NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Oral health promotion in the community.

Date of quality standards advisory committee post-consultation meeting:
15 September 2016.

2 Introduction

The draft quality standard for oral health promotion in the community was made available on the NICE website for a 4-week public consultation period between 23 June and 20 July 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 17 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- NHS dental contract does not include oral health promotion so some statements would not be achievable before reform.
- The roles of a variety of organisations and services could be further highlighted:
    - community dental services
    - private sector dentists
    - NHS England
    - Public Health England
    - local authorities
    - community pharmacies.
- Communication between primary and secondary dentistry needs to be improved.
- There should be a bigger focus on reducing inequalities between areas and particular groups within communities, such as frail older people, adults with learning disability or mental health issues and people with chronic health conditions.
- Overarching outcomes should specify tooth extractions in secondary care due to dental decay. Extractions due to orthodontic reasons will not be affected.
- The introduction implies a causal relationship between oral health problems and other health conditions that may not be supported by the evidence.

Consultation comments on data collection

- Uncertainty about who would collect the data.
- Collating information at a local level is challenging, particularly on access to services and patient experience.
- Child dental health survey is carried out infrequently and data is not available at a low enough geographical level for local authorities.
- Local authorities hold data on looked-after children's dental health.
- Opportunity for data collection through current dental urgent care review being carried out by NHS England.

Consultation comments on resource impact

- Local councils and CCGs need to keep adequate resources free to identify, and to offer advice and support to people at high risk of poor oral health.

- Data collection would be resource-intensive and additional funding may be required, particularly to get data at a local level.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Local authorities carry out oral health needs assessments to identify groups at high risk of poor oral health as part of joint strategic needs assessments.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Local authorities have a statutory requirement to collect local oral health data.
- Oral health strategy needs to be produced in collaboration with key stakeholders and partners and should have SMART outcomes with review dates.
- People with long-term medical conditions may be at high risk as well as socioeconomic groups.
- Looked-after children should be considered as a high risk group.
- Quality of life should be considered as an outcome measure.
- An audit by Public Health England confirms this as an important area for quality improvement.
- Resources would be needed to obtain the information needed as part of the oral health needs assessment, but cost savings may be provided by reducing the number of tooth extractions under general anaesthesia, orthodontic treatment and the number of fillings needed.

5.2 Draft statement 2

Local authorities promote oral health in early years settings and schools in areas where children and young people are at high risk of poor oral health.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Oral health promotion is more than the two programmes specified. Advice should also be given on sugar consumption and only tooth-friendly food and drink provided.
- A combination of universal and targeted activities is needed (proportionate universalism). Concentrating on the most disadvantaged will not reduce oral health inequalities.
- Difficult if schools do not agree to participate in the programmes.
- The NHS dental contract does not include provision of oral health promotion in schools and early years settings by dentists so alternative funding would be required.
- Local authorities are statutorily obliged to provide or commission oral health promotion programmes and can use PHE's toolkit to assist them in this.
- Children placed with childminders should also be included.
- Parents and carers should be targeted as well as children.
- The rationale implies dental decay always leads to extractions.
- Measure of tooth extractions is not a true reflection of the oral health of an area as HES data may be unreliable for smaller areas.
- A measure on caries prevalence would be better than frequency of tooth brushing.
- There is no measure of the quality of the activity – using an accredited scheme could ensure quality.
- Definition of high risk should include location and ethnicity factors above deprivation.
- This statement could lead to cost savings from reducing the need for orthodontic treatment, fillings and long-term maintenance and a social saving of children not missing school.

5.3 Draft statement 3

Health and social care services include oral health in care plans of people who are at high risk of poor oral health.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- The focus should be on oral health assessments that would lead to oral health considerations in a care plan (not currently part of the role of a dentist).
- Community staff need understanding of oral health to carry out oral health risk assessments.
- All patients should be assessed by a dentist at least every 2 years.
- Should include education services.
- This is already a statutory requirement for looked-after children.
- Should be more of a focus on assessments for looked-after children and special educational needs and disability.
- Should not just be people at high risk of poor oral health.
- Measures should capture more than just retention of teeth.
- Structure measure is unclear.
- A process measure could be added.
- Outcome measures are not available at local authority level.
- Quality of life should be an outcome measure.
- There could be cost savings from early identification and management of malnutrition.

5.4 Draft statement 4

Dental practices provide up-to-date information about whether they are accepting new NHS patients.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Publication of this information is already current practice and part of the role of NHS England.
- Universal access should not be the focus, it is more important to ensure access for particular population groups who find it difficult.
- Professionals should explain to people at high risk of poor oral health why their services are important.
- The outcome measure of patient-reported access to NHS dental services may vary according to circumstances and capabilities.
- Could use GP survey to assess ease of access to NHS dental care.
- The terms ‘up-to-date’ and ‘accepting new patients’ should be defined.
- Some services are reluctant to advertise that they are taking on new patients for fear of high levels of requests.
- May need to consider length of active NHS registration as well as attendance.
- Private element of dental care should be reflected.
- Accessing urgent care is also important.

5.5 Draft statement 5

Dental practices providing emergency care provide information about the benefits of attending for routine care.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- This is not necessary – should only signpost people who ask about routine care.
- It is unachievable as it is patient choice whether to access routine care.
- It is already current practice.
- Imparting oral health information at an emergency appointment may not result in uptake of services.
- More important for services that provide urgent and routine care in the same place.
- Dentists should be educating people away from the idea that dental check-ups are needed every 6 months, to comply with NICE dental recall guidance.
- Some people will only want to access urgent care but these people are key to encourage returning to receive preventative messages (see behaviour change guidance).

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Dental care practitioners providing evidence-based preventative messages and interventions based on Public Health England's Delivering Better Oral Health.
- Healthy food and drink choices in public service settings.
- Data collection to enable the oral health needs assessment.
- The importance of sugar consumption in oral health.
- Promoting fluoride.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Organisation name	Section/ statement number	Comments[1]
1	Royal College of General Practitioners	General	The general direction of the document is excellent and in particular making dental/oral health an integral part of the under- five health record. The role of the Community Dental Service needs to be discussed and developed as a service involved in oral health assessments and the special treatment and care of “at risk” groups. Oral health needs assessments OHNA’s are the task of Public Health Dentistry, they are key in providing the information for CCG’s in the amount of work that is then contracted to NHS dentistry. While NHS dentistry struggles, the contract model enables the local epidemiology to be discerned and provision made for treatment needs. There is also a real debate around “paying the dentist” and encouraging prevention and data collection as part of the contract of care. There needs to be engagement with dentists in the private sector too. There is no mention of sugar consumption and in particular sweet eating, or “safer sweet eating”, i.e. after meals. Fluoride in fluoride chewing gum can be important for “hard to reach and engage groups” and the continued debate about the fluoridation of water should not be neglected.

