execution of the needs assessment

Participants from a number of focus group discussions expressed the view that the recommendation should include a requirement to seek and obtain professional expert advice in the planning and execution of the needs assessment.

The importance of having professional and expert advice was that such expertise would help guide the needs assessment to consider which groups to focus attention on, and what methods would be most appropriate to ensure that relevant information was collated.

Enable local authorities to consider commissioning local oral health surveys

Related to this, participants felt that there should be support within the recommendation to commission bespoke local surveys, and not to simply rely on nationally collected survey data. The importance of this suggestion was two-fold. First, it would assist local decision makers to argue for resources in the conduct of local surveys of identified groups and second because much of the national survey data does not permit detailed analysis at sub-local authority level.

> 'You can recommend that individual areas can commission their own more detailed surveys. You would need advice to do it. Use local and national surveys – don't just rely on national surveys. The national surveys cover 5 year olds but you may want to go younger – or increase the size of the sample to do more granular analysis - or you may want to look at the needs of travellers or people with disabilities or some minority ethnic groups. And then you have to develop your own local survey. And the reason I think it should be included is that unless it's in the recommendation, the local authority may say 'well we can use the national survey data – we don't want to put any more money into it.' Whereas if you have a bullet point there that says you can commission a local survey, you can make the case for the particular group.' *Consultant in Dental Public Health, London*

Some tasks identified in the recommendation were felt to be exceptionally difficult to meet.

> 'It's the scope that's the challenge here. People 'in certain settings' will include travellers, Roma – they move from one area to another all the time; it's nearly impossible to keep track.' *CCG Member, York.*

Link the oral health needs assessment to other related needs assessments

Some participants felt that it would be helpful to identify the potential to link the oral health needs assessment to other related needs assessments, and vice versa.

> 'Could it be more specific about how the needs assessment could link to other relevant strategies like obesity, alcohol and tobacco – work with specific groups who are more vulnerable? You might have a needs assessment for these issues – it's cross referencing oral health with these other needs assessments. I feel that it's worth including that because some places may not have considered it.' *Public Health Specialist, Birmingham*

Develop an action plan and seek senior level commitment from key partners

Some participants felt that it would be helpful to include a requirement to link the oral health needs assessment to an action plan.

> 'As a product of the strategy there should be an action plan – and review dates set for the needs assessment. It's probably not a good idea to specify how often this should be reviewed – other than to say it should be reviewed periodically.' *NHS England Commissioner 2, Birmingham*

> 'The last point of Rec 3 needs pulling out as a much bigger piece of work – to develop an action plan and get agreement and sign up and commitment from other parties – senior level people in education for instance - to deliver the plan. And this is different group of people from who's identified in Rec 1.' *Public Health Specialist, Manchester*

Recommendation 4 Use a range of data sources to inform the oral health needs assessment

The oral health strategy and needs assessment group should:

- Use local demographic and deprivation profiles to identify groups that may be at higher risk of poor oral health.
- Use national surveys of oral health (adult and child) and NHS dental epidemiological programme data to gain an idea of local oral health needs relative to the national picture and comparator areas.
- Use national demographic and socioeconomic data and the established link between these factors and dental disease to determine likely local needs.
- Use local expertise and local health and lifestyle surveys and consultations to understand local oral health needs in the context of general health.
- Consider seeking advice on survey design and the collection, analysis and interpretation of epidemiological data relevant to oral health.

Summary

There were several suggestions for improving the contents of this recommendation. All participants agreed that it should be merged with Recommendation 3. Mostly, the concerns of participants were that the list provided was skewed towards epidemiological and national survey data, while participants felt that data that mapped current service provision, access to oral health and dental services, and patient experience data were of equal value.

Suggestions for additional data sources

> 'This is all around surveys and population profiles, but it doesn't mention use of dental service data or access dental services – and when it says 'who should be on the strategy', it includes NHS England commissioners who are the ones who will have access to that information – and they will know whether dentists are doing things like fluoride varnish in practice, what community dental services are doing in terms of outreach – all of these things should be part of the needs assessment.' *NHS England Commissioner 1, Birmingham*

> 'Rec 4 is really only looking at epidemiological data – there's nothing here about service provision.' *Public Health Specialist 2, London*

Participants identified a range of data sources that they felt should be included in the list of information that should be used to inform the oral health needs assessment. These included the following:

- A link to the National Dental Health Epidemiological Programme, currently managed by Public Health England
- Mapping of service provision (asset mapping)

- Dental service access data, that is currently held by NHS England
- Patient experience information
- Commissioning bespoke surveys

> 'It doesn't actually say, 'commission bespoke surveys if necessary to establish oral health needs where these cannot be gleaned from existing sources' – but it should.' *Consultant in Dental Pubic Health 4, Manchester*

> 'Mapping of service provision, access data to dental services, fluoride varnish and linking this information to the epidemiological data is needed.' *NHS England Commissioner 2, Birmingham*

> 'Patient experience data – what people think about the services. That should include children and young people. There is something about understanding that just because these services exist, it doesn't mean they are being accessed by the groups who need them – you could have a service that is located in the middle of an area that really needs it, but if for whatever reason, they don't appeal to the population that surrounds it, you won't address the problem. 'Public *Health Specialist, Birmingham*

Expert advice to interpret data

Some participants felt that there should be specific instructions to seek expert advice on the interpretation of national level data from the main source of expertise, namely Public Health England.

> 'The expertise about interpreting data should be coming out of Public Health England, and local authorities should be advised to seek that level of expert advice.' *Consultant in Dental Public Health 2, Manchester*

> *'*Data needs to be as 'local' as possible, and that can be difficult – where IS "local"?' *Director of Public Health, Newcastle*

> 'We often miss people who are on the borders of that definition (groups that may be at higher risk).*' Oral Health Promotion Manager, York*

5.2 Section 2 Promoting oral health for everyone

Recommendation 5 Include information and advice on oral health in local health and wellbeing policies

Local authorities and other commissioners and providers of public services should:

- Ensure all health and wellbeing and diseases prevention policies for children and young people include evidence-based advice and information about oral health, in line with the 'advice for patients' in Delivering better oral health. This includes policies covering:
  - nutrition for infants and children, including breastfeeding and weaning practices
  - local food, drink and snacks policies that affect children in a range of settings, including nurseries and children's centres
  - providers of childcare services (including child-minding services) in the private and voluntary sector
  - children and young people in primary and secondary education.
- Ensure health and wellbeing and disease prevention policies for adults (including local government health and social care policies and strategies) have information and advice about oral health. This should be included with information about the common risk factors for ill health, such as the use of alcohol and tobacco and a poor diet.

Summary

This recommendation was widely welcomed. There was particular support for the statement on the common risk factor approach and separately for the inclusion of child-minding services. Most oral health promoters felt that this kind of work was taking place in most places already, but that the recommendation was helpful in establishing that the onus should be on local authorities and others to facilitate access to the settings and groups identified.

Relevance

This recommendation was welcomed by Oral Health Promotion Leads in particular. They felt that the contents reflected the range of activities that they undertake routinely – and to that extent they felt that it was not recommending anything new. However, they welcomed the fact that the guidance included a 'nudge' to local authorities and other commissioners and providers of public services (including schools and local education authorities) to facilitate oral health promotion activities.

> 'This is stuff that's already being done. But at the moment we're having to persuade schools to go in, whereas it should be the other way around. This would definitely assist our work.' *Oral Health Promotion Lead, Manchester*

'Having (campaigns such as) "Healthy Schools" and "Better Health at Work" awards made this kind of thing possible.' Health promotion manager*, York*

'Where is the 'brand recognition' for 'Delivering better oral health'? 'Change 4 Life' is very recognisable.' *Social Enterprise Manager, York.*

Several participants were pleased to see the inclusion of reference to the common risk factor approach in this recommendation, as it was felt that this would help professionals to connect oral health to general health and wellbeing. However, some felt that there should be more explicit reference made to this approach throughout the guidance, and through a revised introduction/preamble section that would serve to signpost readers.

'I like the fact that this should be included in the common risk factor approach, because often the mouth is seen as a separate entity to the body- even by health professionals – and it's key.' *Oral Health Promotion Lead, Manchester*

'There should be something at the front that identifies all the groups affected by the common risk factor approach – and that should include people using drugs – and then every time a recommendation comes up that relates to a common risk factor, it's clear which groups they're talking about. So that every time you read it you think 'Oral Health - yes this bit is for me, because I work with the homeless or I work with substance misusers or whatever'. A bit more signposting is needed.' *Public Health Specialist, Birmingham*

Concern that the needs of all adult groups are undifferentiated

Participants liked the focus on the young identified in this recommendation. Some felt that the recommendation should go further and include pregnant women/ante natal services as a group/setting for consideration under bullet point 1.

There was some dislike from a majority of participants from a range of professional groups, at the way all adults had been categorised as a single group under bullet point 2. Participants felt that unless there were specific 'trigger' words, the needs of key vulnerable groups, who NICE clearly intends this guidance to benefit, would be overlooked by local decision makers.

'I think it's about triggering ideas about which groups should be included and targeted – and that could be done by making it more explicit – so for example you may not think necessarily of low income people when you read 'adults' when you look at what Rec 5 is about.' *Dental Health Professional, Birmingham*

'I think they've broken down the children category quite well but with adults – they've lumped all the groups together and they should be teased out more.' *Public Health Specialist, London*

Consider including substance/drug misusers as a key group

Participants with experience of working with people who are homeless and people who misuse substances felt that this recommendation could be improved in the final bullet point by including a reference to these groups. The focus on tobacco and alcohol was welcomed, but it was unclear why

other substances that were particularly harmful to the oral health of some vulnerable groups had not been included.

> 'There are some really basic but incredibly powerful things to be said to people working with alcohol misusers and substance misusers including people on methadone – such as switching to sugar free – things that would never have occurred to them. This could definitely expand on that in this recommendation. It could be far clearer.' *Substance Misuse Service Manager, Birmingham*

Training needs are not identified

Several participants, mainly those working on the front line, felt that this recommendation should include a requirement for training.

> 'As front line staff, we need the education training and communication to get it out there to people who need to deliver it.' *School Nurse, Birmingham*

Recommendation 6 Create environments that promote oral health

Local authorities and other commissioners of public services should:

- Ensure all public services promote oral health by:
  - encouraging and supporting breastfeeding
  - making plain drinking water freely available
  - offering a choice of food, drinks and snacks (including from vending machines) that support good oral health and a healthier diet (for example, that are sugar-free or low in sugar). This includes services based in premises wholly or partly owned, hired or funded by the public sector such as:
    - ◊ nurseries and children's centres and other early years services (including services provided during pregnancy)
    - ◊ schools
    - ◊ food banks
    - ◊ leisure centres
    - ◊ community centres.
- Consider linking up with local organisations in other sectors (for example, commercial food outlets) to promote oral health and a healthier balanced diet.

Summary

This recommendation was felt to be important and was welcomed as identifying and acknowledging key tasks involved in oral health promotion. The main concerns related to the inclusion of 'food drinks and snacks… low in sugar' alongside 'sugar-free'. There were also some participants who failed to appreciate that the recommendation should apply to local authority services as well as commissioned services, and requested that this point be clarified.

Clarity

A number of participants were unclear whether this recommendation was intended to apply to local authorities' own services or just to commissioned services. It was felt that the wording could be improved to make this point clear.

