NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Oral health promotion in care homes and hospitals

Output: Prioritised quality improvement areas for development.

Date of quality standards advisory committee meeting: 10 November 2016

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for oral health promotion in care homes and hospitals. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source(s) referenced in this briefing paper is:

Oral health for adults in care homes. NICE guideline NG48 (2016).

Update not yet scheduled.

2 Overview

2.1 Focus of quality standard

This quality standard will cover oral health, including dental health and daily mouth care, for adults in care homes and hospitals. It will include people in care homes both with and without nursing provision.

Oral health promotion in the community is covered in a separate quality standard.

2.2 Definition

Poor oral health can affect people's ability to eat, speak and socialise (Dental quality and outcomes framework Department of Health). Tooth decay and gum disease are the most common UK dental problems, but are largely preventable (Levine and Stillman-Lowe 2009[1]). They can be painful, expensive and seriously damage health if not treated (Dental quality and outcomes framework).

[1] Levine RS, Stillman-Lowe CR (2009) The scientific basis of oral health education: sixth edition. London: British Dental Journal

Poor oral health (leading to pain or infection) can also precipitate crises in people with dementia.

2.3 Incidence and prevalence

Age UK estimates 426,000 people live in care homes, approximately 405,000 of whom are over 65 (October 2016). Some younger adults also live in residential care because their physical or mental health prevents them from living independently.

Research with adults in care homes with moderate to severe dementia has reported poor oral health (Preston 2006[2]). A 2012 British Dental Association survey (Dentistry in care homes research – UK) found inconsistent oral health care in care homes. It found many residents had oral health problems but staff were reluctant to help and lacked training. Care staff showed little understanding about the importance of oral health or its relationship with general health and a range of risk factors (for example, mouth cancer, cardiovascular disease, aspiration pneumonia).

Oral cancer is rapidly increasing and half of new cases are in people aged 65 and over (Oral cancer – UK incidence statistics Cancer Research UK).

2.4 Management

In care homes, many residents have complex oral health needs, but it is not always clear how these are met. Practice varies across England. Poorly trained staff, lack of access to dental services and advice, existing oral health problems, medicines that decrease saliva, and treatments for chronic medical conditions (including dementia) make it difficult to identify and meet those needs.

Good mouth care in hospital can reduce the risk of infection and improve experience for inpatients, but it is not always done well (1000 Lives Improvement).

2.5 National outcome frameworks

Tables 1–4 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

[2] Preston A (2006) The oral health of individuals with dementia in nursing homes. Gerodontology 23 (2): 99–105

Table 1 Adult social care outcomes framework 2015–16

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life** ***Outcome measures*** **People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs** 1B Proportion of people who use services who have control over their daily life
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services ***Outcome measures*** **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual** This information can be taken from the Adult Social Care Survey and used for analysis at the local level.
4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	***Overarching measure*** 4A The proportion of people who use services who feel safe** ***Outcome measures*** **Everyone enjoys physical safety and feels secure** **People are protected as far as possible from avoidable harm, disease and injuries** **People are supported to plan ahead and have the freedom to manage risks the way that they wish** 4B The proportion of people who use services who say that those services have made them feel safe and secure
Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework ** Indicator is complementary Indicators in italics in development	

Table 2 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
3 Helping people to recover from episodes of ill health or following injury	**Improving dental health** *3.7 i Decaying teeth***
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care iii NHS dental services ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving access to primary care services** 4.4 Access to ii NHS dental services
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework ** Indicator is complementary Indicators in italics in development	

Table 3 Public health outcomes framework for England, 2016–2019

Domain	Objectives and indicators
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.13 Health-related quality of life for older people
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework ** Indicator is complementary Indicators in italics in development	

Table 4 Dental quality and outcomes framework 2016–2017

Domain	Indicators
Patient safety	SA.01 Recording an up-to-date medical history at each oral health assessment/review
Clinical effectiveness	OI.03 Decayed teeth (DT) for patients aged 19 years old and over OI.04 BPE score for patients aged 19 years old and over OI.05 Number of sextant bleeding sites for patients aged 19 years old and over

3 Summary of suggestions

3.1 Responses

In total 8 stakeholders responded to the 2-week engagement exercise (21/9/16-5/10/16).

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 5 for further consideration by the committee.

Full details of all the suggestions provided are given in appendix 4 for information.

Table 5 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Oral health assessment • On admission to a care home • Regular assessments	PUK, PHE, SCM1, SCM2, SCM3, SCM4, NDH
Mouth care plans • Recording and updating mouth care plans • Dental passports	PUK, SCM2, SHF, NDH, NHSE
Daily mouth care • Daily mouth care supported by staff • Mouth care champions	BDA, PHE, SCM1, SCM2, SCM4, SHF
Access to dental services • Ensuring access for care home residents • Governance of visiting dental providers	BDA, NHSE, PHE, SCM1, SCM2, SCM3, SCM4, SHF
Oral health promotion • Oral health promotion activities • Oral health promotion policies	BDA, FGDP, NHSE, SCM3, SCM4, PHE

BDA, British Dental Association
FGDP, Faculty of General Dental Practice
NDH, North Devon Healthcare NHS Trust Special Care Dental Service
NHSE, NHS England
PHE, Public Health England
PUK, Parkinson's UK
SHF, Southern Health Foundation NHS Trust

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 196 papers were identified for oral health promotion in care homes and hospitals. In addition, 27 papers were suggested by stakeholders at topic engagement and 44 papers internally at project scoping.

Of these papers, 7 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Oral health assessment

4.1.1 Summary of suggestions

On admission to a care home

Stakeholders highlighted the importance of determining the oral health needs of new care home residents when they are admitted. This helps with planning for the support and care that an individual may need.

One stakeholder suggested these assessments should be led by a nurse.

Regular assessments

Stakeholders highlighted that oral health assessments should be carried out regularly to ensure any changes in a resident's oral health are noted and staff know how to best support individuals with their oral health.

4.1.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
On admission to a care home	**Oral health assessment and mouth care plans** NICE NG48 recommendation 1.2.1
Regular assessments	**Oral health assessment and mouth care plans** NICE NG48 recommendation 1.2.4

Oral health assessment and mouth care plans

NICE NG48 recommendation 1.2.1

Assess the mouth care needs of all residents as soon as they start living in a care home, regardless of the length or purpose of their stay. Consider using the Oral health assessment tool. Where family and friends are involved in ongoing care, consider involving them in the initial assessment, with the residents' permission, if it will help staff understand the resident's usual oral hygiene routine. Ask:

- How the resident usually manages their daily mouth care (for example, toothbrushing and type of toothbrush, removing and caring for dentures including partial dentures). Check whether they need support.

- If they have dentures, including partial dentures, whether they are marked or unmarked. If unmarked, ask whether they would like to arrange for marking and offer to help.

- The name and address of their dentist or any dental service they have had contact with, and where and how long ago they saw a dentist or received dental treatment. Record if there has been no contact or they do not have a dentist, and help them find one.

NICE NG48 recommendation 1.2.4

Review and update residents' mouth care needs in their personal care plans as their mouth care needs change (see recommendation 1.3.3).

4.1.3 Current UK practice

On admission to a care home

Public Health England's review 'What is known about the oral health of older people' summarises the results of 5 surveys of oral health in older people in Wales, the West Midlands, the North West, East London and the City and Bolton and Kirklees.