[1] PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

2	Royal College of General Practitioners	General	In the 2014 NHS England Stakeholder meeting -call to action on oral health the key messages on quality-included https://www.england.nhs.uk/wp-content/uploads/2014/06/oral-health-cta-evnt.pdf The current General Dental Services Contract has no focus on prevention and needs to change: o Current contract adds to inequalities o Support practices in communicate with non-English speaking patients o Building a community approach is needed o Equity for providers o Need a change in culture to make the contract work o Meaningful support is needed to add wider health checks to contract and fiscal reform to support dental services in tackling health inequality o Free examination to deal with inequality o Contracts need to be structured so there are no disincentives to treat vulnerable people with complex treatment needs o Need to make sure people delivering the work are incentivised properly (performers being remunerated correctly) o Allow time for communication with both patients and primary health professionals o Current contract is the biggest barrier; contract reform is the biggest potential enable These areas do not appear to be addressed by the quality statements.
3	Parkinson's UK	General	Local authorities and CCGs are experiencing huge budget cuts in the current economic climate. It is essential that proactive work takes place around identifying those at risk of poor oral health and offering them advice and support. **Recommendation:** The quality standard must stipulate that local councils and CCGs keep adequate resources free to enable professionals to increase their expertise around oral health, and to give them the time to ensure those at high risk of poor oral health receive the support they need, including those living with Parkinson's.
4	Royal College of Paediatrics and Child Health	General	Data on health assessments of children in care who have been registered with a dentist or not and if their dental health has been assessed is available from data of local authority
5	Royal Pharmaceutical Society	General	The Royal Pharmaceutical Society welcomes the quality standard Oral health promotion in the community. We would like to highlight the role of community pharmacies promoting oral health in the community.
6	Royal College of Midwives	General	The RCM considers that the quality standard reflects key areas for quality improvement
7	NHS England	General	Require quality standard development to improve communication between Secondary and primary care dentistry so that plans/treatment are shared to enable continuity of preventative treatment plans and health promotion messages to child and family.

8	British Dental Association	General	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes the quality standard is achievable. Local authorities are statutorily obliged to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas. In April 2013, the funding for oral health improvement transferred to local authorities. In some cases this did not happen and the funding remained with NHS England local area teams. Where latter is the case, the local authorities should still be in position to say how the funding is to be used through local partnership working. Local authorities can use 'Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities', to review what oral health promotion programmes are being commissioned, there should be disinvestment in interventions/programmes that have limited value or are discouraged. The available funding should then be put t into interventions that are recommended or emerging, and targeted to areas of high need. Some of recommended interventions in this document do not require funding and therefore all local authorities will be in position to have some interventions in place such as influencing local and national government policies e.g. no takeaways within certain radius of early years and schools settings. Improving oral health in children will lead to cost savings by reducing number of extractions under general anaesthesia. Children that have multiple extractions of deciduous teeth can require orthodontic treatment as result of the dental extractions. Reducing the need for this orthodontic treatment will provide cost savings. Also improving oral health will reduce number of fillings needed. Restored teeth require long term maintenance so savings would be throughout life. In addition there is a social saving of time for parents/guardians not having to take time off work and child not missing school. Poor oral health in children also impacts on their ability to learn (time off school) and school readiness. This in turn can have a financial impact – greater resources needed to support children's learning.
9	Faculty of General Dental Practice (UK)	Question 1	**Does this draft quality standard accurately reflect the key areas for quality improvement?** Broadly, yes. Not all local authorities currently carry out an assessment of local oral health needs as part of the JSNA, and few, particularly in England, actively promote oral health in early-years settings and schools. Likewise, oral health assessments are often not carried out when individual care plans are drawn up. However dental practices are already required to update the NHS Choices website as to whether they are able to accept new NHS patients, and we are not aware of an existing delivery gap in respect of statement 5 – as above, we would expect that all practitioners who provide emergency care would already provide information to patients about the benefits of routine care.

10	Association of Directors of Public Health	Question 1	The quality standards reflect needs of children and adults. However it does not adequately reflect inequalities in oral health, particularly within areas and the needs of particular groups with poor oral health within communities. These include frail older people, adults with learning disability or mental health issues, people with chronic health conditions etc. – please see more detailed comments below. The quality standard does not reflect the fact that the major causes of poor oral health (diet) also affects other health issues. There is some recognition of the role of schools and the social care system but improving oral health will need much broader system wide change.
11	National Oral Health Promotion Group (NOHPG)	Question 1	Does this draft quality standard accurately reflect the key areas for quality improvement? Yes it does greatly.
12	Association of Directors of Public Health	Question 2	Much of the data is available although collating the information at a local area is a challenge, particularly on access to dental services and patient experience. Although there is comprehensive epidemiological information on the dental health of 5 year old children there is less reliable information on the oral health needs of adults at a local level and new methods of assessing needs other than traditional surveys may need to be developed.
13	Royal College of Midwives	Question 2	If local systems and structures are in place the local data for the proposed quality measures should be collectable
14	NHS England	Question 3	Monkey Wellbeing (Helen Sadler a parent and school teacher) in Sussex is working in emergency and urgent care and asthma . She has widened her work to dentistry education stories and support for young children. Here is the Website
15	National Oral Health Promotion Group (NOHPG)	Question 3	Do you have an example from practice of implementing the NICE guidelines that underpin this quality standard? Yes we do have established community oral health programmes in Camden and Islington following NICE guidelines PH55 & NG30
16	Faculty of General Dental Practice (UK)	Question 4	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. While the aims and objectives in the draft Quality Standards are laudable, in reality they are unlikely to be achieved without additional funding, whether for the promotion of oral health in schools and early years settings, training and monitoring to ensure that the risk of poor oral health in individuals is identified and mitigated in care plans, or improved data collection.

			While the document does not specify the involvement of dentists in supporting the realisation of Quality Statements 1-3, it is important to note that none of these activities would be covered under the NHS dental contract for England and Wales.
17	British Dental Association	Intro	There should be reference to the fact that NHS England is responsible for commissioning all NHS dental services in England.
18	British Dental Association	Intro	Child dental health survey is only carried out every ten years and the data is not available at low enough geographical level for local authorities to use. When looking at oral health of children, need to look at Public Health England Dental Public Health Epidemiology Programme. Surveys of dental health of five-year-olds are currently carried out every two years. The data is also provided at low enough geographical areas for local authorities to use. Where more local data is required, Local authorities can work with their local fieldwork provider and local dental epidemiology co-ordinator to carry out an enhanced survey to provide information on smaller geographies.
19	Public Health England	Intro	There should be reference early in the document to the roles and responsibilities of organisation with regard to oral health improvement e.g. LAs have the statutory responsibility to commissioning OHP PHE have a responsibility to improve population health and reduce inequalities. NHS England have a role in commissioning preventive focused NHS dental services.
20	Public Health England	Intro	Care should be taken with the following statement: *"Oral health problems are associated with coronary heart disease, diabetes complications, rheumatoid arthritis and adverse pregnancy outcomes."* It reads like there is a causal relationship between these conditions and oral health and the some of the evidence is equivocal.
21	Public Health England	Intro	Child dental health survey is only carried out every ten years and the data is not available at low enough geographical level for local authorities to use. When looking at oral health of children, need to look at Public Health England Dental Public Health Epidemiology Programme. Surveys of dental health of five-year-olds are currently carried out every two years. The data is also provided at low enough geographical areas for local authorities to use. Where more local data is required, Local authorities can work with their local fieldwork provider and local dental epidemiology co-ordinator to carry out an enhanced survey to provide information on smaller geographies.
22	Public Health England	Intro	*The quality standard is expected to contribute to improvements in the following outcomes:* *tooth extractions in secondary care* due to dental decay Should add due to dental decay here as it will not stop extractions for orthodontic reasons.