Questioning the evidence: sugar-free and low in sugar

Several participants were annoyed to see the inclusion of the words 'low in sugar' under bullet point 1, sub point 3. They felt that this was simply not evidence based and would be likely to mislead members of the public.

> ‘The detail was what we would class as ‘incorrect’. Offering drinks that are low in sugar! Low in sugar is never recommended. It should be sugar free.’ *Consultant in Dental Public Health 1, Manchester*

Focusing the recommendation on premises and settings that are used by socially disadvantaged groups

Participants in most groups identified a range of settings that they felt should be included, and felt that the list provided failed to reflect the priority of focusing attention on those groups whose circumstances put them at greater risk of poor oral health.

> ‘It should include hospitals as well in the list of places. Places like job centres where the adults we’re targeting frequent a lot more than leisure centres. Shelters, hostels, housing offices. Age Concern – forums for older people. Third sector agencies.’ *Oral Health Promotion Lead, Birmingham*

Some participants reported their experiences of trying to ensure vending machines in leisure centres offer healthy sugar free food, drinks and snacks, and described how there was an expectation that it should be NHS organisations that should lead on this subject, and how they had found it difficult to implement change in leisure centres because of the heel-dragging attitude of local hospitals.

However, other participants in the group challenged this view and felt that as the NICE guidance is targeted specifically at local authorities, it was unreasonable to expect inclusion of recommendations to the NHS.

> Participant 1 ‘We’ve tried with vending machines – somebody in public health said that unless hospitals stop vending machines then leisure centres won’t. So it’s about having hospitals and health organisations to lead.. .’ *Oral Health Promoter, Manchester*
> Participant 2 ‘As this document is targeted at local authorities – that would be outside the scope..’ *Consultant in Dental Public Health 1, Manchester*

> ‘And this is not only about choice. It is about marketing. Vending machines selling Coke might be the first thing you see when you walk in’. *Dentist, York*

Implementation of the recommendation

Several participants felt that this recommendation should be stronger in its call for local authorities to use their powers of planning and enforcement to improve oral health.

> ‘The final bullet point is very weak. It must be stronger than just ‘consider it’. If we are talking about whether betting shops should be allowed on the high street – as we are in XXX – then we should definitely also be discussing with planning services whether fast food outlets should be permitted a licence near schools.’ *NHS England Commissioner 2, Birmingham*

Other participants felt the recommendation should include identified actions that local authorities could take in relation to enforcement of existing contracts.

‘This recommendation makes it look like it’s very much an external function for local authorities to work with other partners – but in our local authority the environmental health department do inspections on behalf of Healthy Catering Commitment type things. So there are things that can be flagged that can be done internally within the local authority.’ *Public Health Lead, London*

‘The recommendation lacks a sense of how to do these things. It’s not very practical. They could say, ‘put these things into a service specification’ – it’s about using a variety of levers. Rather than just saying, ‘do it’ - it would be more helpful if they gave examples of how to do it. Maybe hyperlinks to case studies would be a good idea.’ *Public Health Specialist, Birmingham*

Recommendation 7 Ensure frontline staff understand the importance of oral health

Providers of health care, social care, child care and education should ensure all staff are aware of:

- the 'advice for patients' in Delivering better oral health
- the fact that tooth decay and gum disease are preventable
- how fluoride can help prevent tooth decay
- links between dietary habits and tooth decay
- links between health inequalities and oral health
- the needs of groups at higher risk of poor oral health
- where to get advice about local dental services, including advice about costs and transport links
- how oral health in childhood affects oral health in adulthood
- links between poor oral health and alcohol and tobacco use.

Summary

This recommendation was welcomed as aspirational, but participants felt that it should include a requirement to commission training of the professionals identified, for it to have hope of being implemented. It was felt to describe activities that were already commonplace (although not implemented consistently). Also, some participants felt that the wording of the recommendation lacked sufficient clarity and impact to motivate the range of professionals identified to consider oral health promotion to be concern that they should take seriously.

Clarity and relevance

> 'This should not say 'understand' (in the title) and 'are aware of' (the introduction), it should say "understand and communicate".' *CCG Member, York*

In general, the intention of the recommendation was clear and the contents were welcomed by participants as being appropriate and potentially valuable in improving oral health. Most Oral Health Promoters involved in the fieldwork felt that the recommendation described the kind of work that they undertook routinely - and described these activities as 'nothing new' - but felt that it was helpful to have a recommendation that sought to systematise the inculcation of basic oral health knowledge to a broad workforce.

There were some participants however – mainly some dental health, oral health and public health specialists - who felt that the contents of the recommendation should be re-worded to emphasise the connection between oral health and general health and wellbeing.

> 'I don't think the point is clear enough about the link between oral health and general health and wellbeing. Rather than someone reading it and thinking 'Oral health - it's only teeth – that's nothing to do with me', it needs to be more explicit about the link between oral health

and diabetes for example – as well as other conditions. So that it's seen to be everybody's concern.' *Public Health Lead, London*

Implementation

The main concern expressed by most participants was that the recommendation lacked any means of ensuring it would be implemented. In order for it to have effect, participants felt that it would require the provision of resources – both financial and human – to train the range of professionals identified to deliver it.

> 'Who will do this? It says that, "all staff should be aware of.." but it's a question of how this will be done, who does it, how knowledgeable they are, and how the information is passed down. If you could create a situation where all those people could suddenly know all that information correctly, that would be fantastic – but I don't know how that could be done. It needs to be done by appropriately trained people.' *Consultant in Dental Public Health 1, Manchester*

> 'I don't know how this recommendation will happen without a bullet point about providing training for health, social care, child care and education. Otherwise – how is it going to happen? Local authorities should commission training to deliver this – and again this is an example where local authorities might work across several authorities.' *NHS England Commissioner 1, Birmingham*

> 'I don't think it says anywhere anything about training. As it stands it's just a good idea.' *Oral Health Promoter, London*

Other participants suggested that any requirement for training should include a requirement that it be delivered by a suitably qualified dental/public health expert.

> 'It would be helpful if it said providers of these organisations should undertake a regular programme of training by a dental public health expert – then that gives it some quality and the programme should be regularly updated and evaluated.' *Public Health Specialist, Manchester*

Some participants described how they had already sought to integrate training for frontline staff through workforce training contracts or as part of other commissioned activities.

> 'In our area we've written this into the commissioning – it's part of workforce training.' *Public Health Lead, Manchester*

> 'In Cumbria with people who are looked after, we've tried to combine it with food focused behaviours – mixed with oral health training – and that's worked very well.' *Looked After Children Lead, Manchester*

5.3 Section 3 Early years services (0 to 5 years)

Some participants found this section over-long and became confused by what they felt was repetitious information. There were calls for the section to be shortened and key points made clearer.

Recommendation 8 Include oral health promotion in early years service specifications

Local authorities and health and wellbeing commissioning partners should:

- Ensure early years service specifications include a requirement to promote oral health. This includes services delivered by:
  - midwives, health visiting teams and family nurse practitioners
  - early years services, children's centres and nurseries
  - child care services in the public, private, voluntary and independent sectors (including childminding services)
  - frontline health and social care practitioners working with families who may be at higher risk of poor oral health (for example, families with complex needs, teenage parents and minority ethnic communities where poor oral health is prevalent and people find it difficult to use services)
- Ensure services include advice about oral health (in line with 'advice for patients' in Delivering better oral health) in information provided on health, wellbeing, diet, nutrition and parenting. (This includes links to established parenting programmes such as those provided by Parenting UK.)

Summary

This recommendation was generally well received. Participants liked the focus on early years services and welcomed the recommendation to include oral health promotion in service specifications as a practical and essential step to implementation. There were some concerns that the recommendation could have been more directive about what to deliver and some additional suggestions were made for professional groups to include. Training was identified as an important omission

Relevance

Participants were pleased to see a recommendation that had as its objective a clear requirement to include oral health promotion in service specifications. This was felt to be essential if the contents of the recommendation were to have hope of being implemented.

> ‘It’s good because in XXX the Child Health programme was introduced and there was nothing in it about oral health. If a particular programme requires oral health, then it gets done. It’s all about what’s in the specification.’ *Oral Health Promotion Lead, Manchester*

> ‘It’s about ensuring that oral health is included. At the moment it’s not identified as separate thing for us. This [recommendation] is good – it will ensure oral health is included in early years services.’ *Early Years Services Manager, Manchester*

> ‘It is clear that it should be put in the service spec – so that’s helpful..’ *NHS Commissioner 2, Birmingham*

Concerns about what oral health promotion should deliver

Some participants, while welcoming the aim of the recommendation, felt that there was insufficient detail about what service specifications should include.

> ‘They should be more specific about what they require. At the moment it varies by local authority.’ *Oral Health Promotion Lead, Birmingham*

A number of participants felt that the *Delivering better oral health* document, while valuable as a resource for oral health promotion practitioners, was not a useful or usable guide for other professional groups, because its contents were too clinical.

> ‘*Delivering better oral health* is familiar to oral health professionals but beyond this group – it is not known. Prevention isn’t really appreciated.’ *Oral Health Promotion Lead, Manchester*

> ‘In my other life I work as a health visitor – and I’ve never seen it as a health visitor – it’s too clinical.’ *Public Health Specialist, Manchester*

Implementation

Participants from a number of groups felt that there were some important levers that the recommendation should reference, that would assist its implementation. These included the Healthy Child programme, the role of Ofsted as a regulator of early years services and recognition that the recommendation would require training of staff groups for it to be implemented.

The Healthy Child programme was identified as a key framework that was used by professionals working with early years services.

> ‘It doesn’t mention the Healthy Child programme. It’s an evidence based tool and there’s one for 0-5 year olds – it covers our practice really.’ *School Nurse, Birmingham*

> ‘I think it would definitely good to include the Healthy Child Programme in here, because all our work seems to be around that.’ *Oral Health Promotion Lead, London*

> ‘I don’t know why they’ve included the link to the Parenting UK thing. That seems a bit random to me. I think a link to the Universal Healthy Child programme is much more appropriate.*’ Health Improvement Manager, York*

The role of Ofsted as a regulator of Children's Centres was also identified. Including oral health as a performance management indicator was identified as a valuable means of ensuring the subject would be implemented.

> 'There is also Ofsted. As a selling point it's important to understand what Children's Centres are being measured on and where oral health sits within their performance frameworks.' *Public Health Specialist, Birmingham*

Training requirements

As with several other recommendations, participants in most of the focus groups questioned the feasibility of implementation of this recommendation without a requirement to provide training on oral health promotion to the professional groups identified.

All participants had failed to connect the training requirement in Recommendation 9 to this recommendation – and when they did see this point – they felt that it should be included as part of the service specification and that it should be given higher prominence within the recommendation.

> 'For all these groups you need them to be trained – when they are training to qualify as a midwife or health visitor of whatever – in oral health promotion.' *Oral Health Promotion Lead, Manchester*

> 'It requires joint working and training the trainers..' *Nurse, London*

Some participants described their practice to deliver this form of workforce training in oral health. A common approach appeared to be to hold twice yearly training sessions for frontline staff.

> 'The only thing we could add to this is about the people who are identified in the recommendation should be equipped to deliver it. Twice a year we have training for frontline staff to give them information about the correct messages – it's about ensuring they are giving the correct messages. I think there should be a training requirement attached to this.' *Oral Health Promotion Lead, London*

There were also views expressed that the recommendation required training – as opposed to referencing to a manual - because of the importance of demonstration.

