BASCD

NHS Dental Epidemiology Programme
Oral Health Survey
of three-year-old children,
2012/2013

National protocol

Version 3 complete

This protocol has been produced for the 2012/13 school year NHS Dental Epidemiology Programme (NHS DEP) Oral Health Survey of three-year-olds. It aligns with the British Association for the Study of Community Dentistry (BASCD) diagnostic criteria for caries prevalence surveys and guidance on sampling for surveys of child dental health (1997).

Published: 19th October 2012

Contents

1. Introduction

The responsibility of primary care trusts (PCTs) to gather information on the health needs of the local population will be transferred to local authorities (LAs) following the White Paper, *Equity and excellence; Liberating the NHS* (DH, 2010). This imperative is described in the Health and Social Care (Community Health and Standards) Act 2003, underpinned by Statutory Instrument 2006 number 185, and is also highlighted in *Choosing Health: Making healthy choices easier* (DH, 2004) and *Choosing Better Oral Health* (DH, 2005).

The Strategic Health Authority (SHA) Dental Public Health Leads Network agreed that during the academic year 2012/13 the population group for scrutiny would be three-year-olds. This follows a feasibility survey in the North West SHA, and similar surveys in Tower Hamlets and Scotland.

These surveys will improve knowledge about caries progression in pre-school years and inform planners about the timing and impact of interventions to meet the targets linked to the oral health of five-year-olds as listed in the Public Health Outcomes Framework *Healthy lives, healthy people: Improving outcomes and supporting transparency* (DH, 2012).

2. Aim of the Survey

The aim of the survey is to measure the prevalence and severity of dental caries in three-year-old children attending child care institutions in each Local Authority to provide a baseline for comparison in subsequent years and, for some areas, establish a cohort for follow-up.

3. Objectives

To identify sites where child care is provided for pre-school children, gain consent and examine three-year-old children using caries diagnostic criteria and examination techniques based on those agreed by the British Association for the Study of Community Dentistry (BASCD), *Diagnostic criteria for caries prevalence surveys 1996/97* (Pitts *et al*., 1997) and using BASCD recommended sampling procedures described in *British Association for the Study of Community Dentistry (BASCD) guidance on sampling for surveys of child dental health. A BASCD co-ordinated dental epidemiology programme quality standard* (Pine *et al*.,1997a).

4. Preparatory communication with relevant work partners

Many child care sites will be unfamiliar with dental surveys or community dental services. This may lead to uncertainty about the sharing of data or co-operating with requests from the NHS Dental Epidemiology Programme (NHS DEP) fieldwork teams. It is therefore essential that colleagues within the LA are approached to seek their support for the survey. If Directors of Public Health (DsPH), Directors of Education and Directors of Children's Services are aware of the purpose and nature of the surveys, and can see the benefit of them, they can be supportive and ensure their colleagues feel confident to take part. A letter from the Chief Dental Officer communicating the support of the Department of Health will be sent to Regional Directors of Public Health for forwarding to LA Directors of Public Health (Appendix Bi). Local Authority DsPH will be asked to convey their support to colleagues in Children's Services Departments and Departments of Education.

Consultants in Dental Public Health (CsDPH) or, in the absence of these, Clinical Directors, leads for dental epidemiology or other suitable person will be required to contact the DsPH, or person acting in that capacity, for each LA. Prior to this they will need to become familiar with the situation for each LA with regard to Departments of Children's Services. The purpose of this contact is to discuss, ideally face to face, the purpose of the 2012/13 NHS DEP survey of three-year-olds and why it is important to LAs.

Once DsPH agree to support the surveys they can be asked to take practical steps which would be to:

- Write a letter or otherwise indicate their support for the survey to relevant partners e.g. Directors of Children's Services, Director of Education;
- Clarify the data sharing agreements that already exist between the Local Authority and NHS partner organisations which allow child care sites to share details of the children in their care;
- Identify who would be able to provide a list of child care providers known to the LA.

If Directors of Children's Services and Directors of Education are also encouraged by the DsPH or CsDPH or similar, to indicate their support this will help to reassure managers of child care sites and nursery department managers. Ideally a letter should be written to advise each site that this survey is going ahead and showing the support of the Director of Education, Directors of Children's Services and the DsPH.

5. Sample

The sampling unit will be LA boundaries; including lower tier where they exist and London Boroughs. In the majority of cases the LA boundaries, their Children's Services Department and those of the PCT will be coterminous. In other cases, where the PCT and LA are not co-terminous, careful consideration of the geographic boundaries and populations within them should be undertaken to ensure that sampling produces the necessary estimates for LAs.

Where it is not sensible for estimates to be provided for all lower tier LAs there should be discussion between the Regional Dental Public Health lead, relevant CsDPH and the BASCD statistical advisor to agree a reasonable sampling method to allow for PCT estimates and local planning.

The default should be to provide a minimum sample of 200 children examined per LA and per PCT.

5.1 Survey population

The survey population is defined as all those children attending child care sites who have reached the age of three, but have not had their fourth birthday on the date of examination and who attend that site for at least three hours per week.

Details of how to classify and code child care sites are shown in Figure 1. Child care sites will include:

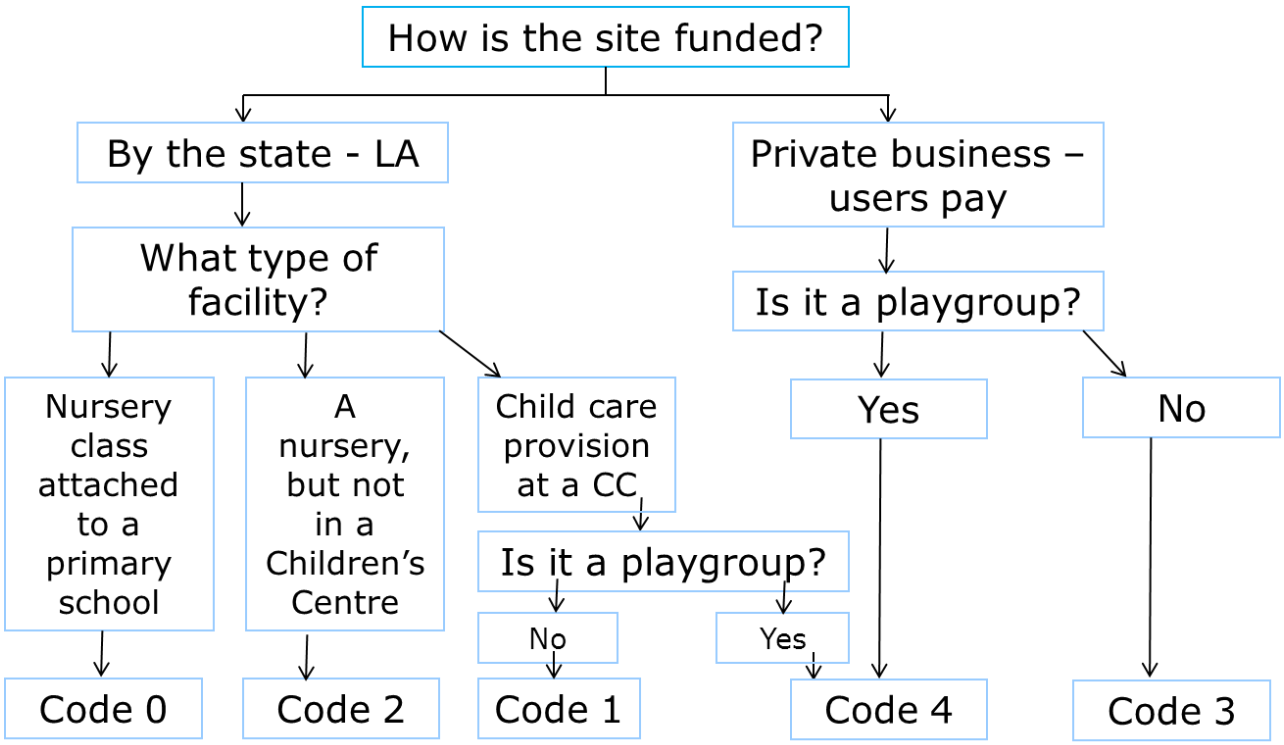
- LA funded nursery classes attached to primary schools;
- LA funded Children's Centre child care facilities for leaving children on a regular basis (not such things as Stay and Play sessions or occasional crèche sessions);
- LA funded nurseries and nursery schools not in Children's Centres;
- private nurseries and nursery schools regardless of site; and
- playgroups regardless of funding or site.