23	The British Association for the Study of Community Dentistry (BASCD)	Intro	There should be reference to the fact that NHS England is responsible for commissioning all NHS dental services in England.
24	The British Association for the Study of Community Dentistry (BASCD)	Intro	Child dental health survey is only carried out every ten years and the data is not available at low enough geographical level for local authorities to use. When looking at oral health of children, need to look at Public Health England Dental Public Health Epidemiology Programme. Surveys of dental health of five-year-olds are currently carried out every two years. The data is also provided at low enough geographical areas for local authorities to use. Where more local data is required, Local authorities can work with their local fieldwork provider and local dental epidemiology co-ordinator to carry out an enhanced survey to provide information on smaller geographies.
25	British Dental Association	1	Does this draft quality standard accurately reflect the key areas for quality improvement? This quality statement does reflect a key area for quality improvement
26	British Dental Association	1	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No – would require collection and review of JSNAs, therefore possibly local, but would require additional resources and whose role would this be and what levers would they have where local authority is not compliant?
27	British Dental Association	1	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? A number of local authorities are carrying out oral health needs assessment, some then feed into JSNA. An audit across England would provide this information.

28	British Dental Association	1	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes statement one would be achievable by local services. The resources necessary would include local dental survey commissioning arrangements and support with design and interpretation of surveys and development of strategies. The support for this should come from Specialist dental public health consultants who are based in Public Health (PHE) Centres; part of their role is to provide advice and support to local authorities. Local Authorities have a statutory requirement to collect local oral health data. These data are used not only by the LA but for the NHS to inform the commissioning of dental services. Improving oral health especially in children will lead to cost savings by reducing number of extractions under general anaesthesia. Children that have multiple extractions of deciduous teeth can require orthodontic treatment as result of the dental extractions. Reducing the need for this orthodontic treatment will provide cost savings. Also improving oral health will reduce number of fillings needed. Restored teeth require long term maintenance so savings would be throughout life.
29	British Dental Association	1	Once an Oral health needs assessment has been carried out, it needs to be used to put together an oral health strategy with SMART outcomes. This needs to be done in collaboration with relevant stakeholders/partners, which includes NHS England, Health Education England and local dental profession There should also be an agreed date to review and refresh data in the oral health needs assessment.
30	Public Health England	1	Does this draft quality standard accurately reflect the key areas for quality improvement? This quality statement does reflect a key area for quality improvement
31	Public Health England	1	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No – would require collation and review of JSNAs, therefore, may possibly need increased local resources.
32	Public Health England	1	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? A recent audit by Public Health England showed that 58% (82/121 of LAs had oral health in JSNA. 73% of LAs had ‘all’ or ‘some of’’ their oral health interventions following NICE guidance. (responses from 142/ 152 LAs).

33	Public Health England	1	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes statement one would be achievable by local services but dental surveys following national dental epidemiology programme methodology are needed to ensure benchmarked, calibrated and quality assured data Resources necessary would include local dental survey commissioning arrangements and support from specialist dental public health advisors (PHE) to assist with design and interpretation of surveys and development of strategies. All upper tier LAs commissioned the last 5 year old survey and therefore had the resources to do so.
34	Public Health England	1	Oral health needs assessments need to be used to put together an oral health strategy which has SMART outcomes. This needs to be done in collaboration with relevant stakeholders/partners, which includes NHS England, Health Education England and local dental profession There should also be an agreed date to review and refresh data in the oral health needs assessment.
35	Faculty of General Dental Practice (UK)	1	We agree with this statement.
36	Parkinson's UK	1	The structure section of this measure suggested that joint strategic needs assessments (JSNA) are used to identify local groups at high risk of poor oral health. People with Parkinson's can have numerous symptoms, and their oral health may well not be considered when developing a JSNA. Clinical Commissioning Groups (CCGs) and local authorities need a joined up approach to health and social care when considering support and treatment for people with Parkinson's. **Recommendation:** The quality standard should instruct local areas and commissioners to introduce Parkinson's - or neurology more generally - into JSNAs, including oral health promotion.

37	Parkinson's UK	1	Statement 1 clarifies people who it believes to be at high risk of poor oral health as being people live in areas that are described as socially and economically disadvantaged. However people with Parkinson's may not be described as socially or economically disadvantaged, it is their condition which makes puts them at risk of poor oral health. People affected by Parkinson's can have difficulty swallowing due to the muscles in their jaw and face weakening. This affects the person's ability to chew and swallow, and also may also reduce their ability to close their lips, which can make it difficult to swallow. They can also get a dry mouth due to some Parkinson's drugs reducing the flow of saliva to their mouth. This can lead to higher rates of tooth decay and gum disease. It may cause dentures to become loose and hard to control, or mean that people with Parkinson's are unable to eat with the dentures they have. Drooling is common for people with the condition and can lead to sores or cracks developing. This can make everyday activities such as talking, eating or having a drink difficult or embarrassing. It is important that people with Parkinson's have regular oral assessments to ensure they are not having problems swallowing, or with their saliva and that their dentures fit properly. **Recommendation:** The identifying features of people who may be at risk of oral health included in the quality standard should include people with long term conditions such as Parkinson's.
38	Royal College of Paediatrics and Child Health	1	Looked after children have higher incidence of poor dental health in comparison to general population and many of them are not even registered with a dentist when come into care .It should be addressed along with children from poor socioeconomic status
39	Oxfordshire Salaried Primary Care Dental Service, Oxford Health NHS Foundation Trust	1	The Oral Health Needs Assessments carried out by local authorities collect data on prevalence of tooth decay. Whilst data on the number of decayed, missing, filled teeth (dmft) is useful in establishing the prevalence of tooth decay, it would be beneficial for the surveys conducted to include outcomes on qualitative data such as quality of life to gather evidence regarding the percentage of people whose quality of life is negatively affected by poor oral health (for example, percentage of people who have experienced dental pain in the last year affecting their ability to eat/sleep, access to services, impact on life, patient experience). This would build a picture of overall oral health experience among the population and a broader scope (not solely those consenting to providing data on dmft as a clinical outcome and therefore data of a quantitative nature only). Local systems are in place to collect surveys from the local population and therefore including additional specific questions relating to quality of life and oral health would be feasible. Quality standards regarding the breadth and scope of oral health needs assessments, linked to joint health needs assessments, would be welcomed.
40	The British Association for the Study of Community Dentistry (BASCD)	1	Does this draft quality standard accurately reflect the key areas for quality improvement? This quality statement does reflect a key area for quality improvement