> 'A lot of stuff about oral health is about parenting and practical support and demonstration – that's why training is so important – you can't rely on people having to read it.' *Public Health Specialist, Manchester*

Professional groups and settings identified in the recommendation

Several participants commented that they felt that the list of professional groups and settings identified in the recommendation was good and that the appropriate roles had been included.

> 'These are the right services and groups for me. It seems to cover all the key places – these are the people I work with.' *Oral Health Promoter, London*

Others made additional suggestions for professional groups that they felt should be included.

‘Speech and language specialists work with vulnerable families and they are very important for oral health. And dieticians – they are really important.’ *Early Years Services Manager, London*

‘I think they should include School Nurses and also pre-school nurseries and pre-school settings in the list.’ *Oral Health Promotion Lead, York*

Recommendation 9 Provide oral health information and advice through early years services

Local authorities and health and wellbeing commissioning partners should:

- Ensure frontline staff in early years services including education and health understand and can apply the principles and practices that promote oral health. They should be able to work with families so parents, carers and other family members understand how good oral health contributes to children's overall health, wellbeing and development. This includes:
  - promoting breastfeeding and healthy weaning and food, snacks and drinks that are part of a healthier diet
  - explaining that tooth decay is a preventable disease and how fluoride can help prevent it
  - promoting the use of fluoride toothpaste as soon as teeth come through (see Delivering better oral health for appropriate concentrations)
  - encouraging people to regularly visit the dentist from when a child gets their first tooth.
- Ensure frontline staff can encourage families to develop good oral health practices by:
  - giving a practical demonstration of how to achieve and maintain good oral hygiene and encouraging tooth brushing from an early age
  - advising on alternatives to sugary foods, drinks and snacks as pacifiers and treats
  - using sugar-free medicine
  - giving details of how to access routine and emergency dental services
  - explaining who is entitled to free dental treatment.
- Ensure staff receive training in oral health at their induction and at annual intervals.

Summary

This recommendation was welcomed as a practical means of delivering oral health promotion. There were few concerns with the contents the recommendation, but there were – as with the previous recommendation – concerns about its implementability. Much of the focus of discussion was on the training requirement, which was felt likely to be overlooked because of its position in the recommendation (last bullet point) and because it was considered to be under-developed. Participants provided suggestions for strengthening this aspect.

Understanding

Many participants failed to identify what was significantly distinct about this recommendation from the previous one. There were suggestions that this entire section – and these recommendations in particular – could be reduced in length/combined for easier navigation.

Relevance

Participants welcomed the contents of the recommendation as appropriate and helpful guidance.

While acknowledging that the guidance is aimed at local authorities, some participants felt that GPs and primary care staff – including pharmacists - should have been identified in the recommendation because most parents will consult these groups about general health matters, including oral health.

There was a suggestion that children's services commissioners should be identified alongside 'local authorities and health and welling being commissioning partners'.

There were some specific and detailed concerns about aspects of the contents, particularly on the second bullet point, 'encourage families to develop good oral health practices by – giving a practical demonstration of how to achieve and maintain good oral hygiene…' There was confusion about what this point intended. Some participants understood it to mean providing a demonstration on a child, others that it may involve a demonstration on a model to parents, others that it would involve a demonstration to staff. Still others thought it would involve a talk with resources. In short, participants felt there should be clarity based on their views (below) of what they understood was appropriate.

> 'It's not about cleaning on every surface of the tooth – that's not the point. The correct messages are, 'this is how you get the toothbrush in, brush from an early age, they should be supervised, only put this much paste on the brush. So the key messages are maximising the yield. This shouldn't be about how to reach the back teeth. It implies someone will stand there and show you how to move the brush all around, and by doing that they may well not be giving the correct messages about frequency, supervision and amount of toothpaste to use.' *Consultant in Dental Public Health 1, Manchester*

> 'For 0-5s it's not the tooth brushing method that you teach, it's about teaching the parent the importance of building it in as a habit.' *Oral Health Promotion Lead, York*

Similarly, in relation to the point 'using sugar-free medicine'

> 'It says "use sugar free medicine", when it should say 'encourage the use of sugar free medicine', because I don't think most of these frontline staff are prescribers, and they're not users.' *Consultant in Dental Public Health, Manchester*

Participants in various group discussions and individual interviews commented on the bullet point, 'encouraging people to regularly visit the dentist from when a child gets their first tooth'. All felt that this was too late and that parents should be encouraged to take their child to the dentist from birth.

> 'The earlier the information gets through the better – they need to be going from the first month so that the mother's oral health is looked at – and it's a common misconception – it's what happens in the first six months that will govern what happens later.' *Dental Health Manager, York*

> 'In York we all recommend a visit to the dentist from birth. I am very surprised to see this statement in this document as it stands – it's not evidence based.' *Oral Health Promotion Lead, York*

A number of issues were felt to be missing from the recommendation:

- Parents' role modelling: some participants felt that there should be greater emphasis given within this recommendation to the role modelling of parents, and their tooth brushing behaviours as a key influence on young children.
- Formula feeding
- Frequency and 'grazing' of food intake

There was a suggestion by some that the recommendation should include social care staff in the list of professional roles.

Training

Most participants' concerns on this recommendation focused on the final bullet point. Overall, there was a feeling that this was the key element to ensuring that this and other recommendations that rely on frontline staff working in early years settings are implemented. As a result, participants felt that it should be given greater prominence with the section, and within individual recommendations, and that the wording should be developed to ensure that decision makers commission the appropriate form of training.

> 'It's again down to training and having evidence that they've done training, so that it's got clout..' *Oral Health Promotion Lead, Manchester*

> 'The last bullet point should come first. And it should be 'ensure staff receive such training that they can apply their knowledge in the environments and services that they manage.' And the training must be provided by someone with correct and up to date knowledge.' *Consultant in Dental Public Health 2, Manchester*

> 'I would like to see the word 'mandatory' in the training point.' *Oral Health Promoter, Manchester*

> 'And also some monitoring – because when staff move on – the message gets diluted and changed. I often think I'd like to be a fly on a wall at a health visitor 9 month check handing out the free pack of toothpaste and see what is actually said at that – and does the parent take it on?' *Community Dental Services Specialist, Manchester*

Other participants questioned the feasibility of this aspect of the recommendation. The main concerns were that the task was too big to be achievable, and that there was a lack of good quality training professionals as a result of the demise of community dentistry services over the past few years.

> 'The last bullet point is a big ask and probably a barrier because it looks unrealistic. It could be about developing a programme of training rather than being specific about annual training.' *NHS England Commissioner 1, Birmingham*

> 'Who is going to provide the training? We used to have really good training from community dentist services – but they no longer exist.' *Public Health Specialist, London*

Recommendation 10 Provide tailored information and advice through early years services in areas where there is a higher risk of poor oral health

Local authorities and health and wellbeing commissioning partners should:

- Provide tailored and targeted services to meet the oral health needs of families at higher risk of poor oral health. (This includes young children who are not attending nursery.)
- Ensure early years services identify and work in partnership with relevant local community organisations (see recommendation 1) to develop and deliver tailored oral health advice and information for these families.
- Ensure health and social care practitioners can demonstrate and provide culturally appropriate advice and information.

Summary

There was a difference of opinion across the various groups about the need for a dedicated recommendation that focuses on providing tailored information in areas where there is a higher risk of poor oral health. Some participants considered it to be a repetition of the previous recommendation, with the sole exception that it targets areas of higher risk. Others felt that it was a valuable inclusion and would serve to focus attention on the needs of discrete groups and communities, which would otherwise be overlooked.

Understanding – 'higher' risk and 'very high risk'

Participants in several groups raised a concern that they did not understand what was meant by the term 'higher risk' in the title of the recommendation.

> 'Would it be about free school meal data? I don't know what that means really.' *Health Improvement Manager, York*

> 'Free school meals data is one of the criteria for the two year pathfinder programmes, so it would be a good starting point.' *Children's Services Manager, York*

> 'Or do they mean hard to reach, not engaging, disengaged?' *Oral Health Promotion Lead, York*

While there was acknowledgement that this term was not explained adequately within the recommendation, the intention of the term was taken to mean areas of higher socio-economic deprivation, and this was felt to be appropriate, good and necessary.

However, there was a concern about the use of the terms 'higher risk' and 'very high risk' used in recommendations 12 and 13.

Several participants described their own practice as having working definitions to identify 'higher risk' areas – based generally on areas of higher socio economic deprivation - but none had such a 'rule of thumb' for the term 'very high risk'.

All participants who commented on this issue felt that the guidance should include a clear statement about what was meant by these two terms and how they should be distinguished. Some participants suggested a link to the groups identified on p24 of the document as a possible starting point.

Potential for labelling and stigmatising children

Several participants in several group discussions and individual interviews discussed the potential for labelling and stigmatising children who are identified for this intervention on the grounds that they are socially disadvantaged.

> 'There is, of course, the very real risk that by selecting the vulnerable ones you could have a negative impact on them – like they might be picked on.' *Oral Health Promotion Lead, London*

> 'The point is you can't go in and fluoride varnish all children – you have to identify and target them. There is a social concern of labelling – but it's outweighed by the benefits of the intervention.' *Oral Health Promotion Lead, Manchester*

Relevance

Some participants felt that this recommendation could be included as a couple of bullet points in Recommendation 9, and did not feel that it warranted a recommendation of its own. It was argued that its inclusion served to lengthen an already over-long section and that it would be easier to navigate the section if the key points of this recommendation were included in recommendation 9.

> 'Could 10 not be tagged onto 9? They're virtually the same except having it targeted more at higher risk areas. Just keep the title and make it a bullet point.' *NHS England Commissioner, Birmingham*

Other participants however, felt that it was important to include this recommendation as a 'stand-alone' because it served to focus attention on the needs of specific groups and communities at higher risk of poor oral health.

> 'I think this is admirable to include – but it is difficult work to do – to engage people who are hard to reach or engage.' *Community Dental Health Services Manager, York*

> 'To my mind it's important. It's not just generic stuff, it's specific to certain cultural and ethnic minorities. For instance in XXX we have some unique issues that are specific to the OJ (Orthodox Jewish) community. We go in and we do programmes about tooth brushing – but we have to provide kosher toothpaste – and sometimes it's about the use of images – and diets - the OJ is high in sweet foods... So yes, I think this is important to have.' *Consultant in Dental Public Health, London*

Recommendation 11 Provide supervised tooth brushing schemes in nurseries based in areas where children are at higher risk of poor oral health

Local authorities and health and wellbeing commissioning partners should:

- Consider providing a supervised tooth brushing scheme as part of early years services in areas where children are at higher risk of poor oral health (identified by the oral health needs assessment – see recommendation 4).The scheme should include:
  - supervised daily tooth brushing using free toothbrushes and toothpaste (for use at school and at home)
  - a designated lead person at all establishments
  - access to dental support and guidance
  - support and training for staff to deliver the scheme (this should be recorded and monitored)
  - arrangements for getting informed consent where needed
  - performance monitoring at least once every term against a checklist drawn up and agreed with the oral health strategy and needs assessment group (see recommendation 2).

Recommendation 12 Provide fluoride varnish programmes in nurseries based in areas where children are at higher risk of poor oral health

Local authorities and health and wellbeing commissioning partners should:

- Consider providing a supervised tooth brushing scheme in nurseries in areas where children are at higher risk of poor oral health (see recommendation 11). If this is not feasible, consider a twice-yearly fluoride varnish programme, as part of early years services for children aged 3 years and older.
- Use information from the health needs assessment to target nurseries in areas of higher risk and follow up children who do not visit the dentist regularly.

