NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Oral health in care homes and hospitals

Date of quality standards advisory committee post-consultation meeting:
9 March 2017

2 Introduction

The draft quality standard for oral health in care homes and hospitals was made available on the NICE website for a 4-week public consultation period between 6 January 2017 and 3 February. 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 29 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.

Stakeholders were also invited to respond to the following statement specific questions:

5. The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes?

6. For draft quality statement 4: Do you know of any relevant evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance relating to daily mouth care for people in hospital have the potential to improve practice? If so, please provide details.

Is there a particular group of people that would most benefit from receiving support for daily mouth care in hospitals?

4 General comments

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

- General support for the quality standard and comment that it is positive that care homes with and without nursing provision are included.
- Suggestion to remove children from the scope of the quality standard.
- Diet is an important consideration and people should be encouraged to rinse their mouths, use fluoride chewing gum and use electric toothbrushes.
- Dental care should be recorded in the medical record.
- Care homes need access to dental services for urgent or regular dental care.
- Sick and dying residents will need 2 hourly mouth care.
- Suggestion to mention additional topical fluoride.
- Suggestion to update the definition of oral health to the new FDI-World Dental Federation definition.
- Comments that whilst care staff can be trained to assess and improve oral hygiene, they are not qualified to assess oral health. It was also suggested that a record of mouth care training for staff should be kept.
- Provision of on-site consultation facilities is key to ensuring care home residents receive dental assessments and treatment.

- A validated mouth care assessment tool with outcomes that inform the care plan should be used on admission and regularly reviewed. Residents should have access to mouth care products identified in the care plan.
- The assessment tool suggested in the NICE guidance should give a holistic approach to oral health.
- Damaging oral habits, trauma from falls and physical abuse are a problem for some people with intellectual disabilities therefore a tooth saving kit has been suggested.

Consultation comments on data collection

Stakeholders made the following general comments in relation to consultation question 2:

- Some areas do have systems in place but this is not universal, eg some care homes have electronic systems and can easily collate data but others do not.
- Most care homes would have the information however data collection and quality may vary by care home.
- Comment that systems are not in place and data collection may not be a priority.
- Systems could be put in place to collect this data. New software may be needed to record data across a region so local authorities and LWABs can collate it.
- Oral care assessment, planning and mouth care documentation should be part of regular record keeping and could be easily measured.
- Collecting data from care homes may be challenging but could be included in local CQUINS.
- Data collection processes differ for care homes and hospitals. For hospitals it relates to ensuring a level of oral hygiene is carried out during the stay and for care homes a more detailed analysis is needed.
- Data collection requirements could be included in contracts and service specifications.
- It is important that data collection does not detract from the quality of mouth care.

Consultation comments on resource impact

Stakeholders made the following general comments in relation to consultation question 4:

- There are insufficient resources and funding cuts which will prevent delivery of the outcomes in the quality standard.
- Several stakeholders commented that additional administrative and training costs would be placed on care homes, particularly in relation to initial and refresher training and mouth care awareness for care home staff.
- Many oral health promotion teams have already been decommissioned.
- Some stakeholders felt that the statements would be achievable within current resources but ensuring and demonstrating it is being done is more challenging.
- The costs identified in the briefing paper for statements 1 – 3 are reasonable.
- Significant investment in the development of a widespread oral health programme will be needed.
- E-learning may be a valuable training method and free resources are available.
- Potential cost for assessment when registering with a dentist and residents may require transport costs. There is a cost for dental home visits and services.
- May be some tensions as the care sector would be expected to bear the costs but financial savings would benefit care home residents or the NHS for dental costs.
- Small additional cost for toothbrushes and pastes. Some savings by reducing hospital admissions or drug usage but small amount compared with the costs.
- Dental nurses, hygienists and therapists could carry out a significant proportion of the dental work which would reduce costs.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults who move into a care home have their mouth care needs assessed on admission.

Consultation comments

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

- Home care staff would need training to carry this out.
- Assessment within one week is too long, this should be sooner particularly for certain groups e.g. people receiving end of life care or with brain injury.
- Risk assessment should be carried out at the care package assessment stage, prior to admission where possible.
- Tool identified in the quality standard is not appropriate but alternative tools are available.
- Providing clear photographs to supplement the assessment tool will help staff make decisions on the state of the mouth.
- Numerous suggestions of additions to the definition of assessment.
- Need to clarify that care staff carry out oral hygiene and mouth care and dentists carry out oral health assessment and treatment.
- Mouth care needs should be reviewed regularly not just on admission.
- Resources should be provided to help care staff find dental services including specialist services if necessary.
- Equality considerations:
  - Should specify learning disability as well.
  - People with physical, medical or neurological conditions may also have difficulty in communicating their needs.
  - Involvement of family and friends should be encouraged not just considered.
  - Should mention power of attorney or welfare guardian.

Consultation comments on data collection

Stakeholders made the following comments in relation to consultation question 2:

- The outcome measure is unclear. Satisfaction for the resident and the carer should be separate.
- Possible alternative outcome measures are: identification of data/help to find a dentist.
- The Oral Health Impact Profile doesn't take into account longer term outcomes.

Consultation comments on resource impact

Stakeholders made the following comments in relation to consultation question 4:

- A high quality, professionally produced generic training programme should be funded and made available. Carer training in mouth care would also mean protected time for the carers to attend the training.
- This statement should be achievable, however both a protected and dedicated time element would need to be accounted for as part of nursing/care staff duties.

5.2 Draft statement 2

Adults living in care homes have their mouth care needs recorded in their personal care plan.

Consultation comments

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

- Staff training is needed to ensure correct care and recording in the mouth care plan.
- The care plan should be easily accessible, clear and understandable to care staff.
- The mouth care plan should be informed by regular assessment and daily monitoring by nursing or care home staff.
- Clarify if mouth care needs are recorded in the overall care plan or a separate mouth care recording plan.
- The quality standard should recommend a validated mouth care recording plan.
- Individuals should not be grouped based on whether they have their own teeth or dentures, as many people will have both. Combine the populations and ensure their mouths are cleaned twice a day.
- Records should be transferred when residents move between hospitals and care homes.
- Regular audits need to be undertaken.

Consultation comments on data collection

Stakeholders made the following comment in relation to consultation question 2:

- Include a quality measure to check compliance with set review times for mouth care plans, to ensure these plans are updated appropriately.

Consultation comments on resource impact

Stakeholders made the following comments in relation to consultation question 4:

- This should be achievable, however the time element would need to be accounted for as part of nursing or care home staff within the parameters of staff duties.

- Provider contracts and service specifications would need to be compliant and audited/monitored on a regular basis.
- Providers should note that regular training should be provided for staff and resources need to be allocated for this.

5.3 Draft statement 3

Adults living in care homes are supported to clean their teeth twice a day or to carry out daily care for their dentures.

Consultation comments

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

- Include ‘at least twice a day’ to statement.
- Residents are likely to have natural teeth and a denture and should be supported to care for them together.
- Staff will need training to support or deliver twice daily mouth or denture care and this should be included in staff induction.
- Unless care plans are updated regularly using risk assessment care homes will not know how many residents have natural teeth.
- Does the statement exclude people who:
  - Do not have teeth who need daily oral care.
  - Brush more than twice daily.
  - Refuse to brush more than once or at all.
  - Won’t wear or have lost their dentures.
- An assessment of needs should be carried out daily.
- Care home staff should be trained to support residents displaying care resistant behaviour.
- Oral care may need to be undertaken in line with specific advice from other professionals, for example dentists, nutritionists or occupational health teams.
- Many of the people living in care homes will need support to enable effective mouth care delivery such as helpful distractions or safe holding.
- Suggestion to include information on daily mouth care outside of hygiene, such as managing dry mouth or other oral conditions and reducing the risk of pneumonia.
- Add Mental Capacity Act/best interests decisions to be considered in the rationale and focus more on training for carers.
- Support should be provided only where required, some people will not need it.
- Include a denture cleaning protocol and a toolkit of protocols of oral/dental implications of the most common conditions affecting the elder population.

- Various equality considerations were suggested, including impaired physical function, religious or cultural beliefs and learning disabilities.
- A stakeholder felt the statement suggests all people who refuse mouth care have a cognitive impairment which is not the case. Residents refusing mouth care should be encouraged to have it but their wishes should be respected.

Consultation comments on measures

Stakeholders made the following comments in relation to consultation question 2:

- Note in the measures that the Oral Health Impact Profile will need to be adapted for people with cognitive impairment.
- The Oral Health Impact Profile may be difficult to use as an outcome measure as this may require ethical approval.
- Consider re-phrasing the measure which suggests all denture wearers can clean their dentures as some people will need this to be done for them.
- If a person is independent in brushing their own teeth morning and night and does it at a time of their choosing, how will this be recorded?

Consultation comments on resource impact

Stakeholders made the following comment in relation to consultation question 4:

- This is achievable but the protected time element from staff perspective would need to be factored in as part of essential core duties.

5.4 Draft statement 4

(Placeholder) Supporting daily mouth care in hospitals.

Consultation question 6: Do you know of any relevant evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance relating to daily mouth care for people in hospital have the potential to improve practice? If so, please provide details.

Is there a particular group of people that would most benefit from receiving support for daily mouth care in hospitals?

Consultation comments

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

- The statement is welcomed.
- Evidence-based general and some condition specific guidance is needed.
- People in hospital experience a deterioration in oral health but have no access to dental care. Some people such as those undergoing medical interventions, taking medication or with conditions which negatively impact oral health, may particularly benefit from routine mouth care.
- All people in hospital should have an oral risk assessment except people in for less than 24 hours. This can be part of the admission process. Specific groups will have greater needs e.g. people receiving end of life care or on ICU wards.
- Recommendation and implementation of both an advanced and basic level of oral care training is offered to various levels of staff graded by the Oral Health Promotion Team.
- Hospitals should have mouth care training in continuing professional development for all nursing staff and allied health care professionals.
- ‘Daily mouth care’ should be replaced with provision of mouth care in line with usual routine and taking into account current medical status.
- Needs a clear definition of hospital e.g. acute, private, community, high/medium secure, mental etc.
- All wards need to stock appropriate mouth care products for patients.

- The rationale should emphasise that good mouth care is necessary for adequate hydration and nutrition and should form part of all patients' general care.

Consultation comments on data collection

Stakeholders made the following comment in relation to consultation question 2:

- There are local systems and structures in place to collect the data.

Consultation comments on resource impact

Stakeholders made the following comments in relation to consultation question 4:

- This could be achievable by local services given the resources needed to deliver it but the staff protected time would need to be included as essential core duties.
- The benefits of improved oral care for inpatients are likely to outweigh the cost implications of training and resources.

Consultation comments on developmental statement (consultation question 6)

The following groups of people were highlighted by stakeholders as being those who would most benefit from receiving support for daily mouth care in hospitals:

- People in long-term care of the elderly care wards.
- People in secure hospitals who cannot easily access external dental services.
- People in mental health, intensive care, high dependency or critical care units.
- Psychogeriatric patients and people with dementia.
- People who are older and frail.
- People with physical, mental or learning disabilities.
- People with cognitive impairment or sensory difficulties.
- People with altered levels of consciousness, limb function and mental capacity.
- People with head injuries.
- People with complex medical issues.
- People who have had a stroke and those at risk of aspiration pneumonia.
- People with dysphagia.
- People on a respirator.
- People with motor impairments limiting self care.

- People who are approaching the end of life or palliative care pathway.
- People with cancer.
- People with diabetes.
- People at higher risk of infection.
- People who are nil by mouth and / or suffer with dehydration and dry mouth.
- People who smoke, drink alcohol, have a poor diet or are obese.
- Vulnerable adults who need support to achieve effective oral care.
- People who are homeless or frequently move, such as traveller communities.
- People who are socially isolated or excluded.
- People from a lower socioeconomic group or who live in disadvantaged areas.
- People from some black, Asian and minority ethnic groups.
- People who have been in care.

6 Suggestions for additional statements

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

- A statement focussing on tooth brushing with fluoride toothpaste and denture care twice a day would help to improve the oral health of children, young people and adults in hospital.
- Care homes should include oral health in their food, drink and nutrition policies.
- Care home staff have training to carry out an oral health assessment and this should be refreshed at appropriate time periods.
- People should be supported to have regular dental check-ups and follow up.

Consultation question 5: The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes?

Stakeholders made the following comments in relation to consultation question 5:

- The arrangement is usually shared locally between general dental practices and community dental services. Local dental practices could adopt a buddy scheme with local care homes.
- Having a named general dental practitioner and oral health team assigned to each care home/hospital.
- The full skill mix of the extended dental team should be utilised to provide effective dental care and minimise costs.
- Dental professionals recording their visits to care homes to help identify those who have not been seen.
- Patient transport to aid accessibility to dental practices.
- All residents have a named dental practitioner and have seen them within the last 12 months/24 months.
- Develop oral health policies, procedures and care plans using service user insight, experience and involvement.
- Residents seeing a dentist within a set period following admission.
- All care home staff should know how to access local and urgent dental care.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
1	British Association of Dental Nurses	General	This standard is URGENTLY required
2	National Older People's Oral Health Improvement Group (Scotland)	General	It is good to see that this is inclusive of care homes with and without nursing provision.
3	Royal College of Nursing	General	The Royal College of Nursing welcomes the opportunity to review and comment on this draft quality standard. The RCN is supportive of the draft quality standard.
4	The Faculty of General Dental Practice	General	The FGDP (UK) welcomes the opportunity to comment on the draft document, and is delighted to see that NICE is recommending such a positive set of proposals in this neglected area of care provision. We would add that the magnitude of problems is only likely to grow with the evolving epidemiology of the issues.
5	British Association of Dental Nurses	General	There should be a reference in the document to DBOH – www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention
6	British Dental Association	General	We believe that the 'dental passport' referred to in the Briefing Paper (p. 10) could help to support these standards. It could also address the issues relating to dental charges, exemptions and fines raised in our stakeholder engagement submission, if the 'passport' were to state the patient's NHS dental charge status, that is whether they are exempt from NHS dental charges.
7	National Older People's Oral Health Improvement Group (Scotland)	General	It states on the cover page that the standard covers oral health for 'adults in care homes (with and without nursing provision) and for children, young people and adults in hospitals'. However, there is no other reference within the document which refers to children and young people. We feel the oral health care needs for care home residents are sufficiently similar to that of long-stay adult hospital patients to merit inclusion in the same quality standard document. However, we do not feel it is helpful for standards for children and young people to be included in this document, even at a later date. There is very little, if any, research that encompasses both groups within a hospital setting.

[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.

ID	Stakeholder	Statement number	Comments[1]
8	RCGP	General	Diet needs consideration and in particular biscuits, cakes and sweets which are often encouraged and in the absence of good hygiene be important in dental disease.
9	RCGP	General	Residents can be encouraged to rinse their mouths after meals, consider simple/fluoride chewing gum and be encouraged if dentulous to use an electric brush.
10	RCGP	General	The dental record should be incorporated into the medical record.
11	RCGP	General	Sick and dying residents will need 2 hourly mouth care. The mouth can become dry and irritable, they are often dehydrated and the dry mouth is distressing for them.
12	The Faculty of Dental Surgery, The Royal College of Surgeons of Edinburgh	General	Mention of additional topical fluoride (varnish, high fluoride toothpaste), for which there is evidence of benefit, should be included.
13	EPA UK	General	With regards to question 1 Does this draft quality standard accurately reflect the key areas for quality improvement? It is important in this statement to highlight and emphasise the importance of mouth care so that all the different audiences (service providers, health and social care practitioners, commissioners and adults living in care homes) work together to make mouth and oral care part of the routine care for self plans. Suggestion to include in the guideline the recent new definition of Oral Health as established by the FDI-World Dental Federation: Oral health is multi-faceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort and disease of the craniofacial complex. FDI's definition is an attempt to propose a universally applicable and acceptable definition of oral health to: more clearly position oral health within health; demonstrate that oral health does not occur in isolation, but is an important part of overall health and well-being;|raise awareness of the different dimensions of oral health as a dynamic construct; and empower patients by acknowledging how individual's values, perceptions and expectations impact oral health. Importantly, this definition lays the foundation for the future development of standardized assessment and measurement tools. Further attributes related to the definition state that oral health: is a fundamental component of health and physical and mental well-being. It exists along a continuum influenced by the values and attitudes of individuals and communities; reflects the physiological, social and psychological attributes that are essential to the quality of life; is influenced by the individual's changing experiences, perceptions, expectations and ability to adapt to circumstances. Source: http://www.fdiworldental.org/oral-health/vision-2020/fdis-definition-of-oral-health.aspx
14	British Association of Dental Nurses	General	The NICE document discusses oral health assessment and care provided by non-dental care staff – should therefore be a reference to the national toolkit for clear messages with are evidence based

ID	Stakeholder	Statement number	Comments[1]
15	College of Mental Health Pharmacy (CMHP)	General	Damaging oral habits are a problem for some PWID. Common habits include bruxism; mouth breathing; tongue thrusting; self-injurious behaviour such as picking at the gingiva or biting the lips; and pica, eating objects and substances such as gravel, cigarette butts, or pens. If a mouth guard can be tolerated, prescribe one for patients who have problems with self-injurious behaviour or bruxism. Trauma and injury to the mouth from falls or accidents occur in PWID in all locations. Suggest a tooth-saving kit for group homes and hospitals. Emphasize to caregivers that traumas require immediate professional attention and explain the procedures to follow if a permanent tooth is knocked out. Also, instruct caregivers to locate any missing pieces of a fractured tooth, and explain that radiographs of the patient's chest may be necessary to determine whether any fragments have been aspirated. Physical abuse often presents as oral trauma. Abuse is reported more frequently in PWID than in the general population.
16	British Dental Association	General	Mouth care needs assessment should flag any health conditions that are risk factors for oral health conditions (ie. diabetes), whether the residents' manual dexterity affects the residents' ability to manage their own mouth care/oral hygiene and what support may be required, and any medications that are known to impact on oral health. These should be recorded in the mouth care needs plan and be reflected in the support given for daily mouth care.
17	National Older People's Oral Health Improvement Group (Scotland)	General	We see no specific mention of 'choice'. What if someone has capacity to consent and chooses to reject oral health care.
18	RCGP	General	There is nothing to object to in a general statement that people in care homes should have clean teeth, and the staff should be trusted either to encourage them if they need encouragement, or to take over the task if the residents are not capable of it.
19	Southern Health NHS Foundation Trust	General	Other resources 'Going to the Dentist' Book Beyond Words (2016) 'The Whole Tooth- Study into General Dentistry Services in Hampshire' Healthwatch in Hampshire 2015 'Making Reasonable Adjustments to Dentistry Services for people with Learning Disabilities' (2013) www.improvinghealthandlives.org.uk
20	Royal College of Surgeons of England	General	Will the CQC mark all homes on a similar basis or will there be some weighting system and/or allowance? If the ability of the residents to comply with an oral assessment or oral care or the complexity of the residents' needs results in the staff being less able to deliver effective oral care e.g. a resident refuses oral care and becomes physically and verbally abusive, it may not be possible to meet the required standard.