41	The British Association for the Study of Community Dentistry (BASCD)	1	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No – would require collection and review of JSNAs, therefore possibly local, but would require additional resources and whose role would this be? and what levers would they have where local authority is not compliant?
42	The British Association for the Study of Community Dentistry (BASCD)	1	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? A number of local authorities are carrying out oral health needs assessment, some then feed into JSNA.
43	The British Association for the Study of Community Dentistry (BASCD)	1	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes statement one would be achievable by local services. The resources necessary would include local dental survey commissioning arrangements and support with design and interpretation of surveys and development of strategies. The support for this should come from Specialist dental public health consultants who are based in Public Health (PHE) Centres; part of their role is to provide advice and support to local authorities. Oral health improvement is now a statutory duty of local authority, in order to carry out this role, local authorities would need to know what the oral health needs of an area are. This would be provided by an oral health needs assessment. The oral health needs assessment would also be relevant to NHS England as it would provide information on gaps in dental service provision, providing commissioners with information on areas in which to commission additional services. Improving oral health especially in children will lead to cost savings by reducing number of extractions under general anaesthesia. Children that have multiple extractions of deciduous teeth can require orthodontic treatment as result of the dental extractions. Reducing the need for this orthodontic treatment will provide cost savings. Also improving oral health will reduce number of fillings needed. Restored teeth require long term maintenance so savings would be throughout life.
44	The British Association for the Study of Community Dentistry (BASCD)	1	Once an oral health needs assessment has been carried out, it needs to be used to put together an oral health strategy with SMART outcomes. This needs to be done in collaboration with relevant stakeholders/partners, which includes NHS England, Health Education England and local dental profession. There should also be an agreed date to review and refresh data in the oral health needs assessment.

45	NHS England	2	Quality statement refers to early years settings but no specific focus on those children placed with childminders and how their oral health promotion would be measured.
46	British Dental Association	2	Does this draft quality standard accurately reflect the key areas for quality improvement? This quality statement does reflect a key area for quality improvement. Local authorities need to apply concept of proportionate universalism, i.e. combination of universal and targeted activities are needed. Concentrating solely on the most disadvantaged will not sufficiently reduce oral health inequalities. Local authorities need to ensure oral health promotion is based on evidence-based interventions/programmes as per Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities, and Delivering Better Oral Health: an evidence-based toolkit for prevention.
47	British Dental Association	2	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No. The resources necessary would include local resource and some national facilitation to collect, collate and report data. Not sure who would be expected to carry this out and what would be consequences for local authorities that do not comply. Focus on frequency of tooth brushing is not the best measure. Data on caries prevalence would be better
48	British Dental Association	2	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? This is happening in a number of local authorities e.g Smile 4life in Cumbria and Bradford Building Brighter Smiles see case studies in LGA document Tackling poor oral health in children http://www.local.gov.uk/documents/10180/7632544/L16-83+Tackling+poor+oral+health+in+children/5cb38916-bddb-4550-9f63-52d44f559591
49	British Dental Association	2	Rationale. There is a need for more than just supervised toothbrushing and fluoride varnish programmes. In order to improve oral health there is a need to reduce amount and frequency of sugar consumption, as this is one of the risk factors for dental caries. Therefore settings should also be providing advice on sugar and should set example by being healthy settings. Only drink available should be water, snacks should be healthy and tooth friendly.
50	British Dental Association	2	Rationale. It does not always follow that dental decay leads to extractions. Suggest changing last sentence to 'This is important to reduce risk of dental caries, which could lead to pain, infection and tooth extraction
51	British Dental Association	2	Process. It is importance that local authorities apply the concept of proportionate universalism, i.e. combination of universal and targeted activities are needed. Concentrating solely on the most disadvantaged will not sufficiently reduce oral health inequalities.
52	British Dental Association	2	As not all decayed teeth lead to extraction under general anaesthesia, the data on tooth extractions in secondary care is not true reflection of the oral health of an area.

53	Public Health England	2	Does this draft quality standard accurately reflect the key areas for quality improvement? This quality statement does reflect a key area for quality improvement, but need to apply concept of proportionate universalism, i.e. combination of universal and targeted activities are needed. Concentrating solely on the most disadvantaged will not sufficiently reduce oral health inequalities. Oral health promotion should be based on evidence-based interventions/programmes as per Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities, and Delivering Better Oral Health: an evidence-based toolkit for prevention.
54	Public Health England	2	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No. Would require local resource and some national facilitation to collect, collate and report data
55	Public Health England	2	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? Happening in a number of local authorities e.g. Smile 4life in Cumbria and Bradford Building Brighter Smiles see case studies in LGA document Tackling poor oral health in children http://www.local.gov.uk/documents/10180/7632544/L16-83+Tackling+poor+oral+health+in+children/5cb38916-bddb-4550-9f63-52d44f559591
56	Public Health England	2	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes the quality standard is achievable. Local authorities are statutorily obliged to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas. Funding for oral health improvement has transferred to local authorities. Where this has not happened, local authorities should still be in position to say how the funding is to be used through local partnership working. Local authorities can use 'Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities', to review what oral health promotion programmes are being commissioned, there should be disinvestment in interventions/programmes that have limited value or are discouraged. The funding should then be put into interventions that are recommended or emerging.
57	Public Health England	2	Rationale. There is a need for more than just supervised toothbrushing and fluoride varnish programmes. One of risk factors for dental caries is amount and frequency of sugar consumption. Important that settings are providing advice on sugar and also settings should set example by being healthy settings. Only drink available should be water, snacks should be healthy and tooth friendly.

58	Public Health England	2	Rationale. Dental decay does not always lead to tooth extraction. Suggest changing last sentence to 'This is important to reduce risk of dental caries, which could lead to pain, infection and tooth extraction
59	Public Health England	2	Process. Local authorities need to apply concept of proportionate universalism, i.e. combination of universal and targeted activities are needed. Concentrating solely on the most disadvantaged will not sufficiently reduce oral health inequalities.
60	Public Health England	2	Data on tooth extractions in secondary care not true reflection of oral health of an area, true levels may not be reflected due to the differences in way extractions for this age group are commissioned. Hospital Episode Statistics (HES) data may therefore be unreliable when looking at smaller areas.
61	Faculty of General Dental Practice (UK)	2	We agree with this statement.
62	Faculty of General Dental Practice (UK)	2	**Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.** General Dental Practitioners are very supportive of public policies which place an emphasis on prevention rather than treatment, and participate in such initiatives where they can, such as in the Childsmile and Designed to Smile programmes funded by the Scottish and Welsh Governments. However, as the NHS dental contract is based on reparative work and does not provide for the provision of oral health advice and promotion in schools and early-years settings, only a handful of similar locally-funded initiatives operate in England, and there is little coordination between these schemes. Therefore, for General Dental Practitioners to be involved in delivering such promotion, either the NHS dental contract would need to be reformed at the national level, additional government funding would have to be found, or local authorities or individual schools would have to fund it.