Recommendation 13 Provide supervised tooth brushing schemes and fluoride varnish programmes in nurseries based in areas where children are at very high risk of poor oral health

Local authorities and health and wellbeing commissioning partners should:

- If resources are available, consider providing both a supervised tooth brushing scheme and a fluoride varnish programme in nurseries in areas where children are at very high risk of poor oral health.

Summary

Recommendations 11, 12 and 13 were considered together because the contents were very similar. Participants understood the hierarchy of the three recommendations and agreed with the intention to gradate and focus the identified oral health promotion programmes at children in areas of increasing risk of poor oral health. The recommendations were welcomed as being evidence based and likely to make an impact on the oral health of children at higher risk of poor oral health. There were few comments on the detail of the recommendation, although some participants raised a concern that the assumed ordering (supervised tooth brushing schemes followed by fluoride varnish programmes) was unnecessary.

Relevance

Most participants felt that it was appropriate to recommend these interventions as a targeted approach to specific groups of children who are at higher risk of poor oral health. A minority of participants voiced concerns about the potential negative impacts of these schemes.

> 'I always worry about tooth brushing schemes because it can lead the parent to think there's no need for them to do anything because it's being done elsewhere.' *Oral Health Promoter York*

Most participants were convinced that the approaches were soundly based on good evidence of effectiveness and saw these interventions as likely to be of benefit.

> 'The evidence is quite strong I think..' *NHS Commissioner 2, Birmingham*

> 'You have some families who do not understand the concept of tooth brushing at all. I think this recommendation is valuable.' *Oral Health Promotion Lead, Manchester*

Implementation

While there was broad support for both interventions, there were several participants who raised concerns about the practicalities of implementation of these interventions. The main concerns focused on the costs of the schemes, the concern about cross infection [tooth brushing schemes] and the need to have a protocol for implementing such schemes – including the involvement of a suitably qualified person to manage them - and the time and human resource required to implement them, including the lack of appropriate and necessary physical infrastructure in many settings.

> 'We've tried them [tooth brushing schemes] and there are big problems with the lack of taps and basins. You can use spit and paper towels and cups, but it's very difficult. And you have to be very careful about the risk of cross infection. You need a high staff to children ratio as well. That's why we tend to only do this in special schools. In mainstream schools it's just too difficult – there are too many children and not enough adults. And you need to have a protocol to follow.' *Oral Health Promoter, London*

Some participants felt that the ordering of the two interventions (supervised tooth brushing first and fluoride varnish programmes second) was an unnecessary addition to the recommendation, and felt that the two programmes should be recommended with equal weight.

‘Both programmes are valuable – if you look at these children – they are less likely to be accessing dentists.’ *Public Health Specialist, London*

‘I would consider both at the same time – there’s no reason to prioritise one over the other**.’** *Health Improvement Manager, York*

Economic analysis

‘As chair of governors I cannot afford a supervised tooth brushing scheme – it works out at £2.50 per child, which is money that has to come from something else like books.’ *School Governor, York*

‘It would be helpful to have the cost per QALY for each of these interventions and have that information stated up front to make the case.’ *Public Health Specialist, Birmingham*

5.4 Section 4 Children in primary education

Recommendation 14 Promote oral health in the primary school curriculum

Local education authorities, school governors and head teachers should:

- Ensure opportunities are found in the curriculum to teach children about the importance of maintaining good oral health. Ensure the information is age-appropriate, relevant to local needs and follows the 'advice for patients' in Delivering better oral health.

Summary

This recommendation was thought to be essential, and many participants confirmed that they do seek to include oral health on the school curriculum. However, there were challenges to this from some school governors and teachers in particular, and participants identified the fact that oral health promotion has to compete with other issues and concerns. The role of school governors was seen as very important here. Ofsted was also thought to be important as all head teachers (of Local Authority run school or Academies) have to take notice of them. More suggestions as to what resources are available to use in school that are not produced or funded by the food and drink industry would be a welcome addition. Participants suggested that school nurses should be mentioned in this recommendation.

Ensuring opportunities are found

Incorporating oral health into existing lessons was thought to be sensible and achievable. The opportunities identified in the curriculum included incorporating oral health into PHSE lessons and incorporating oral health into any obesity programmes.

> 'Work it into the Every Child Matters agenda.' *School Governor and Health Improvement Manager, York*
>
> 'Maybe link with Ofsted stuff. They do look at and monitor obesity work and oral health is linked with obesity - so that could be a way.' *Oral Health Coordinator, Bradford*
>
> 'Something from Ofsted that highlighted oral health - that would be useful.' *Oral Health Promoter, Manchester*
>
> 'Using guerrilla tactics to get it in to the curriculum.' *Oral Health Promoter, Newcastle*
>
> 'As a governor there are some many other Ofsted targets we are trying to reach. It's not going to be top of their list. We try to make sure everything links - e.g. make the link with smoking.' *School Governor, London*

However, there were considerable barriers to making changes to the curriculum.

> 'Schools do not have control over the curriculum; this is decided nationally by the Department of Education. If it is going to be a national issue the depth of education must be

involved in this and say that healthy schools is important and should be part of the curriculum.' *Consultant in Dental Public Health, London*

'The curriculum is set. We won't be able to input until 2016.' *School Governor, London*

Including school governors was seen as important, but some of the school governors interviewed said that schools have so many policies to consider, and most are considered to be more pressing than oral health, that having a model policy on oral health (delivered by the National Governors Association) would be more likely to be adopted. However, having the policy is not enough, schools have to be committed to implementing and monitoring the policy.

'My drawer is full of detailed polices - few of these are monitored.' *School Governor, London*

'It is persuading governors and getting them to find opportunities with the schools administration.' *Healthwatch Representative, Manchester*

'As a governor there are some many other Ofsted targets we are trying to reach it's not going to be top of their list. We try to make sure everything links - e.g. make the link with smoking.' *School Governor, London*

If an opportunity is found in the curriculum the question raised by some was what to include. Citing *Delivering better oral health* was welcomed (NICE should ensure this is referring to the latest updated version) but some thought that this would not solve the problem of what to include in the curriculum.

'It's all very well saying get it into the curriculum but what are people going to use? The MARS foundation oral health pack which say 'a MARS a day does no harm'? We need something other than an industry funding programme on offer - what will the governors and head teacher look to?' *Health Improvement Manager, York*

Participants thought that they needed to draw on an existing tested resource which could be freely used.

'At Foundation level we would go in on general hygiene issue- we would go in with a session and leave them with resources.' *Oral Health Promoter, Bradford*

There was an issue as to how to include Academies in this recommendation and the rest of the guidance.

'One size doesn't fit all - one language for local authorities schools as they have to work with local schools and another language for free schools and academies - as they don't necessarily have to work with the local authority.' *School Governor, Brent*

'Local authorities don't have so much influence on what some schools do, the changes in education and the development of academies.' *Health Improvement Manager, York*

'Academies will respond depending on whether it is a priority for them - the head teacher is very much in control.' *Public Health Commissioner, Newcastle*

Several participants made the case for more Ofsted involvement in oral health.

'Ofsted is the master of them all - head teachers - including Academies. They will do what Ofsted say.' *Oral Health Promoter, Newcastle*

'Ofsted put the frighteners on all schools.' *Health Visitor, York*

Some believed that this recommendation should make reference to supporting the epidemiological programme – see recommendation 4.

'Should include reference to support the epidemiological programme - some school don't even want to get involved and allow people to collect data.' *Consultant in Dental Public Health, London*

Recommendation 15 Promote a 'whole-school' approach to oral health in primary education

Local education authorities, school governors and head teachers should:

- Promote a 'whole-school' approach to oral health by:
  - making plain drinking water freely available
  - providing a choice of food, drinks and snacks that are sugar-free or low in sugar and form part of a healthier diet (including those offered in vending machines)
  - displaying and promoting evidence-based, age-appropriate, oral health information for parents, carers and children (this should be relevant to local needs and include details on how to access local dental services).
- Identify and link with relevant local partners to promote oral health. This could include oral health promotion schemes commissioned by the local authority and local community networks (see recommendation 1).

Summary

The whole-schools approach was supported by all participants as a means of reinforcing the oral health message and minimising the conflicting messages. However, the mention of 'low sugar' food was not supported and the presence of vending machines in primary schools was something many were unfamiliar with. Participants suggested that school nurses should be mentioned in this recommendation.

Clarity, relevance and implementation

The Healthy Schools Programme was mentioned as an existing opportunity where a 'whole-school' approach into which oral health could be slotted. However, some participants stated that not all schools are involved in the Healthy Schools Programme and existing involvement is on the wane.

The whole-school policy would ensure that children are not getting conflicting messages within the school.

> 'Children learn from what they see around them- this whole school approach is important. If kids are given rewards or prizes of toffee and sweets it undermines t e oral health message.' *Health Improvement Manager and School Governor*

> 'Getting people thinking more holistically about oral health.' *Oral Health Promoter, Bradford*

Many participants felt that the advantages of a 'whole-school' approach should also emphasise the added benefits of good oral hygiene to the whole school, i.e. it can have an impact on attendance.

> 'It can have a huge impact on attendance - which helps with the Ofsted inspection.' *School Governor, Birmingham*

> ‘Including oral health in the whole-schools approach is a good idea and you can sell it in, not only because you are improving oral health, but also because it affects the attendance target of 97%.' *School Governor, York*

> 'Work it into different policies and it will be more likely to get traction with governors who have so many other policies to consider.' *Early Years Support Worker, Yorkshire*

Many believed that what would help would be a model policy which people could adapt and apply in their school.

> 'There need to be a model policy. DH worked with National Governors association on a whole school model health policy - it died the death unfortunately - but something like that that needs it be referenced.' *Health Improvement Manager, York*

> 'Need to link to healthy food policy based on a national policy document.' *Consultant in Dental Public Health, London*

Include the wider benefits of good oral health

For primary and particularly secondary school children the wider health and wellbeing benefits of good oral health should be promoted including the social advantages of having good oral hygiene i.e. 'a nice smile gives you confidence'. For teenagers many agreed that the social impacts are more salient than the health impacts as a motivator for change.

> 'If you want to win the X factors you will need a good smile.' *Healthwatch Representative and School Governor, Tower Hamlets*

Choice of food and vending machine

Looking at the second bullet point on ‘choice of food’ many participants believed this should clearly state that it is a ‘choice of healthy food, drinks and snacks that are sugar free’ and that the words ‘*low in sugar’* should be removed .

> ‘Choice is limited in primary schools to fruit and veg only - a bit of raw carrot in the lunch box or we will send you home.' *School Governor, Manchester*

> 'Chocolate is removed from lunch boxes.' *Health Visitor, York*

Some participants in London were concerned about the content of sugar free drinks:

> 'I don’t think we should be promoting aspartame?' *Consultant in Dental Public Health, London*

The mention of vending machines in bullet point 2 was a surprise to many participants, as they asserted that there are no vending machines in primary schools. Of all the people interviewed only two said they thought they had seen a vending machine in a primary school and one of them made sure it was removed when she became a school governor. However, many thought that vending machines should be mentioned to warn people to resist their inclusion in primary schools in the future.

'Covers the fact that someone might try to put a vending machine in the school the future.'
Oral Health Promotion Lead, Kent

Identifying and link with relevant local partners to promote oral health was considered very important as the way to get oral health into school is via more established routes, for example , linking with obesity programmes.