ID	Stakeholder	Statement number	Comments[1]
21	Healthwatch	General	Back in November last year, we published a dental evidence review that reflected what people told local Healthwatch about their experiences of NHS dental services. One of the key issues we raised in that review was the potential for people living in care homes to miss out on both routine and emergency dental care. Our findings suggested that, with dental services and care homes being regulated separately, and primary care not part of the standard NHS dental contract, the problems facing care home residents are not always being identified by the NHS or those responsible for ensuring quality. We've previously raised this with the CQC, and would like to see more focus on the day to day oral health support that residents receive in the KLOEs (perhaps in the sections around maintaining good health or being supported to eat and drink enough). I have attached the evidence review, which I hope will be of interest: the most relevant sections can be found on pages 7,8, and 11.
22	Southern Health NHS Foundation Trust	General	Page1- Care homes- add in 'anyone in receipt of care- to include- supported living/shared lives/private providers and respite services'
23	Advance Healthcare Logistics Ltd	Question 1	We think the draft quality standard is a huge step in the right direction and aims to address the key areas – it will put this overlooked area of healthcare onto the radar. In the past we have offered care homes in Kent a free oral cancer check for residents of the first 10 homes to respond for Mouth Cancer Action Month but not one home took up this offer. Increasingly GP's will not attend for dental issues or prescribe antibiotics for them so it is extremely important that residents without a dentist are helped to find one – however, a high proportion of residents, especially those with dementia and mobility issues will struggle to access dental care outside the home and there are very few domiciliary dentists currently
24	Advance Healthcare Logistics Ltd	Question 1	Our clinicians have expressed concern that while care staff can be trained to assess and improve oral hygiene they are not able/qualified to assess oral health
25	British Dental Association	Question 1	The BDA set out the four key areas for quality improvement in our stakeholder engagement response. While some of these have been addressed in the quality standards, the provision of on-site consultation facilities remains a key issue in addressing the ability of care home residents to receive dental examinations and treatment. Moreover, patient charges add a barrier to treatment for some patients and creates additional complexity, particularly with respect to exemptions.

ID	Stakeholder	Statement number	Comments[1]
26	British Society of Gerodontology	Question 1	Key areas for quality improvement should include: Mouthcare policy that is linked to the nutrition and hydration policy, Record of mouthcare training of staff (number of staff, number trained in mouthcare in past ?3 years), The use of an appropriate validated mouthcare assessment tool that has outcomes that inform the care plan (a tool for a for people with profound and multiple learning disability would be different from a home for people with a serve mental illness who are essentially self caring), Mouthcare assessment tool is used on admission and reviewed regularly dependant on identified risk. The data should be specific and measurable. Mechanism for recording whether or not mouthcare has taken place on a daily basis. Evidence that care homes have access to dental services for urgent or regular dental care. Evidence that all residents have access to mouthcare products as indicated by their care plan. Evidence of reported patient/family experience regarding mouthcare. If there was a quality statement that included that a care home had a mouthcare policy with quality standards these could be included in the contract with the care home for commissioners of care home services for residents. What happens if the home is private and does not have commissioners involved – CQC could then ensure that a mouthcare policy is in place with mechanisms to measure quality standards/measurements that should be in place. Quality Statement1 -Residents should have specific and measurable regular mouthcare assessments. Assessments should be carried out on admission and have repeated follow up assessments (monthly) that are dependent on changes in medical/physical/cognitive/behavioural/family support etc. The risk for oral cancer increases with age and this need to be reflected by repeated follow up assessments. Oral cancer risks needs to be identified in training opportunities for care home staff so that they are aware of appropriate care and referral pathways. How do you measure whether or not a person with cognitive impairment (70% of older person care homes) was satisfied with the admission process? Does the 'or carer' mean family or non care home carer or is the 'carer' the care home staff – it is not clear? It also indicates that support requirements should be checked but this is not indicated in the suggested mouthcare assessment tool, or whether or not a denture is labelled or name of dentist. Quality Statement 2-There should be some indication of how often the care plans are updated and demonstrate clear links to the mouthcare assessment. The assessment must inform the care plan and should highlight any health conditions that are risk factors for oral health conditions (i.e. diabetes, residents' decline in manual dexterity affecting the residents' ability to manage their own oral hygiene and what support may be required, any medications that are known to impact on oral health). These should be recorded in the mouth care plan and be reflected in the support given for daily mouth care. Outcome - How do you measure the ability to access information for care staff? This is an important measurement as often the risk assessment and care plan has been completed by a nurse or senior member of staff and the care staff who carry out the mouthcare are not told what they need to do or have never seen the personal care plan. This break in the ability of the recorded information into the practical side of care giving is the crucial for quality mouthcare for people in care homes. Again the delivery of mouthcare must be reflected from the risk assessment. A quality indicator tool can measure linkage between the assessment and care plan. The Welsh Government WHC/2015/001 Improving mouthcare

ID	Stakeholder	Statement number	Comments[1]
			for older people in care a home is currently testing and validating the correlation between mouthcare documentation and mouthcare delivery. Quality Statement 3-The draft quality standard then moves into very specific measures which do not necessarily indicate quality and may become a tick box exercise for the care homes. It would be better that there is a measure of recording whether or not mouthcare took place daily and if it did not was there a clear explanation of the reason. Structure –Process – the number of adults with natural teeth that are brushed twice daily with a fluoride toothpaste there 3 separate elements to this – the number of residents with natural teeth – the care home will need to measure this from admission mouthcare assessment – if the care home are not regularly using the risk assessments how do they know if a patient who has lost teeth due extraction or periodontal disease still needs to have teeth brushed, what about a person who loses or can no longer wear a denture – if the assessment is not updated so the care home can record this for all residents then this makes measuring twice daily brushing/denture cleaning difficult. The use of fluoride toothpaste – what about patient choice. Are you going to ask staff to go and check all toothpaste on a given day of the year to ensure it contains fluoride? If you say in the mouthcare policy all patients are encouraged to use fluoride toothpaste and only fluoride toothpaste will be issued by the homes. Recording of whether or not a person has had their teeth brushed twice daily is not necessarily a measure of quality? Introducing a toothbrush into a mouth twice a day does not mean the teeth and gums have been brushed effectively – especially if you have untrained carers in mouthcare doing this. A number of residents will refuse brushing twice daily – does this mean that the care home has reduced 'quality' outcomes because of patient choice? What if a person brushes 3 times daily - should the statement say 'at least twice daily'. A resident who only allows brushing once daily will not be recorded as having daily mouthcare even if this is carried out effectively. At end of life residents may not be able to tolerate twice daily brushing and people with dementia or severe mental illness may refuse. Outcome – NICE suggests using the Oral Health Impact Profile to measure the oral health related quality of life – due to the number of people with cognitive impairment in care homes – it should be stressed that a modified version appropriate communication aids and support should be used to measure oral health-related quality of life tools Will staff relate back to the mental Capacity Act? Will they take into consideration Best Interests, patient choice etc? Will they involve the carer/family member?
27	Health Education England (working across London and the South East)	Question 1	Statements 1 to 3 are important quality standards but should also link to assessing common risk factors and promoting a holistic approach to oral health. The assessment tool suggested as part of NICE guidance should allow tailored mouth care to meet an individual's needs based on risk factors such as co-morbidities, their diet, alcohol and tobacco use, and any other oral conditions (e.g. dry mouth which is common with patients on polypharmacy, ulcers, mucosal conditions).
28	British Association of Dental Nurses	Question 1	Yes

ID	Stakeholder	Statement number	Comments[1]
29	RCGP	Question 1	"Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement?" Yes this clearly reflects the key areas for improvement
30	The Faculty of Dental Surgery, The Royal College of Surgeons of Edinburgh	Question 1	Yes
31	Association of Directors of Public Health	Question 1	Does the draft quality standard accurately reflect the key areas for quality improvement? Yes
32	The Faculty of General Dental Practice	Question 1	***Does this draft quality standard accurately reflect the key areas for quality improvement?*** In general we would support the standard, not least that the assessment is a general overview of how the individual feels about their mouth and their perceptions of need. By avoiding any detailed clinical assessment, the data can be obtained through a set of generic questions that can be asked by any member of staff on entry into the care home. We would also emphasis that there are certain co-morbidities, such as arthritis or dementia, which affect the ability of an individual to manage their level of self-care. These should be recorded.
33	Healthwatch Birmingham	Question 1	**Does this draft quality standard accurately reflect the key areas for quality improvement?** Yes
34	HEE – East Midlands	Question 1	Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement? The ASCOF 2015-16 and PHE15/16 outcomes already herald this – therefore this statement does reflect key areas for improvement.
35	Public Health England	Question 1	**Q1. Does this draft quality standard accurately reflect the key areas for quality improvement?** Yes, these are welcomed
	Question 2		
36	Advance Healthcare Logistics Ltd	Question 2	In the region we cover we are not aware of any such systems being in place. Care homes are increasingly burdened with paperwork and regulatory requirements but if data submission is not compulsory or monitored it may not be a priority?
37	British Association of Dental Nurses	Question 2	No but systems could be put in place to record oral health of residents as Q5
38	British Dental Association	Question 2	We are not aware of any local systems or structures, but we believe it would be perfectly feasible to introduce them where they are not.

ID	Stakeholder	Statement number	Comments[1]
39	British Society of Gerodontology	Question 2 and 4	This is difficult as it is not mentioned in an over arching mouthcare policy that a care home signs up to. If a care home has full IT in all rooms that the recording of information is easier. If they do not and many do not then this will need to be recorded using data collection systems that can be uploaded. There is no indication within the quality standard of how often the data is going to be collected for the care home – annually? In Wales it is collected monthly by care homes using a standardised format as part of WHC/2015/001. In nursing homes the nursing homes Health Board nursing assessors are able to check that the mouthcare policy is in place and monitoring is being carried out, CSSIW are also on board with WHC/2015/001 – so CQC should be ensuring the quality standard, care home contracts for resident placements should have within in them that mouthcare quality standards are being followed. Otherwise the monitoring and collection is the responsibility of the care home using data collection that fits with other health care monitoring i.e. skin, falls etc. There appears to be insufficient resources & funding cuts prevent delivery of those desired outcomes stated in the quality standards document.
40	The Faculty of Dental Surgery, The Royal College of Surgeons of Edinburgh	Question 2	Feedback from our members would suggest that there are some areas where the necessary systems and structures are in place. However, we do not believe this to be universal given the significant administrative burden that comes with maintaining them. There have also been suggestions that care homes are reluctant to record daily oral care information.
41	Royal College of Surgeons of England	Question 2	We are not aware of specific systems in place to collect this data but if the Oral health Assessment becomes part of the overall health assessment when a person is admitted to a Care Home, then, this data could be more easily measured. Similarly, if Oral Health care becomes a mandatory part of the overall daily hygiene procedures, this could be easily measured. All actions are recorded in a daily log for nursing homes, so this could be extended (if not already in place) to residential and other care homes
42	Public Health England	Question 2	***Q2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?*** It is unclear whether resources are in place within care homes to record and monitor compliance, and it is unclear whether commissioners and/ or CQC will have the resources to establish systems and processes to monitor compliance. In order to collect the data for the proposed quality measures, the commissioners would have to: ensure that the requirements of the quality standards are included in contracts/service specifications including how often care homes need to supply monitoring data and in what format, put in place monitoring mechanisms which may require additional staffing, staff may require training to understand how to analyse the monitoring data, decide what actions to take if quality standards are not met.

ID	Stakeholder	Statement number	Comments[1]
43	Healthwatch Birmingham	Question 2	**Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?** Most care homes have this information and should ideally be included in an individualised care plan as part of a health assessment. However, the following issues need to be considered: The varied nature and quality of services provided by each care home, would make it difficult to audit implementation. At Healthwatch Birmingham we receive feedback on services from the public, patients and service users. Adherence to care plans by care home staff has not been very good. In one feedback, a relative said *"This used to be a good care home but in recent years the care of my very close family member has been shocking. As a result of neglect my family member has been very unwell.* ***The care plans are neglected beyond belief and complaints fall on deaf ears".*** Generally, there has been feedback that express concern about staff attitudes towards residents and relatives as well as cultural insensitivity. There is variation in the way that care homes put in place arrangements for assessing residents on admission. The procedures for recording everyday activities around oral health are weak or non-existent in some homes which will make auditing the implementation of stated objectives of the guidance difficult. Ideally daily care notes should include brushing of teeth or dentures. There is also variation in the way that care homes collaborate with dental professionals to ensure regular checks etc.
44	Association of Directors of Public Health	Question 2	Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place. The information should be available within care homes. Collecting and auditing the data to demonstrate compliance with the guidance will be more challenging. Some care homes have electronic records and have some measures already in place for audit purposes. Some areas undertake focused audits in conjunction with social care commissioners.
45	HEE – East Midlands	Question 2	Question 2: Are local systems and structures in place to collect data? From the NICE and ASCOF literature Local authorities and LWAB's should be able to collect the data and the responsibility seems to sit with them. This may mean a new piece of software to record data across a region may be needed. Perhaps a strategy akin to the NHS vital signs audit tool could then be used to look at uniformity of assessment, practical care and provide guidance and warning signals.
46	Health Education England (working across London and the South East)	Question 2	The oral care assessment, planning and mouth care documentation should be part of regular record keeping kept by the residential setting. The assessments and care plans should be relatively straightforward to collect but it might be difficult to gather information for documented mouth care as part of quality measures because of the large amount of data that would be generated. Many care homes have high numbers of residents so the best route might be to take a snapshot audit on a particular day as part of a CQC inspection visit. Oral health promotion teams could be used to follow up and ensure that the homes comply with the standards especially if they have been involved in training staff.