Sites designed exclusively for children with special needs will not be included.

A minimum sample size of 200 examined children is required per LA and per PCT, from a minimum of 20 child care sites. This is unlikely to produce a sufficiently large sample to facilitate local service planning, in which case larger samples will be required. If disproportionately larger samples are drawn from particular sub groups the children selected must be coded to indicate this and allow weighted estimates of LA means to be produced. Details of these requirements and the need for local stratification will be determined by CsDPH or other advisers in Dental Public Health to PCTs, in liaison with Dental Managers/Directors of the agencies undertaking the surveys.

NHS DEP Regional Coordinators must be informed of proposed sampling methods so that they can confirm their validity, before the survey commences.

Figure 1: Classifying and coding child care sites



5.2 Sampling procedure

A sampling procedure which stratifies for type of child care site will be used. This is similar to the method used for surveys of five-year-old children. Detailed guidance on a stratified sampling procedure is given in *British Association for the Study of Community Dentistry (BASCD) guidance on sampling for surveys of child dental health. A BASCD co-ordinated dental epidemiology programme quality standard* (Pine *et al*., 1997a). Advice can be requested from Regional Coordinators, The Dental Observatory and further advice may be sought from Girvan Burnside (email: g.burnside@liv.ac.uk).

Lists of all child care institutions in the particular geography known to the LA Children's Services Department, and the numbers of children attending each, will be required as the first stage in the sampling process. These institutions will include nursery classes attached to schools, Children's Centres, independent and LA controlled nurseries and playgroups.

Sites for children with special needs should not be included in the main sampling frame and their results should not be included in the main LA estimates.

In LA areas where there are more than 20 child care sites for the local child population a sampling procedure will be required which takes the distribution of three-year-olds in child care facilities into account. The aim will be to attend sufficient sampled sites and examine all consented willing children until a sample of at least 200 children has been seen, in the proportions calculated.

In some situations it may not be possible for LAs to provide lists of numbers of children at child care sites. In these cases the team should use the numbers of each type of child care type to work out the proportional distribution of child care type in their patch. This method assumes that each child care site has the same number of children attending it, which we know is not accurate but using the number of sites is a reasonable proxy on which to base the estimates of proportional distribution for sampling purposes.

5.3 Calculation of a representative sample

A table should be constructed that shows the distribution of children throughout the various types of child care institutions (Table 1). This information will have been sourced from the LA Department of Children's Services and allows the required proportional sample to be calculated. Simply add together the number of children attending each type of child care institution.

The second stage is to list all child care sites, grouped by type, and give each a unique number ready for random sampling. It is probably easiest to produce enough random numbers to give one for every site, then record the order in which they were sampled.

Each site should then be approached in turn until sufficient children for each group have been examined.

For example, in the fictitious PCT shown in Tables 1 and 2 the fieldwork team may need to go to the first six or seven nursery classes attached to schools that were randomly sampled to examine a target figure of 70 children, allowing for the positive consent issue. If the first seven sites do not yield enough children the team should go onto the eighth site sampled. There may only be a need to visit one playgroup to see the requisite eight children but, in the interests of world peace, the fieldwork team would be advised to examine all consented and willing three-year-olds at each sampled site.

Example of sampling method required:

Table 1: Distribution of three-year-old children at child care facilities in PCT X (estimated number in total population 3,246)

Child care type	A Numbers of places regardless of age	B Proportion of child population	C Calculation if only a minimum sample of 200 is to be seen	D Target number of children to see from each type of institution
Nursery classes attached to school	1,034	35%	200 x 0.35 = 70	70
Children's centres, child care	443	15%	200 x 0.15 = 30	30
Independent/ Private nurseries	1,241	42%	200 x 0.42 = 84	84
LA managed nurseries	118	4%	200 x 0.04 = 8	8
Playgroups	118	4%	200 x 0.04 = 8	8
Total	2,954	100% (91% of whole population)		200

Table 2: Sampling of child care institutions to sample target numbers to be seen

Name of institution	Allocated number	Order randomly sampled within each group	Target of children to see / number examined
Nursery classes attached to school			70
St Swithin's	1	12th	
Brook Road	2	1st	
High Green	3	6th	
St Mary's	4	2nd	
Broad Oak	5	3rd	
Rowley Street	6	8th	
……	and so on		
Children's centres, child care			30
Lowtown C Centre	55	5th	
Northern C Centre	56	12th	
Station Rd CC	57	1st	
…..	and so on		
Independent nurseries			84
Busy Bees	73	4th	
Kids Allowed	74	2nd	
Little Angels	75	1st	
……	and so on		

This is a suggested process for a sampling technique which can be applied to a minimum or a larger simple sample. Discussion is required between commissioners, Dental Public Health Advisers and the fieldwork team via their manager to decide for each LA what they wish to gain from this baseline survey and, therefore, the most appropriate sampling methods. Some areas may choose to undertake census surveys (noting the limitation of positive consent), others may choose to take enhanced samples to permit comparison between groups and implement weighted means to cater for this.

As some children may attend more than one site it is possible that they will be sampled twice. The consent letter allows for parents to report this. No child should be examined twice but if this inadvertently happens, and is realised, then the later examination data should be deleted during the data cleaning process.

The completed tables and explanations of the methodology should be sent to Regional coordinators for agreement before any child care sites are contacted.

6. Consent

Positive consent is required following the guidance from the Department of Health (Appendix E).

It is likely that consent will not be provided for some children, but the sampling method allows for substitution of volunteers until sufficient numbers have been examined.

It is recognised that as the proportion of positive consenters reduces, the representativeness of the sample also reduces.

The procedure for obtaining positive consent must involve:

- giving parents an invitation letter which gives clear information explaining the nature and purpose of dental surveys in broad terms and simple language (example given in Appendix K);

- provision of a form which reports parental consent or refusal for the survey, indicates that parents have read and understood the information letter and includes a signature and a date of this (attached form given in Appendix K);

- distribution of a second letter with consent form, ideally on differently coloured paper, to those who do not respond to the first; and

- acceptance of, and respect for, the decision of a child to decline an examination.

It may help site staff to encourage returns if lists are provided that show which children have been sent consent letters and a column for them to record which ones have been returned (Appendix L).

Other strategies may be necessary to maximise the number of consent forms returned, however, coercion to provide positive consent should not be used.

NHS DEP teams must keep a record of the number of all children approached, the numbers with parental consent, parental refusal and no consent.

The Dental Observatory will analyse these data centrally and it is important that all children must be entered into the database if they had parental consent, even if the child was absent or refused to co-operate on the day of examination.

Details of individual children who were not given parental consent do not need to be entered onto the computer.

7. Personnel

7.1 The overall responsibility for the planning of the surveys lies with CsDPH, where they are in post, or other dental lead. The conduct of the surveys will be the responsibility of the PCT.

7.2 The dental examinations will be carried out by registered dental clinicians who will be trained to national standards by the regional trainers, using the approved BASCD training pack, to ensure that they are familiar with the examination method and criteria. Examiners must also be calibrated annually following the *BASCD guidance on the statistical aspects of training and calibration of examiners for surveys of child dental health* (Pine *et al*., 1997b) and examiners who do not conform to the accepted diagnostic standards will need to be retrained and recalibrated, or replaced. In this instance, training and calibration will be carried out on five-year-olds.