63	School and Nursery Milk Alliance	2	We note that the quality standard seeks to address good oral health behaviours in early years settings and schools in areas where children and young people are at risk of poor oral health. However, by promoting only the dental aspects of oral health in isolation, we believe that the quality standard is missing a significant opportunity to reduce the risk of tooth decay and extraction. The quality standard currently only defines "promoting oral health" as "supervised tooth brushing schemes, fluoride varnish programmes or advice to encourage brushing with fluoride toothpaste", instead of also attempting to influence diet. Quality Statement 2's 'Promote oral health' section of 'Definitions of terms used in this quality statement' states that "advice" on promoting oral health should be based on information in *Delivering better oral health: an evidence-based toolkit for prevention*. However, this document – unlike the quality standard – provides advice not only on tooth brushing and the benefits of fluoride, but also outlines the importance of diet in dental care. This advice particularly focuses on the importance of reducing sugar consumption. Low-fat milk provided to nursery and school children can make a crucial contribution to improving dental health, particularly amongst deprived children who may otherwise consume a large amount of low-cost sugary drinks. Not only can it act as a substitute for sugary drinks that can cause tooth decay, but cow's milk contains micronutrients such as calcium, vitamin B3 (niacin), and vitamin B12 and B2 (riboflavin). These reduce the risk of tooth decay, bleeding gums and mouth sores. By both sustaining the consumption of nursery and school milk and teaching children the habit of consuming non-sugary drinks, we believe that a significant contribution can be made to improving the oral health of children and young people.
64	South West Yorkshire Partnership NHS Foundation Trust	2	There is no mention of parent and carers. Young children are reliant on parent and carers for all their oral health needs and as such should be targeted too
65	South West Yorkshire Partnership NHS Foundation Trust	2	The toothbrushing programme is reliant on the agreement of schools and early years to carry out the programme. This is an issue in our area. What control does the LA have over schools and early years to ensure they participate in the programme?

66	South West Yorkshire Partnership NHS Foundation Trust	2	Consider ethnicity - The latest oral health survey of five-year-old children 2015 indicates deprivation alone does not explain the variation in oral health and that location and ethnicity factors above deprivation (National Dental Epidemiology Programme for England)
67	Oxfordshire Salaried Primary Care Dental Service, Oxford Health NHS Foundation Trust	2	Oral health promotion in 'early years' settings and schools needs to be delivered to a minimum standard of activity, not a one-off activity in the setting but as an on-going activity within the setting to ensure quality work is delivered. This statement may be hard to measure because the quality measures uses the *number* of early years services that promote oral health, however activity in each setting may vary in the standard of oral health promotion they provide to children and young people. Guidance on the minimum standard of activity per setting would ensure sufficient activity is taking place to ensure oral health is promoted continuously at each setting (such as an accredited scheme).
68	The British Association for the Study of Community Dentistry (BASCD)	2	Does this draft quality standard accurately reflect the key areas for quality improvement? This quality statement does reflect a key area for quality improvement. Local authority's need to apply concept of proportionate universalism, i.e. combination of universal and targeted activities are needed. Concentrating solely on the most disadvantaged will not sufficiently reduce oral health inequalities. Local authority's need to ensure oral health promotion is based on evidence-based interventions/programmes as per Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities, and Delivering Better Oral Health: an evidence-based toolkit for prevention.
69	The British Association for the Study of Community Dentistry (BASCD)	2	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No. The resources necessary would include local resource and some national facilitation to collect collate and report data. Not sure who would be expected to carry this out and what would be consequences for local authorities that do not comply. Looking at data on caries prevalence of five year old children in area may be a better measure to look at. Currently dental surveys of five year olds are carried out every other year. To get data to low enough level to be relevant may require commissioning of additional enhanced sampling of children in the dental surveys of five year old children.

70	The British Association for the Study of Community Dentistry (BASCD)	2	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? This is happening in a number of local authorities e.g Smile 4life in Cumbria and Bradford Building Brighter Smiles see case studies in LGA document Tackling poor oral health in children http://www.local.gov.uk/documents/10180/7632544/L16-83+Tackling+poor+oral+health+in+children/5cb38916-bddb-4550-9f63-52d44f559591
71	The British Association for the Study of Community Dentistry (BASCD)	2	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes the quality standard is achievable. Local authorities are statutorily obliged to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas. In April 2013, the funding for oral health improvement transferred to local authorities. In some cases this did not happen and the funding remained with NHS England local area teams. Where latter is the case, the local authorities should still be in position to say how the funding is to be used through local partnership working. Local authorities can use 'Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities', to review what oral health promotion programmes are being commissioned, there should be disinvestment in interventions/programmes that have limited value or are discouraged. The available funding should then be put t into interventions that are recommended or emerging, and targeted to areas of high need. Some of recommended interventions in this document do not require funding and therefore all local authorities will be in position to have some interventions in place such as influencing local and national government policies e.g. no takeaways within certain radius of early years and schools settings. Improving oral health in children will lead to cost savings by reducing number of extractions under general anaesthesia. Children that have multiple extractions of deciduous teeth can require orthodontic treatment as result of the dental extractions. Reducing the need for this orthodontic treatment will provide cost savings. Also improving oral health will reduce number of fillings needed. Restored teeth require long term maintenance so savings would be throughout life. In addition there is a social saving of time for parents/guardians not having to take time off work and child not missing school.
72	The British Association for the Study of Community Dentistry (BASCD)	2	Rationale. There is a need for more than just supervised toothbrushing and fluoride varnish programmes. In order to improve oral health there is a need to reduce amount and frequency of sugar consumption, as this is one of the risk factors for dental caries. Therefore settings should also be providing advice on sugar and should set example by being healthy settings. Only drink available should be water, snacks should be healthy and tooth friendly.

73	The British Association for the Study of Community Dentistry (BASCD)	2	Rationale. It does not always follow that dental decay leads to extractions.. Suggest changing last sentence to 'This is important to reduce risk of dental caries, which could lead to pain, infection and tooth extraction
74	The British Association for the Study of Community Dentistry (BASCD)	2	Process. It is importance that local authorities apply the concept of proportionate universalism, i.e. combination of universal and targeted activities are needed. Concentrating solely on the most disadvantaged will not sufficiently reduce oral health inequalities.
75	The British Association for the Study of Community Dentistry (BASCD)	2	As not all decayed teeth lead to extraction under general anaesthesia, the data on tooth extractions in secondary care is not true reflection of the oral health of an area.
76	NHS England	3	Important for oral health to be reflected in health plans, should also include Education services as having a responsibility in supporting this statement. Is there a need for more focus on Looked after Children Assessments and Special Educational Needs and Disability (SEND) plans.
77	NHS England	3	Consider capturing data from audits of SEND health plans/Looked After Children Plans to establish if oral health plans and outcomes captured.
78	British Dental Association	3	Does this draft quality standard accurately reflect the key areas for quality improvement? This quality statement does reflect a key area for quality improvement. With an aging population and with more people retaining teeth throughout life, this statement is very important and should be expanded to include the following: oral health assessment (a brief screening of the mouth) should take place at first assessment for care, at regular intervals and as need arises. It should form the basis for planning oral care and referral to a dental professional if required. oral health care planning with input from dental professionals where patient has accessed dental care. This should be incorporated within the individual's general care plan. Where daily oral hygiene support by care staff is required, this should be monitored to ensure it is being carried out. All patients should be assessed by a dentist at least every two years. As per NICE guidance Focus should not be only on those at high risk of poor oral health – reference proportional universalism again