ID	Stakeholder	Statement number	Comments[1]
47	RCGP|	Question 2	"Question 2: Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?" Collecting data from care homes is likely to be challenging although this could be woven into local quality cquins by commissioners
48	The Faculty of General Dental Practice	Question 2	***Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?*** While we support the standard, we have doubts as to whether such data are available or indeed there are arrangements in place to obtain it. We would suggest that NICE could make a stronger statement on the methodology to be used, and that this should be a generic tool applicable to all care homes. Furthermore, we note that the guidance covers both care homes and hospitals. We would suggest that on the grounds of likely length of stay (hospital stays are likely on average to be far shorter than those within care homes), the processes are different for the two. For hospitals it is more about ensuring a level of oral hygiene is carried out during the stay, while for care homes a more detailed analysis is required of the state of an individual's mouth, and whether they have or would wish to have access to oral health care.
49	Real Life Options	Question 2	We would expect the quality standard to be checked by our local authority commissioners and CQC, we are not able to comment on the collection of data.
	Question 3		
50	British Association of Dental Nurses|	Question 3	No

ID	Stakeholder	Statement number	Comments[1]
51	British Dental Association	Question 3	We consider the Residential Oral Care Sheffield (ROCS) scheme to be an excellent example of good practice. As part of the scheme, dentists in Sheffield provide a free oral health needs assessment screening for all consenting clients in care homes. Dentists provide treatment for the patients and work with the care home staff to develop oral health promotion in care homes. The objectives of this domiciliary oral healthcare service are as follows: Establish a system that will identify individuals in the community who have an oral healthcare need and for whom domiciliary provision is the only reasonable option. Provide an oral healthcare service to address patients' needs, taking into account their personal circumstances and their wishes, consistent with the most appropriate use of resources. Deliver high quality oral healthcare in a person-centred way that respects the dignity of the individual receiving it (http://www.smile-onnews.com/news/view/pilot-scheme-improves-domiciliary-dental-care). ROCS is funded on a sessional payment basis. The scheme is cost neutral in that an agreed number of Units of Dental Activity (UDAs) are converted into ROCS sessions to cover an agreed number of 'beds' in an agreed number of care homes. The general dental practitioner does not increase his or her contract value but just works in a different way to fulfil the contract. Any advanced work/complex medical histories (for example, hoist pts/Warfarin checks) are referred to the Specialist in Special Care; the work is done and the patient is then referred back for routine care. It fits well with the model for new commissioning guidelines.
52	British Society of Gerodontology	Question 3	We will ensure examples are submitted to NICE local practice collection on NICE website
53	Real Life Options	Question 3	This case study is from our work in Scotland but we feel helpful to this consultation. Oliver* has a diagnosis of learning disabilities, ASD and experiences a range of sensory differences which had resulted in episodes of aggressive and challenging behaviour. This meant Oliver had never visited the dentist and his teeth were in poor condition. We planned a phased introduction to the dentist, which we devised with Oliver and the local dentist and detailed in his Health Action Plan. Oliver's first experience was accompanying a staff member on her regular check-up. His views and feelings of the experience were discussed with him on return to his home over a cup of tea. He said that he liked the reception staff but was worried about the 'big chair' and the 'noises of the machines'. This information was used as the basis to develop a staged plan. Oliver's action plan was implemented over 12 weeks, working in close partnership with the dentist surgery. He initially attended the surgery, spending time chatting to the reception staff and waiting in the 'waiting area'. An appointment was then booked so that he could spend time in the surgery and learn about the equipment used and to hear the sounds of the machines. He also visited twice to try sitting in the 'big chair'. At the end of the 12 weeks, Oliver stated that he was ready to have his first appointment. The appointment went well and this structured, person-centred approach enabled him to overcome his anxieties. He now regularly attends the dentists without fear and has improved dental health. (*names have been changed)

ID	Stakeholder	Statement number	Comments[1]
54	Association of Directors of Public Health	Question 3	Example from practice. There are local examples from St Helens of implementing training for care home staff, oral health assessment and care plans for residents. Competency toolkit followed by a focused audit of oral health in each care home has been undertaken by the local authority. Examples of resources have been submitted separately.
55	Royal College of Surgeons of England	Question 3	a) "*Developing an Oral Health Care Plan: A Carer's Guide*" is an excellent practical guide to devising oral health care plans for those who require carer support, which has been produced by the Community Dental Health Service in East Dorset. We can provide a copy of this guide to NICE and further information if that would be helpful.
56	Healthwatch Birmingham	Question 3	**Example from practice of implementing the NICE guideline(s)** None
57	HEE – East Midlands	Question 3	Question 3: Examples of care from practice? Re: Statement 3: Adults living in care homes are supported to clean their teeth twice a day or undertake daily oral care for dentures. (Can we include Christine Utting's work in this- Derbyshire Oral Health team.)An Oral health champion will be needed each residential homes to oversee the implementation of the practical side of this statement and to liase with dental colleagues if there is a problem.
58	Public Health England	Question 3	Q3. Do you have an example from practice of implementing the NICE guideline(s) that underpin this quality standard? If so, please submit your example to NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted-No
59	British Society of Gerodontology	Question 4	The statements are open to interpretation and there is no indication how often the data need to be collected. It is important that the data collection tools does not detract from the quality of mouthcare provided only acts as an 'aid' to ensuring appropriate and effective mouthcare is provided. There needs to be a local authority/health agency ownership of the Quality Standards and robust mechanisms of collection of data that is meaningful and ensures that mouthcare is being carried out effectively in care homes
	Question 4		
60	Advance Healthcare Logistics Ltd	Question 4	They place additional administrative and training costs on care homes which will be unwelcome given the living wage increases and squeeze on local authority contribution for funded patients. Most homes want to do their best but staff turnover means there will be an ongoing need for training and who will monitor compliance if this is not compulsory?

ID	Stakeholder	Statement number	Comments[1]
61	Health Education England (working across London and the South East)	Question 4	Funding will be required for making care home staff more aware of the importance of oral health and providing training based on the NICE guidance on oral health assessment and planning mouth care. Currently oral health promotion sits under public health within local authority budgets. The national guidance on commissioning oral health promotion leaves the decision with the local authority whether their population needs oral health promotion dependent on local oral health needs. Older people have a recognised higher treatment need but this has not necessarily been captured in local needs assessments. As a result many oral health promotion teams have already been decommissioned or are involved in a tender process, which doesn't include this work stream. The development of this NICE guidance is most welcome and clarification of potential funding is a matter of urgency.
62	Royal College of Surgeons of England	Question 4	Appropriate training in practical oral health care is essential for those providing personal care and support to vulnerable people, otherwise care which is ineffective, inappropriate or harmful may be provided. Lack of training in practical oral health care puts the resident and the care worker at risk of harm. Training in oral health assessments and mouth care would need resources in terms of a training venue, trainers and course material. Currently, course material is usually developed locally by oral health promotion teams and can vary in quality. A high quality, professionally produced generic training programme should be funded and made available for training of carers and for mouth care champions to refer to when helping to resolve problems or cascade training. Carer training in mouth care would also mean protected time for the carers to attend the training (on costs). Time constraints are an important issue for nursing staff in acute hospitals where mouth care may not be a priority. Poor nutritional intake leading to deterioration in oral and general health, will lead to longer hospital stays and increased cost of care.
63	Public Health England	Question 4	Q4. 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 requirement that you think would be necessary for any statement. Please describe any potential savings or opportunities for disinvestment. No these quality standards would not be achievable by local services within current net resources. in order to achieve the quality standards: local service providers would need to ensure that their staff has the appropriate skills which would require training. They would also need training refreshed over time possibly on an annual basis to be able to carry out oral heath assessments, support adults to clean their teeth twice a day or to carry out daily care of dentures, and to provide required monitoring data, may require additional staffing time and depending on size of care home may require additional staff. additional funding maybe required to provide resources such as toothbrushes, fluoride toothpaste, denture cleaning solutions and gloves
64	British Association of Dental Nurses	Question 4	Yes

ID	Stakeholder	Statement number	Comments[1]
65	RCGP	Question 4	"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 resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment." Yes this should be achievable within local resources and would be appropriate as part of current care for clients
66	Association of Directors of Public Health	Question 4	Achievability and resources. Assessment and delivery of mouth care needs within the care home is achievable and has already been achieved in many areas. Ensuring and demonstrating that it happens systematically is more challenging. Larger providers may have electronic systems to collate information for audit purposes. Smaller providers will rely on manual audits. A 'one design uniformed approach' for mouth health assessments and Mouth Care Plan would facilitate audit. Accessing dental care will require resources. There are financial resources from the patient or relatives if they have power of attorney and resources in terms of transport and accompanying the client if that is needed.
67	Healthwatch Birmingham	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?** Assessing the mouth care needs of residents and recording this in a care plans is achievable. Most homes carry out a health assessment as part of the care plan and it is possible to include a dental element to this assessment, with specific questions around any dental problems, registering with a dentist, daily oral care needs, etc. It is however, more difficult to assess the extent to which plans are being implemented, especially on things like brushing teeth twice a day. That said, most homes have a morning and evening routine to which brushing of teeth can be added and this activity recorded in the daily handover notes that staff write following each activity. ||Generally, a standardised and reliable oral assessment tool can be developed and used for initial as well as ongoing assessments.||In terms of resources, the following will be essential: Human resources - Accessing dental needs will require collaboration between care homes and local dental services as this will assist care homes to draw up policies, procedures and referral processes for the residents. Human resources – training will be required for care home staff so that they effectively support the residents but also understand the importance of oral health and how this relates to overall health and dignity. In addition, training is needed on how the diet of the residents has an impact on oral health Financial resources – There might be a need to pay for assessments when registering with a dentist. Depending on ability of residents, those attending dental services might need money for transport as well as for any services provided. Those that have home visits need money to pay for home visits as well as services provided unless this is funded. Financial resources – cost for staff training.
68	British Dental Association	Question 4	The briefing paper indicates that the combined costs of quality standards one, two and three would be approximately £1,000 per care home. We believe this to be reasonable.

ID	Stakeholder	Statement number	Comments[1]
69	National Older People's Oral Health Improvement Group (Scotland)	Question 4	It is difficult to see how these standards will be met without a significant investment in the development of a widespread oral health training programme.
70	Health Education England (working across London and the South East)	Question 4	If face-to-face training is not available, e-learning may be an alternative, with several free resources available. Health Education England Thames Valley and Wessex have produced an E learning module for carers called, "Improving Mouth Care" it is available as a free resource at E- Learning for Health: http://www.e-lfh.org.uk/programmes/improving-mouth-care. The aims of the e-learning are:- To provide an understanding of the importance of oral health and the causes of poor oral health. To show how to check a mouth, follow a mouth care plan and what it may include. To provide up to date information on techniques and products for effective mouth care in order to tailor regimes for the individual, especially for those with additional needs such as dementia. To train nursing staff how to make an oral health needs assessment for each individual using a dedicated assessment tool, which can then be followed by care staff. To offer alternative protocols for use when there are mouth care challenges. To give a guide to record keeping. To understand when to escalate a problem and to refer to a dentist if necessary. There are 3 units/ levels: Introduction to mouth care – Aimed at first year pre-registration nurses and care staff working in the community. This level has simple, retainable advice on mouth care with guidance suitable for Health Care Assistants (HCAs). Mouth care for Adults – Aimed at providing additional material for nurses responsible for assessment and care planning, covering systemic diseases and extended content on how to support individuals with dementia or diminished capacity. Mouth care for people with additional needs- suitable for staff looking after people with more challenging oral health issues and or behaviour that makes mouth care difficult. The format for each module includes pictures and videos with additional links to evidence and further reading. All 3 levels have an assessment with a pass mark of 80%. The training is patient centred, with the intention to facilitate participants to meet the standards as directed by CQC. It also follows best practice as part of Essence of Care and NICE guidance. All the recommendations are based on guidance from "Delivering Better Oral Health - An evidence-based toolkit for prevention" – 3rd Edition by Department of Health and the British Association for the Study of Community Dentistry, published June 2014.
71	National Older People's Oral Health Improvement Group (Scotland)	Question 4	There is a tension here as, in general, the standard suggests that the cost of resources needed to improve the oral health of residents will need to be met by the care sector alone (unless the NHS provides free training as it does in Scotland), while the savings that would likely be made would be to the benefit of either the residents themselves (lower costs for dental treatment) or to the NHS for whole or part of urgent and emergency dental treatment costs.

ID	Stakeholder	Statement number	Comments[1]
72	Healthwatch Birmingham	Question 4	A recent report by Healthwatch England identifies cost of dental visits as a deterrent for residents of care home accessing dental services. The report also observes that it is harder to access dental services for care home residents especially for those that need hoist facilities, suffer from dementia and have poor mobility. The report can be found here: http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/access_to_nhs_dental_services_-_what_people_told_local_healthwatch.pdf
73	The Faculty of General Dental Practice	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 resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.*** There is likely to be a small additional cost in terms of toothbrushes and toothpastes. It may well be possible to agree a 'care home oral hygiene pack' along the lines of those developed for children by the toothpaste manufacturers to agreed standards. While the costs of gathering the additional data on need is heavily dependent on the instrument used and, perhaps more importantly who undertakes the assessment, the overriding issue will be the challenge of meeting the unmet need, not the process in identifying it. There may be some savings identified by reducing the number of hospital admissions or drug usage, but this seems likely to be a small figure when compared to the costs of oral health treatment, however basic that treatment may be. Given the current lack of oral health care, we would suggest there are few if any opportunities for disinvestment.
74	HEE – East Midlands	Question 4	Question 4: Are the Statements achievable? Statements 1-3 should be achievable in the current financial envelope and are mirrored in PHE literature and ASCOF 15-16. I think you need some outside support from the dental community and access to DCP groups with education and any queries/anomalies that may occur. I think dental nurses, hygienists and Therapists could be contracted to carry out 80% of the potential dental work and this would save money. I think Dental staff coming into the residential home regularly could help collect data, implement the practical care and keep residential staff in touch, calibrated and motivated.However with regards to Statement 4 (Re: Supporting daily mouth care for people in hospital.)More funding will be needed to educate and support hospital staff and families. I think an Elec TB on the ward would help and disposable sleeves and heads to prevent re- introduction of MRSA etc. Manual brushing takes time and a mechanical brush would cut the time down- thus saving resources.
75	Real Life Options	Question 4	We believe these quality standards should be the baseline for all services.
	Statement 1		

ID	Stakeholder	Statement number	Comments[1]
76	British Dental Association	1	The risk of oral cancer increases with age and this should be highlighted in training for care home staff so that they are able to identify the warning signs of oral cancer and aware of the appropriate action to take.
77	National Older People's Oral Health Improvement Group (Scotland)	1	Which grade of staff/training/qualifications will be required for staff to do this? The skills to carry out an oral health assessment requires a level of training.
78	The Faculty of Dental Surgery, The Royal College of Surgeons of Edinburgh	1	It would help if there was clarification as to whose responsibility the oral assessment is, what training they should have had and a timeline for this.
79	Public Health Department, Wiltshire Council	1	Whilst supporting the need to assess the mouth care of people on admission, there needs to be a very clear assessment process and training for staff to be able to deliver systematically and effectively so that all mouth care issues are identified appropriately and by confident trained staff.
80	Skills for care	1	We feel that staff with responsibility for assessing new residents may have training and development requirements.
81	British Society of Gerodontology	1	Oral health risk assessments should be carried out or sooner if the resident's mouthcare needs change especially for frail older people, adults with brain injury, profound and multiple learning disabilities who are dependent on carers for oral care. Those adults who are self caring this may not need to be carried out so often i.e. people detained under the mental Health Act.|BSG recommends the PHW 1000 Lives programme as all risk assessments (including mouthcare) for residents in care homes and hospitals are carried out and reviewed on a monthly basis as a minimum requirement. http://www.1000livesplus.wales.nhs.uk/mouthcare. Mouthcare Matters and Dorset have similar programmes that recommend regular reviews. Scotland's Caring for Smiles Programme is also recommended. Dorset Health Care University NHS Foundation Trust are currently testing and validating the attached mouthcare risk assessments and care plans.
82	Health Education England (working across London and the South East)	1	One week is too long to wait to assess residents' oral health, for example someone in pain may not be able to eat or sleep properly for a week, which could seriously affect their health and well-being.
83	National Older People's Oral Health Improvement Group (Scotland)	1	For a person receiving end-of-life care the oral health assessment needs to be recommended to be sooner than within one week. Currently suggests 'sooner for people on short stays'. End-of-life care needs of residents need to be highlighted.