The review reported that an oral health needs assessment was carried out on admission in 61% of care homes in the West Midlands and 90% in the North West.

Regular assessments

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.1.4 Resource impact assessment

The resource impact report for NG48 states that there may be a cost related to the training of staff to carry out assessment of people on admission to care homes. Where this training is not currently carried out, the cost of providing the training and cover to allow staff to attend it, may be an additional cost to organisations.

In the economic analysis prepared to support NG48 it was estimated that the cost of advanced training for supervisors, which would take about half a day, is around £700 per care home. This training would include the assessment of people being admitted to the care home.

4.2 Mouth care plans

4.2.1 Summary of suggestions

Recording and updating mouth care plans

Stakeholders highlighted that residents in care homes and people in hospitals should have a care plan that records the results of their oral health assessment and any appointments with dental practitioners. This should be reviewed and updated as the individual's mouth care needs change. One stakeholder suggested that any plans for dental treatment should be agreed with dental practitioners.

Dental passports

Stakeholders suggested that the use of dental passports can help to make sure all relevant information is shared when people attend general dental practices.

4.2.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Recording and updating mouth care plans	**Oral health assessment and mouth care plans** NICE NG48 recommendation 1.2.3
Dental passports	Not directly covered in NICE NG48 and no recommendations are presented

Oral health assessment and mouth care plans

NICE NG48 recommendation 1.2.3

Record the results of the assessment and the appointment in the resident's personal care plan.

4.2.3 Current UK practice

Recording and updating mouth care plans

The What is known about the oral health of older people review described that in the North West, oral health was part of the overall care plan in 77% of care homes and in 31% of cases in hospitals.

In Bolton and Kirklees[3], overall 76% of care home manager respondents reported that oral health was part of the care plan, although the percentage was lower in the Bolton care homes at 52%.

Dental passports

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.2.4 Resource impact assessment

No resource impact was anticipated from recommendations in this area of NG48. This is because it is considered that where clinical practice changes, as a result of the guidance, there will not be a significant change to resource impact.

[3] Healthwatch Bolton & Healthwatch Kirklees (2014) Oral health in care homes. Evidence from Bolton and Kirklees

4.3 Daily mouth care

4.3.1 Summary of suggestions

Daily mouth care supported by staff

Stakeholders highlighted that staff should support care home residents and hospital patients to meet their daily mouth care needs, as detailed in their mouth care plan. In particular, stakeholders emphasised the importance of helping people to brush their teeth twice a day with fluoride toothpaste, including ensuring the provision of any equipment necessary such as toothbrushes and toothpaste.

It was also highlighted that people with a learning disability or other cognitive impairment may be particularly at risk of poor care in this area.

Mouth care champions

Stakeholders suggested that identifying a mouth care champion in every hospital and care home would ensure systems are in place to support oral health improvement and could help to improve the practice of daily mouth care.

4.3.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Daily mouth care supported by staff	**Daily mouth care** NICE NG48 recommendation 1.3.1
Mouth care champions	Not directly covered in NICE NG48 and no recommendations are presented

Daily mouth care supported by staff

NICE NG48 recommendation 1.3.1

Ensure care staff provide residents with daily support to meet their mouth care needs and preferences, as set out in their personal care plan after their assessment. This should be aligned with the advice in the Delivering better oral health toolkit, including:

- brushing natural teeth at least twice a day with fluoride toothpaste

- providing daily oral care for full or partial dentures (such as brushing, removing food debris and removing dentures overnight)
- using their choice of cleaning products for dentures if possible
- using their choice of toothbrush, either manual or electric/battery powered
- daily use of mouth care products prescribed by dental clinicians (for example, this may include a high fluoride toothpaste or a prescribed mouth rinse, see NICE's guideline on managing medicines in care homes)
- daily use of any over-the-counter products preferred by residents if possible, such as particular mouth rinses or toothpastes; if the resident uses sugar-free gum, consider gum containing xylitol.

4.3.3 Current UK practice

Daily mouth care supported by staff

The North West dental health survey of services for older, dependent people (2012-13) surveyed care home managers and hospital ward managers. It reported that 96% of care homes and 87% of hospitals with in-patient facilities had a system in place to ensure that people received help with oral hygiene if they needed it.

84% of care homes and 78% of hospital ward managers had a system in place so that residents could clean their teeth twice a day.

Mouth care champions

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.3.4 Resource impact assessment

The resource impact report for NG48 states that there may be a cost related to the training of staff, to provide people with help and support with their oral hygiene if they need it. Where this training is not currently carried out, the cost of providing the training and cover to allow staff to attend it, may be an additional cost to organisations.

In the economic analysis prepared to support NG48 it was estimated that, the cost of basic training for all staff, which would take about 1 hour, is around £300 per care home. This training would include the importance of residents' oral health and daily mouth care.

4.4 Access to dental services

4.4.1 Summary of suggestions

Ensuring access for care home residents

Stakeholders highlighted that residents in care homes should be able to receive routine or specialist care as necessary. Stakeholders suggested that care homes should provide support to residents to attend appointments, such as travel arrangements, and provide information about costs. One stakeholder suggested that some dental care could be provided by members of the dental care team other than a dentist. Another suggested that all new care homes should have an on-site specialist consultation room.

Governance of visiting dental providers

A stakeholder emphasised that dental providers who visit care homes should be adequately governed to protect the vulnerable population.

4.4.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 9 to help inform the committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Ensuring access for care home residents	**Oral health assessment and mouth care plans** NICE NG48 recommendation 1.2.2 **General dental practices and community dental services** NICE NG48 recommendation 1.7.1
Governance of visiting dental providers	**Care home policies on oral health and providing residents with support to access dental services** NICE NG48 recommendation 1.1.4

Oral health assessment and mouth care plans

NICE NG48 recommendation 1.2.2

Make an appointment for the resident to see a dental practitioner, if necessary.

General dental practices and community dental services

NICE NG48 recommendation 1.7.1

Provide residents in care homes with routine or specialist preventive care and treatment as necessary, in line with local arrangements (see NICE's guidelines on dental checks: intervals between oral health reviews, oral health: approaches for local authorities and their partners to improve the oral health of their communities and oral health promotion: general dental practice).

Care home policies on oral health and providing residents with support to access dental services

NICE NG48 recommendation 1.1.4

Ensure the oral health policy makes it clear that only practitioners registered with the General Dental Council and acting within its scope of practice may diagnose and treat dental disease or refer someone for specialist treatment (see NICE's guideline on suspected cancer: recognition and referral).

4.4.3 Current UK practice

Ensuring access for care home residents

Public Health England's review 'What is known about the oral health of older people detailed that in the study of Welsh care homes, 17% of managers had difficulty accessing routine care for residents. In the West Midlands, 39% of managers always or occasionally had difficulty.

The 2010-11 study of residents in Welsh care homes[4] reported that 19.3% of dentate care home residents reported going for regular dental check-ups.

The survey of care home managers in Bolton and Kirklees (2014)[5] reported that 46% of the care homes did not have a relationship with a dental service provider and 40% were not able to get home visits.