79	British Dental Association	3	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No local systems in place and not sure how feasible it would be. Focus should not be on retention of teeth alone but on wider measures of oral health
80	British Dental Association	3	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard?
81	British Dental Association	3	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes the quality standard is achievable but will require collaborative working across all sectors and raising awareness that poor oral health can impact on patient's general health and quality of life. Maintaining good oral health will help with patient's general health and can help with cost savings. There is a relationship between good oral health and independence, good oral health can support people to stay independent for longer, or recover more quickly from episodes of ill health. For example eating and drinking are crucial to well-being and health of vulnerable older people. Early identification and management of malnutrition is estimated to have the third highest potential to deliver cost savings to the NHS.
82	British Dental Association	3	Outcomes should include patients oral health related quality of life should be included. This was measured in last Adult Dental Health Survey. The outcomes data are not available at LA level
83	Public Health England	3	Does this draft quality standard accurately reflect the key areas for quality improvement? This quality statement does reflect a key area for quality improvement. With an aging population and with more people retaining teeth throughout life, this statement is very important and should be expanded to clarify: oral health assessment (a brief screening of the mouth) to form the basis for planning oral care and potentially triggering referral to a dental professional. This assessment should take place at first assessment for care, at regular intervals and as need arises. oral health care planning which may need input from dental professionals. The oral health care plan is incorporated within the individual's general care plan. daily oral hygiene support – by care staff as required. This should be monitored to ensure it is being carried out. dental professional assessment & treatment – as required. All patients should be assessed by a dentist at least every two years.
84	Public Health England	3	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No local systems in place and not sure how feasible it would be. The structure measure is not well defined CQC are regulators for care homes and this could be a key line of enquiry during inspections

85	Public Health England	3	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? Yes Examples of local schemes such as Mouth care Matters – in Kent https://nhw14.files.wordpress.com/2013/11/mcm_a3_print.pdf
86	Public Health England	3	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes the quality standard is achievable but will require collaborative working across all sectors and raising awareness of impact of poor oral health on patient's general health and quality of life. Maintaining good oral health will help with patient's general health and can help with cost savings. There is a reciprocal relationship between oral health and independence. Poor oral health will shift vulnerable older people towards high dependency, good oral health can support people to stay independent for longer, or recover from episodes of ill health. For example eating and drinking are crucial to well-being and health of vulnerable older people and improving the early identification and management of malnutrition is estimated to have the third highest potential to deliver cost savings to the NHS.
87	Public Health England	3	In outcomes patients oral health related quality of life should be included. This was measured in last Adult Dental Health Survey. The outcomes data are not available at LA level
88	Faculty of General Dental Practice (UK)	3	We agree with this statement. However, oral health assessment does not always take place, and explicit mention of it would better support identification of those at risk and therefore needing oral health included in their care plans. We would therefore suggest re-wording this statement to: "Health and social care services carry out individual oral health risk assessments and include oral health in the care plans of people who are at high risk of poor oral health". We would further suggest, particularly in relation to care of the elderly (whether domiciliary, hospital-based or residential) that the types of health and care workers identified in the description be educated as to the major risk factors for poor oral health, namely high sugar consumption, polypharmacy and dry mouth.

89	Faculty of General Dental Practice (UK)	3	**Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.** As above, we believe that the realisation of Statement 3 would require oral health risk assessments to be carried out on all those being given individual care plans, which could either be carried out by an oral health practitioner or by other healthcare workers given specific training in oral health risk assessment and oral health care planning. While the document does not specify the involvement of dentists in supporting or delivering this, for the avoidance of doubt it is important to note that such activities are not covered under the standard NHS dental contract for England and Wales, and therefore until and less the contract is reformed to allow for the delivery of such work, dentists' involvement would require separate national or local commissioning. Delivery of oral health assessment and oral health care planning by non-dental healthcare practitioners would not only require funding for initial training, but also funding across a range of health and care settings for additional staff time on an on-going basis.
90	Parkinson's UK	3	We fully endorse statement 3. Health and social care services should include oral health in care plans of people who are at high risk of poor oral health, which includes people with Parkinson's. In comment 3 we highlighted some of the issues people with Parkinson's face regarding oral health and we believe these issues need to be a key feature of their care plans. We believe it is crucial that community based health and care staff have a good understanding of Parkinson's to ensure people with the condition get the care they require. To this end we offer online and face-to-face training to equip health and care professionals with information on the condition. Frontline health and care staff need to be able to give information and advice about the importance of oral health. **Recommendation:** Ensure everyone with Parkinson's has their own individual, tailored care plan to ensure good oral health. And that people with Parkinson's receive regular oral assessments/ mouth care assessments. We also think there should be improved training for community based staff around oral health and the importance of personal care plans, it would be useful if the quality standard signposted to our training *One hour introduction to Parkinson's training sessions: http://www.parkinsons.org.uk/professionals/education-and-training/introduction-parkinsons-care-staff-excellence-network *24 hour Understanding Parkinson's for health and care staff: http://www.parkinsons.org.uk/understandingparkinsonsonline
91	Royal College of Paediatrics and Child Health	3	In a care plan for a child in care this should be documented –statutory requirement

92	Oxfordshire Salaried Primary Care Dental Service, Oxford Health NHS Foundation Trust	3	It is essential that Health and Social Care Services use the information that is collected as part of an oral health care plan to inform practice and that any needs identified by the plan are addressed for the patient. For example, if an oral health care plans asks when a person last accessed dental services, if the answer indicates +3 years, action is required by the setting/service to address this. A process measure could be added to this statement to ensure information from Health and Social Care Services is collected regarding their local activity (for example, numerator – number of services with oral health identified as part of the health care plans; denominator – overall number of Health and social Care Services). Additional resources would be required to gather new data relating to this standard.
93	The British Association for the Study of Community Dentistry (BASCD)	3	• Does this draft quality standard accurately reflect the key areas for quality improvement? This quality statement does reflect a key area for quality improvement. With an aging population and with more people retaining teeth throughout life, this statement is very important and should be expanded to include the following: oral health assessment (a brief screening of the mouth) should take place at first assessment for care, at regular intervals and as need arises. It should form the basis for planning oral care and referral to a dental professional if required. oral health care planning with input from dental professionals where patient has accessed dental care. This should be incorporated within the individual's general care plan. Where daily oral hygiene support by care staff is required, this should be monitored to ensure it is being carried out. All patients should be assessed by a dentist at least every two years. As per NICE guideline cg19 Focus should not be only on those at high risk of poor oral health. Need to apply concept of proportionate universalism, i.e. combination of universal and targeted activities are needed.
94	The British Association for the Study of Community Dentistry (BASCD)	3	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No local systems in place and not sure how feasible it would be. The focus should not be on retention of teeth alone but should look at the oral health related quality of life. This was measured in the last Adult Dental Health Survey.
95	The British Association for the Study of Community Dentistry (BASCD)	3	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard?