ID	Stakeholder	Statement number	Comments[1]
84	Association of Directors of Public Health	1	The timescale of 1 week seems quite long for the mouth care needs assessment. A 48-hour timescale for assessment may be more useful. Loss of dentures is a significant issue in care homes and hospitals, particularly in patients with dementia and can have a significant impact on their wellbeing causing unnecessary distress (and in some instances, cost) for patients and their families. Patients often find it challenging to adapt to a new denture and this can lead to difficulties in eating, speaking and socialising, malnutrition and weight loss & additional dietetic involvement. The statement “they also check if the person wants their dentures marked with their name” should be changed to “they also ensure the dentures are adequately marked”. Bullet point 2- suggest changing the sentence “If unmarked, ask whether they would like to arrange for marking and offer to help” to “If unmarked offer to mark the dentures, particularly if the care home has any residents with dementia or there is a possibility of hospitalisation in the future”. Bullet point 3. Add. “Discuss with patient and family access to dental care and agree details of transport, support and any financial implications”. Mouth care assessment would benefit from a ‘comment box’ to capture the Voice of the patient and family and to incorporate the above comments
85	HEE – East Midlands	1	Re: statement 1: The NICE guidelines give up to a week for the assessment to take place. In my view this needs to be changed to a maximum of three days. Particularly if the patient is medically compromised, may have a dry mouth, and preventing early lesion formation in Periodontal disease aetiology and the 3 day time line with that.
86	Public Health England	1	Staff should carry out the oral health assessment on admission rather than within a week of admission. The longer this is left the more chance there is of it being forgotten.
87	National Older People’s Oral Health Improvement Group (Scotland)	1	Would also include risk assessments and care planning, ideally started before admission i.e. at assessment for care package stage

ID	Stakeholder	Statement number	Comments[1]
88	British Society of Gerodontology	1	The quality statement regarding the mouthcare assessment on admission and how to measure it is sensible. NICE recommends an old mouthcare assessment tool that does not help to inform the completion of the mouthcare plan and uses an out dated scoring system (8 years old). Nothing in the tool mentions the support needs of an individual for example or whether or not a person has a dentist etc. It should say that a 'validated' mouthcare assessment tool which includes the key areas for assessment and outcome should be used. The assessment should also include questions on oral health related quality of life subject like ability to eat and speak, swallowing medication etc as this will impact on their mouth care needs as well as information on dry mouth. A comments section should be included about residents with specific care needs for example dysphagia, on modified diets, those that are PEG fed or other aspiration risk factors. An oral health assessment should include whether or not an individual will need support to enable mouth care to be delivered effectively such as helpful distractions or some degree of safe holding. There has been no mention of this within the document and this will affect the quality of the outcome. If the ability of the residents to comply with an oral assessment or oral care or the complexity of the residents' needs results in the staff being less able to deliver effective oral care , it may not be possible to meet the required standard. The care home should not be penalised for not meeting the standard in this case. Currently, course material is usually developed locally by oral health promotion teams and can vary in quality in England. A high quality, professionally produced generic training programme should be funded and made available for training of carers and for mouth care champions to refer to when helping to resolve problems or cascade training. Carer training in mouth care would also mean protected time for the carers to attend the training (on costs).
89	British Society of Gerodontology	1	As the recommended NICE mouthcare risk assessment tool does not include need for support, labelled dentures, name of dentist – it should be indicated that an OH assessment tool should include these questions. Any mouthcare assessment tool should have clear descriptive outcomes and not numerical ones as a number outcome is meaningless for care staff carrying out the mouthcare. Clarification on who marks the denture.
90	Health Education England (working across London and the South East)	1	Making use of an oral health assessment tool compulsory would ensure important care details are not missed and mouth care assessment is standardised between residents and carers.
91	Health Education England (working across London and the South East)	1	The oral health assessment tool that is recommended needs to be reviewed. It suggests that all clients that have a dry mouth need to see a dentist. This would mean that nearly every client would need to see a dentist, which is not practical. The algorithm needs amendment.
92	Public Health Department, Wiltshire Council	1	Clear reference needs to be made to a nationally acceptable assessment tool

ID	Stakeholder	Statement number	Comments[1]
93	Royal College of Surgeons of England	1	It is not clear from the documentation provided (OH Tool), what is the significance of the total score e.g. 16 might prompt a request for an urgent dental visit. A score of 2 in the Pain, Tongue, Lips or Gums sections, should do the same. There are other more useful assessment tools available - see example in section 3 (Question 3) which trigger a request for an assessment by a dentist.
94	Royal College of Surgeons of England	1	The OH Tool does not record if the patient has additional risk factors which need to be taken into consideration with the oral care e.g. risk of aspiration pneumonia, Dysphagia etc.
95	Public Health Department, Wiltshire Council	2	Clear photographs need to be made available to supplement the assessment tool to help staff make decisions on the state of the mouth
96	British Dental Association	1	The definition of 'mouth care needs assessment' would benefit from further clarification. It should be clearly stated that the assessment is to identify how the care home team can support the resident's oral hygiene and mouth care routine, and that it is not a clinical assessment. Clinical assessments of oral health can only be conducted by dentists registered with the GDC. These documents suggest that care homes consider using the 'oral health assessment tool' to assist with mouth care needs assessments. We feel that the use of the terms 'mouth care needs assessment' and 'oral health assessment' interchangeably risks creating confusion as to the purpose of the assessment and who should conduct it. The term oral health assessment has been used by the Department of Health since 2010 in designing a reformed General Dental Services contract and the use of this term means an assessment tool for registered dental practitioners to use to assess the oral health needs of a presenting patient. With reference to the oral health assessment toolkit https://www.nice.org.uk/guidance/ng48/resources/oral-health-assessment-tool-2543183533 some of this must only be done by a registered dentist and therefore is not appropriate to be used as a tool for care home staff undertaking a mouth care needs assessment. The standard and accompanying advice would benefit a clear indication of what care staff should do – oral hygiene and mouth care – and should not do – oral health assessment and treatment, so as to ensure that care is provided safely and by the appropriately qualified individual. As drafted the standard has the potential to assist in improving the undertaking of a mouth care needs assessment on admission, the recording of this in a care plan on admission, but there is less emphasis on the need for a full oral health assessment on a regular basis. Given the complexity of delivering care to this group, chronic oral disease management will be needed for many residents. A requirement to have a full reassessment of mouth care need on an annual basis will prompt, at least once a year, consideration of referral for some dental care. Statement 1 could be amended to read "... on admission and reassessed at least annually thereafter."
97	British Dental Association	1	As submitted in our stakeholder engagement response, we believe that providing care home residents with information on basic oral health quality of life indicators to help them to manage their own mouth care needs and to understand the importance of good oral health to their general well-being. We note that other stakeholders made similar submissions at

ID	Stakeholder	Statement number	Comments[1]
			the previous stage. There is evidence that a conversation about oral health is more effective than providing written information. We believe that a conversation about oral health quality of life indicators could form part of the Mouth Care needs assessment and could assist in improving the oral health of adults in care homes.
98	British Society of Dental Hygiene and Therapy	1	Important that a patients swallow is assessed especially if the patient has Parkinson's or dementia as this will have an impact on what they can eat or drink but also the use of toothpaste.
99	British Society of Dental Hygiene and Therapy	1	Adults moving into care homes – you will need to know if the patient have a fixed or removable Implant retained dentures. Not only should there dentures be named but also their denture storage boxes.
100	British Society of Gerodontology	1	The definition of 'mouth care needs assessment' would benefit from further clarification. It should be clearly stated that the assessment is to identify how the care home team can support resident's oral hygiene and mouth care routines. It is not a clinical diagnosis assessment; this can only be carried out by dentists/dental care professionals registered with the GDC**.** There is a clear distinction between people who are in care homes and those who are in hospital. Care homes are people's 'homes' and hospitals (medical/psychiatric) should only be an interim stay. The quality standards for the differing types of accommodation would be useful.
101	British Society of Gerodontology	1	The accompanying briefing statement does suggest there is no evidence to support 'updates' of mouthcare needs assessments. Anyone who provides care for people in care homes know that mouthcare needs can vary due to change in diet, medical or physical health, deterioration in cognitive ability, change in behaviour, a family member unable to provide daily mouthcare for a relative, advice from the dental care team etc and so it is essential that the mouthcare needs are assessed at regular intervals, if there is a change in condition or behaviour or advice from dental team
102	British Society of Gerodontology	1	There is no indication in this statement about patient choice in having an assessment or the fact that a resident cannot tolerate or allow someone to assess them due to a cognitive impairment or physical disability. Other groups including those with hidden disabilities that may not be able to express their needs including physical and medical disabilities.
103	College of Mental Health Pharmacy (CMHP)	1	If use of particular medications has led to gingival hyperplasia, emphasize the importance of daily oral hygiene and frequent professional cleanings.||Advise patients taking medicines that cause xerostomia to drink water often. Suggest sugar-free medicine if available and stress the importance of rinsing with water after dosing.

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104	County Durham & Darlington NHS Foundation Trust, Community Dental Service	1	Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement? Answer: Yes, I believe that it does, however you would need to see written evidence of the documentation records in order to demonstrate that this has been carried out by both a dental care professional and individual care/nursing staff. (see Oral Health Assessment Tool). This should apply as a 'duty of care expectation linked to both nursing and care staff roles and responsibilities as part of the patient/resident pathway. A screening for oral cancer should be provided. Question 2: Are local systems and structures in place to collect data for the proposed quality measures? Answer; No, I don't believe that this is the case in all care homes. I would suggest the development of an oral health policy within the setting which promotes raising the awareness raising of the link and importance of good oral health and the link to overall general health and wellbeing. Question 3: Do you have an example from practice implementing the NICE guidelines that underpins this quality standard? No, not at this present time 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? Answer: Yes, it definitely should be achievable, however both a protected and dedicated time element would need to be accounted for as part of nursing/care staff duties. Provider contracts and service specifications would need to be compliant and audited /monitored on a regular basis, CQC inspectors, Commissioners. Also, a level of competency, linked to practical knowledge and skills of staff would need to be audited
105	Health Education England (working across London and the South East)	1	This section should include assessing residents for other oral conditions, such as dry mouth (common in older persons as a side effect of medications), ulceration, candida infections and angular cheilitis, all found frequently in older populations. Such conditions will impact on hydration, nutrition and mouth care needs. Residents should also be questioned on oral health related quality of life, e.g. ability to eat and speak, swallowing medication, establishing whether they are in any pain or discomfort, and all of this should be clearly recorded.
106	Health Education England (working across London and the South East)	1	Assessment should include what residents' mouth care preferences are (e.g. unflavoured toothpaste), what mouth care products they have brought with them and what is missing to meet their mouth care needs.
107	Health Education England (working across London and the South East)	1	A comment should be included about residents with specific care needs for example dysphagia, those on modified diets, those that are PEG fed or have other aspiration risk factors.
108	Health Education England (working across London and the South East)	1	Clarification is required on who marks the denture and the statement should include that this be mandatory for residents.

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109	Health Education England (working across London and the South East)	1	On admission carers should check whether residents are on a recall system for dental care and whether their new residence is within the catchment area if they are seen within the salaried dental service.
110	National Older People's Oral Health Improvement Group (Scotland)	1	Could this information be collected at pre entry assessment (care homes have paperwork in place for recording?) Is this currently recorded by care homes??
111	National Older People's Oral Health Improvement Group (Scotland)	1	Ideally started before admission i.e. at assessment for care package stage – e.g. discussion at the person's home prior to admission. Discussion with resident/guardian/family to allow easier transfer of oral care provision and their likes and dislikes of care to be record to allow reduction of non compliance /declining of oral care
112	RCGP	1	A standard document with laudable aims. It would be helpful to consider dental care in terms of appearance, functional ability, comfort and hygiene when making assessments and that the assessment be recorded and repeated at 3 monthly intervals. The person doing the assessment needs training and ideally a dentist should be available for training, support and to provide necessary treatments.
113	Royal College of Surgeons of England	1	Assessment of the tongue section, would benefit from an assessment which looks at all surfaces of the tongue (the current tool does not make this an imperative).
114	Public Health England	1	Staff need to check as well as ask if dentures are marked. Where they aren't marked, the resident should be advised to do so, or if the resident is unable this should be organised by the care staff.
115	British Dental Association	1	Given that periods of stay in care homes can be long for some residents, it would be advisable for regular reviews of residents' mouth care needs to take place as a range of factors, such as medications, can cause rapid change/deterioration in oral health and mouth care required.
116	Health Education England (working across London and the South East)	1	As well as assessment on admission, there should be sections on how frequently the oral health assessment needs to be reviewed and how to seek emergency dental care.
117	Public Health Department, Wiltshire Council	1	The ongoing assessment of oral health care and documentation of such in care plans should be an ongoing process and not limited to admission only
118	Health Education England (working across London and the South East)	1	It would be useful to provide guidance and/or sources for care staff to use when they are trying to find dentists for residents. Relatives and Care Home staff often do not know where to look for a dentist or how to access community and domiciliary dental services.

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119	Southern Health NHS Foundation Trust	1	Page 5- under 'Adults moving into Care Homes'- if the person is new to the home then what type of assessment they will need, who will do this. If appropriate the person may need to be referred to Specialist Dental Services.
120	Royal College of Surgeons of England	1	A key area for improvement is ensuring each person has their own dentist and there is a question within the OH tool which alludes to this need. It also states; "if you don't have a dentist, would you like help finding one"? Will the Commissioners provide a list of NHS practices and the local CDS who are willing and able to provide domiciliary care, with private dentists for those who specifically request private care i.e. will there be options available with clear information for patients and their carers to help them make the right decision? Should the question be asking about current registration with a dentist and how to find one, be in a separate/standalone section/guideline?
121	Public Health England	1	All care home staff should be aware of how to access local routine and urgent care for their patients. NHS Choices has information on how to access dental care at: www.nhs.uk/NHSEngland/AboutNHSservices/dentists/Pages/find-an-NHS-dentist.aspx and how to access urgent/emergency care at: www.nhs.uk/chq/pages/1776.aspx?categoryid=74 Care home residents may require specialist dental services such as access to community dental services. NHs Choices at www.nhs.uk/NHSEngland/AboutNHSservices/dentists/Pages/community-dental-services.aspx provides information on dental treatment for patients with special needs. Care home staff need to know how to access their local community dental services as in some places this may be on a referral basis.
122	Health Education England (working across London and the South East)	1	Physical and medical disabilities and neurological impairment, as well as cognitive difficulties, may lead to difficulties in communication of needs.
123	Health Education England (working across London and the South East)	1	Consider re-phrasing to actively encourage the involvement of family and friends, i.e. instead of the word 'consider', use the phrase 'care home staff should make every effort to involve'. For residents with communication difficulties, mouth care needs could be easily overlooked or missed without engagement from family and friends.
124	National Older People's Oral Health Improvement Group (Scotland)	1	We suggest mentioning involving a person's power of attorney or welfare guardian in this paragraph.
125	Southern Health NHS Foundation Trust	1	Page 6- under 'Equality and Diversity' please add in 'Learning Disability' with dementia and other cognitive difficulties- not group LD with other cognitive difficulties- this is very different
126	National Older People's Oral Health Improvement Group (Scotland)	1	Outcome is 'satisfaction of resident or carer with care home admission process.' This is a very vague outcome, the presumption is that this outcome is in relation to the oral health assessment but it could be read as the whole admission process. Also, how will satisfaction be measured?

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127	Dental Faculty of the Royal College of Physicians and Surgeons of Glasgow	1	Satisfaction of resident or carer with care home admission process. – but surely also baseline data indentified in order to better plan for oral healthcare
128	Dental Faculty of the Royal College of Physicians and Surgeons of Glasgow	1	Record if there has been no contact or they do not have a dentist, and help them find one - and provide support to help them attend or be seen in the home/ record if the individual can attend a clinic and how they get there
129	Public Health Department, Wiltshire Council	1	Satisfaction of resident needs to be separate from carer so there are two outcomes
130	National Older People's Oral Health Improvement Group (Scotland)	1	Paperwork i.e. risk assessments and care plans should be available to all grades of care staff and easily accessable. If dental professionals are auditing these should also be made available
131	Royal College of Surgeons of England	1	The Oral Health Impact Profile does emphasise the importance of maintaining good oral health in terms of reducing incidence of pain/distress and its effect on general health and dignity. However, it does not highlight the longer term outcomes of oral neglect which include difficulties in managing complex restorative care and oral surgery on a domiciliary basis, access to radiographic equipment, and the fact that older people who have never worn dentures previously are likely to find it more difficult to adapt later in life. Furthermore, the same applies to young people who may be experiencing mental health problems or who have a LD or traumatic brain injury. If extractions are required and they cannot tolerate dentures, this may have a longer term effect on their diet and quality of life in terms of the ability to eat, to enjoy eating food and eating with others. If treatment is not possible due to compliance, effective preventive care may avoid the need for a general anaesthetic or sedation. These latter options may also not be possible if the person cannot move from the domiciliary setting or if systemic health creates too great a risk.