7.3 The NHS DEP Regional Coordinator has a duty to ensure, from a regional perspective, that the appropriate BASCD quality standards for dental epidemiological programmes are maintained. This will be undertaken in consultation with the CsDPH or other Dental Public Health Advisers responsible to PCTs, who may wish to apply their own additional quality standards in line with local policy.

8. General Conduct of the Survey

An overview of the survey is shown in plan form in Appendix F.

8.1 The planning and organisation of the survey will be carried out in liaison between CsDPH and the LA Directors of Children's Services who will link with site managers in preparation for contact with the PCT Dental Services Epidemiology Team (see Section 4). Reference to the Statutory Instrument 2006 No 185 (Appendix A) should be made if difficulties are encountered.

8.2 Following random selection of the child care institutions to be included in the survey, the relevant managers will be contacted in turn. The aims and objectives of the survey will be explained and the co-operation of the managers sought. Dates for examination will be set at a mutually convenient time and date.

8.3 Lists of all age eligible children to be included in the survey will be obtained prior to the examination. These lists should include the following information: name, date of birth and residential postcode.

8.4 Using these lists, children who will be age eligible on the planned day of examination will be identified (see Appendix J). A list of these sampled children, along with their home postcodes will be formed and the data entered into a list to record consent status.

8.5 A letter will then be sent to each selected child's parent or guardian outlining the details of the survey and informing them that their child may be included, and seeking their consent.

A second letter will be distributed to those who have not returned a form from the first drop.

8.6 The provision or withholding of consent or non-return of valid consent forms will be recorded for each child and entered onto the sheet mentioned at 8.4.

8.7 Appendix N must be used to record child details and their allotted unique ID number. This must be kept securely if longitudinal surveys are planned so that children can be traced and their examination details matched up in follow-up surveys in subsequent years.

8.8 The dental examinations will take place in the child care institutions in a situation identified as being suitable for that purpose and convenient for the smooth running of both the survey and the site.

8.9 It is good practice to inform parents/guardians if a clinical condition requiring closer investigation is seen during examination, for example sepsis or extensive caries. If a therapist or hygienist is undertaking the examinations, or if there is no intention to provide information about a child's clinical status, then the consent letter (Appendix K) should be modified to reflect this.

9. Fieldwork

Examinations will take place in the selected sites, after training and calibration of examiners and should be completed by the end of June 2013. This gives sufficient time for entering, checking and cleaning of data, primary analysis and reporting.

Equipment, Instruments and Materials

To ensure standardisation, no mobile surgeries or equivalent should be used.

9.1 The children will be examined supine on tables with mats and the examiner seated or standing behind them.

9.2 An inspection light (Daray X100 with PivotD desk mount or Brandon Medical MT608BASCD are suitable if a replacement is needed) yielding approximately 4000 lux at one metre will be used for illumination. This requires that the Daray Versatile be set to the **brighter** of the two settings. A spare bulb will be carried in case of failure. Daray lamps must be firmly secured to a rigid surface before use and the attachment mechanism correctly orientated to ensure it cannot topple over (see Appendix H).

9.3 The instruments required for the caries examination will include No.4 plain mouth mirrors, ball ended CPITN probes or blunt or ball ended probes (0.5mm). Mirror heads will be replaced when they become scratched or otherwise damaged.

The attachment of the mirror head to the stem and the stem to the handle should be checked for security.

9.4 Local PCT policies and infection control arrangements will be applied to prevent cross-infection and avoidance of allergic reactions to latex and glove powder. A fresh set of autoclaved instruments and a new pair of examination gloves will be used for each subject

9.5 Cotton wool rolls, cotton buds, or pledgets of cotton wool will be used to clear teeth of moisture. These will also be used to clear debris where necessary.

9.6 Suitable spectacles will be used to protect the subject's eyes from the light and the possibility of damage.

9.7 Data may be entered either onto paper record sheets (Appendix M) or directly onto computer, with safeguards for both methods (see 10.4).

10. The Collection of Data - General Information

10.1 Training and calibration

Trained and calibrated dental clinicians, assisted by appropriately trained assistants, will undertake the collection and recording of both non-clinical and clinical data. Evidence of intra-examiner reproducibility is desirable – brief guidance is given in Pine et al (1997b).

10.2 Computer software

Data will be collected and processed using the National Format **[3YR2012]** (Appendix O) with the Dental Survey Plus 2 version 2.1 release 3. The format is available electronically from: www.nwph.net/dentalhealth

This contains several free fields for local use. If these are insufficient for local information requirements it is requested that additional fields are added to the end of the National Format and the revised format labelled to show that it differs from the national one.

10.3 Confidentiality

Primary Care Trusts will ensure that all data will be handled with full regard to confidentiality and the Data Protection Legislation. Access to all data files will be controlled and protected by passwords. Primary care trusts will only retain anonymous processed data files for purposes of further analysis. As personal data processed for purposes of research and statistics falls within the scope of the Act (but may be exempt from subject access) each PCT will register their data collection and analysis computer systems.

10.4 Security

Where data is recorded directly onto computers a back-up copy will be made every day and stored separately from the main database.

If data is collected onto paper sheets in the field, transfer onto computer will occur with the minimum of delay. Paper copies will be kept securely and distant from the electronic database when inputting is not occurring. These should be retained and destroyed according to local protocols.

10.5 File management

Master and sub-data files should be labelled to indicate the population group to which they refer. It is insufficient to simply label files with the age group and year of survey. The name of the LA/PCT or other is required.

Survey files should be saved into the 'Survey' folder of DSP2.

Guidance instructions on the checking, cleaning and labelling of data files will be available from: www.nwph.net/dentalhealth

10.6 File transfer
Data files will only be transferred on disk or stick by hand delivery from the PCT NHS DEP Team to the Regional Coordinator or by sending as an attachment to an e-mail from an nhs.net address to the Regional Coordinator's nhs.net address.

11. Collection of Non-Clinical Data

Non-clinical data may be entered onto paper sheets or DSP2 before going to the school for the clinical examination.

11.1 Organisational boundary coding
Each child will be coded to show the LA and PCT from which they are drawn. This is defined by the geographical position of the child care site within LA boundaries and should be clear as the LA will have provided lists of the sites they control.

A table of codes for LAs is provided in Appendix I.

Local planning requirements may also necessitate the recording of wards, purchasing hubs or other units. Space for this will be provided in the national format as an optional field.

11.2 Examiner
A name or code must be used to identify the examiner.

11.3 Site name, postcode and type
The site name and postcode will be entered and the type will be coded.

0 LA Nursery class attached to a primary school
1 LA Children's Centre child care facility
2 LA funded nursery not in Children's Centre
3 Private nursery regardless of site
4 Playgroup regardless of funding or site

11.4 Examination date
The date of the examination will be recorded.

11.5 Identity number
A unique identity number will be entered for each child, which consists of a prefix from the site code and a suffix, which numbers participants from class lists. The list of site prefixes should be locally agreed.

The use of identity numbers instead of names improves anonymity of the data, but if longitudinal surveys are intended it is essential that the examination sheet is used (Appendix N) and kept securely to allow the child participants to be identified and tracked in subsequent years**.**

11.6 Date of Birth
Use of just the month and year of birth increases anonymity. However this causes difficulty when checking ages of examined children in the complete datasets. It has therefore been agreed that all children will be recorded onto computer as being born on the 15th of the month. DSP2 will then automatically indicate when a child is possibly too old or too young for inclusion. In these cases a double check should be run on the actual date of birth to ensure that they are in fact three years old on the day of examination.

Age eligible children will have dates of birth that fall within the widest range of dates of birth September 2008 to August 2010 (Appendix J also helps to identify the narrower ranges for examination dates in each month).

11.7 Home address postcode

Home postcodes **will** be recorded for all children for whom parental consent is provided. This should be sought from the child care site or, in the rare instances when this is refused, lists from PCT child health databases can be requested.