96	The British Association for the Study of Community Dentistry (BASCD)	3	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes the quality standard is achievable but will require collaborative working across all sectors and raising awareness that poor oral health can impact on patient's general health and quality of life. Maintaining good oral health will help with patient's general health and can help with cost savings. There is a relationship between good oral health and independence, good oral health can support people to stay independent for longer, or recover more quickly from episodes of ill health. For example eating and drinking are crucial to well-being and health of vulnerable older people. Early identification and management of malnutrition is estimated to have the third highest potential to deliver cost savings to the NHS.
97	The British Association for the Study of Community Dentistry (BASCD)	3	Outcomes should include patients oral health related quality of life should be included. This was measured in last Adult Dental Health Survey. The outcomes data are not available at LA level
98	NHS England	4	Up to date information about accepting new NHS patients, how do we ensure the quality of the offer, for example family join as NHS patients then practice changes offer to only children under NHS. Potential impact on attendance of child. Is there a need to consider length of active NHS registration not just attendance.
99	British Dental Association	4	Does this draft quality standard accurately reflect the key areas for quality improvement? Yes but this is role of NHS England rather than the local authority. The standard should include something on information on how to access NHS dental service is made available to population groups who struggle with access. The following website: http://www.nhs.uk/NHSEngland/AboutNHSservices/dentists/Pages/find-an-NHS-dentist.aspx provides information on how to find a NHS dentist, including accessing urgent dental care. There needs to be a way of cascading the information to population groups who struggle with access to dental care. This may is a role for LAs as well as NHSE
100	British Dental Association	4	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? Yes this is recorded on NHS choices however it does not reflect a true picture as many practices do not update their status regularly. Could also use GP survey to assess ease of access to NHS dental care
101	British Dental Association	4	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? In Thames Valley practices have volunteered to accept patients in pain directly from 111. Information is given to the patients by 111.

102	British Dental Association	4	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes this is achievable with the reformed contract that is being led by Department of Health. Would need additional staff in NHS England dental teams to be able to monitor whether or not practices are complying. Also process of updating information needs to be simple. Need to define the term “accepting new patients” as in practice it is capable of a variety of interpretations. Data on access to NHS services is already collected and monitored by NHS England. Any standard would need to reflect the private element of dental care which can be considerable in some parts of the country
103	British Dental Association	4	Rationale. Accessing urgent dental care is also important.
104	Public Health England	4	Does this draft quality standard accurately reflect the key areas for quality improvement? Yes. This is role of NHS England who should ensure this is in place as part of their commissioning arrangements with practices The standard should include something on how information to access NHS dental service is made available to population groups who struggle with access. This may apply to LAs as well as NHSE.
105	Public Health England	4	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? Yes this is recorded on NHS choices however it does not reflect a true picture as many practices are reluctant to state they are taking on patients for fear of having a huge number requesting appointments.
106	Public Health England	4	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? No
107	Public Health England	4	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes this is achievable with reformed contract, which is being led by Department of Health. Would need to see what levers are available to achieve this and capacity issues within Local NHS England teams. Some work may be needed to better define the term “accepting new patients” as in practice it is capable of a variety of interpretations.

108	Public Health England	4	Rationale. Accessing dental services is just as important as for urgent care.
109	Faculty of General Dental Practice (UK)	4	We agree with this statement. However we note that dental practices are already required to keep the NHS choices website up to date with information on whether they are accepting NHS patients, will usually put this information on their own website as well, and can always advise potential patients of availability in response to a simple phone call or email enquiry.
110	Parkinson's UK	4	It is vital that people with Parkinson's who do not have a dentist are signposted to oral health services and encouraged to use these services. Professionals should explain why these services are so important, and how Parkinson's might cause oral health to be at risk. Many people with Parkinson's are often older and could be frail or lack capacity. Depending on the severity of their Parkinson's, they can experience issues with communication and getting around. They may also be unaware of the impact their condition could have on oral health. It is also important to note that many people with Parkinson's also live with dementia in the community, supported by friends, family members and professional carers. Having dementia may well mean they do not have the ability to book a dentist appointment, or remember when they need a check-up. They might also not be able to communicate if they have an oral problem, or pain in their mouth. **Recommendation:** The quality standard should stipulate that tailored oral health promotion services for adults at high risk of poor oral health must be commissioned. To include people with Parkinson's, and those with Parkinson's dementia and dementia with Lewy Body.
111	Oxfordshire Salaried Primary Care Dental Service, Oxford Health NHS Foundation Trust	4	Who would dental practices be reporting information to and how would it be measured? Practices would need an appropriate timescale to reflect the meaning of 'up to date'; for example, would monthly updates be appropriate? How would someone know if it was up to date? A website or NHS choices update should be dated so everyone viewing the information could measure how current it was. This is reliant on regular self-reporting by individual practices which is difficult to encourage without it being standardised in an IT format (having a monthly reminder) or involving an incentive (for example it could be a KPI). It would need to include a breakdown of the acceptance of adults and children to be truly reflective.
112	The British Association for the Study of Community Dentistry (BASCD)	4	Does this draft quality standard accurately reflect the key areas for quality improvement? Yes but this is role of NHS England rather than the local authority. The standard should include something on information on how to access NHS dental service is made available to population groups who struggle with access. The following website: http://www.nhs.uk/NHSEngland/AboutNHSservices/dentists/Pages/find-an-NHS-dentist.aspx provides information on how to find a NHS dentist, including accessing urgent dental care. There needs to be a way of cascading the information to population groups who struggle with access to dental care. This may is a role for LAs as well as NHSE

113	The British Association for the Study of Community Dentistry (BASCD)	4	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? Yes this is recorded on NHS choices however it does not reflect a true picture as many practices do not update their status regularly. The GP survey includes questions on ease of access to NHS dental care and could be used.
114	The British Association for the Study of Community Dentistry (BASCD)	4	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? In Thames Valley, there are practices who will accept patients in pain directly from 111. Information is given to the patients by 111
115	The British Association for the Study of Community Dentistry (BASCD)	4	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Yes this is achievable with the reformed contract that is being led by Department of Health. Would need additional staff in NHS England dental teams to be able to monitor whether or not practices are complying. Also process of updating information needs to be simple. Need to define the term “accepting new patients” as in practice it is capable of a variety of interpretations. There is a need to reference how patients can access private dental care as in some parts of the country the level of care provided by private dentistry is very significant.
116	The British Association for the Study of Community Dentistry (BASCD)	4	Rationale. Accessing urgent dental care is also important.