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132	EPA UK	1	Regarding question 1 Does this draft quality standard accurately reflect the key areas for quality improvement? A key area for quality improvement for this quality standard would be the support of self-care (including oral self-care) amongst service providers and the health and social care practitioners. There is diverse evidence that suggests that self-care attitudes and behaviours are essential in order to provide care for others. This would be a key point to achieve the outcome 'Oral health-related quality of life for adults living in care homes.' **Healthy You** *Delivering safe and compassionate patient care is easier once nursing staff have addressed their own needs, which are equally valid.* Source: Royal College of Nursing http://www2.rcn.org.uk/newsevents/campaigns/healthy-workplace/healthy-you **The Importance Of Self-Care For Nursing Professionals** *Nursing professionals dedicate to the well- being of people in situations of vulnerability or not; however, with certain frequency, these professionals neglect the care of their own health. However, it is known that self-care is essential to the physical, mental and spiritual balance of the worker as well as factor that may qualify the care for others.* http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/viewFile/23360/14207 **Oral Health Knowledge, Attitude and Practices amongst Health Professionals in Ludhiana, India|** *(…)With proper knowledge and oral health behavior, health care professionals can play an important role in the oral health education of individuals and groups and act as role models for patients, friends, families and the community at large. Before health professionals are trained as oral health educators, there is a need to determine the status of their own oral health knowledge and behaviours* https://www.omicsonline.org/open-access/oral-health-knowledge-attitude-and-practices-amongst-health-professionals-in-ludhiana-india-2161-1122-1000315.php?aid=55159 **Assessment of preventive dental care among dental students and dental professionals in India: A knowledge, attitude, and practice study** *Knowledge and oral health behavior of dental students and professionals play an important role in oral health education of patients and community at large. It is therefore important that their own oral health behavior conforms to expectations of the population. (…) Although published research has been concerned with how to motivate the patients to follow a prescribed, effective oral health care program, little attention has been given to the context of* how and when dental students undergo motivational *behavior changes with respect to their self- care regimen. (…)* Citation: Khinda PK, Mahajan R, Gill AS, Uppal RS, Kaur J, Shewale A, Saravanan S P, Bhatia N. Assessment of preventive dental care among dental students and dental professionals in India: A knowledge, attitude, and practice study. Saint Int Dent J [serial online] 2015 [cited 2017 Jan 8];1:105-11. Available from: http://www.sidj.org/text.asp?2015/1/2/105/177942 http://www.sidj.org/article.asp?issn=2454-3160;year=2015;volume=1;issue=2;spage=105;epage=111;aulast=Khinda

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133	EPA UK	1	Regarding question 1 Does this draft quality standard accurately reflect the key areas for quality improvement? A key area for quality improvement for this quality standard would be the support of self-care (including oral self-care) amongst service providers and the health and social care practitioners. There is diverse evidence that suggests that self-care attitudes and behaviours are essential in order to provide care for others. This would be a key point to achieve the outcome 'Oral health-related quality of life for adults living in care homes.' **Healthy You** *Delivering safe and compassionate patient care is easier once nursing staff have addressed their own needs, which are equally valid.* Source: Royal College of Nursing http://www2.rcn.org.uk/newsevents/campaigns/healthy-workplace/healthy-you **The Importance Of Self-Care For Nursing Professionals** *Nursing professionals dedicate to the well- being of people in situations of vulnerability or not; however, with certain frequency, these professionals neglect the care of their own health. However, it is known that self-care is essential to the physical, mental and spiritual balance of the worker as well as factor that may qualify the care for others.* http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/viewFile/23360/14207 **Oral Health Knowledge, Attitude and Practices amongst Health Professionals in Ludhiana, India|** *(…)With proper knowledge and oral health behavior, health care professionals can play an important role in the oral health education of individuals and groups and act as role models for patients, friends, families and the community at large. Before health professionals are trained as oral health educators, there is a need to determine the status of their own oral health knowledge and behaviours* https://www.omicsonline.org/open-access/oral-health-knowledge-attitude-and-practices-amongst-health-professionals-in-ludhiana-india-2161-1122-1000315.php?aid=55159 **Assessment of preventive dental care among dental students and dental professionals in India: A knowledge, attitude, and practice study** *Knowledge and oral health behavior of dental students and professionals play an important role in oral health education of patients and community at large. It is therefore important that their own oral health behavior conforms to expectations of the population. (…) Although published research has been concerned with how to motivate the patients to follow a prescribed, effective oral health care program, little attention has been given to the context of* how and when dental students undergo motivational *behavior changes with respect to their self- care regimen. (…)* Citation: Khinda PK, Mahajan R, Gill AS, Uppal RS, Kaur J, Shewale A, Saravanan S P, Bhatia N. Assessment of preventive dental care among dental students and dental professionals in India: A knowledge, attitude, and practice study. Saint Int Dent J [serial online] 2015 [cited 2017 Jan 8];1:105-11. Available from: http://www.sidj.org/text.asp?2015/1/2/105/177942 http://www.sidj.org/article.asp?issn=2454-3160;year=2015;volume=1;issue=2;spage=105;epage=111;aulast=Khinda

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134	British Dental Association	1	Undertaking assessments on admission could be undertaken without writing anything in a care plan. No data would then be available (and potentially no follow up care provided). The appropriate way to collect data covering both statements 1 and 2 would be to check the care record for evidence of both assessments (an admission and thereafter) and related care plan content on actions to be taken as a result of the assessment.
135	British Society of Dental Hygiene and Therapy	1	Service providers – We have devised a teaching package for care home staff to enable them to undertake the assessment. We are in the process of putting this forward to be endorsed by NICE.
136	National Older People's Oral Health Improvement Group (Scotland)	1	Look at other national and local programmes i.e. Caring for Smiles.
137	Public Health Department, Wiltshire Council	1	Need to be very clear about the definition of carer
138	Royal College of Surgeons of England	1	There are concerns that this could just become a tick box exercise and not an actual measure of quality.
139	Royal College of Surgeons of England	1	The Standard is simple and should be easy to implement.
	Statement 2		

ID	Stakeholder	Statement number	Comments[1]
140	County Durham & Darlington NHS Foundation Trust, Community Dental Service	2	Question 1: Does this draft quality standard accurately reflects the key areas for quality improvement? Answer: Yes, this draft quality standard accurately reflects the key areas for quality improvement, however, Both nursing and paid carers need to complete robust clinical documentation records on a frequent basis every day. All personal care plans should be accurately reviewed on a regular daily basis by both nursing and paid carers. An oral care plan should form part of a personal care plan. The first part of an effective oral care plan is to carry out an oral health risk assessment. It relies on communication, competence, consent and compliance. Carers or nursing staff should record and act upon obvious or suspected changes in oral health, problems or complaints. Question 2: Are local systems and structures in place to collect data for the proposed quality measures? Answer: Yes, within my area of work *the OHP team provide a service delivering education and training programmes and liaise with various health, education and social care staff colleagues promoting the importance of oral health in care plans of people who are receiving health or social care support. E.g. health care facilitation teams, social workers, care co-ordinators. This could be an option to explore in further detail.* Question 3: Do you have an example from practice implementing the NICE guidelines that underpins this quality standard? Answer: *The CDS Dental Team have set as a good practice standard the implementation of oral care plans to support patients within various care settings across the county. Liaison has taken place with the local Dental Professional Network Partnership raising the importance of this area.In relation to the Health and Social Care Act, 2012, the provision of training, information & advice as currently delivered by the OHP Team to various core target groups.* 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? Answer: Yes, it definitely should be achievable, however both a protected and dedicated time element would need to be accounted for as part of nursing/care/health or social care services within the parameters of staff duties. Provider contracts and service specifications would need to be compliant and audited /monitored on a regular basis, CQC inspectors, Commissioners |Also, a level of competency, linked to practical knowledge and skills of staff would need to be audited Question 5 The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes? Answer; See comment above as answered in key statements 1-3 for this question
141	Public Health Department, Wiltshire Council	2	Support the recording of mouth care in care plans, but need to have support and training for staff to ensure that this is done in a consistent way based upon what works well and has been trialled elsewhere.
142	Skills for care	2	We feel that staff with responsibility for recording mouth care needs in care plans may have training and development requirements.

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143	British Society of Gerodontology	2	Agree with this quality statement but there should be an indication about how often the care plan should be reviewed and updated along with a new mouthcare assessment. The outcome says that care home staff can access the care plan – it does not measure if they understand it or actually follow it on a daily basis. Oral care plan considerations are the amount of support an individual needs, the best environment, appropriate equipment, the best time of day; best position; preferred carer or number of carers; communication; any extra prevention input required and any planned physical intervention to enable oral healthcare to be carried out safely. Care staff need to know what equipment and materials they should be using for oral health care, and how they should be using them. It should contain a clear pathway for the person carrying out oral health care to follow if they suspect a dental problem, or if they are unable to carry out oral health care for an individual. There should be space to make notes for anyone involved with the oral health care of the individual. There may be ways to encourage someone who is reluctant to carry out oral health care, or to accept support. Unfortunately, it is not known whether these things are taken into consideration when a verdict of '*refused oral care'* is made for people who lack capacity. The oral care plan should have a method of recording areas that need particular attention. which trigger a request for an assessment by a dentist
144	Health Education England (working across London and the South East)	2	This section should also include regularly establishing and recording whether adults are experiencing discomfort or pain, if they have any problems with eating or dry mouth, what their mouth care preferences are (e.g. unflavoured toothpaste), what mouth care products they have brought with them and what is missing to meet their mouth care needs.
145	Royal College of Surgeons of England	2	The Oral Care Plan must be easily accessed so that every member of staff who is involved in a person's care, can note this on a daily basis to see how and what type of individual oral care has been recommended. How will accessibility be measured? The CQC would measure this easily but there needs to be some way in which daily accessibility is proven. One suggestion is to have an Oral Care Plan which has an extended section for recording daily care. This would ensure that the staff have access to the individual care plan at the time of taking action. However, to ensure this is not just a tick box exercise, there needs to be some form of quality measure in place. Regular appointments with a hygienist would provide an opportunity to assess the effectiveness of oral care. Although it would be impossible for them to confirm whether or not daily care has been applied, it would be possible to see if it is effective or not by assessing gingival status and plaque accumulation, using e.g. CPITN measures. There are limitations which need to be taken into consideration with regard to both ability to assess the CPITN and to deliver effective oral care. These are dependent on the person being able to cope with, and to tolerate these actions and may have cost implications for the individual.
146	British Society of Gerodontology	2	Agree but only if an appropriate mouthcare assessment is being used that indicates the outcomes required for the mouthcare plan. There is no mention of daily monitoring.
147	Health Education England (working across London and the South East)	2	There needs to be a validated mouth care recording plan that is recommended.

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148	Health Education England (working across London and the South East)	2	It would be helpful to clarify whether mouth care needs should be recorded in a separate mouth care plan or the individual's overall care plan.
149	Public Health Department, Wiltshire Council	2	Clear reference made to a nationally acceptable assessment tool that will aid recording and regular evaluation of individual oral health
150	The Faculty of General Dental Practice	3	***Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard?*** While we would support this standard, we note that it is too simplistic to group individuals according to whether they have their own teeth or dentures, as many individuals will have both. We would suggest grouping the two current populations together and simply ensuring, irrespective of whether they have their own teeth and/or dentures, that their mouths are cleaned twice a day, ideally with a fluoride toothpaste.
151	Public Health England	2	There is a need for more than just recording mouth care needs. There also needs for monitoring and recording of what on-going support is provided for each patient to ensure it is being carried out.
152	British Dental Association|	2	Where patients/residents are transferred between hospitals and care homes, it should be ensured that records about mouth care needs are transferred to ensure that the necessary oral hygiene support is provided regardless of the setting in which care is being delivered.
153	Health Education England (working across London and the South East)	2	Regular audits need to be undertaken. This could be part of the older people's survey.
154	Health Education England (working across London and the South East)	2	This section should also include a quality measure to check compliance with set review times for mouth care plans, to ensure these plans are updated appropriately.
155	Health Education England (working across London and the South East)	2	Regular training should be provided for staff, and there will need to be resources allocated for this. Organisations such as HEE can help provide this training resource.
156	British Society of Dental Hygiene and Therapy	2	Recording of Oral Hygiene plans need to be an element of CQC inspection.

ID	Stakeholder	Statement number	Comments[1]
157	College of Mental Health Pharmacy (CMHP)	2	PWID develop caries at the same rate as the general population| The prevalence of untreated dental caries, however, is higher among people with intellectual disability, particularly those living in non-institutional settings. The prevalence of malocclusion in PWID is similar to that found in the general population, except for those with coexisting conditions such as cerebral palsy or Down syndrome. A developmental disability in and of itself should not be perceived as a barrier to orthodontic treatment. The ability of the patient or caregiver to maintain good daily oral hygiene is critical to the feasibility and success of treatment
158	Southern Health NHS Foundation Trust	2	Page 7- under 'rationale'- please add examples of a dental passport www.solent.nhs.uk and/ or 'My dental Care Plan'. www.easyhealth.org.uk
159	Association of Directors of Public Health	2	No comments – Agreed
160	EPA UK	2	Refer to research evidence already presented in comment 2 for QS 1.
	Statement 3		
161	Royal College of Nursing	3	*"Adults living in care homes are supported to clean their teeth twice a day or undertake daily oral care for dentures"* – we suggest that this should read, 'at least twice a day' as some older people like their teeth cleaned after every meal.
162	Public Health Department, Wiltshire Council	3	The statement should reflect that some individuals may need more than twice daily oral care. Suggest it states " at least twice a day"
163	Health Education England (working across London and the South East)	3	The statement currently implies residents will either have natural teeth *or* a denture, whereas it is likely that residents will have some natural teeth *and* a denture. The more likely partially dentate situation should be addressed, so that residents are supported to care for their natural teeth and their dentures together.
164	Health Education England (working across London and the South East)	3	Consider re-phrasing as this sentence currently implies all denture wearers are able to clean their own dentures independently to some degree. However some residents will need not just support, but will need to have their dentures cleaned for them.
165	British Society of Dental Hygiene and Therapy	3	Health and social care practioners will need to undergo training to enable them to support or undertake residents in twice daily mouth or denture care. This should be included in the induction of any new member of staff.

ID	Stakeholder	Statement number	Comments[1]
166	County Durham & Darlington NHS Foundation Trust, Community Dental Service	3	Question 1: Does this draft quality standard accurately reflects the key areas for quality improvement? Answer: Yes, this draft quality standard accurately reflects the key areas for quality improvement, however an assessment of the adult's needs should be carried out on a daily basis. Observations required should be taken in the form of a level of oral care practical support should be provided by nursing or paid care staff whom have undertaken an oral health training course programme. A daily oral care sheet whereby problems encountered are listed by the carer or nurse. Training should form part of a mandatory requirement for all frontline staff on induction and at regular intervals as this would help to give oral health care training the emphasis it deserves. Question 2: Are local systems and structures in place to collect data for the proposed quality measures? Answer; I am unsure whether or not this is demonstrated across all care home sites? Question 3: Do you have an example from practice implementing the NICE guidelines that underpins this quality standard? Answer: Yes, we currently offer an accredited award scheme to Care homes in the Darlington Locality titled 'Golden Smiles Award ' 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? Answer: I would like to hope that this would be the case, however suspect that the protected time element from staff's perspective would need to be factored in as part of essential core duties required. Question 5 The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes? Answer: See comment above as answered in key statements 1-3 for this question
167	Dental Faculty of the Royal College of Physicians and Surgeons of Glasgow	3	Care home managers should make sure that care staff understand the needs of people with dementia and other cognitive difficulties – and other additional needs eg those at risk of aspiration
168	Public Health England	3	Statement should include something about staff having appropriate training to provide this support.
169	Skills for care	3	We feel that staff with responsibility for supporting adults living in care homes to clean their teeth twice a day or undertake daily oral care for dentures may have training and development requirements. Including establishing Oral health-related quality of life using the Oral Health Impact Profile as it is unlikely that this is commonly used in care homes at present.

ID	Stakeholder	Statement number	Comments[1]
170	British Society of Gerodontology	3	As mentioned before unless staff are regularly updating care plans by using a risk assessment how do the care homes know how many residents have natural teeth? What about residents who brush more than twice daily will they be included, what about residents who choose to brush only once daily or refuse altogether? The same issue about dentures – what about when they are lost or residents choose not to wear them? Will the CQC measure quality of all homes on a similar basis or will there be some weighting system and/or allowance if the complexity of the residents' needs results in the staff being less able to deliver effective oral care e.g. a resident refuses oral care and not able to tolerate mouthcare due to sensory, behaviour or cognitive impairment issues.
171	British Society of Gerodontology	3	This excludes those people who are edentulous who require daily oral care such as tongue brushing or for someone who has had a stroke to ensure food residue has been removed to avoid aspiration
172	Public Health Department, Wiltshire Council	3	The statement needs to acknowledge that oral care may need to be undertaken in line with specific advice from other professionals (dental; nutritionist; occupational health etc) For example, someone with a stroke may need their mouth checking and oral care carried out after every time they eat something. Those with alternative nutritional support (Percutaneous endoscopic gastrostomy - PEG) also require mouth care, even though they may not eat in the normal way.
173	College of Mental Health Pharmacy (CMHP)	3	Some patients cannot brush and floss independently due to impaired physical coordination or cognitive skills. All caregivers will not know the basics of oral hygiene. Emphasize that a consistent approach to oral hygiene is important--caregivers should try to use the same location, timing, and positioning. Some patients benefit from the daily use of an antimicrobial agent such as chlorhexidine. Recommend an appropriate delivery method based on your patient's abilities. Rinsing, for example, may not work for a patient who has swallowing difficulties or one who cannot expectorate. Chlorhexidine applied using a spray bottle or toothbrush is equally efficacious.
174	Royal College of Surgeons of England	3	Many of the people living in these care homes will need support to enable mouth care to be delivered effectively such as helpful distractions or some degree of safe holding. There has been no mention of this within the document and this will affect the quality of the outcome.
175	Royal College of Surgeons of England	3	The emphasis of the standard is on tooth brushing and denture care but does not include additional oral care which is vital in order to reduce incidence of pneumonia i.e. brushing the dorsal surface of the tongue and removal of debris/food which may be retained in the mouth if there is poor oro-motor and muscular control and movement. The oral care plan should have a method of recording areas that need particular attention. The OH Tool has a section on Oral Cleanliness which could have this added or made more clear within the assessment. The link between poor oral hygiene and particular systemic diseases such as aspiration pneumonia, ventilator assisted pneumonia and hospital acquired infections, is well established.