Recommendation 16 Promote oral health in primary schools in areas where children are at higher risk of poor oral health

Local education authorities, school governors and head teachers should:

- Identify primary school staff in schools in areas where children are at higher risk of poor oral health who could be trained to promote oral health.
- Train these staff to give:
  - age-appropriate, evidence-based advice and information from 'advice for patients' in Delivering better oral health
  - advice and information about where to get routine and emergency dental treatment, including advice about costs (for example, transport costs)
  - advice and help to access local community networks offering further information, advice and support about general child health and development.
- Implement and promote local authority-commissioned oral health promotion schemes.
- Look for opportunities to talk with parents or carers about, and involve them in, improving their children's oral health. For example, opportunities might arise at parent-teacher evenings, open days or by encouraging parents and carers to get involved in developing the school food policy.

Summary

This was considered to be an important recommendation as it highlights the requirement for evidence based local authority commissioned programmes in primary schools. Tapping into existing community assets was considered a good way forward. However, some elements were considered aspirational but difficult to implement. Training school staff was felt unlikely to happen, but providing local authority funded specialists to go into schools was a more feasible option. The tone of this recommendation could be changed to say 'should work towards' achieving these goals.

Who should take action?

In terms of who should take action, school nurses and the school nursing team were mentioned, as was Ofsted. Several participants suggested that Ofsted should include oral health education outcomes in their assessments.

There was some ambiguity when reading 'Local authorities and school governors'

> 'Academies have school boards rather than governors. NICE should look at the language so they embrace all possibilities - governing bodies or equivalents.' *Healthwatch Representative, Newham*
>
> 'You should include reference to the PTAs.' *Public Health Consultant, Leicester*
>
> 'Children's trust boards - where they are present they do have great influence.' *Public Health Consultant, Leicester*

Training staff

Many participants believed training staff to deliver advice and information would be difficult as they have so much to do already. Oral health is low down the list of their priorities.

> 'It's a big ask of school to do this work.' *Public Health Advisor, London*

> 'Who are these staff we are going to find to give this advice?' S*chool Governor, London*

> 'Also , it's not the teaching staff it's the support staff, working with targeted parents, who would probably need this training if it was available - and they had the time to do it.' *School Nurse, York*

> 'This is too aspirational - not feasible at the minute.' *General Dental Practitioner, Whitby*

Furthermore, investing in training staff to deliver advice and information would create some problems because of the turnover in staff.

> 'You can train a member of staff and next year they are gone - there is nothing about continuity and sustainability.' *Health and Wellbeing Board Member, Brent*

Many participants preferred assisted help (public health, health promotion specialists) to be brought into the school at key times during the year.

> 'This is not really a goer, to expect schools to take this on alone. In deprived areas with multiple problems and many languages, you need public health to go in and assist the school with these and other health issues.' *Public Health Commissioner, Enfield*

> 'We train people under the health promotion schemes to work with the schools.' *Public Health Commissioner, Enfield*

Identifying those at higher risk

Many participants thought that teaching and support staff should develop skills to identify children at risk of many health and social problems of which oral ill health is one.

> 'Gently identify children at higher risk and involve parents - episodes of toothache is a good indicator.' *Oral Health Promotion Lead, Newcastle*

There was no consistent method described by participants for describing and identifying a school and a child at higher risk. Some participants described how they used a compound deprivation measure.

> 'We identify 5 things that put children at risk - free school meals etc. ' Oral *Health Promotion Lead, Manchester*

> 'They need to go into the document and assess the risk factors - a hyper link would be good.' *Consultant in Dental Public Health, London*

'In London, schools can be very mixed in terms of pupils from deprived and well off backgrounds, so it is difficult to identify a high risk school per se.' *Healthwatch Representative, Brent*

'The number of children with toothache might be the best indicator.' *General Dental Practitioner, Yorkshire*

'Schools need to be provided with the information to do this.*' Public Health Consultant, Leicester*

Oral health promotion schemes

The recommendation to implement local authority based schemes was welcomed, as it would steer people away from dubious industry-sponsored programmes (the MARS programme was mentioned). However, identifying schemes was difficult. *Delivering better oral health* was seen as a good start but more information about oral health promotion in schools, that was not so clinically focused as in that document, was needed.

'There needs to be some sort of standard for delivering oral health education.' *Oral Health Promotion Lead, Birmingham*

There were also doubts about the quality of current oral health promotion in schools.

'Some of the things children are told about oral health education in schools are just not correct.' *Dentist, York*

Building on existing programmes and making the most of existing resources was seen as the most feasible option.

'Asset based - involving community assets rather than creating new programmes.' *Oral Health Promotion Lead, Bradford*

'Identifying opportunities where we can piggy-back on other areas like obesity.' *Health Visitor, York*

Participants gave several examples.

'The "Busy Teeth" resource for early years; the "Action aid" resource; "*Bright Bites"* and a book called "*To be a Star*" which we adapted for use in areas of highest need.' *Oral Health Promotion Lead, York*

Involving parents

The last bullet point which describes involving parents was seen as a good idea, but many participants believed the parents of children most at risk from many health and social concerns would be the least likely to attend the parents' evenings.

'The kids that are at higher risk of poor oral health - kids struggling academically from problem families, the parents are less likely to turn up at a parents evening. We have to do

home visits to discuss academic progress with these parents.' *Health Improvement Manager and School Governor*

Some participants re-iterated the point that it is the support staff that are important here.

'It's not really the teaching staff it's the support staff working with targeted parents.' *Oral Health Promotion Lead, Newcastle*

Recommendation 17 Provide supervised tooth brushing for primary schools based in areas where children are at higher risk of poor oral health

Local education authorities, school governors and head teachers should:

- Consider providing a supervised tooth brushing scheme in primary schools in areas where children are at higher risk of poor oral health. Focus in particular on reception and year 1 (up to age 7). (See recommendation 11.)

Recommendation 18 Provide fluoride varnish programmes for primary schools based in areas where children are at higher risk of poor oral health

Local education authorities, school governors and head teachers should:

- Consider providing a supervised tooth brushing scheme in primary schools in areas where children are at higher risk of poor oral health (see recommendation 17). If this is not feasible, consider providing a twice-yearly fluoride varnish programme.

Recommendation 19 Provide supervised tooth brushing and fluoride varnish programmes for primary schools in areas where children are at very high risk of poor oral health

Local education authorities, school governors and head teachers should:

- If resources are available, consider providing both a supervised tooth brushing scheme and a fluoride varnish programme in primary schools in areas where children are at very high risk of poor oral health.

Summary (Recommendations 17, 18 and 19 as a set)

Overall participants were very positive about these recommendations (17,18 and 19) agreeing that multiple interventions should be applied to high risk areas to ensure disadvantaged children are protected and given the best opportunity to have good oral health.

Understanding – risk terminology

As with recommendations 10, 11, 12 and 13, there was some confusion about the terminology of 'risk' used in recommendations 17, 18 and 19. None of the participants could define the difference between 'higher risk' and 'very high risk'. Participants put forward what they felt may have been the intention of NICE, that 'high risk' may equate to the bottom 20 per cent of people on an index of deprivation and 'very high' the bottom 10 per cent on the index of deprivation.

To identify areas of high deprivation some participants reported using a range of measures; high deprivation post codes; people who have difficulty accessing services e.g. Eastern European communities, and the incidence of toothache.

'Number of children in the class with toothache.' *General Dental Practitioner*, *Yorkshire*

'We use a compound variable to identify the schools which needed fluoride varnish - four measures - school attainment, school attendance, ACORN deprivation index and free schools meals.' *Public Health Advisor, London*

Free school meals and the pupil premium were also mentioned by several participants.

'Free schools could be an indicator but everyone is updating their free school meals data because every child on free school meals attracts a pupil premium which can mean a lot of extra cash for the school.' *School Governor, York*

But identifying higher risk was challenging in some areas.

'In London schools can be very mixed in terms of pupil from deprived and well off background so it can be difficult to identify a high risk school.' *Healthwatch Representative, Brent*

However, no one could come up with an agreed definition of the distinction between 'higher risk' and 'very high risk'. One suggestion was as follows,

'...probably families on safe guarding child protection registers or families in temporary accommodation.' *Health Visitor, York*

A clearer definition of the risk categories was requested by all participants.

Supervised tooth brushing and fluoride varnish - which is more effective?

There were questions about the implicit hierarchy of interventions suggested in the recommendations i.e. tooth brushing first, if not possible then fluoride varnish in 'higher risk' or both interventions in 'very high risk' areas.

Participants were unsure if this was supported in the cost effectiveness evidence. Some had a sense that one or other scheme may be more cost effective, but no one knew for sure.

'I think the Cochrane review recommended varnish above tooth brushing.' *Senior Dental Officer, Tower Hamlets*

Most participants believed both programmes were valuable and should be targeted at children at higher risk to give them the best chance. However, with limited resources, tough funding decisions have to be made, and there was a request from many participants for the inclusion of a statement on the cost effectiveness of the different approaches.

'Both programmes are valuable as those kids at higher risk are less likely to visit a dentist and would benefit from varnish administered in school.' *Oral Health Promotion Lead, Newcastle*

'Varnish has to be targeted - it's too expensive otherwise.' *Senior Dental Officer, Manchester*

'Fire everything at them - but as a commissioner you can't do everything.' *Public Health Commissioner, London*

'We need some economic analysis here - how do I decide as a commissioner what to fund?' *Public Health Commissioner, Newcastle*

Supervised tooth brushing

There was general support for supervised tooth brushing schemes as they were felt to help train children for life.

'Teaching tooth brushing is a skill for life and varnish should not be alternative to that but a supplement.' *Oral Health Promotion Lead, Birmingham*

Implementation

While supervised tooth brushing schemes were believed to be more cost effective than fluoride varnish for the whole population of children within a school (regardless of whether an indivdual child was at high/very high-risk or not) , some thought it was a challenge to introduce these schemes into lessons in an already packed timetable. Furthermore, the logistics of providing equipment for children to practice (bowls, water etc.) presented challenges for some.

Others said it was possible and not too disruptive.

'Schools don't like them (tooth brushing schemes) - only the old Victorian school have sinks in the classroom.' *Public Health Consultant, London*

'The resistance to tooth brushing programmes is considerable and shouldn't be underestimated. I have tried to get this into schools but the amount of will it takes to get in requires some fairly unique teachers to smooth it through.' *Public Health Specialist, Tower Hamlets*

'People have piloted dry tooth brushing school programmes and they seem to be working well.' *Oral Health Promotion Lead, Kent*

There were also some concerns that supervised tooth brushing in schools would absolve some parents from their responsibilities.

'Oh - the schools doing that now - I don't have to.' *Oral Health Promotion Lead, Bradford*

But many participants were aware of parents who never brush their own teeth, so are providing no instruction to the child.

'Some families don't understand the importance of tooth brushing.' *Oral Health Promoter, Newcastle*

Fluoride varnish

Many participants believed fluoride varnish to be a more expensive intervention but probably more cost effective in terms of preventing caries in disadvantaged children. However, there was concern

that this should not be recommended as a substitute for tooth brushing schemes. Some participants felt that suggesting fluoride varnish alone can undermine the locus of control from the child's and the parents' responsibilities, who may invest less time in supervised tooth brushing as a result.