N.B. Computer programmes can only read postcodes if they are entered in the correct format (A = alphabetic N = numeric):

Formats	**Example**
AN NAA	M6 5CQ
ANN NAA	M25 7GH
AAN NAA	BB3 4RL
AANN NAA	SK15 8PY

Postcodes should be entered with the first part (Outward code) in the first box and the second part (Inward code) in the second.

The most common data entry faults are the substitution of the letters I and O for the numbers 1 and 0.

11.8 Sub-group

To facilitate the identification of samples, which are taken in addition to the minimum requirement, coding is required to assist in the calculation of weighted means. For example, if an additional sample is required for an area of particular concern it is essential that children sampled for this purpose are identifiable; this allows weighted means to be calculated to produce valid estimates for the overall population.

All 'additional' samples, if used, should be defined locally and descriptions communicated to The Dental Observatory.

The coding to assist with identification of sample types is as follows:

0 Main sample
1 Additional sample A
2 Additional sample B
3 Additional sample C
4 Additional sample D
5 Additional sample E

11.9 Examination type

The type of examination will be recorded as follows:

0 Survey examination
1 Replicate examination – for intra-examiner reliability
2 Training examination
3 Absentee
4 Child refusal on day of examination

12. Collection of Clinical Data

Subjects will be examined lying down on a mat or a table. The examiner will be seated **behind** the subject. The examination will be visual, aided by mouth mirrors and the standardised light source only.

The teeth will not be brushed, but may be rinsed prior to the dental examination. Where visibility is obscured, debris or moisture should be removed gently from individual sites with gauze, cotton wool rolls or cotton wool buds. Compressed air should **not** be used in the interests of comparability and cross-infection.

Probes must **only** be used for cleaning debris from the tooth surfaces to enable satisfactory visual examination and for defining fissure sealants as indicated below (12.7). Radiographic or Fibre-optic transillumination examination will not be undertaken.

Only the primary teeth will be recorded.

12.1 Oral cleanliness: Assessment of Plaque

It is of interest for local surveys to include a variable about oral cleanliness as this provides a proxy for toothbrushing activity and likely exposure to fluoride toothpaste. A simple measure based on a modification of the Silness and Low Index (1964) will be used. A probe is not used for this part of the examination, which involves visual examination of upper canine to upper canine only. No disclosing should be done. Only easily visible plaque should be considered and recent debris such as small pieces of crisp found in an otherwise clean mouth immediately after a school lunchtime or break should be ignored.

The coding to be used is:

0 Teeth appear clean
1 Little plaque visible
2 Substantial amount of plaque visible
9 Assessment cannot be made for upper anterior sextant

12.2 Dentition Status

Teeth and surfaces will be examined in a standard order. Either the conventional nomenclature or the FDI 2 digit tooth numbering system may be employed. The objective is for the examiner to record the present status of the teeth in terms of disease and treatment history.

The condition of each tooth surface will be recorded using the BASCD standardised criteria (BASCD) *Diagnostic Criteria for Caries Prevalence Surveys* - 1996/97. The application of these criteria will be taught using the BASCD teaching pack.

Data will be recorded by tooth surface. The boundary between mesial / distal surface and the adjacent lingual / buccal surface is demarcated by a line running across the point of maximum curvature.

12.3 Conventions

The following conventions will apply:

a) A tooth is deemed to have erupted when any part of it is visible in the mouth. Unerupted surfaces of an erupted tooth will be regarded as sound.

b) **The presence of supernumerary teeth will not be recorded. If a tooth and a supernumerary exactly resemble one another then the distal of the two will be regarded as the supernumerary.**

c) **Missing primary incisors are assumed exfoliated and assigned tooth Code 8 in the main chart (see 12.5 for more detail on recording these).**

d) **Caries takes precedence over non-carious defects, e.g. hypoplasia.**

e) **Retained roots following extraction or gross breakdown should be recorded as Code 3.**

f) **Discoloured, non-vital incisors, without caries or fractures should be scored T for trauma on all surfaces.**

g) **Surfaces which are obscured e.g. banded teeth, should be assumed to be sound and coded '-' or '0'.**

12.4 Teeth present

Before coding the status of individual surfaces, it may be useful to identify which primary teeth are present and which are absent. A staged examination is recommended as follows:

a) **the teeth are described: mirror only.**
b) **tooth surface examination: mirror + cotton wool (for drying).**

12.5 Absent teeth

Tooth Code 6 - Extracted due to caries

Surfaces are regarded as missing if the tooth of which they were a part, has been extracted because it was carious. Surfaces, which are absent for any other reason, are **not** included in this category.

If there has been an extraction and root remains have been left in place, Code 3 should be used.

All missing primary canines and primary molars will be considered to have been extracted (Code 6) unless there is unquestionable evidence that a tooth has been extracted or lost for other reasons or, among the youngest children, they have clearly not yet erupted (Code 8).

Tooth Code 8 - Unerupted or missing other

Code 8 will be used to denote primary molars and canines for which there is evidence that they have not yet erupted.

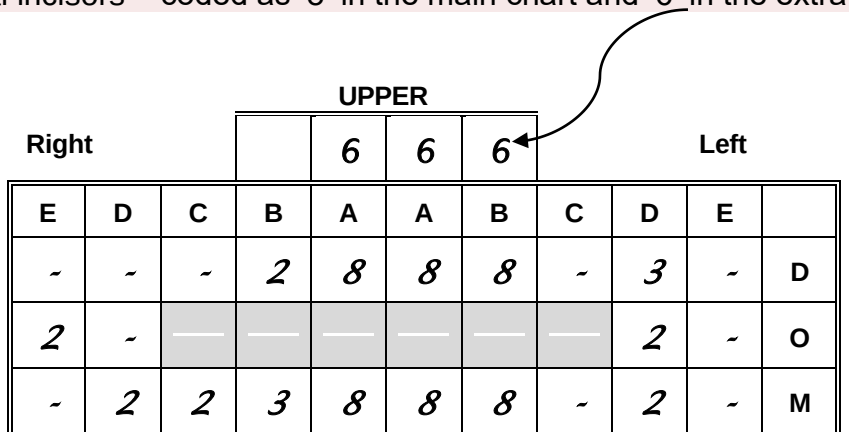
This code will be used in the main chart where there are missing primary incisors. This is the same convention as for five-year-olds and will allow for comparison between the two age groups.

Missing incisors

In order to capture the real number of incisors that have been extracted, two additional rows have been added to the chart. These boxes are for the recording of missing incisors that have probably been extracted because of caries.

The Code ‘6’ should be used in these boxes to denote such a tooth. This will allow for separate analysis of extracted missing incisors, yet still allow for the standard convention regarding them.

The example below shows how the boxes should be completed for a child with missing upper central incisors – coded as ‘8’ in the main chart and ‘6’ in the extra box.



Among three-year-olds it is likely that most missing incisors will have been extracted because of caries, so the Code 6 should be placed in the additional box unless there is overwhelming evidence that the tooth is missing for another reason.

Code 8 should be used in the additional boxes for missing incisors only when there is overwhelming evidence that there is absence for a reason other than caries. Reasons for missing incisors, other than extraction for caries would be:

- absence in a pattern which is suggestive of delayed eruption;
- absence in a pattern that would be suggestive of loss due to trauma; and
- absence of other teeth in a pattern that would be suggestive of congenital hypodontia or ritual tooth bud enucleation.

12.6 Obscured surfaces

All obscured surfaces are assumed sound (surface Code ‘0’ or ‘-‘ sound) unless there is evidence of disease experience on the remaining exposed part of the tooth, in which case the tooth should be coded according to its classification for those exposed surfaces.