Governance of visiting dental providers

In the West Midlands care home dental survey (2011)[6], 8.3% (97/1170) of care homes reported that they had some issues or concerns with a dental care provider, including concerns about infection control and providers not treating people with respect.

[4] Morgan M. et al (2012) Wales care home dental survey 2010-11. Cardiff University and Public Health Wales
[5] Healthwatch Bolton & Healthwatch Kirklees (2014) Oral health in care homes. Evidence from Bolton and Kirklees
[6] Watson F. et al (2015) West Midlands Care Home Dental Survey 2011. Part 1: Results of questionnaire to care home managers. British Dental Journal 219, 343-346

4.4.4 Resource impact assessment

There may be a resource impact if a change in practice is needed to ensure people in care homes have access to dental services. This may include additional transport costs for taking residents to dental appointments.

In the economic analysis prepared to support NG48 it was estimated that the cost of providing oral care to a resident is around £370 over 2 years which includes staff time but assumes that toothbrushes and toothpaste are supplied by resident's families.

4.5 Oral health promotion

4.5.1 Summary of suggestions

Oral health promotion activities

Stakeholders highlighted the importance of promoting good oral health and its link with quality of life to residents in care homes and patients in hospitals. For example, by encouraging a healthy diet through promotional materials, as well as providing healthy meals. Promotional messages should be accessible to the target group and may need to be adapted, for example, for people with dementia.

Oral health promotion policies

A stakeholder highlighted that policies should be in place in care homes that promote evidence-based oral health and ensure staff know how to support residents with oral care.

4.5.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 10 to help inform the committee's discussion.

Table 10 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Oral health promotion activities	**Oral health promotion services** NICE NG48 recommendation 1.6.1
Oral health promotion policies	**Care home policies on oral health and providing residents with support to access dental services** NICE NG48 recommendation 1.1.1

Oral health promotion services

NICE NG48 recommendation 1.6.1

Develop and provide care homes with oral health educational materials, support and training to meet the oral health needs of all residents, especially those with complex needs. Also explain the role of diet, alcohol and tobacco in promoting good oral health, in line with advice in the Delivering better oral health toolkit and NICE's guideline oral health promotion: general dental practice.

Care home policies on oral health and providing residents with support to access dental services

NICE NG48 recommendation 1.1.1

Ensure care home policies set out plans and actions to promote and protect residents' oral health. Include information about:

- local general dental services and emergency or out-of-hours dental treatment
- community dental services, including special care dentistry teams (see the NHS Choices information on NHS dental services)
- oral health promotion or similar services, depending on local arrangements (see recommendation 1.7.1)
- assessment of residents' oral health and referral to dental practitioners (see section 1.3)
- plans for caring for residents' oral health
- daily mouth care and use of mouth and denture care products
- what happens if a resident refuses oral health care (in line with the Mental Capacity Act and local policies about refusal of care)
- supply of oral hygiene equipment (for example, basic toothbrush or toothpaste).

4.5.3 Current UK practice

Oral health promotion activities

A 2006 survey of nurses and healthcare professionals working on elderly care wards in hospitals and staff working in nursing homes found that 43% of care staff in hospitals and 54% of care staff in care homes gave oral care advice to the elderly patients in their care.[7]

Oral health promotion policies

The North West dental health survey of services for older, dependent people reported that 41% of residential care homes had an oral health policy in place.

[7] Preston AJ, Kearns A, Barber MW, Gosney MA (2006) The knowledge of healthcare professionals regarding elderly persons' oral care. British Dental Journal 201, 293-295

4.5.4 Resource impact assessment

No resource impact was anticipated from recommendations in this area of NG48. This is because it is considered that where current practice changes, as a result of the guidance, there will not be a significant change to resource impact.

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 10th November 2016.

Training

A number of stakeholders highlighted that staff working in care homes and hospitals should be trained so that they are better equipped to help residents and patients with their oral health needs. One stakeholder suggested that doctors should be trained in oral health at undergraduate or postgraduate level. Training is not normally covered directly in quality statements as staff being trained is an underpinning concept of all quality standards.

Triple aim framework

A stakeholder suggested that incorporating the three dimensions of the triple aim framework (experience of care, population health and per capita cost) would improve oral health in care homes and hospitals. These dimensions are considered throughout the process of developing quality standards.

Person-centred care

One stakeholder highlighted that patients and residents should be involved in decision-making about their care and that provision of care should be based on their needs and preferences. This is addressed by the quality standard on patient experience in adult NHS services.

Links with Care Quality Commission (CQC)

A stakeholder suggested that CQC inspections should take account of basic markers of oral care provision. CQC inspectors look for evidence of how providers are using quality standards to improve the care they offer. This is used to inform the award of good and outstanding ratings.

Joint strategic needs assessments

One stakeholder suggested that the oral health of people with neurological conditions such as Parkinson's Disease should be considered in joint strategic needs

assessments. Joint strategic needs assessments are addressed by a separate quality standard (in development) on oral health promotion in the community.

Appropriate equipment

A stakeholder suggested that more evidence is needed about what equipment and treatments are suitable in specific situations. It is not within the remit of quality standards to address this issue.

Clinical interventions

A stakeholder suggested that the quality standard should consider how more complex oral health needs such as extraction of wisdom teeth can be addressed. Clinical dental treatment is outside the scope of this quality standard.

