NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC HEALTH GUIDELINE

DRAFT SCOPE

1 Guideline title

Oral health: approaches for dental health practitioners on promoting oral health, including how to make a visit to the dentist a positive experience

1.1 Short title

Oral health promotion approaches for dental health practitioners

2 Background

a) The National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health (DH) to develop a public health guideline for dental health practitioners on effective approaches to promoting positive oral health behaviour. This includes how to make a visit to the dentist a positive experience.

b) This guideline will support a number of related policy documents including:

- 'Delivering better oral health: an evidence-based toolkit for prevention' (DH and British Association for the Study of Community Dentistry 2009)
- 'Dental quality and outcomes framework' (DH 2011)
- 'Equity and excellence: liberating the NHS' (DH 2010)
- 'Essential standards of quality and safety: Guidance about compliance' (Care Quality Commission 2010)[1]
- 'Healthy lives, healthy people: our strategy for public health in England' (DH 2010)
- 'Improving oral health and dental outcomes: developing the dental public health workforce in England' (DH 2010)

[1] Outcome 1 – Respecting and involving people who use services.

- ‘NHS dental contract: proposal for pilots December 2010’ (DH 2010)
- ‘The NHS outcomes framework’ (DH 2010) [2]
- ‘The operating framework for the NHS in England 2011/12’ (DH 2010)

c) This guideline will provide recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness. It is aimed at dental health practitioners and their teams including dentists, dental hygienists, dental nurses, managers and administrative staff. It may also be of interest to members of the public.

d) The DH has also asked NICE to produce 2 additional NICE public health guidelines on oral health:

- Guidance for local authorities on oral health needs assessments and community oral health promotion programmes.
- Guidance for carers working in health and social residential care settings (including nursing homes, residential care homes).

The guideline will complement NICE guidance on dental recall. For further details, see section 6.

This guideline will be developed using the process and methods described in Methods for development of NICE public health guidance (2012) and The NICE public health guidance development process (2012).

3 The need for guidance

a) Oral health is important to health and wellbeing. Poor oral health can affect people’s ability to eat, speak and socialise normally (DH 2011).Tooth decay (dental caries) and gum disease

[2] Domain 4 – Ensuring that people have a positive experience of care.

(periodontal disease) are the most common dental problems in the UK. They can be painful, expensive to treat and can seriously damage health if left unchecked (DH 2011). However, they are largely preventable (Levine and Stillman-Lowe 2009).

b) Overall, oral health in England has improved significantly over recent decades, although oral cancer rates have been steadily increasing in the UK since 1989 (Cancer Research UK 2010). The 'Adult dental health survey 2009' (Health and Social Care Information Centre 2011) reports that the proportion of adults in England without natural teeth has dropped from 28% to 6% in the past 30 years. In 2003, 47% of children aged 12 and 49% of young people aged 15, had fillings. This compares with 60% and 63% respectively in 1993 (Health and Social Care Information Centre 2005). However, wide variations in oral health exist across England, with the prevalence of tooth decay among children aged 5 years ranging from 12.5% in Brighton and Hove to 53.2% in Leicester (Public Health England 2013).

c) Risk factors for poor oral health include: diet (for example high sugar consumption), tobacco (including smokeless tobacco), alcohol consumption, trauma and stress (Watt and Sheiham 2012). Factors associated with severe tooth decay include: living in a deprived area; being from a lower socioeconomic group or living with a family in receipt of income support; belonging to a family of Asian origin; living with a Muslim family in which the mother speaks little English (Rayner et al. 2003); or having a chronic medical condition (DH 2007). The relationship between ethnicity and oral health is complex. However, children of Pakistani or Bangladeshi origin generally have higher than average levels of tooth decay in their first teeth, even after adjusting for socioeconomic status. In adults, more gum disease (gingivitis) is generally found among Asians than black or white adults (Marshman 2013).