12.7 Caries Diagnostic Criteria and Codes

The diagnosis of the condition of tooth surfaces will be visual and the diagnostic criteria and codes will be strictly adhered to. Unless the criteria are fulfilled, caries **will not** be recorded as present. A single digit code, the descriptor code, will be used to describe the state of each surface. These codes, which are mutually exclusive, are as follows:

Surface Code 0 - Sound

Criteria - a surface is recorded as ‘sound’ if it shows no evidence of treated or untreated clinical caries at the ‘caries into dentine’ threshold. The early stages of caries, as well as other similar conditions are excluded. Surfaces with the following defects, in the absence of other positive criteria, should be coded as present and ‘sound’:

- *white or chalky spots;*
- *discoloured or rough spots;*

- *stained pits or fissures in the enamel that are not associated with a carious lesion into dentine; and*
- *dark, shiny, hard, pitted areas of enamel in the tooth showing signs of moderate to severe fluorosis.*

All questionable lesions should be coded as 'sound'.

Surface Code 1 - Arrested dentinal decay

Criteria - surfaces will fall into this category if there is arrested caries into dentine. This code should only be used for arrested dentinal decay.

Surface Code 2 - Caries into dentine

Criteria - surfaces are regarded as decayed if after **visual** inspection there is a carious lesion into dentine. On incisors where the lesion starts mesially or distally, buccal/lingual surfaces will normally be involved.

Surface Code 3 - Decay with pulpal involvement

Criteria - surfaces are regarded as falling into this category if there is a carious lesion that involves the pulp, whether or not there is a filling in the surface.
Retained roots following extraction or gross breakdown should also be recorded as Code 3.

Surface Code 4 - Filled and Decayed

Criteria - a surface that has a filling and a carious lesion fulfilling the criteria for Code 2 (whether or not the lesion[s] are in physical association with the restoration[s]) will fall into this category unless the lesion is so extensive as to be classified as 'decay with pulpal involvement', in which case the filling would be ignored and the surface classified Code 3.

Surface Code 5 - Filled with no decay

Criteria – surfaces which contain a satisfactory permanent restoration of any material, will be coded under this category (with the exception of obvious sealant restorations which are coded separately as Code N).

Surface Code R - Filled, needs replacing (not carious)

Criteria - a filled surface is regarded as falling into this category if the restoration is chipped or cracked and needs replacing but there is no evidence of caries into dentine present on the same surface.

Lesions or cavities containing a temporary dressing, or cavities from which a restoration has been lost will be regarded as 'filled, needs replacing' unless there is also evidence of caries into dentine in which case they will be coded in the appropriate category of 'decayed'.

Note: The number of teeth/surfaces scored R should be separately identified. However, if categories are to be combined later, Code R surfaces are to be considered as part of the 'filled' component as no new caries is evident.

Surface Code C - Crown

Criteria - this code is used for all surfaces which have been permanently crowned. This is irrespective of the materials employed or of the reasons leading to the placement of the crown.
NB: Code C also applies to pre-formed and stainless steel crowns.

Surface Code T - Trauma

Criteria - a surface will be recorded as traumatised if, in the opinion of the examiner, it has been subject to trauma and as a result is fractured so as to expose dentine, or is discoloured, or has a temporary or permanent restoration (excluding a crown). Minor trauma, affecting enamel only, will be ignored.

Where a tooth is missing through trauma, all surfaces should be coded T but see 12.5 above for dealing with missing primary incisors and canines.

Any surface exhibiting caries experience, as defined by the caries criteria, will be recorded with the appropriate caries experience code (Code 1 - 5), **irrespective** of the presence of traumatic damage.

12.8 Sealed surfaces

The ball-ended probe should be used to assist in the detection of sealants. Care should be taken to differentiate sealed surfaces from those restored with tooth coloured materials used in prepared cavities which have defined margins and no evidence of fissure sealant. The latter are regarded as fillings and are allocated the appropriate code, i.e. 4, 5 or R. Sealant codes should only be used if the surface contains evidence of sealant (including cases with a partial loss of sealant), is otherwise sound and does not contain an amalgam or conventional tooth coloured filling.

Surface Code $ - Sealed Surface, type unknown

Criteria - All occlusal, buccal and lingual surfaces containing some type of fissure sealant but where **no** evidence of a defined cavity margin can be seen (note: this category will inevitably include both preventive and therapeutic sealants).

Where a clear sealant is in place and there appears to be a lesion showing through the material, the surface should still be coded Code $ - Sealed Surface, type unknown.

Surface Code N - Obvious Sealant Restorations

Criteria - All occlusal, buccal and lingual surfaces containing a tooth coloured restoration where there is evidence of a defined cavity margin and a sealed unrestored fissure. If doubt exists as to whether a preventive sealant or a sealant restoration is present, the surface should be regarded as being preventively sealed - Code $.

When doubt exists about the classification of any condition, the lower category should always be recorded.

12.9 Abscess/Sepsis

Following examination of the mouth for caries, if, in the opinion of the trained examiner, the presence of an abscess or sinus has been noted – record Code 1 in the appropriate section on the chart. If no abscess or sinus present – Code 0.

All sepsis must be recorded regardless of cause. No attempt should be made to identify the cause of the infection.

12.10 Optional variables

12.10.1 Optional variable for ethnic code

It is of particular and increasing importance for the ethnic coding to be recorded for this age cohort and fieldwork teams are encouraged to do this. Best practice is to use the ethnicity data collected by child care sites from parents.

The coding method should not vary, as there is now a standard method of categorisation and coding for Education Skills and Children's Services (ESCS). These are suitable for alignment into the 2011 Census groupings, which are:

Highest level grouping	To include these groups
A White	A1. English/Welsh/Scottish/Northern Irish/British A2. Irish A3. Gypsy or Irish Traveller A4. Any other white background
B Mixed	B1. White and Black Caribbean B2. White and Black African B3. White and Asian B4. Any other Mixed/multiple ethnic background
C Asian/Asian British	C1. Indian C2. Pakistani C3. Bangladeshi C4. Chinese C5. Any other Asian background
D Black / African/Caribbean / Black British	D1. African D2. Caribbean D3. Any other Black / African / Caribbean background
E Other Ethnic group	E1 Arab E2 Any other ethnic group

There are three additional codes which may be used for local use and should be defined to allow for particular additional ethnic groups which may be of interest in each locality:

F Specific ethnic other - 1
G Specific ethnic other - 2
H Specific ethnic other - 3

Further guidance and descriptions of groupings can be found on page 20 of the *Ethnicity Data Standard* provided by the Information Standards Board for Education ESCS which can be downloaded from:
www.education.gov.uk/escs-isb/standardslibrary/a0077051/ethnicity-data-standard

12.10.2 Optional variable for assessment of treatment need

An optional spare variable may be used in the DSP2 format to collect broad information on treatment need. Criteria will be agreed locally.

12.10.3 Optional data to identify ward, locality or other unit

It may be helpful in some cases to record the ward, purchasing locality or other unit to enable local analysis to be carried out. Space is provided for this option as a spare variable.

National codes for wards can be found at:
www.ons.gov.uk/ons/search/index.html?newquery=ward+codes

12.10.4 Questionnaire data

Some PCTs may wish to provide questionnaires for the parents of the participating children. If this will mean that more than three spare variables are required then the DSP2 format will need to be modified, with all additional variables being added to the end, and the new format being re-named to denote this.

12.10.5 Information on children with special needs

Information on dental health status of children with special needs is useful for comparison purposes and to establish priority areas for action. Special needs schools should not be included in the main sample but coded separately and saved in a separate file. The identification of children attending mainstream child care sites that have special needs may be facilitated by using School Action Plus classification information, which may be collected by these sites. A separate protocol is available for those wishing to survey children attending special needs sites.

For details about this email: janet.neville@centrallancashire.nhs.uk

12.10.6 Other optional data

Other measures may be helpful to inform local planning functions and can be coded to suit needs and incorporated into the regional format within the spare variables section or following this. The new format should be renamed to distinguish it from the standard format.