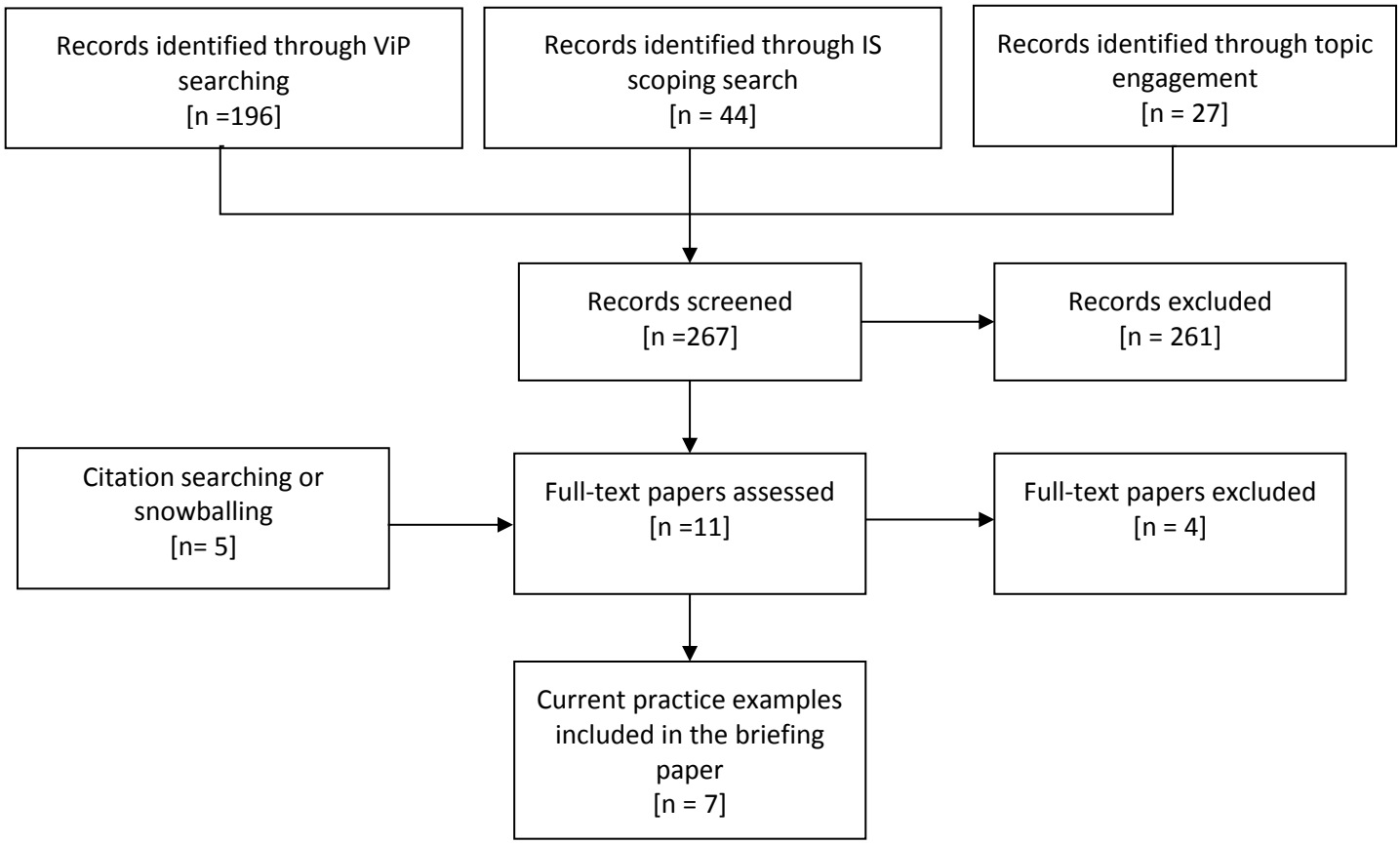
Free dental check-ups for over 60s

A stakeholder suggested that dental check-ups for people over 60 should be provided free of charge to increase access to dental services. This is outside the remit of quality standards.

Gaining consent

A stakeholder highlighted that treatment should be provided with clear capacity assessments and with the consent of people close to the patient. This is included in legislation and is outside the remit of quality standards.

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Oral health assessment					
1	Parkinson's UK	People with Parkinson's receive regular oral assessments/ mouth care assessments	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.	We believe that mouth care assessments could have a huge impact on improving outcomes for people with Parkinson's. Regular mouth care assessments could help people affected by Parkinson's manage their condition and prevent them from deteriorating. Parkinson's UK recommend that the NICE standard references that professionals who specifically support people with the condition, such as Parkinson's nurses, should be involved in the assessment process. They are experienced working as part of a multi-disciplinary team and bring specialist knowledge about Parkinson's that could improve the outcomes for people with the condition, while also striving to reduce the costs to health and social care.	Dental and oral health for people with Parkinson's http://www.parkinsons.org.uk/content/dental-and-oral-health-parkinsons-information-sheet
2	Public Health England	Key area for quality improvement 1 Development and routine use of oral health policies and oral health assessments in care homes and hospital	Use of oral health policies and assessments is recommended within NICE guidance (NG48) Evidence based oral health policies (i.e. based on Delivering Better Oral Health) should encourage consistency of approach and help ensure that staff know how to support individuals with their oral care. Use of oral health assessments	Use and content of oral health policies And oral health assessments are reported to vary markedly. This is highlighted in the publication by PHE (2016) of - What is known about the oral health of older people in England and Wales? A review of oral health surveys of older people. https://www.gov.uk/government/publications/oral-health-of-older-people-in-england-and-wales)	Examples of oral health policies and oral health assessments will be included in Resources section of Commissioning Better Oral Health for Vulnerable Older People which will be published by PHE in early 2017.

			is essential to allow staff to plan for the individual and determine what support they may need.		
3	SCM1	Key area for quality improvement 4	Ensuring that residential homes are aware or a person's level of oral health needs by conducting an assessment on entry to the residence	Appropriate levels of intervention and action MUST be tailored to individual's needs, limitations, requirements and customs/habits	
4	SCM2	Oral health assessment on admission	To identify the condition of the patients oral health and to check for signs and symptoms of dental disease	UK national minimal standards for care homes for older people requires a review of oral health status to be undertaken as part of any initial health evaluation	British Society of Gerodontology 2010
5	SCM3	Key area for quality improvement 1	Local authority 'assessment of care needs' policy. If there is not a question relating to oral health care needs within the Local Authority 'assessment of care and support needs' this allows oral care needs to be overlooked when a person is admitted into a care home.	Oral care/mouth care is often neglected due to the lack of specificity in various assessment protocols. It is too often assumed that oral care is an integral/automatic part of personal care but evidence suggests this is often not the case.	
6	SCM3	Key area for quality improvement 3	Oral health assessment	Even for those with a lifetime of good oral self care, there is often a period before admission into care homes of declining ability. With deteriorating cognitive impairment, people will forget or be less inclined to perform a number of aspects of personal care. Therefore, many people will be admitted into care homes with pre-existing poor oral health status and without an appropriately conducted oral health assessment, this will not be identified or treated. Oral health assessment using a valid assessment tool (leading to an individual plan of care) should be central to care home	NG48

				policy, and should also be considered in any inspection programme.	
7	Northern Devon Healthcare NHS Trust Special Care Dental Service	i) Nurse-led oral health assessment for every service user, to form part of the care record.			
8	SCM4	Key area for quality improvement 3 ORAL HEALTH ASSESSMENTS	Members of staff should know how to spot changes in a resident's mouth – this is important especially when there are gaps between appointments and for residents who are reluctant to see a dentist. In my view, spotting bad breath can be crucial – may be an indicator of infection or another underlying cause.	There are residents who may have no intention of seeing a dentist, possibly through fear or embarrassment. This may be the only opportunity for his/her mouth to be inspected. So it is important but I have reservations over this - are members of staff up to this? It could be a crucial opportunity if there are abnormalities, possibly co-existing too – an ulcer that doesn't heal or a lichenoid or even mouth cancer. Is this too much responsibility for staff? Something for QSAC to discuss.	Delivering better oral health tool kit 3rd edition June '14 www.gov.uk/government/data/DBOHv32014OCTMain Document – patients' propensity to seek treatment is mentioned in this document. See also note above re training
Mouth care plans					
9	NHS England	Key area for quality improvement 1	Key standards for mouth care recording in Hospitals and Care Homes. There is some inconsistencies in mouth care recording in Hospitals. Recommending standards that include a mouth care risk assessment, oral assessment and mouth care recording form would aim to identify patients at risk, ensure mouths are assessed regularly and all mouth care regularly	East Surrey CQC Report 2014 identified a lack of awareness of where to record mouth care. The following paper identifies the importance of mouth care tools. Stout, M., Goulding, O., Powell, A. (2009) Developing and implementing an oral care policy and assessment tool. *Nursing Standard*; 23 : 42-48.	None

			recorded		
10	Parkinson's UK	Ensure everyone with Parkinson's has their own individual, tailored care plan and that oral health is referenced in the plan to ensure a high standard is maintained.	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.	Some people with Parkinson's may not have care plans, and if they do, these may not have a focus on oral health. We want to see a person's long term condition referenced in their personal care plan. Alongside having specific details on oral health in a care plan, will mean that this information can be transferred with the person if they move to other care settings. Parkinson's UK recommend that the NICE standard references the need for relevant information on oral health is included in an individuals' care plan.	Information about oral health and eating, swallowing and saliva control can be found in our information sheets (www.parkinsons.org.uk) which have all been information standard accredited.
11	SCM2	Personalised Care Plans	Provide all residents/patients with a personalised care plan regardless of the length of stay in care home or hospital	To identify the individual needs of the patient in relation to their daily mouth care.	Caring for Smiles NHS Scotland British Society of Gerodontology 2010