> 'You put tooth varnish on and they haven't got a toothbrush at home.' *Dental Therapist, Newham*

> '"We are the dentists, we will sort it out "- it's shifting the whole locus of control thing with disadvantaged communities.' *Consultant in Dental Public Health, London*

> 'Protect them in primary school with varnish, then they go to secondary and they are not protecting themselves because they are not brushing.' *Public Health Specialist, Leicester*

Free tooth paste and tooth brushes

Some participants questioned the absence of a recommendation to consider providing free tooth paste and toothbrushes twice a year to selected school years.

> 'Look at Scotland where it is national programme for all schools - look at the reduction in decay rates and this is primarily based on tooth brushing programmes. In Scotland the government funds free toothbrush/toothpaste packs twice a year (age 3 and age 4 – every 6 months and age 5 -one pack a year) plus a health visitor paid for by the Scottish Government.....they have good reductions in decay by giving out free toothpaste - but it's not a recommendation here.' *Consultant in Dental Public Health, London*

> 'Buying and distributing a free toothpaste pack is a good way to soak up any end of year under spend!' *Public Health Specialist, London*

> 'Fluoride varnish can cost up to £30 per varnish? How much does tooth paste cost - £2.50 a year? It is just as effective and cheaper? *Dental Health Practitioner*, *London*

Consent

As parental consent is required to administer fluoride varnish, this can be a barrier in terms of the time invested to secure that consent.

> 'Because of the issue of parental consent, we have only achieved varnishing for 60-65%. The 30% I am missing are probably the ones who need it more. It takes a massive amount of time to do - the cost for the dentists' time is not that much in comparison.' *Senior Dental Officer, Tower Hamlets*

A minority of participants mentioned that the perception that the varnish included alcohol was a problem they had to address in some of the predominately Muslim communities they served, but this perception was mainly caused by translation/language problems.

> 'There was a problem that people thought there was alcohol in the varnish - but that has been sorted out now - it's more of a language problem, there are 70 languages spoken in Tower Hamlets.' *Senior Dental Officer, Tower Hamlets*

Stigmatising higher risk children

Although the recommendations (18 and 19) say ‘higher risk’ and ‘very high risk’ areas, there was some concern that ‘higher risk’ children may be identified, thus stigmatising those children. The counter argument to this was that greater stigma would occur later in life when the consequences of not intervening earlier would become more obvious. Furthermore, with the ‘pupil premium’ and free school dinners , disadvantaged children are already identified for more attention so this additional initiative will not really add much, if anything, in terms of increased stigmatisation of disadvantaged families.

5.5 Section 5 Secondary education

Recommendation 20 Include information about oral health in the secondary school curriculum

Local education authorities, school governors and head teachers should:

- Ensure opportunities are found in the curriculum to teach the importance of maintaining good oral health. This should use age-appropriate, evidence-based information based on 'advice for patients' in Delivering better oral health.
- Ensure school nursing services encourage good oral health, including effective tooth brushing, use of fluoride toothpaste and regular dental check-ups.
- Ensure all school leavers know where to get advice and help about oral health, including dental treatment and help with costs. Provide them with details of relevant services, including links to relevant local community networks.
- Consider identifying and training secondary school staff in areas where children and young people are at higher risk of poor oral health who could advise on dental issues. This includes giving advice about dental treatment and costs, and promoting oral health among students (for example, explaining the links between diet, alcohol, tobacco and oral health).

Summary

Overall this recommendation was considered to be clear and relevant. Participants could identify several opportunities to include oral health in the curriculum and agreed that equipping children before they leave school is a good investment in oral health improvement. The absence of the 'whole-school' in this recommendation was questioned as it was felt to be relevant in both primary and secondary schools. The recommendation of training of secondary school staff in oral health issues was considered to be more of an aspiration and unlikely to be implemented, given competing priorities, the time available to staff and the high turnover of staff in certain areas.

Clarity, relevance and implementation

Secondary schools

Compared to primary schools, many participants considered secondary schools a less accessible setting for oral health promoters. There was also a view that greater investment should be made in younger children as the 'return on investment' was likely to be greater among the younger group.

While oral health education is important throughout the school years it was thought to be essential to equip students with good advice and information before they leave secondary education settings - as some them will not go on to tertiary education and be exposed to further oral health education opportunities.

Some participants questioned why tertiary education settings were not included in this or other recommendations. Others assumed it would be covered by the section 'providing adult services' but most agreed that it should be mentioned somewhere in the guidance.

While out of the jurisdiction of the local authorities, there was still concern that academies were not mentioned here.

The mention of the School Nurse in this recommendation was welcomed. Many believed that they should have been mentioned in the primary school recommendations.

As a motivator to do more on oral health, schools should be made aware of the benefits to school performance in helping children maintain good oral health e.g. lower absenteeism which will help with the Ofsted report.

Finding opportunities in the curriculum

The suggestion that oral health promotion be worked into the existing curriculum was welcomed as many believed that trying to introduce a specific oral health teaching session into secondary schools was challenging, given all the demands on the curriculum to include an ever increasing number of new government initiatives. Suggested entry points into the curriculum included: citizenship, sports lessons - whereby students are encouraged to hydrate with sugar free drinks. Opportunities for including oral health in sports lesson could also address issues around sports related injury/trauma prevention - for example the use of gum shields in rugby, boxing and martial arts.

Some participants mentioned that opportunities could also be found in extracurricular activities.

> 'It's not just opportunities in the curriculum but extracurricular activities.' *Health and Wellbeing Board Member, Brent*

The Healthy Schools programme was identified as a good opportunity to include oral health education, but it was acknowledged that not every school was part of this programme and participation in this initiative was felt to be dwindling.

Participants agreed that a version of the 'whole-school' approach described in recommendation 15 for primary schools should be copied into recommendation 20. Doing this would address the issue around school meal policies and the availability of healthy snacks on school premises, including vending machines. While participants thought that few primary schools have vending machines the impression was different for secondary schools and it was felt that this approach should be highlighted in this recommendation.

> 'Can't you just copy and paste "whole school approach" in recommendation 15 and put it in recommendation 20.' *Public Health Specialist, London*

There was agreement that a whole-school policy should also include reference to approving plans near schools for fast food shops etc. As the local authority is responsible for schools and also has responsibility for approving retail outlets - and is now responsible for public health (including oral health) , there was felt to be an opportunity to join up these roles and responsibilities.

'Approving plans nears school is important - we are all part of the council now - we are missing a trick here.' *Public Health Commissioner, Brent*

'It's ok having a policy but they tend to stay in the drawer. If they are applied in schools that's all very well but then children go out to lunch and are exposed to so many unhealthy choices... so working with local shops is important.' *Oral Health Promotion Lead, Kent*

'It's a hard slog getting oral health into schools - you have to work hard over the years.' *Oral Health Promotion Lead, Birmingham*

'People in the local authority who are commissioning must be on the same page as those delivering the work in schools.' *Tobacco Control Officer, London*

Linking oral health promotion to motivating factors of secondary school aged children

Participants from a number of groups discussed their experience of success in engaging children in secondary schools by focusing on the key concerns of this age group – namely appearance and self-esteem. They felt that the guidance should acknowledge this reality and encourage oral health promotion to link to teenagers' concerns and interests in – for instance – teeth bleaching, dental braces, piercings of the lips and tongue and oral hygiene in general.

Details of relevant dental services

Providing school leavers and other adults with information about dental services, particularly NHS dental services was supported by everyone. Many believed the current information available to people to be very limited and out of date. The website 'NHS Choices' provides links to NHS dentists but many participants believed the data base needed updating. Several participants felt that dentists should be allowed to update the website with their details.

'NHS Choices is the only thing they can use to find a free dentist..... It's not up to date but it's the only thing around..... At one point we (dental practices) weren't allowed to update it or change it.' *Dentist, York*

'Even the area teams don't know who is and who isn't an NHS dentist.' *General Dental Practitioner, Whitby*

'Healthwatch is where people can complain. Our Healthwatch is making links with local dental practices.' *Healthwatch Representative, York*

As with many of the recommendations, the question 'who is going to allocate funds to this issue?' was raised.

'Financial constraints - where is the money coming from? We need to make the case for all of this and the guidance should help us make the economic case for prevention.' *Tobacco Control Officer, London*

Training of staff

It was noted that in this recommendation it states, 'consider identifying and training ...' whereas in recommendation 16 the statement is more emphatic, 'identify primary school staff...'

Identifying and training secondary school staff in areas where children and young people are at higher risk was thought to be a good recommendation, but many thought it was more of an aspiration and unlikely to be implemented. Staff have too much to do already with existing requirements and the introduction of other new initiatives that have a higher priority. For staff working in deprived areas there is even more demand on their time. Oral health training is not going to be high on their list of new things for which they will receive training.

As part of the 'whole-school' approach participants agreed that this should include discussions about the role of diet, tobacco (not just smoking) and alcohol in oral health. However, a more likely and achievable scenario is to include oral health issues in established lessons on diet, tobacco (not just smoking) and alcohol. Several participants suggested including oral health in sex education lessons as part of social development and also making the link with oral cancer.

> 'Look at relationships and sex education programmes and include it there.' *Oral Health Promotion Lead, Sussex*

> 'It's not just about caries it's about oral cancer and HPV.' *Consultant in Dental Public Health, Leicester*

> 'We did something about tongue piercing.' *School Nurse, London*

For primary and particularly secondary school children, the wider health and wellbeing benefits of good oral health should be promoted including the social advantages of having good oral hygiene i.e. 'a nice smile gives you confidence'. For teenagers, many agreed that the social impacts are more salient than the health impacts as a motivator for change.

> 'If you want to win the X factor you will need a good smile.' *Healthwatch Representative and School Governor, Tower Hamlets*

In the last bullet point of this recommendation it states, 'dental issues'. Most participants agreed that this should be changed to 'oral health issues'.

5.6 Section 6 Providing adult services

Recommendation 21 Promote oral health in the workplace

Local authorities and NHS England area teams should:

- Work together to promote oral health using the 'advice for patients' in Delivering better oral health. This should be part of efforts to improve general health and wellbeing at work.
- Consider commissioning programmes to raise awareness of evidence-based oral health information and advice.
- Display information on all premises about local dental services. This information should include details of eligibility for reduced cost or free treatment. It should also include details on how to obtain appropriate forms (for example, for people receiving certain benefits, including pregnancy and maternity benefits).
- Consider displaying national guidelines on oral health in all premises. This information should include, for example, details about effective oral hygiene techniques, including the use of fluoride products and tooth brushing techniques.
- Consider providing employees with dental services, free or discounted toothbrushes, fluoride toothpaste and other oral hygiene products in the workplace.

Summary

There was considerable confusion as to whether this recommendation referred only to local authority and NHS premises, or to all workplaces. Many participants felt that, if this were the latter, it would be too onerous, partly due to the sheer volume of businesses in each area, but also because it would be impractical to work with small businesses, especially in certain settings.

If the guidance covered LA/NHS workplaces, participants felt this should be a contractual issue, and that this should be more prescriptive, and therefore more likely to be implemented.

Clarity and relevance

Many participants felt this recommendation encompassed a volume of work which would be impossible for most of them to influence.

> 'This is very aspirational!' *CCG Member, London*

There was uncertainty about the scope of the recommendation and whether it was intended to apply only to local authorities own workplaces, or more broadly to commercial and other workplaces.