13. Reporting of Data

Prior to sending on data files, each PCT team is responsible for checking their data for inaccuracies. The main areas for error occur with incorrect dates of birth and/or ages, duplicate entries for children or sites and entry of clinical data for children coded absent. Guidance will be provided which will give a step-by-step guide to the whole data handling process. This will be available from: www.nwph.net/dentalhealth

Once the data have been checked and errors corrected, files can be formed including children from identified sub-groups, which should be sent on to Regional Coordinators to upload. Files can be passed by hand on password protected memory sticks or disks directly to the Regional Coordinator or they can be sent as attachments to e-mails from an nhs.net address to an nhs.net address. Separate files should be formed for each PCT and LA, labelled to indicate the PCT and LA to which they refer. Where non-standard samples have been taken this should be noted and details provided to Regional Coordinators to pass on to The Dental Observatory.

The following will be reported:

1) Start and finish dates of the period of examinations (dd/mm/yyyy – dd/mm/yyyy).

2) Total number of sites providing childcare for three-year-old children.

3) Number of sites visited.

4) Total number of three-year-old children attending listed child care sites.

5) Number of children sampled.

6) Number of children with parental consent, parental consent refused and consent form not returned.

7) Number of consented children examined, absent and refused examination.

8) Explanation of sample sub-group codes if necessary (Appendix P).

9) Results will be submitted as cleaned data files and completed Word documents.

10) All returns should be made to Regional Coordinators for re-checking as soon as possible after completion of the survey and no later than **July 31st 2013.** These must only be made by direct handing over of a password protected memory stick or disc or by attachments from an nhs.net address to an nhs.net address and should include:

    i) the completed reporting sheet & questionnaire – Appendix P;

    ii) the survey files labelled to indicate LA and PCT to which they refer; and

    iii) explanation of sampling methods and intensities.

Primary care trusts will be provided with a cleaned and verified copy of the data. These will also be sent to the respective CsDPH or Dental Public Health Adviser **after** central analysis.

14. References

Department of Health (2012). Healthy lives, healthy people: Improving outcomes and supporting transparency [Online]. Available at: www.dh.gov.uk/health/2012/01/public-health-outcomes/

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coordinated dental epidemiology programme quality standard. *Community Dental Health* 14, (Supplement 1), 10-17.

Pine, C.M., Pitts, N.B., Nugent, Z.J. (1997b): British Association for the Study of Community Dentistry (BASCD) guidance on the statistical aspects of training and calibration of examiners for surveys of child dental health. A BASCD co-ordinated dental epidemiology programme quality standard. *Community Dental Health* 14, (Supplement 1), 18-29.

Pitts, N.B., Evans, D.J., Pine, C.M. (1997): British Association for the Study of Community Dentistry (BASCD) diagnostic criteria for caries prevalence surveys – 1996/97. *Community Dental Health* 14, (Supplement 1), 6-9.

Silness J and Loe H (1964). Periodontal disease in pregnancy. II Correlation between oral hygiene and periodontal condition. *Acta Odontologica Scandinavica* 22:121–135.

Statutory Instrument 2006, No 185. The Functions of Primary Care Trusts (Dental Public Health) (England) Regulations 2006 [Online]. Available at: www.legislation.gov.uk/2006/185

15. Table of Appendices

* Documents will be available in Word format from www.nwph.net/dentalhealth

STATUTORY INSTRUMENTS

2006 No. 185

NATIONAL HEALTH SERVICE, ENGLAND

The Functions of Primary Care Trusts (Dental Public Health) (England) Regulations 2006

Made	*26th January 2006*
Laid before Parliament	*6th February 2006*
Coming into force	*1st April 2006*

The Secretary of State for Health makes the following Regulations in exercise of the powers conferred by section 16CB(1) of the National Health Service Act 1977[1]:

Citation, commencement and interpretation

1. —(1) These Regulations may be cited as the Functions of Primary Care Trusts (Dental Public Health) (England) Regulations 2006 and shall come into force on 1st April 2006.

(2) In these Regulations—

"the Act" means the National Health Service Act 1977;
"oral health promotion programme" means a health promotion and disease prevention programme the underlying purpose of which is to educate and support members of the public about ways in which they may improve their oral health;
"oral health survey" means a survey to establish the prevalence and incidence of disease or abnormality of the oral cavity; and
"water fluoridation programme" means—
(a) until the coming into force of section 58 of the Water Act 2003[2] (fluoridation of water supplies), fluoridation arrangements made under section 87(5) of the Water Industry Act 1991 (fluoridation of water supplies at request of health authorities); and

(b) upon the coming into force of section 58 of the Water Act 2003, fluoridation arrangements made under new section 87(1) (fluoridation of water supplies at request of relevant authorities) of the Water Industry Act 1991.

Exercise of functions of Primary Care Trusts

2. —(1) A Primary Care Trust shall have the following functions in England.

(2) A Primary Care Trust shall provide, or secure the provision of, the following, to the extent that it considers necessary to meet all reasonable requirements within its area—

(a) oral health promotion programmes;

(b) dental inspection of pupils in attendance at schools maintained by local education authorities; and

(c) oral health surveys to facilitate—

(i) the assessment and monitoring of oral health needs,

(ii) the planning and evaluation of oral health promotion programmes,

(iii) the planning and evaluation of the provision of primary and specialist dental services, and

(iv) the monitoring and reporting of the effect of water fluoridation programmes.

(3) A Primary Care Trust shall participate in any oral health survey required by the Department of Health as part of a survey conducted or sponsored under section 5(2)(d) of the Act [3] (other services).

Rosie Winterton
Minister of State, Department of Health

26th January 2006

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations set out the functions to be exercised by Primary Care Trusts in England in relation to oral health.

Those functions relate to oral health promotion programmes, dental inspection of pupils in schools maintained by local education authorities and oral health surveys.

Notes:

[1] 1977 c.49. Section 16CB(1) was inserted by section 171(1) of the Health and Social Care (Community Health and Standards) Act 2003 (c.43).back

[2] 2003 c.37. Section 58 prospectively substitutes section 87 of the Water Industry Act 1991 (1991 c.56).back

[3] Subsection (2) of section 5 has been amended by section 1 of the Public Health Laboratory Service Act 1979, (c. 23), and S.I. 2002/2759.back

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ISBN 0 11 073966 3

Appendix Bi – Letter of support from Chief Dental Officer to Directors of Public Health, via Regional Directors of Public Health asking for support to be expressed to Directors of Children's Services

Skipton House,
80 London Road,
London
SE1 6LH

Tel: 020 7972 2323
Email: barry.cockcroft@dh.gsi.gov.uk

GATEWAY REF:18136

To: Directors of public health
Directors of dental public health

18 October 2012

Dear colleague,

NHS Dental Epidemiological Survey of 3 year olds; school year 2012/13

I write to seek your support in delivering the above survey, which is part of a rolling programme of nationally coordinated dental surveys designed to provide quality assured local information on dental needs.

The responsibility of primary care trusts (PCTs) to gather information on the health needs of the local population will be transferred to local authorities, as set out in the white paper 'Equity and excellence; liberating the NHS' (July 2010) and in subsequent papers specific to public health – 'Healthy Lives, Healthy People': update and way forward (July 2011). Previously, the need for collection of dental needs information was described in the Health and Social Care (Community Health and Standards) Act 2003, underpinned by Statutory Instrument 2006 number 185, and was also highlighted in Choosing Health (2004) and Choosing Better Oral Health (2005). Information on oral health needs should be considered as part of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), as well as a required component of the dental measure in the Public Health Outcomes Framework, i.e. rate of dental caries among children aged 5 years (decayed, missing or filled teeth), for which local authorities will have responsibility.

The Strategic Health Authority Dental Public Health Leads Network agreed that during the academic year 2012/13 the population group for scrutiny would be three year olds. This follows a feasibility survey in the North West SHA, and similar surveys in Tower Hamlets and Scotland.

These surveys will improve knowledge about caries progression in pre-school years and inform planners about the timing and impact of interventions to meet the targets linked to the oral health of five year olds which are listed in the Public Health Outcomes Framework. The surveys will measure the prevalence and severity of dental caries in three year old children attending child care institutions in each local authority to provide a baseline for comparison in subsequent years and, for some areas, establish a cohort for follow up.