12	Southern Health Foundation NHS Trust	Key area for quality improvement 1 Use of Dental Passports	To ensure all relevant information is shared	The dental passport provides a mechanism to enable improved communication, add clarity with regard to treatments past and present and ensure individual's needs are met	http://www.accessibleinfo.co.uk/pdfs/MyDentalPassport.pdf
13	Southern Health Foundation NHS Trust	Additional developmental areas of emergent practice Development an agreement of clear treatment plans with dental practitioners	Links with use of passport but also have a 'no surprise' approach to treatments Clarity how dental treatments impact on/are impacted by other current treatments		
14	Northern Devon Healthcare NHS Trust Special Care Dental Service	ii) Written oral care plan for every service user, to form part of the care record, updated annually.			
15	Northern Devon Healthcare NHS Trust Special Care Dental Service	iii) Written documentation of every episode of delivery of oral care for every service user who is partially or completely unable to clean their own mouth, to form part of the care record.			
Daily mouth care					
16	British Dental Association	Key area for quality improvement 1 – Hospitals should facilitate toothbrushing twice daily for in-patients.	There is good evidence to demonstrate that brushing teeth twice daily is important for maintaining good oral health and, therefore, good general	There is significant evidence which suggests that hospitalisation is linked to a deterioration in oral health. Poor oral health can lead to a deterioration in general health, increase the risk of hospital-acquired infections and,	Please see the following example of a study which explores the links between oral health and undernutrition in older people in hospital settings:

			health. In addition, maintaining good oral health among hospital in-patients is important for quality of life and patient dignity, maintaining nutrition and hydration and ensuring the patient's ability to take medication.	therefore, lengthen hospital stays. Under- and Malnutrition have been found to be a particular issue for hospitalised older people and maintaining good oral health has been linked to improved nutritional status. The change of routine for patients and the barriers which hospitalisation can present to maintaining good oral health habits should be overcome through healthcare professionals facilitating toothbrushing twice a day.	Poisson, P., Laffond, T., Campos, S., Dupuis, V., & Bourdel-Marchasson, I., 'Relationships between oral health, dysphagia and undernutrition in hospitalised elderly patients', 2014, Gerodontology, 33(2), 161-168. doi:10.1111/ger.12123 Please see the following example of a study which explores the impact of hospitalisation on oral health: Sousa LLA, Silva Filho WLSe, Mendes RF, Moita Neto JM, Prado Junior RR., 'Oral health of patients under short hospitalization period: observational study', 2014, J Clin Periodontol, 41, 558–563. doi: 10.1111/jcpe.12250. Mouth Care Matters is a scheme at East Surrey Hospital which has identified the need to improve the provision of oral healthcare to deliver better outcomes for older people in hospital settings. Please see: https://nhw14.files.wordpress.com/2013/11/mcm_a3_print.pdf

17	NHS England	Key area for quality improvement 2	Training mouth care champions in every hospital and care home so that all staff have access to continuous mouth care training and education including hands-on training	There are many documented barriers to staff not carrying out effective daily mouth care. Mouth care is a practical skill and due to the high turnover of staff it is important to have accessible staff available daily with enhanced oral health skills Preston, A.J., Kearns, A., Barber, M.W., Gosney, M.A. (2006) The knowledge of healthcare professionals regarding elderly persons' oral care. *British Dental Journal*; 201 : 293-295. This paper identifies the lack of knowledge amongst health care professionals.	None
18	Public Health England	Key area for quality improvement 2 Staff support residents/patients with their oral care (and are trained to do so)	Recommended within NICE guidance (NG48) Care home residents and some hospital patients are likely to be more at risk of oral disease than the general public and more in need of support with their self-care. Furthermore, oral health affects general health, wellbeing and quality of life. Poor oral health appears to be associated with some systemic disease though evidence of causality is limited at present. Public Health Wales conducted a rapid review of the evidence concerning the link between oral and systemic disease; they concluded aspiration of oropharyngeal commensals has some role in the aetiology of nursing home acquired pneumonia and it is possible that this allows for improved oral care as a therapeutic intervention.	There is considerable variability in terms of the support that is provided for care home residents. West Midlands Care Home Dental Survey 2011: part 1. Results of questionnaire to care home managers.Br Dent J 2015; 219(7):343-6 (http://www.nature.com/bdj/journal/v219/n7/full/sj.bdj.2015.757.html There is often a high staff turnover in care homes and so would need to ensure easy way to access this training for example through an e-learning module. Training needs to give staff the confidence to support daily mouth care for residents Staff in hospitals may not have capacity to help/support patients with their oral health. Important to include whether help or support is needed by patients within their care plan and how this need will be met.	Examples of training for care homes will be included in Resources section of Commissioning Better Oral Health for Vulnerable Older People which will be published by PHE in early 2017. In addition PHE will shortly be publishing rapid evidence reviews of the link between oral and general health (including pulmonary disease and aspiration pneumonias)

			(Accessed via: http://www.1000livesplus.wales.nhs.uk/mouthcare)		
19	Public Health England	Key area for quality improvement 4 Development of care home/hospital oral health leads	Recommended within NICE guidance (NG48) to provide oral health leadership within settings. It would be beneficial to identify a staff member as an oral health lead or champion responsible for delivery of the NICE guideline in the care home/hospital. They could monitor delivery locally against NICE quality standards and lead work to improve care locally They could also facilitate the establishment of a training the trainer model. With oral health champions being trained up to pass training on to others. They could also support or coordinate visits to dental practices or domiciliary services.	Limited use of oral health champions at present. There is a need for appropriate good leadership and to be clear on who is responsible for oral health improvement. It needs to be integrated into other care elements. The oral health champion should ensure systems are in place to support oral health improvement	Examples of the role of oral health champions will be included in resources section of Commissioning Better Oral Health for Vulnerable Older People which will be published by PHE in early 2017
20	SCM1	Brushing with a fluoride toothpaste twice a day	Both the Public Health and NICE guidelines on oral Health and the DoH document “delivering better Oral Health” acknowledge that this simple hygiene act is the most efficient measure for preventing decay. It also helps	It is evidence based and because of the reasons cited in the previous column	Delivering Better oral health. And relevant NICE guidelines

			to prevent periodontal (gum) disease which leads to tooth loss. Finally it is a basic human hygiene function, and should be instituted as part of the routines which aim to maintain a person's dignity (washing, dressing, bathing etc)		
21	SCM1	Key area for quality improvement 5	Ensuring supply of appropriate oral health supporting materials to residential homes e.g. toothbrushes, toothpaste		
22	SCM2	Support for residents/patients to carry out daily mouth care	To prevent dental disease and to reduce ill health and inequalities	Chronic disease and poor oral health share common risk factors	Public Health England Delivering Better oral health Community Dentistry and epidemiology, Aubrey Sheiham and Richard Watt
23	Southern Health Foundation NHS Trust	Key area for quality improvement 2 Knowledge of how to provide oral hygiene (OH)	Patients with a LD or other cognitive impairment (dementia etc) are often provided inadequate OH due to lack of knowledge and skill	Examples from clinical practice demonstrate clear lack of knowledge with potentially harmful outcomes for patients	National information re risk/high harm/complaints/invesitagtions?