> 'Does this mean local authorities' own workplaces?' *Oral Health Promoter, Manchester*

> 'If this is about local authority or health premises, well, OK – but is it about businesses?' *Oral Health Promotion Manager, York*

> 'I don't understand which workplaces this means. If it's about all workplaces, then I don't think that's something we'd know how to approach.' *Disability Charity Manager, London.*

There was a sense that this might have been located, more logically, under Recommendation 6 ('creating environments that promote oral health'), since it does not cover the provision of 'services', *per se.*

Some felt there should be a role for PHE, working together with local authorities and NHS England.

Some participants, speaking from recent experience, said that working with businesses was time-consuming, and did not always bear fruit. Giving information and advice on oral health was not a priority for businesses, especially if employers could not see a cost benefit.

> 'Is there data on, say, time lost to the company if people are off with toothache? *'Public Health Consultant, York.*

Some participants asked why the reference to 'advice for patients' was cited, since the target audiences would be employees rather than patients. It was assumed that this was what the relevant section had been titled, in *Delivering better oral health*, and that this wording may be amended.

Some mentioned the difficulties of getting any information displayed in workplaces.

> 'If you had a business that was a garage with only two mechanics, would you have something on oral health?' *Oral Health Promotion Manager, London*

There was confusion, and some cynicism, about the reference to 'national guidelines'.

> 'Why on earth would any workplace display 'national guidelines'? Do they mean health promotion - posters, etc.?' *Oral Health Promoter, London*

The complexities of working with a wide variety of employers were seen as a major difficulty, with some participants advocating that this should be attempted, via other key players.

> 'Should this be the responsibility of 'occupational health' in bigger employers?' *Public Health Consultant, London*

Speaking about their own workplaces, some said that providing such information was the norm, and they welcomed the addition of oral health as an issue with which they could help employees and service users.

> 'This is very much in line with how we work. We're promoting oral health amongst residents now, and we make sure that - residents* and staff - they all get the same advice together. We'll run an oral health promotion week on the back of this (the NICE guidance).' *Homeless Charity Director, York.*
>
> (* 'Residents' here refers to homeless people housed temporarily, on resettlement and re-housing plans)

There was a concern that some employees may not wish to ask openly about welfare benefits, and this should be done in a confidential way.

There were also some suggestions that information and advice could be provided in less 'traditional' ways.

> 'You could use e-mail or SMS in a business (to get messages across).' *Dentist, York*

Some were keen to do more on health promotion, though this was dependent on resources.

> 'We had a health awareness week; healthy eating was one of the things we looked at and we provided a healthy menu that day. A dental practitioner was due to come in to give a presentation, but they didn't come.' *Homeless Charity Director, York.*

Turning to the last bullet point, some said that there was a considerable challenge in making a case to employers,

> 'I'm looking at the idea of 'free stuff' (last bullet point): that's quite a cost implication!' *Independent Health Services Provider, York*

There was also a suggestion that there would need to be a 'return on investment' for such initiatives.

Recommendation 22 Commission targeted services for groups of adults at higher risk of poor oral health

Local authorities and NHS England area teams should:

- Provide tailored oral health interventions, including outreach services, to meet the needs of people at higher risk of poor oral health who live independently in the community
- Review adult community health and social care service specifications to ensure oral health is included in care plans.
- Ensure services deliver evidence-based oral health advice in line with the 'advice for patients' in Delivering better oral health.
- Ensure services promote oral health, for example by:
  - giving demonstrations of how to clean teeth and use other oral health and hygiene techniques (as appropriate)
  - promoting the use of fluoride toothpaste
  - providing free or discounted materials including fluoride toothpaste and manual and electric toothbrushes.
- Ensure local care pathways encourage people to use dental services.

Summary

There was a discussion about the definition of 'higher risk'; some participants felt the list presented (pages 1 and 2 of draft guideline document) lacked focus. The phrase 'some black, Asian and minority ethnic groups' elicited the question: 'Is this evidence-based?' There was also a question as to why certain ethnic groups should be singled out. Was NICE saying some cultural norms within certain groups needed to be addressed i.e. the practice of sugaring the milk in babies bottles creating 'nursing bottle caries'? Participants felt the reason for identifying certain black and Asian groups needed explanation. Also most participants tended to prefer the more established term 'Black and Minority Ethnic (BME) groups'.

There was concern about the cost of targeted services, with many participants concerned that the initial mapping of local populations was difficult, time-consuming and may be inaccurate.

Clarity and relevance

The specific reference to local authorities and NHS England was questioned. There was a discussion about how different, key organisations should work together. There should be recognition of the fact that third sector organisations were often commissioned to provide services, especially for vulnerable adults.

> 'Local authorities should ensure that PHE does this.' *CCG Member, London*.
>
> 'How are CCGs involved? *'Public Health Consultant, Manchester.*
>
> 'This should include voluntary services.' *Dentist, York*

Some participants suggested that ‘higher risk groups’ should have more detailed definitions and include migrants and travellers.

There were questions as to what sort of ‘outreach’ services was desired, how these were targeted, and how they provided value for investment.

On the suggestion to provide toothpaste and toothbrushes, third sectors organisations hinted that ‘beggars can’t be choosers’ and said they were grateful for whatever products they had donated.

> 'I think that's what we get (from dental practices) is what they’ve had donated to them - by a sales rep. I don’t know if what we have is the best kind, but now I’m going to ask! We don’t have a lot of choice - trying to get money out of the CCG is very difficult in this day and age.' *Homeless Charity Director, York.*

On the final bullet point: encouraging people to use dental services, there was some concern about the financial and funding implications of this.

> 'Isn’t this going to create more demand for dental services? Is there money for that or isn’t it capped?' *Public Health Consultant, York.*

Recommendation 23 Develop specifications for targeted, 1-to-1 services for adults at a higher risk of poor oral health

Local authority commissioners and health and wellbeing commissioning partners should:

- Ensure specifications for 1-to-1 services delivered to people at higher risk of poor oral health include a requirement to promote oral health in the context of overall health and wellbeing. Relevant services include: domiciliary care, services caring for or supporting people with learning difficulties or mental health problems, and substance misuse services.
- Ensure service specifications include:
  - an assessment of oral health, including referral or advice to go to a dentist or other clinical services (this may be because of pain, concerns about appearance or difficulty in eating)
  - making oral health care – through self-care or clinical services – an integral part of care planning
  - support to help service users maintain good oral hygiene
  - staff training in how to promote oral health during inductions and once a year (see recommendations 9 and 24).

Summary

As with recommendation 22, there were questions over the definition of 'higher risk' as used in this recommendation. Overall, participants discussed the paucity of resources in the settings listed (caring for people in their own homes, working in centres with various service users). There were questions about the definition of '1-to-1' and whether this would involve brief interventions, or something more complex.

Clarity and relevance

Some felt a description of a '1-to-1 service' would be helpful.

> 'What does 1-to-1 mean?' *Drop-In Centre Manager, Manchester*.

On the last bullet point ('staff training'), many felt that 'staff'; should include volunteers, especially since many centres were run mainly by voluntary workers.

> ''Workers' would be better than saying 'staff'.' *Public Health Consultant, York.*

> 'They should train the wider workforce.' *Social Enterprise Manager, York.*

Implementation

Participants who worked in community and voluntary sector day care and drop-in centres spoke of the day-to-day interaction with service users. Clients had many other pressing priorities, especially if they were homeless, unable to receive benefit payments, or had other health concerns.

> 'I can't say to someone – so you've slept out under the arches last night; let me talk to you about toothpaste.' *Drop-In Centre Manager, York*.

There was agreement that service users may well respond to simple messages about oral health, as they often had regarding smoking. However, 'overall health and wellbeing' was regarded as irrelevant and inappropriate to many; suggesting that clients cut down on sugar was challenging. Other simple, strong messages may be more successful.

> 'They're much more interested in oral cancer, to be honest. If you can give a simple message about that, maybe related to smoking, then you can have a longer conversation.' *Drop-In Centre Manager, York.*

> 'Appearance is the issue, more than anything else.' *Homeless Charity Director, York.*

Many working with vulnerable adults spoke about the time required to help clients make changes, and said that a great deal of sensitivity and experience was needed, to gauge the right time to intervene.

> 'We have a lot of IV drug users, and many of them have very poor dental hygiene - and of course they like to take 98 sugars in their tea! It's like any behavioural change: it has to be at the right time. There's a small window of opportunity when you can say something. But we do show people how to brush their teeth, and we do have a 'medical room' here, so all we need are the dentists!' *Homeless Charity Director, York.*

Participants working with people with learning disabilities said that 1-on-1 interventions, especially with dental practitioners, would demand more time, and that this may have cost implications.

> 'People with autism have high level needs. They can be extremely anxious. They can be badly affected by noise, or by strong lights. Any appointment would take at least twice as long as with a 'neuro-typical'* patient.' *Disability Charity Manager, London.*

> (* used to denote non-autistic)

Other third sector staff working directly with services users said that health services could provide opportunities to promote oral health, and general health and wellbeing.

> 'If they're having a service provided for them, the dynamic is different. It's not just someone standing up and dishing out advice. Anyone who has done Crisis at Christmas (homeless shelters) knows that dentistry and chiropody were always popular - and hairdressing! And those are the times to engage, 1-on-1. People are often mistrustful of anybody with whom they haven't built up a relationship.' *Crisis Worker, London.*

Some suggested that daycentres could be used more, with services provided on a regular basis.

> 'We want people to be accessing mainstream services, but there is potential in daycentres, where they'll be around people they know. I don't know if these services are funded anymore, but they'd help in overcoming a lot of the anxiety. People with autism can have bad experiences in the waiting room, before they even get in to see the dentist.' *Disability Charity Manager, London.*

Recommendation 24 Train frontline staff working with adults at higher risk of poor oral health

Local authorities and health and wellbeing commissioning partners should:

- Commission training for frontline staff to ensure they can meet the needs of adults in groups at higher risk of poor oral health. The training should be based on 'advice for patients' in Delivering better oral health. It includes:
  - How good oral health contributes to people's overall health and wellbeing.
  - The consequences of poor oral health, for example, dental pain and infection. (This can exacerbate symptoms associated with dementia and can also contribute to malnutrition among older people.)
  - How the appearance of teeth contributes to self-esteem.
  - Basic assessment and care planning for oral health.
  - Causes, symptoms and secondary prevention of dental decay (including root caries in older people).
  - Causes, symptoms and how to prevent gum disease. This includes: the role of plaque in gum disease and how it can affect the immunity of people with diabetes; the role of high sugar diets; the link between the use of sugar-sweetened methadone and poor oral health; and smoking as a risk factor for gum disease and oral cancer.
  - Techniques for helping people maintain good oral hygiene (including the use of fluoride toothpaste).
  - Local pathways for routine, urgent and domiciliary care, and specialist services.
  - Entitlements to free dental treatment or help with costs.

Summary

Throughout the fieldwork, participants pointed to the fact that the recommendations identified many valuable actions that would help to improve the oral health of the key groups identified. However, many respondents perceived training as being of relatively low priority within the guidance, and felt that references to training were insufficiently demanding to ensure they would be implemented. There were competing views that either individual recommendations should include a training requirement, or that training should be more clearly signalled as a separate recommendation and perhaps not put at the end of a long list of recommendations. Either way, respondents agreed that there needed to be more emphasis on addressing the training needs in this area.

Clarity, relevance and implementation

Overall, the final recommendation was seen as important and as necessary to underpin many of the other recommendations. However, there was concern that the list covered too many issues. There was a call for a 'tiered' approach.

> 'This has to be at different levels. Staff need to be clear about the level of advice or information they're giving.' *Social Enterprise Manager, York*

Who will deliver the training?