d) In 2009, 76% of people reported attending the dentist in the past 2 years – of these, 61% attended regular check-ups, 10% went occasionally and 27% only when they had problems with their teeth. (Adult Dental Health Survey, Health and Social Care Information Centre 2011). The proportion of children going to the dentist before the age of 5 years is associated with their mother's reported attendance pattern. In 2003, nearly all (92%) of children aged 5 whose mothers were regular attenders had visited the dentist before the age of 5. This compared with around half (55%) of those whose mothers only attended when they had problems (Health and Social Care Information Centre 2005).

e) According to the Adult Dental Health Survey 2009 (Health and Social Care Information Centre 2011), 91% of those surveyed felt that the dentist they saw most recently listened carefully to them; 89% felt they were given enough time to discuss their oral health and were involved in decisions about their care or treatment; and 94% received answers they could understand. However, 20% were not satisfied with the dentist. Those with a poor relationship with the dentist tend to rate their own oral health lower, leave longer intervals in between visits to the dentist and are more likely to be extremely anxious about visiting a dentist.

f) Although 22% of all adults reported being smokers, only 9% of smokers said they had been advised to stop by a dentist. Similarly, although 50% of adults with natural teeth in England are classified as having a high sugar intake, 64% of adults did not recall being asked about their diet by the dentist. Overall 78% of adults recalled being given advice at the dentist on cleaning their teeth or gums (Health and Social Care Information Centre, 2011).

g) Seventy-five percent of adults with natural teeth in England report that they brush their teeth at least twice a day, with 76% using high or medium strength fluoride toothpaste. Women, people from a managerial and professional occupation household, and those who have regular dental check-ups, were more likely to brush twice a day. Older adults were less likely to use fluoride toothpaste. People who regularly go to the dentist were more likely to other oral hygiene products as well (such as mouthwash, dental floss and interspace brushes).

4 The guideline

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

4.1 Who is the focus?

4.1.1 Groups that will be covered

Adults and children.

4.1.2 Groups that will not be covered

Adults and children who do not visit the dentist.

4.2 Approaches

4.2.1 Approaches that will be covered

The guideline will focus on how dental teams can convey the oral health promotion messages set out in Delivering better oral health: an evidence-based toolkit for prevention (DH and British Association for the Study of Community Dentistry, 2009)[3]. It will also consider how to make a visit to the

[3] This contains advice on positive oral health behaviours including: oral hygiene practices (for example, tooth brushing and the use mouth rinses); using the appropriate concentration and amount of fluoridated toothpaste; maintaining good dietary practices (including reducing the amount and frequency of sugary food and drinks); not smoking or using smokeless tobacco; and keeping to guidelines on alcohol intake). The 3rd edition of Delivering better oral health: an evidence-based toolkit for prevention is expected before publication of this guidance.

dentist a positive experience. It will include the following approaches and activities:

a) Verbal information (planned or as the opportunity arises) for example, brief or very brief advice, giving information on useful resources and motivational interviewing (helping motivate people to change their behaviour)

b) Practical demonstrations, for example, of how to remove dental plaque and how to brush teeth properly.

c) Leaflets, posters and other printed information. This includes different presentations (for example, visual and numeric formats) and different writing styles (for example, personal accounts and scientific facts).

d) New media, including websites and social media, email and text messaging.

The Committee will take reasonable steps to identify ineffective approaches.

4.2.2 Areas that will not be covered

a) The evidence base underpinning positive oral health behaviours (to prevent tooth decay, gum disease and oral cancers). This is already covered in guidance provided by the DH and British Association for the Study of Community Dentistry and cited above (in 4.2.1).

b) Clinical dental treatment.

c) Approaches to tackling clinical diagnoses of dental anxiety and phobia (as listed as one of the specific phobias in the Diagnostic and Statistical Manual of Mental Disorders [DSM-V]).

d) Oral health needs assessments.

e) Community-based oral health promotion programmes and interventions.

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

4.3 Key questions and outcomes

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

Question 1: What are the most effective and cost-effective approaches that dental health practitioners and their teams can use to convey oral health promotion messages?