ID	Stakeholder	Statement number	Comments[1]
176	Health Education England (working across London and the South East)	3	This section should also comment on daily mouth care outside of hygiene, such as managing dry mouth or other oral or mucosal conditions e.g. dysphagia, ulceration, candida infections, angular cheilitis, groups with high aspiration risk. There should also be training for care homes for residents who display care resistant behaviour. Oral health promotion teams need to have specific guidance for managing patients with such conditions or who display care resistant behaviour, e.g. an adapted Delivering Better Oral Health (Public Health England).
177	Health Education England (working across London and the South East)	3	The word 'cleaning' may be more appropriate than the word 'brushing', as denture hygiene may require processes beyond brushing (e.g. sterilisation tablets, being sent to laboratory for further cleaning).
178	Public Health England	3	Support should be provided where required. If patient is able to clean their own teeth/dentures this support may not be required.
179	Health Education England (working across London and the South East)	3	Impaired physical function should be included alongside impaired sensory and cognitive function.
180	National Older People's Oral Health Improvement Group (Scotland)	3	If a person chooses to brush their teeth only once a day as that was their custom, how staff respond to personal choice and capacity should be mentioned here.
181	Royal College of Surgeons of England	2	What if a person refuses to receive oral care? There is a box to tick at the bottom of the first page of the OH Tool if they refuse. However, it does not say what to do if this is the case. Will staff relate back to the Mental Capacity Act? Will they take into consideration Best Interests, Patient Choice, Deprivation of Liberty etc? Will they involve the carer/family member? An oral care pathway involving a mouth care champion for advice and the MDT team if necessary, needs to be developed. Oral care plan considerations are the amount of support an individual needs, the best environment, appropriate equipment, the best time of day; best position; preferred carer or number of carers; communication; any extra prevention input required and any planned physical intervention to enable oral healthcare to be carried out safely. Care staff need to know what equipment and materials they should be using for oral health care, and how they should be using them. It should contain a clear pathway for the person carrying out oral health care to follow if they suspect a dental problem, or if they are unable to carry out oral health care for an individual. There should be space to make notes for anyone involved with the oral health care of the individual. There may be ways to encourage someone who is reluctant to carry out oral health care, or to accept support. Unfortunately, it is not known whether these things are taken into consideration when a verdict of '*refused oral care'* is made for people who lack capacity.
182	National Older People's Oral Health Improvement Group (Scotland)	3	No mention of religious or cultural beliefs in this statement

ID	Stakeholder	Statement number	Comments[1]
183	Southern Health NHS Foundation Trust	3	Page 9- add in MCA/Best Interests Decisions to be considered. There needs to be more enthuses on training for carers in this section.
184	Southern Health NHS Foundation Trust	3	Page 11- Again add in Learning Disabilities- separate to cognitive difficulties. More information needed about the Mental Capacity Act- maybe the 5 main principles just to remind readers.
185	Association of Directors of Public Health	3	Equality and diversity considerations. This can include access to specialist resources and training- e.g. the use of 3 way toothbrushes, prescription toothpaste, dental modifications This statement implies that the route for accessing dental treatment is for dentists to visit the patient in a care home. This is now unusual and most care home patients would need to visit a dental surgery. The rationale for this commissioning decision is on quality of care. The guidance as currently worded may be misleading and give rise to mismatches in expectation and provision reducing access for patients. There is a resource cost to care homes or families in providing transport and time in accompanying residents to dental care. DBOH lacking in support for denture cleaning advice in this topic, daily for f/f may be acceptable, however, part denture and dentate requires twice daily oral care, therefore, consideration is needed to this statement of denture cleaning in QS3
186	British Society of Gerodontology	3	This statement suggests that all residents who refuse mouthcare have a cognitive impairment which is not the case as patients may refuse through choice. This statement should indicate that residents who refuse should be encouraged to have mouthcare but their wishes should be respected if they continue to refuse
187	College of Mental Health Pharmacy (CMHP)	3	In general, people with intellectual disability (PWID) have poorer oral health and oral hygiene than those without this condition. Data indicate that PWID have more untreated caries and a higher prevalence of gingivitis and other periodontal diseases than the general population. Medications, malocclusion, multiple disabilities, and poor oral hygiene combine to increase the risk of periodontal disease in PWID. Missing permanent teeth, delayed eruption and enamel hypoplasia are more common in PWID and coexisting conditions than in people with intellectual disability alone. Many PWID also have other conditions such as cerebral palsy, seizure or psychiatric disorders, attention deficit/hyperactivity disorder, or problems with vision, communication, and eating. Though language and communication problems are common in anyone with intellectual disability, motor skills are typically more affected when a person has coexisting conditions. Intellectual disability does not always include a specific physical trait, although many people have distinguishing features such as orofacial abnormalities, scoliosis, unsteady gait, or hypotonia due to coexisting conditions. Countering physical challenges requires attention to detail. Cerebral Palsy occurs in one-fourth of those who have intellectual disability and tends to affect motor skills more than cognitive skills. Uncontrolled body movements and reflexes associated with cerebral palsy can make it difficult to provide care.

ID	Stakeholder	Statement number	Comments[1]
			Seizures are common in this population but can usually be controlled with anticonvulsant medications. The mouth is always at risk during a seizure: Patients may chip teeth or bite the tongue or cheeks.
188	British Society of Gerodontology	3	Oral Health-related quality of life – Oral Health Impact Profile will need to be adapted for people with cognitive impairment (70% of older people in care homes have cognitive impairment) – there should be an indication of that adaptations for communication used to support residents in expressing their opinions on mouthcare provision. How often do you ask residents annually? It may be difficult to separate the mouth from the rest of the body. For example when asking a resident on a scale of 1 -10 how comfortable is their mouth, the answer may well be skewed if the patient is in pain from a non related mouthcare problem – a significant proportion of older adults in care home are in pain often muscular/skeletal .
189	Health Education England (working across London and the South East)	3	Residents are likely to have some natural teeth and also have a denture. To address this common situation, wording should be changed to “clean their teeth twice a day *and* undertake daily oral care for dentures where appropriate”.
190	Health Education England (working across London and the South East)	3	The Oral Health Impact Profile may be difficult to use as an outcome measure, as this may require ethical approval.
191	National Older People’s Oral Health Improvement Group (Scotland)	3	If a person is independent in brushing their own teeth morning and night and does it at a time of their choosing, how will this be recorded?

ID	Stakeholder	Statement number	Comments[1]
192	EPA UK	3	An area that can benefit for quality improvement would be to include a denture cleaning protocol in place to be used when people receiving care do not have a preferred method and/or established routine of cleaning their dentures. Examples: The instructions given in the book Levine, R. and Stillman-Lowe, C. (2014). *The scientific basis of oral health education*. 7th ed. British Dental Association, pp.115-118. Denture Care Instructions – Information for Patients by the University Hospitals of Leicester, NHS Trust http://www.leicestershospitals.nhs.uk/EasysiteWeb/getresource.axd?AssetID=3668&type=full&servicetype=Inline Another suggestion is to develop/include a toolkit of protocols of oral/dental implications of the most common conditions affecting the elder population so that the care homes are better equipped to understand and deal with the oral and mouth care of their residents. Examples: |the British Society of Gerontology has a wide resource and guidelines on Oral Health Instructions for diverse conditions (e.g. stroke survivors, people with mental health problems, people with dementia) http://www.gerodontology.com/content/uploads/2015/10/BSG-OH-RESOURCE-Revised-June20151.pdf Parkinson's UK Dental and Oral Health in Parkinson's Information Sheet https://www.parkinsons.org.uk/content/dental-and-oral-health-parkinsons-information-sheet Multiple Sclerosis Society Oral Health (factsheet) https://www.mssociety.org.uk/ms-resources/oral-health-factsheet Consider implementing groups of discussion amongst staff, home care residents and their families 'Toothbrush club' style - in my experience as a dental health professional I find that I am always learning and understanding more of the challenges faced by patients to care for their oral and mouth health and by my colleagues in delivering oral health education. At the same time, I learn a lot from patients about wonderful tips and routines that they develop with regards to their oral and mouth health as well as from my colleagues about how to best support the patients in their oral health routine. I find these interactions invaluable as we can all learn from each other and from different approaches, especially with regards to caring for people that require specific and tailored oral health care.
193	Southern Health NHS Foundation Trust	3	Page 10- under 'source guidance' add in as a resource- 'Oral Health Care Advice for Carers' in www.easyhealth.org.uk
194	EPA UK	3	Refer to research evidence already presented in comment 2 for QS 1.
	Statement 4		
195	Dental Faculty of the Royal College of Physicians and Surgeons of Glasgow	4	It is welcome that the importance of oral healthcare while in hospital should be supported and standardised. The link between respiratory infections and oral micro-organisms is known. The reduction in ventilator associated pneumonias by implementation of a strict oral care regime is known. The work by Ian Needleman's team sheds much light on the link between oral health/ oral hygiene and systemic infections.

ID	Stakeholder	Statement number	Comments[1]
196	EPA UK	4	Definitely new evidence-based guidance relating to daily mouth care for people in hospital have the potential to improve practice, based on the reasons already presented by the British Dental Association (BDA) in its comments on the engagement exercise – refer to ID 16 in Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders With regards to the question 'Is there a particular group of people that would most benefit from receiving support for daily mouth care in hospitals?' Given the reasons explained on the bullet point above, daily mouth and oral care should be given and/or supported routinely for all patients in hospitals. However, given the particularities of each condition and its effects in the mouth, specific guidance for specific conditions are necessary. Below is an example of a guideline specific for oncology patients requiring radiotherapy, chemotherapy and/or bone marrow transplantation: The Oral Management of Oncology Patients Requiring Radiotherapy, Chemotherapy and/or Bone Marrow Transplantation by N.Kumar, A.Brooke, M.Burke et al, created in association with the British Society for Disability and Oral Health (Update of the 1997 Guideline by J.Shaw, N.Kumar, M.Duggal et al) - https://web1.rcseng.ac.uk/-/media/files/rcs/fds/publications/oncology-guidelines-october-2012.pdf?la=en Please refer to in comment 4 for QS3 for other examples of protocols specific for conditions affecting the elder population.
197	British Dental Association	4	Studies have observed a general deterioration in oral health among hospitalised individuals*. This has been observed for short and longer periods of hospitalisation, in critical/intensive care units and in general wards, for those unable to undertake oral care independently and those dependent on nurses, those intubated and those not intubated, and at various ages. However, some patients, such as those undergoing medical interventions, taking medication, or with medical conditions that have a negative impact on oral health, may particularly benefit from oral health and hygiene interventions and support with routine mouth care. Neglect of mouth care presents risk of aspiration pneumonia (Almirall J, Cabre M, Clave P. Aspiration pneumonia. Med Clin. 2007;129(11):424–32.). This is an issue for patients in intensive care units, but also a potential risk for any patient unable to keep their own mouth free of plaque and debris, particularly those who have altered swallowing function (Marik PE, Kaplan D. Aspiration pneumonia and dysphagia in the elderly. Chest. 2003;124). Given this evidence and the noted impact of poor oral health on quality of life and the association of poor oral health with hospital-acquired infections, it may be appropriate for standards one to three to be applied to hospital in-patients, in addition to care home residents.
198	British Society of Dental Hygiene and Therapy	4	All patients would benefit from daily oral care while in hospital long term, as by a decline in oral health could lead to other systemic health problems.
199	Public Health Department, Wiltshire Council	4	Important to consider those in hospital as this area often gets forgotten or not regarded as crucial

ID	Stakeholder	Statement number	Comments[1]
200	Association of Directors of Public Health	4	Supporting daily mouth care in hospitals. The standards for care homes would be applicable to a hospital setting although the timescales for assessment and mouth care plans would be shorter and the risk of confusion and loss of dentures much greater. The people who would benefit most from receiving support for daily mouth care in hospitals include people with dementia and people who have neurological or limited mobility or motor function to perform self care- e.g. stroke, trauma. Training would need to be offered to relevant staff. The hospital should use appropriate resources to support mouth care e.g. dental. Useful resources including • Dental Communications/ desensitising tools|• Dental Resource Sales poster available on display i.e. toothbrushes etc • Dementia friendly dental / hospital practice toolkit
201	Health Education England (working across London and the South East)	4	All patients should have an oral health and mouth care needs assessment on admission to hospital.
202	Southern Health NHS Foundation Trust	4	Page 14- Ensure that hospitals have this within their initial assessment paperwork upon admission. Consideration for patients with LD and capacity and consent issues as above in page 3 comments
203	Central Manchester Foundation Trust (CMFT)	4	As an organisation we have developed some tools and information for staff to help improve standards of oral hygiene in hospitals. This has been part of the 'Surgery School' enhanced recovery programme for patients undergoing elective surgery and also as a drive to improve oral hygiene in all in-patient areas, particularly stroke and head and neck cancer patients. We struggled to find useable guidelines and evidence based literature so national guidance would be useful. We are happy to share what we have developed so far and would welcome any involvement in the development of these NICE guidelines. Adequate oral hygiene and assistance to achieve this is a fundamental aspect of care that we know is not performed well in many areas.

ID	Stakeholder	Statement number	Comments[1]
204	County Durham & Darlington NHS Foundation Trust, Community Dental Service	4	Question 1: Does this draft quality standard accurately reflects the key areas for quality improvement? Answer: Yes, this draft quality standard accurately reflects the key areas for quality improvement, however all nursing and paid care staff have a duty of care to acknowledge, as part of their role and responsibility within a hospital environment, supporting personal care. A certain level of encouragement, whilst acknowledging independence, should be provided whilst observing behaviour as a 1-1 or reported behaviour. Close collaboration with oral health care professionals is important to optimise the oral health of patients within a hospital setting. The level of support shall vary but carers and nursing staff should be able to carry out toothbrushing for individuals who are unable to do so, e.g. physical impairment, dementia etc. I recommend that NHS Trusts look at policies and procedures for patient care (for example, admission and discharge advice, in-patient oral care provision, nutritional policies for in-patients, out-patients and their carers and visitors to NHS premises. I feel it also important that the availability of information about local dental services and treatment charges is available for patients and their carers. For example, signposting and improving access to dental care. To ensure that oral health advice, care and equipment, where necessary, are available at every point in the patient journey and that practices in NHS Trusts support good oral health for all patients within care settings. Recommendation & implementation of both an advanced and basic level of oral care training is offered to various levels of staff graded by the OHP Team within my NHS Trust. Question 2: Are local systems and structures in place to collect data for the proposed quality measures? Answer: Yes, this may also be the case within hospital settings/environments however my own NHS Trust has this standard in place as part of a new patient pathway induction. (CDDFT ward based performance framework titled “Quality Metrics supporting in-patient wards). The aim is to promote patient experience and to help support the reduction in hospital acquired infections. Question 3: Do you have an example from practice implementing the NICE guidelines that underpins this quality standard? Answer: We have suggested to our NHS Trust as part of our internal mouth care guidelines /toolkit that this should be a recommendation as part of a new patient experience pathway. (Essence of Care Patient Focussed Benchmarking for health care practitioners, 2010, DOH). (examples contained are a patient care information sheet, oral hygiene routine checklist, oral health risk assessment tool) 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? Answer: I would like to hope that this would be the case, however suspect that the protected time element from staff’s perspective would need to be factored in as part of essential core duties required. Question 5 The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes? Answer; See comment above as answered in key statements 1-3 for this question

ID	Stakeholder	Statement number	Comments[1]
205	Health Education England (working across London and the South East)	4	Hospitals should have mouth care training in continuing professional development for all nursing staff and allied health care professionals.
206	Southern Health NHS Foundation Trust	4	The phrase 'daily mouth care' should be replaced with provision of mouth care in line with usual routine and taking into account current medical status, i.e. nil by mouth, oxygen therapy, other treatments etc. Particular groups of patients will be at more risk – frail, immuno-suppressed, cognitively impaired, neurology patients, i.e. traumatic and acquired brain injury, respiratory any patient unable to access oral hygiene independently. Evidence based guidance would be very beneficial – assessing oral cavity and care planning appropriately, See recent webinar provided via national stroke nursing forum Need to involve pharmacy and dentistry regarding most appropriate treatments options for oral infections etc.
207	British Society of Gerodontology	4	What is the definition of 'hospitals' – acute, private, high security hospitals, private care home firms which call their premises hospitals? In Wales 1000 Lives plus have a Mouthcare for Adults in Hospital programme which can be accessed from their website http://www.1000livesplus.wales.nhs.uk/mouthcare as well as Mouthcare Matters in South East England. Hospitals require a NICE guidance for mouthcare that sits outside Essence of Care
208	Health Education England (working across London and the South East)	4	All wards need to stock appropriate mouth care products for patients.
209	Health Education England (working across London and the South East)	4	There are currently only a few hospitals that provide urgent dental care for patients. NHS England does not commission this service and there is no tariff for inpatient dental care, so this is an area of poor care. Many inpatients have no access to dental care. There are patients for example who have very mobile teeth that are an aspiration risk or those that have ulcers cause by a sharp tooth that need care so that they can eat and drink again. Dealing with this will contribute to overall recovery and help shorten hospital stays.
210	Health Education England (working across London and the South East)	4	Rationale should emphasise that good mouth care is necessary for adequate hydration and nutrition and should form part of all patients' general care. In hospitals there needs to be more of a focus on the links between oral health and general health in terms of nutrition and hydration, patient safety, hospital acquired infections and compassion and dignity.
211	Health Education England (working across London and the South East)	4	The benefits of improved oral care for inpatients are likely to outweigh the cost implications of training and resources.