24	SCM4	Key area for quality improvement 1 ORAL HEALTH MOUTH CARE PLANS	Brushing teeth 2x per day, a fluoride toothpaste, use of mouth care products prescribed by a dentist, use of over the counter products all contribute to the well being and oral health of residents. Efficient cleaning of dentures and palets with facility for overnight intensive cleaning. Good from a patient empowerment perspective – helps to give confidence and positive image perception. Regular check ups further develop this by giving residents confidence that all is well.	My experience of visiting a family member in a care home has led me to believe that these aspects of care are patchy; my overall impression is that staff are so busy, oral health can be neglected. Dental products frequently go missing. NB I am unsure about use of products eg steradent – risk of resident consuming them. Also re chewing gum, there is risk of choking. And in the case of mouth wash, there is danger of residents drinking them.	NICE guidance no 48 July 2016 Managing Medicines in Care Homes SC1 – recommendation re care home staff giving non-prescription & over the counter products to residents. Staff members involved to be named in homely remedies process Improving oral health for adults in care homes – a quick guide for care home managers – work in progress, currently being developed by Scie in association with NICE. This has the potential to be a crucial aid for staff (work I have done with the Audience Insight arm of NICE – working on a template for a short fact-sheet – an early prototype during development stage – very confidential at this stage). This would also be relevant re my suggestion under 2 – Oral Health Promotion Services.
Access to dental services					

25	British Dental Association	Key area for quality improvement 3 – All new care homes should provide on-site specialised consultation rooms and existing care home providers should take all reasonable actions to ensure there is a suitable setting for dental examinations on their premises.	Regular dental check-ups and timely treatment are an important element in maintaining good oral health. As set out in NICE guidance CG19, the interval between dental check-ups should be tailored to each patient on the basis of an oral health review but should not exceed 24 months. The provision of on-site specialised consultation rooms allows for care homes to better ensure and more conveniently deliver regular dental check-ups for their residents.	While in many care homes appropriate facilities exist to allow for dental examinations (either through specialised rooms, the ability to locate a temporary dental chair near to a sink or the ability to park a mobile dental unit on-site), there are a significant minority of care homes where this is not possible and residents must be transported to a dental surgery to receive an examination and treatment. Local surveys have found that significant numbers of care home residents have not attended a dental check-up in several years. On-site provision can help to support regular dental examinations and timely treatment.	In a Welsh study, more than 15 per cent of care home managers stated that their home did not have a dental chair or suite, and could not provide space for a chair near a sink or parking for a large van. Monaghan, N. and Morgan, M., 2010, 'Oral health policy and access to dentistry in care homes', *Journal of Disability and Oral Health*, 11(2), 61-68. A survey in the Avon area found that 71 per cent of care home residents had not seen a dentist in the last five years. Frenkel, H., Harvey I., and Newcombe, R., 2000, 'Oral health among nursing home residents in Avon', *Gerodontology*, 17(1) 33-8.
26	British Dental Association	Key area for quality improvement 5 – Free and comprehensive oral health assessments should be provided for those aged over 60 and information about NHS dental charges should be simplified and publicised to older people and carers.	There is evidence to suggest that cost presents a significant barrier to accessing NHS dentistry and also that a lack of information, or the complexity of this information when available, regarding dental charges and the exemptions to them also deters people from seeking dental assessments and treatment. As set out above, regular dental check-ups are a vital component in maintaining good oral health. Care home staff can also be unaware of whether residents are exempt	Numerous studies have demonstrated the deterrent effect of charges on patients seeking dental check-ups. The introduction of free oral health assessments for over 60s would bring dental treatment in line with other benefits for older people, notably free prescriptions, and would remove the deterrent effect of charges. Improved information on dental charges would enable patients to make better informed decisions and would remove some of the fear of perceived high costs which also acts as a deterrent. The advice on charges and exemptions are overdue simplification as the current NHS advice leaflet explaining the scheme to patients is 39 pages long and the	Please see this Citizen's Advice research on the impact of patient charges and the information available to patients on charges and exemptions. Unhealthy Charges, 2000, Citizen's Advice, https://www.citizensadvice.org.uk/Global/Migrated_Documents/corporate/unhealthy-charges.pdf

			from charges and therefore complete forms incorrectly leading to patient fines of £100.	Low Income Scheme application form and accompanying advice is 20 pages long.	
27	NHS England	Key area for quality improvement 3	Development or referral care pathway for hospitals and care homes on accessing appropriate dental services including general dental practice, special care	There is a lack of awareness about dental services by hospital and care home staff that lead to unnecessary delays in accessing appropriate treatment. Guidance needs to be aimed at staff/patients and carers. Please refer to the following guidance in Wales http://www.wales.nhs.uk/documents/Complete%20-%20Integrated%20SCD%20referral%20form%20Feb%202015.pdf	

28	Public Health England	Key area for quality improvement 3 Staff understand how to access routine and emergency dental services. Staff are aware of NHS dental charges and exemptions and are able to facilitate payment where necessary.	Recommended within NICE guidance (NG48) Ensuring staff can access care for patients routinely and, in particular, for those in pain, is essential. These are vulnerable groups of the population who may not always be able to indicate when they are in pain and if routine care is not being delivered. It is important that care homes have contact and knowledge of NHSE care pathways appropriate for their residents needs NHS dental charges apply to many care home residents but often there is some confusion amongst staff about this.	Knowledge of NHS dental care pathways and how to access routine and emergency care will vary across the country. High staff turnover in care homes is likely to be a particular issue with new staff unaware of local services.	There are a number of ways staff can access urgent dental care, this can be done through: Calling NHS 111 Looking on NHS Choices (http://www.nhs.uk/chq/Pages/1776.aspx) Access to routine dental care can be through word of mouth or by going onto NHS Choices pages. The following site explains how to find a NHS dentist http://www.nhs.uk/NHSEngland/AboutNHSservices/dentists/Pages/find-an-NHS-dentist.aspx However this group of patients may require access to Salaried Dental Services/Community Dental Services and/or domiciliary care. As this varies from area to area, we would suggest quality standard to include each NHS England area providing details of how to access appropriate care locally. This could be facilitated through Local Dental Networks who have a key role in clinical leadership and development of such care pathways to meet local needs