Training was considered important, but, time and again, participants asked, "Who's going to deliver this?" Participants said that training staff in the third sector working with vulnerable adults was often difficult to organise, and they felt this was not always appreciated.

> 'We have 35 staff, all on rotas. Any piece of training we do here has to be run three or four times.' *Homeless Charity Director, York*

A response (first voiced in recommendation 7 for the general population) was reiterated that good quality oral health training should be included in any new contract with providers of services for adults at high risk. From the group discussions and the in-depth interviews, there were no examples provided of this happening when applied to higher risk groups but there was good support for the suggestion.

As with previous recommendations that included a reference to training, the issue as to who would commission and pay for it was raised again.

> 'Who will pay for this?' *Health Improvement Manager, York*

> 'I work in a charity. Who will pay for me to go on this training, there are so many other more pressing priorities.' *Charity Worker, Birmingham*

> 'These things are important but when you are dealing with someone who is hungry and homeless other training comes first.' *Homeless Charity Manager, Manchester*

Many participants believed that it was right to give the local authorities the lead to deliver this recommendation.

> 'Local authorities should commission training to deliver this.' *Public Health Commissioner, Birmingham*

Stand-alone training or working oral health issues into other health training?

Positioning oral health within a range of wider health issues faced by adults at higher risk was thought to be a more feasible approach by many and the best way to move oral health higher up the agenda.

As well as providing stand-alone oral health training many thought that existing training for frontline staff to address many of the other health issues such as smoking, alcohol, drugs and mental ill health should include references to oral health. This could be worked into a range of service specifications for those delivering services and support for higher risk adults.

Moreover, emphasising the fact that oral health could be an early warning for more serious life threatening conditions should also be highlighted in the training recommendations as this would give it more leverage.

> 'Some of the signs of oral ill health being an early warning for other diseases will give the issue more traction when working it into existing training programmes.' *Public Health Commissioner, Birmingham*

Linking oral health training with other training would also help address one of the major challenges facing oral health i.e linking oral health with general health, which was voiced by many participants, in different ways, during the course of the fieldwork.

> 'People don't see oral health as part of general health and this guidance needs to make that very clear.' *Public Health Manager, Walsall.*

6 Discussion

This fieldwork set out to explore a broad range of professionals' views on the draft guidance. The professional groups included dental and oral health specialists, and professionals working in each of the key settings and with each of the key population groups identified in the guidance. The fieldwork involved both group and individual interviews.

Every effort was made to ensure that participants were familiar with the contents of the guidance ahead of interview, but inevitably, some had failed to read it prior to interview. As a result, while some participants had a good sense of the broad overview of the contents, others read the recommendations for the first time at interview.

Inevitably again, some participants were more – and others less - familiar with the evidence base of individual recommendations.

Overall, as reported in this report, the draft guidance was broadly welcomed as likely to assist local authorities to prioritise and resource actions that would improve oral health. There were however, many suggestions for how the guidance may be improved, and some key areas identified that participants felt deserved further consideration.

In summary, the key messages included the following:

- The view that the document provided a comprehensive guide to local authorities as they take on the responsibility of planning and delivering oral health promotion
- At the same time however, while the life course approach was felt to be appropriate, the guidance was felt to offer more content and recommendations for tackling the oral health needs of children than of adults
- That many of the recommendations focused on individual level factors and that the guidance failed to tackle the broader social determinants of oral health. This was considered particularly important because of the range of relevant powers at the disposal of local authorities
- That the guidance lacked a clear focus in terms of actions that would address the needs of the vulnerable adult groups identified in the preamble
- That the training needs inherent in many of the recommendations had not been stated clearly enough nor given the appropriate priority
- That some of the assumptions about how local authorities plan and deliver oral health were mistaken and that this may impact local authorities ability to implement the guidance.

Appendix 1 Topic guide

10.00	**WELCOME** **Introduce NICE colleague (if present), and facilitators** **Introduce the draft guidance and the purpose of the discussion group** • Outline the **purpose (part of NICE process – road testing)** and **design** of the fieldwork, i.e. that it includes consultation with a wide range of practitioners from a range of backgrounds across 4 areas, together with individual interviews and– in addition to a *separate online consultation organised by NICE, and which any registered stakeholders, including those at the workshop today, are allowed to also submit to.* • Groups and activities that are IN and OUT of scope – refer to page at the end of this guide • The **objectives** of the fieldwork are to elicit the views of professionals working in the various sectors/roles identified by NICE on the draft recommendations. The key questions to be addressed are: a. What are professionals' views on the relevance and usefulness of the draft recommendations to their current work or practice? b. What impact might the draft recommendations have on current *local* policy, commissioning, service provision or practice? c. What factors (for example, available time, training, access to services) could help or hinder the implementation of the guidance? • Explain how important it is for NICE to get the views of professionals: 'this is your opportunity to influence national recommendations'. • Remind participants that they are likely to have more experience with some recommendations than with others and therefore they may want to comment less on some questions and say more in response to others – and that the format of the consultation will allow for this. • Explain how views will feed into the development of the final recommendations. • REMIND PARTICIPANTS OF SPEAKING IN TURN AND NOT OVER ONE ANOTHER **Consent and confidentiality** • *We don't anticipate any disclosure of a personal or sensitive nature. But for information, when we report, we will not be attributing personal information in our report to NICE. – but we will identify quotes with role/sector/geog area* • Audio recordings will be made during the discussion group for research purposes only. • Please respect the opinions of other participants. Please also do not discuss the name or organisations of other group participants outside of the meeting. • Explain that the group is time-limited, please do not be upset if we have to try and move the discussion on – this is not because we're not interested in your views but that we have a lot of ground to cover. Also remember that additional comments can be made as part of the NICE stakeholder consultation via NICE website. • Remind participants to complete the sign-in sheet and to give consent that they wish to take part (if they have not already done so)

10.15	**Participants to introduce self, role and responsibilities** Ask each person to introduce self, role and responsibilities and locality. 1 sentence only
10.25	**Views on the recommendations overall – opportunity to 'clear the air' on what's good and limitations of the recommendations** **(Important to identify GOOD as well as limitations – where they exist)** **PROMPTS** ➢ **What was your response on reading the recommendations…?** ➢ **Do they cover the right areas/issues? If not – how can they be improved?** ➢ **Is anything missing - *that's in scope* - in terms of key areas – if yes - what?** ➢ **Is too much emphasis (or too little) devoted to some areas over others? – if yes – which ones, why, what should be done?** ➢ **(Is the structure right? Are the recommendations in the right order?)** ➢ Is the guidance clear, will it be useful ➢ Will it be implemented – any specific areas that warrant more attention when we discuss in more detail individual recs - what will help/hinder this? ➢ Is there any more that can be done to aid implementation by NICE? ➢ Will it make a difference – if so how, for whom? ➢ Who will benefit most/least – why? **(If not mentioned spontaneously – explain the omission of fluoridation of water, because it is mentioned in the Preamble) EXPLAIN/REFER TO SCOPE AND CLOSE DOWN DISCUSSION**
10.45	**Section 1: Oral health strategy and oral health needs assessment** **Recommendation 1 *Make oral health a core component of the joint health and wellbeing strategy*** **READ OUT RECOMMENDATION** **General views on the recommendation** a. Is the recommendation clear and easily understood and worded? b. Will this recommendation help you, and your colleagues? c. is this recommendation relevant and <u>useful</u> to you in the services you work for? d. What <u>impact</u> might it have on current local practice, services, or policy? e. What factors might influence its <u>implementation</u> *positively or negatively* or effectiveness? f. Does it conflict with existing advice/protocols that you follow at a local level? If yes – what how why? Are you aware of any national advice/protocols it might conflict with? g. Who should take action on this recommendation? h. Is action required by anybody other than those specified and/or have the right people been listed under 'who should take action'?

REPEAT for all 6 sections/24 recommendations.

ORGANISATION OF DISCUSSION OF RECOMMENDATIONS

There will be insufficient time in groups to discuss all 24 recommendations in all group discussions. We therefore need to divide recommendations among the various groups – ensuring a) that all recommendations are considered, b) that the time allocated is sufficient to enable reasonable discussion and c) that the selection is sensible given the nature of the recommendations. NICE has divided the recommendations into 6 sections based on who the sections are primarily aimed at. Given this, we propose the following division for the 4 fieldwork areas

In Birmingham and York (2 groups) – each group to cover the following sections

- Group A: Sections 1,2,5,6 (11 recs in total)
- Group B: Sections 3,4,5 (12 recs in total)

In London (3 groups) – each group to cover the following sections

- Group A: Sections 1,2,6 (10 recs in total)
- Group B: Sections 3,4 (11 recs in total)
- Group C: Sections 4,5,6 (11 recs in total)

In Manchester (3 groups) – each group to cover the following sections

- Group A: Sections 1,2,6 (10 recs)
- Group B: Sections 3,4 (11 recs)
- Group C: Sections 1,2, (and possibly 3)(13 recs)

Section 1 Oral Health Strategy and Oral Health Needs Assessment (Recs 1-4)

Section 2 Promoting Oral Health for Everyone (Recs 5-7)

Section 3 Early Years Services (0-5 Years) (Recs 8-13)

Section 4 Children in Primary Education (Recs 14-19)

Section 5 Secondary Education (Rec 20)

Section 6 Providing Adult Services (Recs 21-24)

Spend final 15 minutes (12.10-12.25) reviewing the entire set of recommendations based on the discussion.

12.25-12.30 THANK PARTICIPANTS AND CLOSE MEETING

READ OUT In/exclusion criteria for the guidance.

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.

Groups that will not be covered

- **Children, young people and adults living in residential care.**

Activities that will be covered

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.

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)**

Appendix 2 Invitation to participate sent via National Oral Health Promotion Group newsletter

NATIONAL ORAL HEALTH PROMOTION LEAD NEWSGROUP 2014/ Issue 7
7th March 2014

(If you have problems opening any of the links, try copying and pasting the link into the address bar of your internet browser instead).

Can you help? Participants required to contribute to fieldwork on NICE guidance

*****Please note the fine time scales *****

The National Institute of Health and Care Excellence (NICE) is producing new guidance on, 'Oral health: local authority oral health improvement strategies'. The guidance will focus on improving the oral health of local populations through a range of community activities and interventions. For further background information about the guidance click here http://guidance.nice.org.uk/public health G/61

NICE has commissioned independent fieldwork to test the forthcoming guidance with a wide range of professionals at whom the guidance is aimed. This includes Oral Health Promotion Leads and managers, directors of public health, oral health/medical leads in local authorities, representatives from Health and Wellbeing Boards, community dentistry services, NHS England area teams, frontline staff working in health and social care services, local education authority representatives, representatives from early years, primary and secondary schools and community groups.

Fieldwork is an important part of NICE's methodology and the findings from fieldwork are considered by the Public Health Advisory Committee (Public Health AC) when it produces the final guidance.

The fieldwork will involve group discussions to be held during early April in London (4 April), Birmingham (8 April), Manchester (9 April) and York (10 April).

Your opinions about the draft guidance are sought in your capacity as an individual, and not as a representative of any organisation you work for. Organisations can provide views by registering as a stakeholder with NICE. Details of how to do this are available at the link above.

If you would like to contribute to a group discussion – or if you can help identify key individuals who you feel should be involved – please contact the project manager, Adam Crosier of Word of Mouth Research Ltd at adam@womresearch.org.uk. Please provide your name, contact details and your geographical area.