ID	Stakeholder	Statement number	Comments[1]
212	Health Education England (working across London and the South East)	4	Mouth Care Matters (a Health Education England, Kent, Surrey and Sussex initiative to improve the oral health of hospitalised patients) is currently working on this area of care and collecting data that will produce a good level of baseline evidence. Data is being collected on current mouth care practice in 13 trusts across Kent, Surrey and Sussex over the next 12 months. Each trust has a mouth care lead that is implementing changes in relation to mouth care in terms of training. Changes in practice are being measured and this data could be used to form the basis for evidence-based practice.
213	Health Education England (working across London and the South East)	4	The Mouth Care Matters team have developed a mouth care recording pack with a multidisciplinary team. It has been audited and modified. This could be validated and then used nationally.
214	Health Education England (working across London and the South East)	4	Buckinghamshire Healthcare has developed an evidenced based guidance (359.3 Mouthcare guidance for adult patients), which encourages a holistic approach to oral health for patients in hospital. All new health care assistants and nurses receive training as part of the Trust induction, with further specialized training at specific induction programmes for the Intensive Care Unit (ICU) and Spinal Injuries. The training supports the adoption of the guidance and includes the importance of mouthcare, oral hygiene techniques and use of mouth care products, incorporating a practical session of cleaning each other's teeth. It also develops staff to competently use the Trust assessment tools, care plans and record keeping documents for mouth care. On the ward training has helped develop assessment tools and mouth care plans relevant to different patient groups. The results are in the process of being audited to ascertain if the documentation is being completed by staff and if this has produced positive outcomes and an improvement in the oral health of patients.
215	Health Education England (working across London and the South East)	4	The following guidance and literature relates predominantly to ventilated and critically ill patients: Guideline for the Development of Local standards of Oral Care for Dependent, Dysphagic, Critically and Terminally Ill Patients: Report of BSDH Working Group; Revised 2000 http://www.bsdh.org/userfiles/file/guidelines/depend.pdf| Ortega et al (2014): Oral Health in Older Patients with oro-pharyngeal dysphagia. Age and Ageing 43: 132-137 Alhazanni et al (2013). Tooth brushing for Critically Ill Mechanically Ventilated Patients: a systematic review and meta-analysis or randomised trials evaluating ventilator associated pneumonis. Crit Care Med 41: 646-655 Oral hygiene care for critically ill patients to prevent ventilator-associated pneumonia.|Hua F, Xie H, Worthington HV, Furness S, Zhang Q, Li C. Cochrane Database Syst Rev. 2016 Oct 25;10 Shi et al (2013). Oral hygiene care for critically ill patients to prevent ventilator-associated pneumonia. Cochrane Database of Systematic Reviews Issue 8 Randomized controlled trial of toothbrushing to reduce ventilator-associated pneumonia pathogens and dental plaque in a critical care unit. Needleman IG, Hirsch NP, Leemans M, Moles DR, Wilson M, Ready DR, Ismail S, Ciric L, Shaw MJ, Smith M, Garner A, Wilson S., J Clin Periodontol. 2011 Mar;38(3):246-52 7. Brady et al (2010): Staff-led Interventions for improving oral hygiene following stroke. Cochrane database for systematic reviews. Update Issue 4

ID	Stakeholder	Statement number	Comments[1]
216	Health Education England (working across London and the South East)	4	New evidence based guidance would highlight the importance of daily mouth care in hospitals to healthcare workers and hospital managers and may therefore drive change to improve mouth care practice.
217	Health Education England (working across London and the South East)	4	The literature consistently supports evidence that various illnesses or their related symptoms increase an individual's risk of oral complications so there is a need for support for daily mouth care particularly for the following patients: Older patients, especially those with dementia, depression, frailty and debility Patients receiving intensive care, especially if ventilated and/or unconscious Patients receiving chemotherapy and patients receiving radiotherapy to the head and neck Patients who are immunosuppressed or receiving immunosuppressive therapy, i.e. transplant patients Patients with Diabetes Patients with stroke/ cerebrovascular disease Patients with learning disabilities Patients with degenerative diseases – e.g. Parkinson's Patients with severe mental illness Patients who are enterally fed Patients with a spinal injury Patients with heart disease Patients with existing oral disease Patients with anaemia Patients with thyroid dysfunction Trauma patients Terminal illness, palliative care Patients on medication with oral health side effects. Patients at particular risk of complications are those who are taking: Cytotoxic agents, corticosteroids, antibiotics, antihistamines, antispasmodics, anticholinergics, psychotropics, anti-depressants, tranquillizers, diuretics, opiates. In addition any patient exhibiting the following or receiving these treatments will need support for daily mouth care: Acute/chronic breathing difficulties (e.g. on inhalers and or oxygen therapy) Patients with dysphagia Limited/restricted fluids or dehydrated Mouth breathers Poor nutritional intake or those refusing food and drink Nil by mouth groups Insufficient saliva production Patients receiving oral suction

ID	Stakeholder	Statement number	Comments[1]
			A general lack of motivation or inability to undertake oral hygiene Difficulty in communicating. These lists are not exhaustive and every patient should be assessed and supported with their daily mouth care as required. All inpatients are potentially at risk from poor mouth care, especially as there is often a lack of focus on oral care by hospital staff. Other considerations: Intensive Therapy Unit or High Dependency Unit patients will have one on one nursing, so may tend to have better levels of oral care. Winter pressure on wards means that this is a time of year where oral care can be further neglected. Hospitals that are in special measures or have problems with nursing levels are likely to have poor oral care.
218	Royal College of Surgeons of England	4	The standard should include the number of care home staff who have received appropriate training in oral health care (which should include annual updates). Oral health assessments should be carried out on an annual basis - adequate and effective continuing care should be monitored and take into account potential changes in the medical, mental and physical condition of the person.
	Question 6		
219	Advance Healthcare Logistics Ltd	Question 6	Elderly long-stay patients and patients with dementia, especially denture wearers as our experience shows that many dentures are lost when a patient is admitted to hospital and unless you can access domiciliary, dental services it is incredibly hard to get them replaced. Patents in secure hospitals who have high dental need but cannot easily access external dental services because they are not allowed out, or are unlikely to keep appointments
220	British Association of Dental Nurses	Question 6	Yes, stroke wards/elderly/dementia. Nurses (ie general nurses) to be trained in oral hygiene routines and follow poster as “aide memoire”. Again, oral health teams/dental nurses with OHE qualification could provide this training.
221	British Society of Gerodontology	Question 6	There needs to be a clear definition of a hospital - acute, private, community, high/medium secure mental, some care homes call themselves hospitals, rehabilitation, neurodisability, etc. They can be very diverse and recommending one type of risk assessments and care plan will not be appropriate for all hospitals. There needs to be local flexibility. All patients in hospital should have an oral risk assessment tailored to their needs the exception would be day case and those in for less than 24 hours. Particular groups include frail older people, cognitive impairment, long(er) stay patients (>5 days) awaiting/following surgery (e.g. transplants/oncology), patients with a severe mmental illness, stroke/neurological wards, people in hospital may be nil by mouth and/ or suffer with dehydration and dry mouth. Those adults on End of life care should have oral care on a more regular basis depending on their need. Those adults in ICU, children wards, cardiac wards etc. Numerous studies have long documented general deterioration and poor oral health for patients in hospital. This has been observed for short and longer periods of hospitalisation, in critical/intensive care units etc and in general wards, for

ID	Stakeholder	Statement number	Comments[1]
			those unable to manage their own mouthcare, and those dependent on nurses, those intubated / not intubated, and of varying age. However, there is a patient group, such as those undergoing medical interventions (Oncology therapy) that have a negative impact on oral health. This patient group will particularly benefit from oral health interventions and support with routine mouth care. Given the evidence and the association of poor oral health with hospital-acquired infections, it is necessary for all of the standards (one to four) to be applied to hospital in-patients, in addition to care home residents. A quality standard focusing on delivery of mouthcare, and denture care twice a day may help improve the oral health of patients in hospital. Where patients and or residents are transferred between hospitals/care homes, it must be possible that all mouth care needs and documentation are transferrable. This would ensure that appropriate oral hygiene is provided regardless of the setting in which mouthcare is being delivered. A single unified assessment and care plan utilised across both community and secondary care settings would ensure that seamless fluid delivery of mouthcare. BSG would recommend: PHW 1000 Lives Mouthcare for Adults in Hospital programme (has been running for 4 years) and Welsh Government WHC/2015/001National Advisory Group are developing a single unified mouthcare programme for community and secondary hospital care settings. Both of the above programmes are an excellent example of good practice and include: Delivery of core and oral champion staff training for up skilling health and care professionals. This includes competency skills for mouthcare delivery. Documentation of mouth assessment and care plan for residents in care homes and patients in hospital, Delivery of high quality person centred mouthcare for residents and patients, Links with other health and care professionals and health and social care services – Speech and Language therapists, occupational therapists, physiotherapist, dietitians, medical and nursing staff, Community Learning Disability Teams, Older Person Community Mental Health teams, Continuing Care Teams etc. Developed core training into pre registration nurse programme every year. Data collection linking to Health and Care Standards for Wales. Ensuring procurement and right resources are available Wales wide. Established a referral system for urgent dental care for patients in hospital. Managed Clinical Networks for Special Care Dentistry in Wales have developed a referral system for a model of domiciliary shared care between GDS and CDS – this helps ensure the patient is seen by the right person in the right setting in a timely manner utilising Dental Care Professionals. Currently undertaking a validation exercise for the mouthcare documentation (assessment and care plan). http://www.1000livesplus.wales.nhs.uk/mouthcare Mouthcare Matters in South East England. Mouth Care Matters (acute side) is currently working on this area of care and collecting data that will produce a good level of baseline evidence. All inpatients are potentially at risk from poor mouth care. The team have found that due to a lack of focus on oral care by hospital staff that those most at risk are: those that have dementia, those with dysphagia, frail patients, those dependant on oxygen, have undergone head and neck radiation, those with learning difficulties, nil by mouth, palliative care, those refusing food or drink, with severe mental health, who have had a stroke or are unable to communicate, and those who have undergone chemotherapy. ITU/HDU patients will have one on one nursing so tend to have better levels of oral care. Winter pressure on wards mean that this is a time in the year where oral care can be

ID	Stakeholder	Statement number	Comments[1]
			further neglected. Hospital that are in special measures or have problems with nursing levels will have poor oral care. Hospitals need to have Mouth care training in continuing professional development for all nursing staff and allied health care professionals. All wards need to stock appropriate mouth care products for patients. Mouthcare Matters have developed a recording package with a multidisciplinary team and audited the pack and modified it. This could be validated and then used nationally. There are currently only a few hospitals that provide urgent dental care for patients. NHS England does not commission this service and there is no tariff for inpatient dental care so this is an area of poor care. Many inpatients have no access to dental care There are patients for example who have very mobile teeth that are an aspiration risk or those that have ulcers cause by a sharp tooth that need care so that they can eat and drink again. This will contribute to overall recovery and help shorten hospital stays. In hospitals there needs to be more of a focus on the links between oral health and general health in terms on nutrition and hydration, patient safety, hospital acquired infections and compassion and dignity. There will be cost implications but the benefit will outweigh this. Mouth care Matters is collecting information of current mouth care practice in 13 trusts across Kent, Surrey and Sussex over the next 12 months. Each trust has a mouth care lead that is implementing changes in relation to mouth care in terms of training. Changes in practice are being measures and this data could be used to form the basis for evidence based practice.
222	County Durham & Darlington NHS Foundation Trust, Community Dental Service	Question 6	Is there a particular group of people in hospitals for whom quality improvement is most needed in this area? Answer: In my opinion the following groups of people in hospital settings for whom quality improvement is needed in this area: Patients who are approaching the End of Life or Palliative Care Pathway. Those who are homeless or frequently move, such as traveller communities. Those who are socially isolated or excluded. Those with diabetes. Those with dementia. Those who are older and frail. Those who have physical or mental disabilities, learning disabilities. Those who are from a lower socioeconomic group. Those who live in a disadvantaged area who smoke or misuse substances (including alcohol). Those who have a poor diet from some black, Asian and minority ethnic groups for example, people of South Asian origin. Those who are, or who have been, in care (LAC, Foster care). I also think that it is worth considering the “common risk factor” policies within both hospital and care home environments, such as those on smoking, alcohol, and obesity, all of which should make reference to – and include advice on – the importance of good oral health practices.
223	National Older People’s Oral Health Improvement Group (Scotland)	Question 6	Cancer patients, patients at palliative and end-of-life stages, and adults with learning & disabilities. Resources could be incorporated into existing training for nurses and carers to be cost effective.
224	National Older People’s Oral Health Improvement Group (Scotland)	Question 6	Adults within long-term care of the elderly care wards, and those in mental health units

ID	Stakeholder	Statement number	Comments[1]
225	National Older People's Oral Health Improvement Group (Scotland)	Question 6	ANDERSSON, P., HALLBERG, I.R., LOREFLT, B., UNOSSON, M. and RENVERT, S., 2004. Oral health problems in elderly rehabilitation patients. *International journal of dental hygiene,* **2**(2), pp. 70-7. AZARPAZHOOH, A. and LEAKE, J.L., 2006. Systematic review of the association between respiratory diseases and oral health.[see comment]. *Journal of periodontology,* **77**(9), pp. 1465-1482. BRADY, M., FURLANETTO, D., HUNTER, R.V., LEWIS, S. and MILNE, V., 2006. Staff-led interventions for improving oral hygiene in patients following stroke. *Cochrane Database of Systematic Reviews,* (4), pp. 003864. GILLAM, J.L. and GILLAM, D.G., 2006. The assessment and implementation of mouth care in palliative care: A review. *Journal of The Royal Society for the Promotion of Health,* **126**(1), pp. 33-37. MALKIN, B., 2009. The importance of patients' oral health and nurses' role in assessing and maintaining it. *Nursing times,* **105**(17), The above papers may help inform NICE's position on Quality Statement 4, but most are specific to one group or an individual condition such as stroke.
226	National Older People's Oral Health Improvement Group (Scotland)	Question 6	As above studies indicate, stroke patients and those at risk of aspiration pneumonia require particular attention to mouth care in hospitals. Other groups are those in intensive care, palliative and end-of-life stages and oncology patients.
227	Royal College of Nursing	Question 6	For draft quality statement 4: Is there a particular group of people in hospitals for whom quality improvement is most needed in this area? Those with cognitive impairment and or sensory difficulties using and recognising dental care aids are particularly in need.
228	Real Life Options	Question 6	We would want to see people with learning disabilities specifically mentioned in the context of statement 4.
229	RCGP	Question 6	"Question 6: For draft quality statement 4: Is there a particular group of people in hospitals for whom quality improvement is most needed in this area?" Patients with altered levels of consciousness, limb function and mental capacity would be the most at risk
230	Southern Health NHS Foundation Trust	Question 6	Page 3- Under Question 6- when considering any particular patient group in supporting daily mouth care in hospitals. To include patients with a learning disability- consider capacity/compliance/current support plans. Ensuring that if a patient with LD is admitted to hospital that information re mouth care is handed over- use of Hospital Passports (sometimes called 'All about Me')
231	The Faculty of Dental Surgery, The Royal College of Surgeons of Edinburgh	Question 6	Psychogeriatric patients, ICU/HDU patients, recent stroke, dysphagia
232	Association of Directors of Public Health	Question 6	Is there a particular group of people in hospitals for whom quality improvement is most needed in this area? The groups most at risk are patients with: • dementia, learning disability or neurological impairment, and those with motor impairments limiting self care, • dysphagia or at risk of aspiration pneumonia

ID	Stakeholder	Statement number	Comments[1]
			• higher risk of infection, • HDU /ICU care.
233	Royal College of Surgeons of England	Question 6	All vulnerable adults who need support to achieve effective oral care and maintain a healthy oral environment. This includes those with physical as well as other disabilities or impairments which would prevent them managing their own oral care. People in hospital may be nil by mouth and/ or suffer with dehydration and dry mouth. They may be particularly susceptible to oral ulceration and infections due to their systemic condition. Those adults on 'End of life' care should have oral care on a more regular basis depending on their need. An oral assessment will enable a suitable care plan to be devised for these adults in hospital enabling them to maintain oral comfort and nutrition, where possible. Those adults in ICU should also have more regular mouth care.
234	The Faculty of General Dental Practice	Question 6	***For draft quality statement 4: Is there a particular group of people in hospitals for whom quality improvement is most needed in this area?*** We would suggest that NICE might consider a recommendation surrounding ensuring all care personnel receive a basic course in oral hygiene practices to help support individuals, irrespective of the premises through which they provide care. There would appear to be a number of barriers to general care providers helping support and maintain individuals' oral hygiene, in which basic knowledge and methods are missing.
235	Healthwatch Birmingham	Question 6	**For draft quality statement 4: Is there a particular group of people in hospitals for whom quality improvement is most needed in this area?** The elderly/Older patients with complex medical issue, People with mental health issues, Dementia, learning disability, Patients with complex health needs and at higher risk of infection. Critical care patients. End of life patients
236	HEE – East Midlands	Question 6	Question 6: The most critical patient groups in hospital would be :- Head injuries, Stroke/ CVA and those on a respirator, Parkinsons, Hutchinsons, Motor neurones, MD, Long term bed ridden elderly, Long term infirmed cancer patients. **Literature search related to oral care in hospital.** 1.Clinical Guidelines: Guidelines for the development of local standards of oral care dependent, dysphagic critically and terminally patients www.bsdh.org.uk/guidelines/oncolradio 2.Ransier A, Epstein JB, Lunn RA, Spinelli J. A combined analysis of a toothbrush, foam brush, and a chlorhexidine-soaked foam brush in maintaining oral hygiene. Cancer Nursing 1995;18(5):393–6 3. Mouth Care in Palliative Care : www.nhslothian.scot.nhs.uk/ourservices/palliative 4. 1000 lives - improving mouth care in adult patients|www.1000livesplus.wales.nhs.uk
	Additional areas		
237	Public Health England	Additional area	The standard should have a statement about all care home staff needing to have appropriate training to carry out an oral health assessment and that this should be refreshed at appropriate time periods.