29	Public Health England	Key area for quality improvement 5 Care homes and hospitals should have processes in place to ensure that visiting providers of oral health promotion services are themselves adequately governed; there should be a process for checking the identity and role of those seeking to access care home / hospital residents.	This population cohort is a particularly vulnerable group and safeguarding issues must be taken into consideration.	These issues were highlighted in the West Midlands care home survey, which reported that a proportion of care homes had concerns with dental providers including probity, poor standards of cross infection, poor treatment planning, and poor patient management. *West Midlands Care Home Dental Survey 2011: part 1. Results of questionnaire to care home managers.Br Dent J 2015; 219(7):343-6* *(http://www.nature.com/bdj/journal/v219/n7/full/sj.bdj.2015.757.html)* Issues about probity and quality of dental care provided to care home residents featured heavily in a criminal prosecution case in 2012. http://www.bbc.co.uk/news/uk-england-birmingham-19845764	In a letter from the West Midlands Director of public health highlighted concerns to NCB Local Area Team Directors, Chairs, Clinical Commissioning Groups, Directors of Adult Care, Local Authorities and outlined suggested steps that may be helpful to prevent such issues including the use of service level agreements and contractual mechanisms to include quality standards
30	SCM1	Key area for quality improvement 3	Ensuring that there is access to appropriate dental services for those with expressed or symptomatic need	Human rights	
31	SCM2	Access to dental services	To ensure residents/patients receive routine or specialist preventive care and treatment as necessary	To identify dental disease and to be able to provide treatment which allows patients to be free from pain therefore enhancing quality of life	NHS England Dental Care and Oral health Call to Action
32	SCM3	Key area for quality improvement 2	General dental practices and community dental services Access to dental services	See comments in 'Additional development areas of emergent practice'. Lack of capacity or adequate incentives for dental practices to provide domiciliary services could be ameliorated somewhat by more efficient use of extended dental team, especially those with special care expertise.	Monaghan NP & Morgan MZ (2015), What proportion of dental care in care homes could be met by direct access to dental therapists or dental hygienists?

33	SCM3	Additional developmental areas of emergent practice		Although the dental care needs of some care home residents can be complex and require specialist in special care dentistry, there is a large proportion of more simple dental treatment need which may take additional time because of client group characteristics but does not require high level specialist care.	The proportion of care which could be delivered by hygienist of therapist is yet to be established, but Monaghan and Morgan paper has estimated the proportion of residents' dental treatment needs which could be delivered by a hygienist or therapist. 22-27% could be addressed by dental hygienist or therapist, and for those DHs or DTs with special care dental experience this rose to between 43% and 53%. (NB Although dentist with special care experience could provide all aspects of care for 90% of residents, a dentist without such experience could only provide all care for 39%)
34	Southern Health Foundation NHS Trust	Key area for quality improvement 5 Support to patients to attend appointments	Person centred approach required to enable patients to feel at ease as possible to attend appointments Consideration for people unable to attend a clinic	Ability to request longer appointments, desensitisation techniques etc. to ensure individuals experience successful and as least traumatic as possible treatments.	
35	SCM4	Key area for quality improvement 4 A FOCUS ON INCREASING ACCESS TO DENTAL SERVICES	This is relevant for both residents in care homes and patients in hospitals – when in pain, there should be quick access to dentists	Important to provide facility for transporting people to a local dental surgery or making an appointment in situ if unable to travel.	Could not find specific reference to this but think it would be covered under NICE Oral Health:local authorities & partners. The www reference above makes the point that access to treatment differs around the country.

Oral health promotion					
36	British Dental Association	Key area for quality improvement 2 – Care homes should provide residents with basic information on quality of life indicators relating to oral health and care home staff should receive proper training to ensure they have the skills and knowledge necessary to support residents to meet their oral health needs.	Providing care home residents with oral health quality of life information will enable them to prioritise their oral health requirements.	Oral health among older people in care homes has been shown to be poorer than for the general population of older people. Enabling care home residents to better understand their oral health needs and the impact of poor oral health on their quality of life can help them to understand how to prioritise their oral health requirements, routine and treatments. There is evidence to demonstrate that there is a significant amount of unmet dental care need among care home residents and providing better quality of life information to these residents may support them in seeking dental treatment and oral health care.	Please see: Porter et al, 'The impact of oral health on the quality of life of nursing home residents', 2015, *Health and Quality of Life Outcomes*, 13, doj: 10.1186/s12955-015-0300-y
37	Faculty of General Dental Practice (UK)	Dietary policy	Quality care to promote oral and dental health within care homes and hospitals must by necessity cover dietary provision/policy in these types of institution, and this should be explicitly stated. We therefore recommend that section 3.1 (Population and topic to be covered) is amended to read: "This quality standard will cover oral health, including dental health, daily mouth care and dietary policy, for adults in care homes and hospitals…"	Dietary choices are a key determinant of oral and dental health, as well as wider health, and therefore a comprehensive view of oral health promotion in care homes and hospitals must include quality statements describing a dietary policy which promotes health eating. The Food Standards Agency issues universal guidelines on nutrition for UK institutions, as well as specific guidance on food served to older people in residential care. However this is only advice, and the FSA's supplement paid to care homes meeting high standards of safe food preparation does not incentivise the provision of food meeting its nutritional guidelines. It would be remiss not to include	Guidance on food served to older people in residential care (Food Standards Agency, 2007): http://www.food.gov.uk/sites/default/files/multimedia/pdfs/olderresident.pdf Nutrient and food based guidelines for UK institutions (Food Standards Agency, 2007): http://www.food.gov.uk/sites/default/files/multimedia/pdfs/nutrientinstitution.pdf

				compliance with these among the quality statements in this Quality Standard.	
38	NHS England	Additional developmental areas of emergent practice	To develop and implement Care Home policies with a focussed approach on Oral Health Promotion	Policies to be based on fundamental principles i.e. patient-centred, safe, effective, timely, efficient, and equitable.	Patient Centred Care: 1. Compassion, empathy and responsiveness to needs, values and expressed preferences 2. Co-ordination and integration 3. Information, communication and education 4. Physical comfort 5. Emotional support, relieving fear and anxiety 6. Involvement of family and friends (Institute of Medicine 2001).
39	SCM4	Key area for quality improvement 2 ORAL HEALTH PROMOTION SERVICES	Development of promotional materials to meet needs of residents. Benefits of diet, reduction of sugary food & drinks, risks associated with alcohol and tobacco	In all my visits to care homes – both formally as part of ppi activities and informally as a visitor to relatives or friends, have led me to believe that this is an area which needs developing – I have not seen any wall charts or other materials. The only poster I have seen was one advising of the dangers of giving steradent tablets directly to residents – see my note above	NICE Oral Health Promotion:General Dental Practice NG30 Dec 2015 NICE Oral Health:local authorities & partners – oral & dental health included in overview. NB training is mentioned – is this outside of scope ie we assume staff are trained well. Care staff knowledge & skills are included in NICE pathway – oral health for adults in care homes review I have a question – is oral health covered in CQC inspections?