Question 2: Are oral health promotion messages more likely to have an impact if they are linked with wider health outcomes, such as heart and lung disease or diabetes?

Question 3: What helps dental health teams to deliver oral health promotion messages?

Question 4: What can help people to understand and act on oral health promotion messages?

Question 5: How can a visit to the dentist be made into a more positive experience?

Expected outcomes:

- Changes in dental health practitioners' knowledge, ability, intentions and practice in relation to oral health promotion.
- Changes in people's experience of visiting the dentist.
- Changes in people's knowledge and ability to improve and protect their oral health.
- Changes in people's oral health behaviours.
- Changes in the oral health of people attending dentists. For example, changes in the incidence and prevalence of oral cancers, tooth decay, gum disease and dental trauma.

- Changes in quality of life, including social and emotional wellbeing.

4.4 Status of this document

This is the draft scope, released for consultation from 18 March until 15 April 2014. Following consultation, the final version of the scope will be available on the NICE website from June 2014.

5 Related NICE guidance

Published

- Behaviour change: individual approaches. NICE public health guidance 49 (2014)
- Patient experience in adult NHS services. NICE clinical guideline 138 (2012)
- Smokeless tobacco cessation –South Asian communities. NICE public health guidance 39 (2012)
- Maternal and child nutrition. NICE public health guidance 11 (2008).
- Behaviour change: the principles for effective interventions. NICE public health guidance 6 (2007).
- Dental recall. NICE clinical guideline 19 (2004)

Under development

- Oral health: local authority oral health improvement strategies. Publication expected October 2014
- Oral health in nursing and residential care. Publication expected May 2015.

Appendix A Referral from the Department of Health

The Department of Health asked NICE to develop:

‘Guidance for dental health practitioners on effective approaches to promoting positive oral health behaviour, including a positive patient experience of attendance at the dentist.’

Appendix B Potential considerations

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

- Target audience, actions taken to promote oral health and improve the patient's experience of the dentist, by whom, context, frequency and duration.
- Whether activities or approaches are based on an underlying theory or conceptual model.
- Whether activities or approaches are effective and cost effective.
- Critical elements. For example, whether effectiveness and cost effectiveness varies according to:
  - the diversity of the population (for example, in terms of age, gender, ethnicity, religion, education level, fluency in English, physical or mental disabilities)
  - the status of the person delivering an activity and the way it is delivered
  - the frequency, length and duration of an activity, the medium through which it takes place, where it takes place and whether it is transferable to other settings
  - intensity of an activity.
- Any trade-offs between equity and efficiency.
- Any factors that prevent – or support – effective implementation.
- Any adverse or unintended effects.
- Current practice.
- Availability and accessibility for different groups.

Appendix C References

Cancer Research UK (2010) Oral cancer – UK incidence statistics [online: accessed 28 February 2014]

Department of Health (2011) Dental quality and outcomes framework. London: Department of Health

Department of Health and British Association for the Study of Community Dentistry (2009) Delivering better oral health: an evidence-based toolkit for prevention. London: Department of Health

Department of Health (2007) Valuing people's oral health: A good practice guide for improving the oral health of disabled children and adults. London: Department of Health

Health and Social Care Information Centre (2011) Adult dental health survey 2009. Leeds: Health and Social Care Information Centre

Health and Social Care Information Centre (2005) Child dental health survey 2003. Leeds: Health and Social Care Information Centre

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

Marshman Z (2013) Oral health and access to dental services for people from black and minority ethnic groups. London: Race Equality Foundation

Public Health England (2013) National Dental Epidemiology Programme for England, oral health survey of 5 year old children 2012. London: Public Health England

Rayner J, Holt R, Blinkhorn F et al. (2003) British Society of Paediatric Dentistry: A policy document on oral health care in preschool children. International Journal of Paediatric Dentistry 13: 279–85

Watt RG, Sheiham A (2012) Integrating the common risk factor approach into a social determinants framework. Community Dentistry and Oral Epidemiology 40: 289–96