ID	Stakeholder	Statement number	Comments[1]
238	British Dental association	Additional area	A quality standard focusing on toothbrushing with fluoride toothpaste and denture care twice a day would help to improve the oral health of children, young people and adults in hospital. *See: Needleman et al, 2011, 'The impact of hospitalization on oral health: a systemic review', Journal of Clinical Periodontology; Needleman et al, 2012, 'The impact of hospitalization on dental plaque accumulation: an observational study', Journal of Clinical Periodontology; Poisson et al, 2014, 'Relationships between oral health, dysphagia and undernutrition in hospitalised elderly patients', Gerodontology; Sousa, 2014, 'Oral health of patients under short hospitalization period: observational study', Journal of Clinical Periodontology
239	Health Education England (working across London and the South East)	Additional area	A further quality statement should be included to ask care homes to include oral health in their food, drink and nutrition policies. Care homes now routinely assess weight and the nutritional needs of their residents. For those that have lost weight increased calorie intake is encouraged by promoting a "little and often" approach to higher fat/ sugar foods and drinks. A system to review the mouth care plan in light of this increased risk to oral health should be put in place. The current assessment tool suggested as part of the NICE guidance should reflect this. Care homes should make more healthy food and drink choices available to residents.
240	Real Life Options	General	We welcome this quality standard and feel that, on the whole, it accurately reflects the key areas for quality improvement. The oral health of people with learning disabilities has often not been seen as a priority and we believe they are a key group of people where this quality standard could be vital. We are concerned, however, that whilst the need to check that a person is registered with a dentist and when they last saw a dentist is stated in standard 1, this is not followed through with a requirement that a person is supported to have ongoing regular check-ups with a dentist and necessary treatment. We would see this as essential for the people we support.
	Responses to Q5		
241	County Durham & Darlington NHS Foundation Trust, Community Dental Service	Question 5	Question 5 The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes? Answer: No I don't believe so. The arrangement is usually shared locally between general dental practices and community dental services. It may be worthwhile scoping the possibility to explore the option for local dental practices to adopt a buddying scheme with their local care homes in their localities?
242	Advance Healthcare Logistics Ltd	Question 5	Commission more NHS domiciliary dental services and work in partnership with private domiciliary dental services. It is often impractical to get residents out to a dentist for all sorts of reasons – dementia/mobility issues/transport/staffing.

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243	British Dental Association	Question 5	Access to dental services for adults in care homes could be improved by NHS England ensuring these services are commissioned. A quality standard could be developed with a numerator of the number of local areas where dental services are commissioned for adults in care homes and a denominator of the number of local areas. Use of the NICE recall guidelines would ensure that where patients (as recorded in their mouth care assessment) were in excess of their recommended recall, an appointment would be arranged for them with a dentist. The number of patients and their recall period is a specific measurement. Commissioning should reflect that, as stated by Public Health England, approximately half of care home residents would find it difficult or impossible to receive emergency treatment in a general dental practice and that the treatment required by older people is increasingly complex and is more likely to involve dental surgery. At the stakeholder engagement stage, we proposed that 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. Appropriate transport to support residents in accessing clinic care is something which also needs to be in place to support the delivery of this care.
244	British Society of Gerodontology	Question 5	Variable access to dental care for care homes: This must include what proportion of the local dental services have accessible premises, parking and toilets. What are the local arrangements for domiciliary dental care? Is there a local care pathway for domiciliary care that ensures that referrals are valid? What is access to NHS or private dental care locally? What are the waiting times for accessing routine dental care? Do local Community Dental Services accept referrals for people in care homes? Is there access to Special Care Dentistry? What are the local arrangements for people who require urgent dental care – does this include domiciliary dental care? Residents should be encouraged to continue to access their local dental team as far a possible. More Commissioning of domiciliary-based care for CDS & GDPs with enhanced skills. Commissioning should take into account the need for enhanced UDA payments or sectional payments and any other system to encourage dentists to provide for this population of patients. Improved patient transport services for those needing to travel to surgeries/clinics would also improve access to dental services for those without transport and with physical disabilities. There is very little in the NG48 about the role of the Dental Care Professional who in the future will be pivotal in supporting care home residents in oral health prevention and dental care rather than a dentist A problem may arise when an oral health assessment for an individual resident identifies an oral problem and the carer requests an examination by a dentist. This will incur a fee if the resident is not exempt from charges and this may discourage the individual, their family or carers from agreeing to necessary examination and treatment. Free oral examination and checkups for care home residents would be an action that will improve access to dental services for adults in care homes

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245	RCGP	Question 5	"Question 5: The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes?" Directly incentivising access for clients in care homes to dental services via commissioning or via a LES would improve access for clients. Alternatively such a service could be commissioned from a community dental service
246	The Faculty of Dental Surgery, The Royal College of Surgeons of Edinburgh	Question 5	In order to improve access, the number of dentists offering and trained in the provision of domiciliary care will need to be increased. This is also the case for the provision of domiciliary dental equipment.
247	Royal College of Surgeons of England	Question 5	All people in care homes to have a named dentist. This dentist must be able to offer a review (as appropriate to the person's need) within the clinic/practice preferably local to the care home with accessible surgeries OR a domiciliary visit if the person cannot travel. If a domiciliary visit is necessary, a minimum level of equipment/resources must be available and access to specific specialist care if required (see BSDH/BSG Domiciliary Guidelines). This may be a problem in areas of high care home population where there is insufficient provision of NHS surgeries, domiciliary services and specialist care. Commissioning should take into account the need for enhanced UDA payments or sessional payments and any other system to encourage dentists to provide for this population of patients. Improved patient transport services for those needing to travel to surgeries/clinics would also improve access to dental services for those without transport and with physical disabilities. A problem may arise when an oral health assessment for an individual resident identifies an oral problem and the carer requests an examination by a dentist. This will incur a fee if the resident is not exempt from charges and this may discourage the individual, their family or carers from agreeing to necessary examination and treatment. **Free oral examination and check-ups/reviews for care home residents** would be an action that will improve access to dental services for adults in care homes. All Care Homes have been put together into one category which is not ideal. Provision of care and type of care may vary between for example a home where there are younger people with brain injury, to those in a nursing home where there are older people with dysphagia and dementia.
248	HEE – East Midlands	Question 5	Question 5: Measurable action to improve access? Indeed yes, contracting DCP groups and creating a contract/ pathway for them to do so. Accurate auditing and triaging of need could then take place and education of care home staff. This could produce measurable results quickly. A prudent healthcare model.
249	British Association of Dental Nurses	Question 5	A named GDP and Oral Health Team assigned to each care home/hospital. This could be provided by dental nurses with extra training, as previously in epidemiology.

ID	Stakeholder	Statement number	Comments[1]
250	Health Education England (working across London and the South East)	Question 5	Regular training for the dental team is needed, starting at undergraduate or pre-qualification level, to equip the workforce with the knowledge and skills required to provide effective dental care for care home residents both in dental practice and the care home setting. Often dentists, dental care professionals and dental nurses do not feel as if they have the appropriate training to manage complex cases or offer domiciliary services. HEE has a responsibility for workforce education and training of staff to enable them to provide safe, effective, caring, responsive treatment for their older patients in line with CQC standards: Improving professional awareness and understanding of treating older people, particularly those with dementia. Enabling a higher quality of care by an informed and effective workforce. Assisting the development of user friendly care environments for older people with additional needs. Promoting pragmatic, longer term care planning with a robust evidence base and prevention as a fundamental principle.
251	Health Education England (working across London and the South East)	Question 5	Appropriate remuneration for treating care home patients in general practice should be sought and the provision of this treatment is reliant on additional funding being made available. Money could be clawed back from an annual underspend in certain areas to fund pilot projects to explore different funding options. In the long term, permanent funding routes should be found and in order to minimise costs care could be provided using a different skill mix of dental personnel. It would be hoped that the continued review of the dental contract in the current pilot schemes will give information regarding the best formula for remunerating dental care for older people in care homes e.g. Capitation weighted for higher needs patients The British Dental Association 'case-mix model' is a tool allowing objective assessment of the complexity of care provision for people with disability, often used in community dental services. It could also be used for commissioning and planning services and their provision in general dental practice as a measure for appropriate remuneration reflecting levels of case complexity. Under the existing dental contract this could help to define the level for an increased UDA value associated with treating patients in care homes. The important factor will be that this will allow continuity of care for the resident for as long as possible in order to delay referral to more specialised (and more expensive) care. Patients that can still travel to the surgery can still be treated in general practice if appropriate; however an increasing problem is releasing care staff from the home to accompany a resident. Even if this is possible there is a growing trend for care homes to charge the individual a supplement to recuperate the costs incurred. The British Society for Disability and Oral Health states, "Domiciliary care should be a routine option, not a last resort, for patients whose circumstances make it impossible, unreasonable or otherwise impractical to receive that care at a fixed centre." Community dental services are receiving an increasing number of requests to provide care for residents in care homes and domiciliary visits. This is expensive and often results in only palliative care. With additional funding dental practices could support patients and the care staff looking after these patients on a regular basis. It is also hoped that a new grade of worker for dental practice, an Oral Health Practitioner- who could assist care homes and those requiring some domiciliary preventive care could assist with this.

ID	Stakeholder	Statement number	Comments[1]
252	Health Education England (working across London and the South East)	Question 5	The full skill mix of the extended dental team should be utilised to provide effective dental care and minimise costs.
253	Health Education England (working across London and the South East)	Question 5	There is a requirement for training more gerodontists and developing specialised services to work alongside dentists in primary care. This should include providing GDPs with additional skills in the treatment of older vulnerable adults and those with co-morbidities. Joint clinics could be run from general dental practices where under a specialist's guidance a dentist could carry out the treatment plan, but receiving help and advice when needed for more complex cases. By supporting general dental practitioners to look after care home patients for as long as possible within familiar practice surroundings, patient waiting times and overall costs are likely to be minimised, as secondary care will be provided only when the person is no longer able to be seen in general practice.
254	National Older People's Oral Health Improvement Group (Scotland)	Question 5	Additional training for General Dental Practitioner (GDP) services to increase number of GDP services willing to support care homes. Also, recording of data as to number of residents registered and seen by a GDP in previous 12 months
255	National Older People's Oral Health Improvement Group (Scotland)	Question 5	Ideally, an increase in the special care dentistry specialty workforce. Encourage dental teams to attend postgraduate training with regards to older people's dental care and dementia awareness, to encourage and increase domiciliary attendance
256	National Older People's Oral Health Improvement Group (Scotland)	Question 5	Dental professional recording practices within the care home of their visits should be encouraged this would identify residents who have not had dental attendance to be easily identified
257	National Older People's Oral Health Improvement Group (Scotland)	Question 5	Look at patient transport options to aid accessibility to dental practice. Steps to increase domiciliary care provision for residents who are unable to travel to dental surgeries.
258	Real Life Options	Question 5	We believe people in care homes should have a minimum twice yearly check at the dentist.
259	Association of Directors of Public Health	Question 5	Variability in access to dental services. A specific measurable action is that all clients have a named dental practitioner and that they have seen this practitioner within the last 12 months/ 24 months.

ID	Stakeholder	Statement number	Comments[1]
260	Healthwatch Birmingham	Question 5	**The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes?** Ensure that oral health policies, procedures and care plans are developed using service user insight, experience and involvement to ensure that they are shaped by the needs of residents. This would ensure ownership by residents of the plans and lead to better outcomes for residents. Homes should have written down policies, procedures and referral policies for oral health: these should have specific and measurable objectives such as registering with a dentist, name of and contacts for dentist stated in care plan, visiting a dentist twice a year, and procedures for recording dentist appointments (with clear indications on when the last appointment was and when another is due) etc. Include dental access arrangements in the home. Periodic reviews of dental policies and activities in the home i.e. annually. Periodic training or refresher courses for staff in oral health would ensure continuity considering the high turnover of staff in the care industry.
261	Public Health England	Question 5	**Q5.The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes?** If all care home residents had to see a dentist within set period of time after admission e.g. within a couple of months (sooner if having problems) of admission. This would be easier to measure and would help any potential oral health problems to be picked up sooner. If there was a named dentist for each care home this would also help improve access. An example of a scheme that has named dentist for care homes is the Residential Oral Care Sheffield (ROCS) scheme in Sheffield. Asking a resident on admission whether or not they have a dentist is helpful. Where the care home resident is no longer able to travel to a dental practice, the care home should then check with the dental practice whether or not they would be able to provide domiciliary care for the patient. Where a patient requires domiciliary care and a dental practice is unable to provide such care, the care home staff should know how to access dental care for that patient. All care home staff should know how to access local routine and urgent care for those patients who can travel to a dental practice and for those who require domiciliary dental care.
262	The Faculty of General Dental Practice	Question 5	***The committee identified variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes?*** The major problem that needs to be overcome lies with the current NHS General Dental Services contract. Under the current arrangements, even if resources were appropriate for the general population, the additional requirements to support this particular section of society, and the manner in which contract performance is judged by commissioning teams, mean that dental personnel are unlikely to engage with this group to the required level. We would strongly urge NICE to note this failing.

ID	Stakeholder	Statement number	Comments[1]
	No comments		
263	Department of Health	Other	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.
264	NHS England	Other	Thank you for the opportunity to comment on the above Quality Standard. We can confirm that there are no comments to be made on behalf of NHS England.
265	Royal College of Paediatrics and Child Health	Other	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Oral health in care homes and hospitals draft quality standard. Unfortunately, on this occasion we have not received any responses for this consultation.

Registered stakeholders who submitted comments at consultation

- British Society of Dental Hygiene and Therapy
- Advance Healthcare Logistics Ltd
- Association of Directors of Public Health
- British Association of Dental Nurses
- British Dental Association
- British Society of Gerodontology
- Central Manchester NHS Foundation Trust
- College of Mental Health Pharmacy (CMHP)
- County Durham & Darlington NHS Foundation Trust, Community Dental Service
- Dental Faculty of the Royal College of Physicians and Surgeons of Glasgow
- Department of Health
- EPA UK

- The Faculty of Dental Surgery, The Royal College of Surgeons of Edinburgh
- The Faculty of General Dental Practice
- Health Education England (East Midlands)
- Health Education England (London and the South East)
- Healthwatch
- Healthwatch Birmingham
- National Older People's Oral Health Improvement Group (Scotland)
- NHS England
- Public Health Department, Wiltshire Council
- Public Health England
- Royal College of General Practitioners (RCGP)
- Real Life Options
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Surgeons of England
- Skills for Care
- Southern Health NHS Foundation Trust