40	SCM3	Key area for quality improvement 4	Oral health promotion services (NG48) And Care staff knowledge and skills (NH48) Ensuring context of any training or resources is appropriate for target group – key oral health messages may need adapted for people with dementia and those who are nutritionally vulnerable.	For many care home residents, it is likely to be a their cognitive status and, significantly, the actual stage of impairment that will dictate a person's oral health status, i.e. those with most advanced levels are likely to suffer from the poorest oral health. Many oral health promotion services will have little experience of working with people with cognitive impairment. Any oral health training programme should include specific oral care strategies or recommendations for people with cognitive impairment. Many care home residents are nutritionally vulnerable and oral health messages for this group may differ from those for the general population. Also, the oral health messages of nutritionally vulnerable younger adults may differ from those from the majority of older care home residents.	Pearson A & Chalmers J (2004) Oral hygiene care for adults with dementia in residential aged care facilities NHS Health Scotland (2012) Oral Health and Nutrition Guidance for Professionals
41	Public Health England	Key area for quality improvement 1 Development and routine use of oral health policies and oral health assessments in care homes and hospital	Use of oral health policies and assessments is recommended within NICE guidance (NG48) Evidence based oral health policies (i.e. based on Delivering Better Oral Health) should encourage consistency of approach and help ensure that staff know how to support individuals with their oral care. Use of oral health assessments is essential to allow staff to plan for the individual and determine what support they may need.	Use and content of oral health policies And oral health assessments are reported to vary markedly. This is highlighted in the publication by PHE (2016) of - What is known about the oral health of older people in England and Wales? A review of oral health surveys of older people. https://www.gov.uk/government/publications/oral-health-of-older-people-in-england-and-wales)	Examples of oral health policies and oral health assessments will be included in Resources section of Commissioning Better Oral Health for Vulnerable Older People which will be published by PHE in early 2017.
Additional areas					

42	NHS England	Key area for quality improvement 4	Basic oral health training for doctors including hospital doctors and those general medical practitioners.	There is currently none or very minimal training for doctors in oral health at an undergraduate or postgraduate level. Vulnerable adults are more likely to make contact with medical teams and it is important that they have oral health training to manage or sign post patients as necessary. A survey in September 2016 at East Surrey Hospital found that only 2 out of 78 core medical trainees had had any mouth related training. Rabiei S, Mohebbi S, Patja K, Virtanen J. Physicians' knowledge of and adherence to improving oral health. BMC Public Health. 2012;12(1).	No national guidance
43	Parkinson's UK	Improved training for care home staff and hospital staff around oral health and the importance of ensuring relevant details are included in an individuals' care plan.	We believe the skills and knowledge of care home staff and hospital staff are crucial to ensuring people affected by Parkinson's get the care they require. Frontline health and care staff need to be able to give information and advice about the importance of oral health. As well as providing regular mouth care assessments.	Many professionals based in care homes and hospitals are not experts in Parkinson's and may not understand all of the symptoms that can impact oral health. Parkinson's UK recommend that NICE reflects the need for general oral health training for care home staff in the standard. Alongside this we believe the guideline should reference training from patient organisations and link to Parkinson's UK training resources for professionals.	Parkinson's UK provide training to professionals on all aspects of Parkinson's and would encourage the guideline to highlights this. https://www.parkinsons.org.uk/professionals/education-and-training-professionals
44	SCM2	Oral healthcare training for health and social care staff	To increase knowledge and skills to improve mouth care of residents/patients	To reinforce best practice so that daily mouth care becomes part of an overall personal care plan which has an overall effect on a patients wellbeing and dignity	Caring for Smiles NHS Scotland Residential Oral Care Sheffield – NICE shared learning data base

45	Northern Devon Healthcare NHS Trust Special Care Dental Service	iv) Mandatory training for all carers/support workers on oral health and delivering oral care.			
46	British Dental Association	Key area for quality improvement 4 – Provision of care should be for the convenience of the patient and not the providing organisation.	Patient-centred care is a central principle of the NHS' approach to delivering healthcare and this principle should extend to all patients regardless of the setting in which they are receiving care and who is providing it.	Patients and residents should be supported, insofar as is possible, to share decision-making regarding their care and the provision of care should be structured around their needs, preferences and priorities. This approach not only prioritises the patient's wishes, but in doing so upholds their dignity. It is important that patients' and residents' differing capacities to share in the design of their care are acknowledged and accounted for.	Please see: 'How can we transform how care looks and feels for patients?' NHS England https://www.england.nhs.uk/about/our-vision-and-purpose/imp-our-mission/patients/#car3
47	NHS England	Key area for quality improvement 5	Incorporate the three dimensions of Triple Aim Framework to improve Oral Health in Care Homes and Hospitals.	Triple Aim Framework: Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and Reducing the per capita cost of health care (Institute of Healthcare Improvement)	
48	Parkinson's UK	Introduce Parkinson's - or neurology more generally - into the Joint Strategic Needs Assessments (JSNAs).	People with Parkinson's can have numerous symptoms, and their oral health may well not be considered when developing a JSNA. Local Clinical Commissioning Groups and local authorities need a joined up approach to health and social care when considering support and treatment for people with	Parkinson's rarely appears in JSNAs and we are concerned that they are not equipped to deal with the general health needs of their local population with neurological conditions, particularly their oral health. Parkinson's UK recommend that the NICE guideline insists that neurology and individual conditions such as Parkinson's are highlighted and are properly considered by	Research from Sue Ryder (Forgotten Millions, 2011) demonstrated that only 5% of local authorities know exactly how many individuals with any neurological conditions they care for and showed that only 10% of responding local authorities have an agreed local commissioning strategy for people with

			Parkinson's.	health and wellbeing boards and CCGs in their JSNAs.	neurological conditions.
49	Southern Health Foundation NHS Trust	Key area for quality improvement 3 Appropriate types and use of equipment	Provide information to teams/staff/family/patient re appropriate equipment and treatments	Need evidence of which equipment and treatments are most suitable/effective and specific advice for given situations	
50	Southern Health Foundation NHS Trust	Key area for quality improvement 4 When and how to gain to consent	Anecdotal evidence of poor adherence to treatment plans and more extreme treatments being provided in the absence of escalation agreements	Potentially litigious situations with treatments being provided without clear capacity assessments, consent and involvement of people close to the patient.	Mental Capacity Act Assessment DOLS
51	Northern Devon Healthcare NHS Trust Special Care Dental Service	v) CQC inspections to take account of these basic markers of oral care provision (e.g. oral health assessments, up-to-date oral care plans and fully-completed oral care documentation for every service user) and factor them into their reports on care homes and hospitals.			
52	SCM4	Key area for quality improvement 5 PROVISION OF ONGOING CARE FOR PEOPLE WITH MORE COMPLEX ORAL HEALTH NEEDS	Important to consider what can be done for people with more complex, unusual complaints eg ablation of roof of mouth, extraction of wisdom teeth. In my view implants would also fall under this heading – not necessarily for cosmetic reasons- may be result of an accident. This could apply to residents in care homes and also patients in hospitals, especially long stay.	This area must be extremely challenging for service providers ie the transition from care home/hospital to a specialist dental hospital. I am unsure whether this is completely outside of scope and would appreciate hearing the views of other committee members	I see this as important but could not find specific NICE or other documentation. Related are the following:-Radiofrequency ablation of soft palate for snoring IPG 476 Jan 2014 Guidance on extraction of wisdom teeth TA1 March 2000 Work in progress – Third molars (impacted) – prophylactic removal ID898 June 2017

General comments					
53	Public Health England	Additional comment		The quality standard refers to both those in care homes and hospital however NICE guideline NG 48 was for adults in care homes. What evidence base would any quality standard for oral health promotion for adults in hospitals be based upon?	
54	Royal College of Nursing	This is to let you know that there are no comments to submit on behalf of the Royal College of Nursing in relation to the stakeholder engagement exercise oral health promotion in care homes and hospitals quality standard.			