117	National Oral Health Promotion Group (NOHPG)	4	This statement may be hard to measure because there is a lack of “Accurate and up-to-date information about whether dental practices are accepting new NHS patients to find and access dental services. It does fluctuate throughout the year because of several reasons.
118	National Oral Health Promotion Group (NOHPG)	4	Patient-reported access to NHS dental services varies depending on their circumstances and capabilities. Ground reality is not very good as many of them do not get NHS appointment.
120	British Dental Association	5	Does this draft quality standard accurately reflect the key areas for quality improvement? No, as there will always be a cohort of patients who will only access urgent care. It is important to sign post these patients on how to access to routine care if requested but not necessary to provide information on the benefits of attending for routine care, as this may be counterproductive and may put some patients off routine care - reference Steele pathway to show that not everyone will move from urgent to routine care.
121	British Dental Association	5	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No, not sure with how feasible or important this would be.
122	British Dental Association	5	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? Provision of dedicated urgent care services as part of GDS contracts so that when a patient is ready to move to routine care they have a link to a practice – compare this with access centres where no routine care is available
123	British Dental Association	5	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment No, this is not achievable as it would be patient choice to access routine dental care after emergency care. Good access to in hours urgent care reduces need for more costly out of hours services. Timely resolution of dental pain can reduce time off work for a person and so improve productivity. Good urgent care access at dental practices/ services reduced the demand on medical urgent care services e.g. A&E.

124	Public Health England	5	Does this draft quality standard accurately reflect the key areas for quality improvement? Yes, as although there will always be a cohort of patients that will only wish to access urgent care, there is evidence in NICE's behaviour change guidance that these people are key to encourage returning to receive preventive messages. "particularly take care of irregular attenders'.
125	Public Health England	5	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No systems in place but an opportunity through the current dental urgent care review being carried out by NHS E to inform practice
126	Public Health England	5	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? No
127	Public Health England	5	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment Could possibly systemise data capture if based on band 1 urgent claims followed definitive (non-urgent) claims for the same patients within x months of the urgent claim. In some areas there are no dentists on NHS choices showing they are taking on patients for routine care
128	Faculty of General Dental Practice (UK)	5	We agree with this statement. However we are unclear as to the need for it, as we would strongly expect that this is already being done. As a matter of course, we would expect all practitioners who provide emergency care to patients to also be providing information about the benefits of routine care.
129	Oxfordshire Salaried Primary Care Dental Service, Oxford Health NHS Foundation Trust	5	Need to clarify what sort of evidence a practice would provide to show they are delivering the information; documentation of verbal conversation or handing out of written information. How would data be collected? It could be incorporated into the dental software so that when emergency claims are submitted, the practitioner has to include the information (in a 'tick box' format). However, unless there is an automatic prompt, then this optional exercise will often get missed and data will be inaccurate. To improve compliance, it could be made a KPI. Is there any evidence to suggest that imparting oral health information at an emergency appointment results in uptake of services or is this 'making every contact count'?

130	The British Association for the Study of Community Dentistry (BASCD)	5	Does this draft quality standard accurately reflect the key areas for quality improvement? No, as there will always be a cohort of patients who will only access urgent care. The independent review of NHS dental services in England (2009) led by Professor Steele, recommended that 'urgent care services should be accessible and commissioned to a high and consistent level of quality'. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf). It is important to sign post these patients on how to access to routine care if requested but not necessary to provide information on the benefits of attending for routine care, as this may be counterproductive and may put some patients off routine care.
131	The British Association for the Study of Community Dentistry (BASCD)	5	Are local systems and structures in place to collect data for the proposed quality measure? If not, how feasible would it be for these to be put in place? No, not sure with how feasible or important this would be.
132	The British Association for the Study of Community Dentistry (BASCD)	5	Do you have any examples from practice of implementing NICE guidelines that underpin this quality standard? No If urgent care is provided by general dental practices who can then continue to provide routine care for those patients that wish to go onto regular routine care, Will remove barrier of having to find another dental practice taking on NHS patients will make it easier for this group of patients to move from urgent to routine care.
133	The British Association for the Study of Community Dentistry (BASCD)	5	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment No, this is not achievable as it would be patient choice to access routine dental care after emergency care. Dentists will need to ensure that they are complying with NICE recall guidance and educate patients away from idea that dental check-ups are needed every six months. This should free up capacity and UDAs to see more new patients. Providing good in hours urgent care will reduce the need for out of hours urgent care which is more costly. Also by increasing the number of patients accessing routine dental care should in long term reduce the need for urgent care.
134	British Dental Association	Additional area	In order to improve oral health dental teams need to provide evidence based messages as per Delivering Better Oral Health: an evidence based toolkit for practitioners and NICE ng 30. Therefore there should be a statement that dental practitioners should provide evidence-based preventive messages and interventions based on the fore mentioned guidance.

135	British Dental Association	Additional area	Healthy settings influence healthier food and drink choices and this is supported by NICE PH 55 recommendation 6 &17. Therefore there should be a statement to reflect this such as: All public service settings such as schools, NHS premises should promote oral health and healthier food and drink choices specifically to reduce the amount of sugars consumed. Also drinking water should be free and easy to access at these sites.
136	Public Health England	Additional area	Consideration should be given of adding a recommendation that LAs continue to survey their population to assess need so that they have the information to do an oral health needs assessment Although this is a requirement of the SI (responsibility to undertake dental surveys) , and they are responsible to do so for the PHOF, the cuts to LA budget mean that this is threatened alongside other mandated services.
137	Public Health England	Additional area	There should be a statement that dental practitioners should provide evidence-based preventive messages and interventions (based on Delivering Better Oral Health: an evidence based toolkit for practitioners).
138	Public Health England	Additional area	As suggested in Public Health England's response to consultation on these Quality Standards, there should be a statement that all public service settings such as schools, NHS premises should promote oral health and healthier food and drink choices. Healthy settings influence healthier food and drink choices and this is supported by NICE PH 55 recommendation 6 &17
139	The British Association for the Study of Community Dentistry (BASCD)	Additional area	In order to improve oral health dental teams need to provide evidence based messages as per Delivering Better Oral Health: an evidence based toolkit for practitioners and NICE ng 30. Therefore there should be a statement that dental practitioners should provide evidence-based preventive messages and interventions based on the fore mentioned guidance.
140	The British Association for the Study of Community Dentistry (BASCD)	Additional area	Healthy settings influence healthier food and drink choices and this is supported by NICE PH 55 recommendation 6 &17. Therefore there should be a statement to reflect this such as: All public service settings such as schools, NHS premises should promote oral health and healthier food and drink choices specifically to reduce the amount of sugars consumed. Also drinking water should be free and easy to access at these sites.
141	Department of Health		Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
142	Royal College of Nursing		The Royal College of Nursing have no comments to submit to inform on the above quality standard consultation

143	The British Association for the Study of Community Dentistry (BASCD)		BASCD as a registered stakeholder organisation are pleased to be given the opportunity to comment on the draft guidance.

Registered stakeholders who submitted comments at consultation

- Association of Directors of Public Health
- The British Association for the Study of Community Dentistry (BASCD)
- British Dental Association
- Department of Health
- Faculty of General Dental Practice (UK)
- National Oral Health Promotion Group
- NHS England
- Oxfordshire Salaried Primary Care Dental Service, Oxford Health NHS Foundation Trust
- Parkinson's UK
- Public Health England
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Paediatrics and Child Health

- Royal Pharmaceutical Society
- School and Nursery Milk Alliance
- South West Yorkshire Partnership NHS Foundation Trust