The success of these surveys will be much increased if you could actively express your support to relevant colleagues, in particular heads of education and children's services and early years. This may be achieved, in part, by forwarding a copy of this letter to these colleagues.

Yours faithfully,

Barry Cockcroft CBE
Chief Dental Officer (England)

Appendix Bii – Letter of support from Chief Dental Officer to Directors of Childrens' Services, asking for support to be expressed to relevant colleagues

Skipton House,
80 London Road,
London
SE1 6LH

Tel: 020 7972 2323
Email: barry.cockcroft@dh.gsi.gov.uk

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The success of these surveys will be much increased if you could actively express your support to relevant colleagues, with whom co-operation will be sought within your department and leads in all pre-school child care sites. This may be achieved, in part, by forwarding a copy of this letter to these colleagues.

Yours faithfully,

Barry Cockcroft CBE
Chief Dental Officer (England)

Appendix C – Information about the purpose and nature of the survey for sites requesting this.

BASCD

National Health Service Dental Epidemiology Programme
Survey of three-year-old children 2012/2013

Dental health surveys involving children have been carried out across the UK since 1987. The information arising from them allows health authorities to plan dental services and health improvement teams to tailor programmes for groups where oral health is poor. The overall aim is to support actions to improve oral health, reduce health inequalities and improve the provision of treatment services.

Local fieldwork teams from the Community Dental Service usually carry out these surveys. As with all NHS employees the teams are covered by the Data Protection Act and take confidentiality very seriously. National and regional training is provided to ensure that high standards are kept and all teams work to the same level at all stages in the survey.

Fieldwork teams will contact child care sites that have been randomly sampled from a list of all schools within a Local Authority area. They will ask for cooperation from the child care setting and for access to lists of all children that may be included, showing dates of birth and home postcodes. From these lists they will randomly select a sample of children who will be the correct age on the day of examination. Positive, written consent will then be sought via letters home to parents, which the team will provide.

On the day of examination the team will set up their mobile equipment at an agreed location at the child care site and undertake brief examinations of the consented children's teeth. These examinations take no more than a minute and, as the teams are child friendly, should cause no discomfort or distress.

The information is recorded anonymously; no names, gender or complete dates of birth are recorded. All data are kept securely and only staff with the dedicated computer programme can view the information. Datasets are securely sent to regional centres for uploading via a web portal to the national coordinating centre. This centre collates data from all over England and produces reports on levels of dental health for England as a whole and at Strategic Health Authority, Primary Care Trust and Local Authority levels. At no point is any individual identifiable, as the data are anonymised from the examination stage and only reported or published as grouped data.

It is hoped that all sites contacted will be able to assist the fieldwork teams in this national survey which the Primary Care Trust must undertake by law. They try to keep disruption to a minimum and ensure the children involved have a positive experience with the dental team.

Appendix D - Letter showing opinion that this health needs assessment, which is based on the North West feasibility survey protocol, does NOT require ethical approval.

NHS
National Patient Safety Agency

National Research Ethics Service

Mrs Joan Kirkbride
Head of Operations
National Research Ethics Service
Darlington PCT
Dr Piper House, King Street, Darlington DL3 6JL

Direct Line – Mobile 07979 806425
Tel: 01325 746167 (Assistant – Janet Kelly)
Fax: 01325 746272
Email: joan.kirkbride@nres.npsa.nhs.uk
Website:www.nres.npsa.nhs.uk

28 October 2010

Dr Gill Davies
Development Manager
North West Regional Co-ordinator for NHS DEP
The Dental Observatory
Gill.davies@manchester.nhs.uk

Dear Gill

Full title of project: **NHS Dental Epidemiology Programme – health needs of 3 year old children**

Thank you for seeking the National Research Ethics Service advice about the above project.

You provided the following documents for consideration:

Email dated 27 October with details about the project.

These documents have been considered by Joan Kirkbride, Head of Operations, NRES and Dr Hugh Davies, Ethics Adviser, NRES.

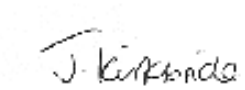
Joan Kirkbride and Dr Hugh Davies have advised that the project is not considered to be research according to our guidance "Defining Research". Therefore it does not require ethical review by a NHS Research Ethics Committee.

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feels that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

Yours sincerely



Joan Kirkbride
Head of Operations

National Research Ethics Service, National Patient Safety Agency, 4-8 Maple Street London W1T 5HD
Tel: 020 7927 9898 Fax: 020 7927 9899

Appendix E - Requirement for positive consent

Consent for School Dental Inspections and Dental Epidemiological Surveys

We have had reason to consider the issue of consent for both school dental inspections and dental surveys. Guidance was issued by the former NHS Management Executive in May 1992 which implied that it is acceptable to rely on negative consent for dental surveys. We are aware that PCTs are relying on this previous guidance to support the use of negative consent. **This guidance should no longer be followed.**

As both of the above stated processes inevitably involve physical contact between a dentist and a child, it is necessary to obtain consent from the child (if he/she is competent to give consent) or from a person with parental responsibility for the child, in accordance with the Department's guidance on consent to treatment[1]. Whilst the risk of any proceedings[2] being brought against a dentist or PCT in relation to a school dental inspection or epidemiological survey might be considered low, in the event that there was, a dentist may not be able to prove that consent had been obtained simply on the basis that letter had been sent out to parents and no objection had been received.

We are aware of concerns about the impact that obtaining positive consent might have on the NHS oral health epidemiology programmes within England. Where programmes are surveying older children eg.10-11 year olds it is likely that a child of this age would be competent to consent to the dental examination, provided it is explained to them what the process involves, for what purpose the information obtained will be used, and that they can refuse to take part if they wish. If the competent 10-11 year old child consents, this will be sufficient.

In relation to younger children, we have been exploring whether positive consent to dental inspections/surveys obtained from the child's parent (or relevant person with parental responsibility) when their child begins school would be sufficient proof of consent.

We consider that a dentist performing these inspections and surveys might be able to rely on such consent, as long as sufficient information is provided to the parent at the time that consent is obtained to enable their consent to be fully informed. It would be good practice to inform parents how many times the procedures would take place and in which school years, and that they may withdraw their consent at any time. It would also be good practice to write to parents to inform them when examinations/surveys are about to be carried out and reminding them that they may withdraw consent if they wish.

As this will be additional information that will need to be obtained from parents at school entry, we will need to discuss with colleagues in DfES how this might be incorporated into the school entry procedures prior to our issuing further formal guidance.

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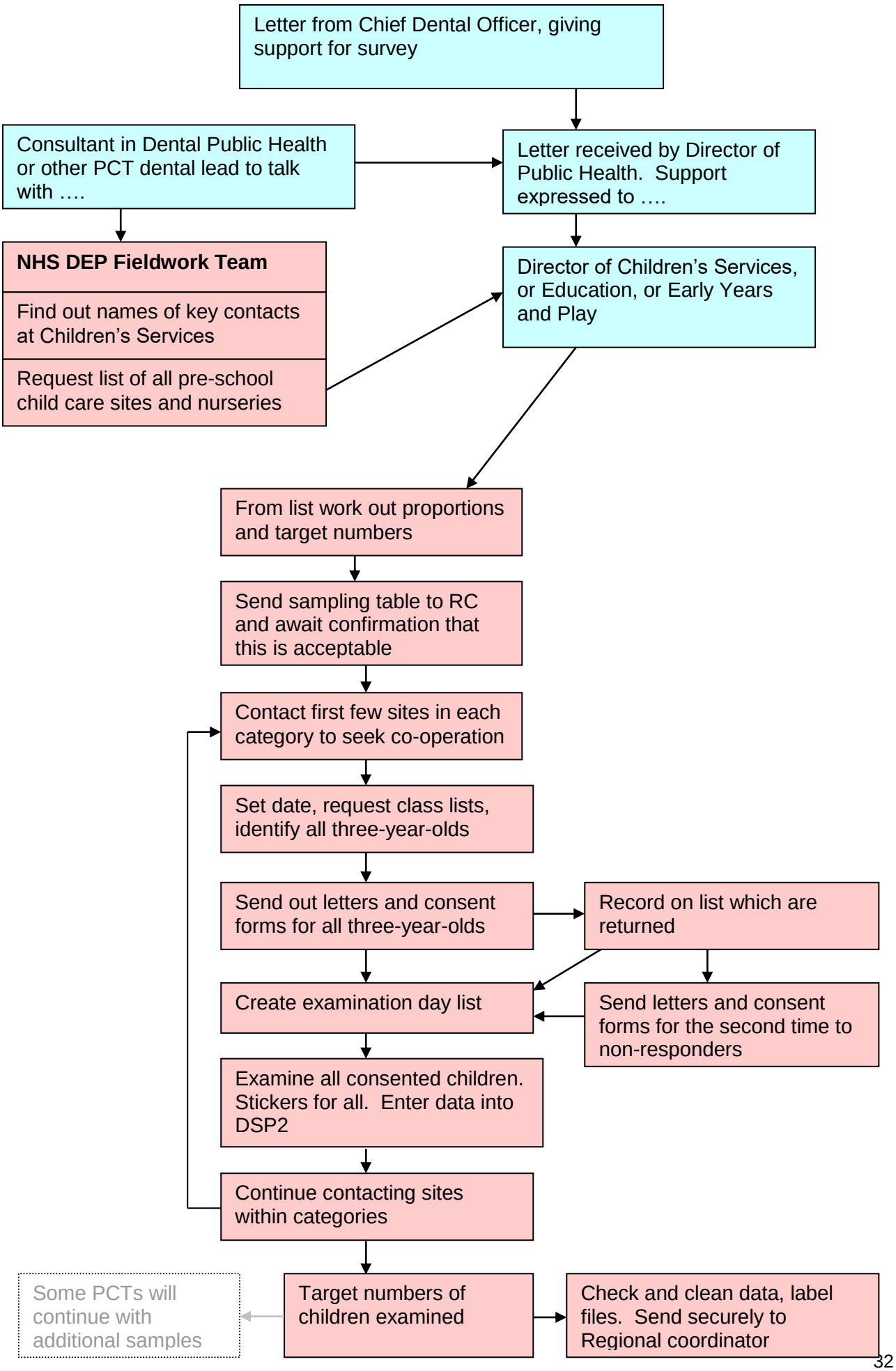
[1] *Good practice in Consent* (HSC 2001/023)
http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/HealthServiceCircularsArticle/fs/en?CONTENT_ID=4003736&chk=OigZnc

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4005762&chk=7ENk2Q

[2] for battery/assault or negligence, or disciplinary proceedings

Appendix F - Stages for NHS DEP teams to undertake the 2012/13 survey of three-year-olds.



Appendix G - Operational timetable

Training for Regional Coordinators – National Protocol	13th to 14th June 2012
National clinical training and calibration	
Regional training and calibration	As soon as can be arranged following national training
Planned sampling methods sent to Regional Coordinators for verification	Following regional training
Preparation of samples, seeking consent and recording of responses	From receipt of approval from Regional Coordinators
Data collection	To start as soon as possible and completed by 30th June 2013
Completion of data entry, checking and labelling of PCT and LA samples. Secure forwarding of LA and PCT cleaned data files to Regional Coordinators as soon as possible before deadline	By 31st July 2013
Regional Coordinators to upload summaries and copies of LA and PCT data files to The Dental Observatory via the web portal www.nwph.net/dentalhealthupload/login.aspx	To be uploaded as and when they have been checked, completed by 31st August 2013
TDO - Checking of data and collation	As and when data files arrive
NWPHO / TDO – compute estimates for LAs and PCTs	From end of August 2013
Publication of results on website www.nwph.net/dentalhealth	October 2013 or two months after receipt of last data set
Feedback of cleaned data with SOAs attached to Regional Coordinators, PHOs, PCTs, SHA, CsDPH	November 2013 or three months after receipt of last data set
Publication of PCT estimates in Community Dental Health	March 2014 dependent upon receipt of last set of data

Appendix H - Safe use of Daray lights for dental epidemiology fieldwork

The Daray lamps recommended as standard for dental epidemiology fieldwork are fit for purpose but it is likely that many dental epidemiology fieldwork teams are using Daray lamps that are now some years old. It is important that they are used and maintained correctly to ensure they are safe. This advice is provided in conjunction with Daray Ltd.

These lamps should be PAT tested, as with any electrical equipment, and signs of damage noted and acted upon.

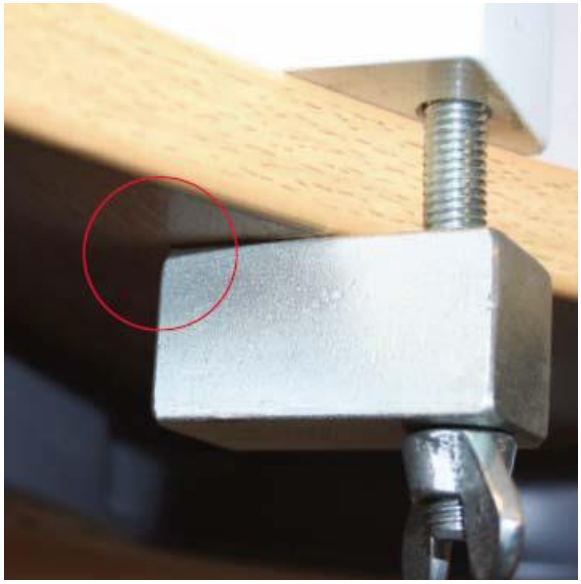
The clamps should be fitted and used correctly and checked to ensure they are firmly fixed to a work surface. For this reason it is best practice to establish a set examination site at a venue and avoid moving around from one room to another.

The Pivot D2 clamp has replaced the Pivot D clamp and can be sourced from Daray Ltd
Tel: 0870 777 2664 Sales.team@daray.co.uk www.Daray.com

The pictures below show how the clamp with a silver clamping bar should be fitted to ensure that the block of the clamp is in full contact with the base of the desk or table surface (Pictures 1 and 2). If the wedge shaped bar is fitted upside down it will not be stable (Pictures 3 and 4).

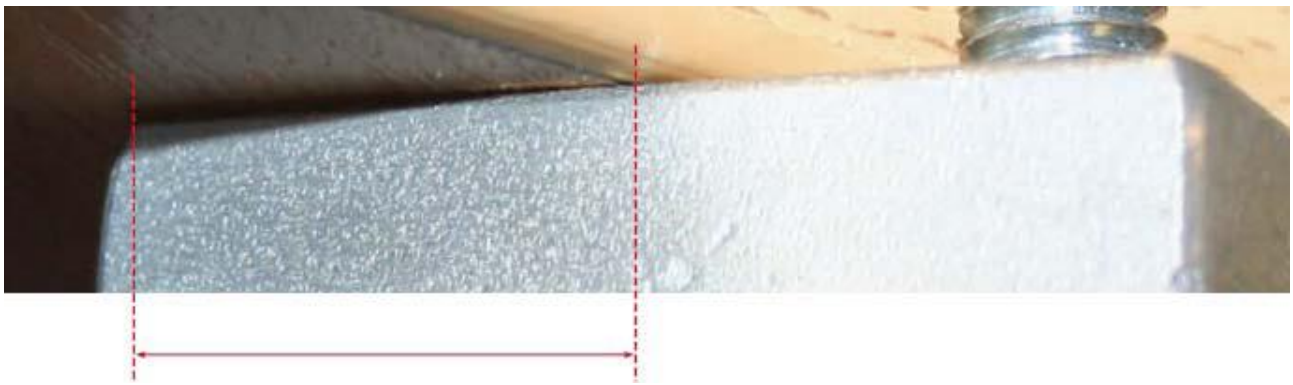
Examiners should check that the lamp is stable before undertaking examinations.

Pic 1: Correct fitting and use of the clamp



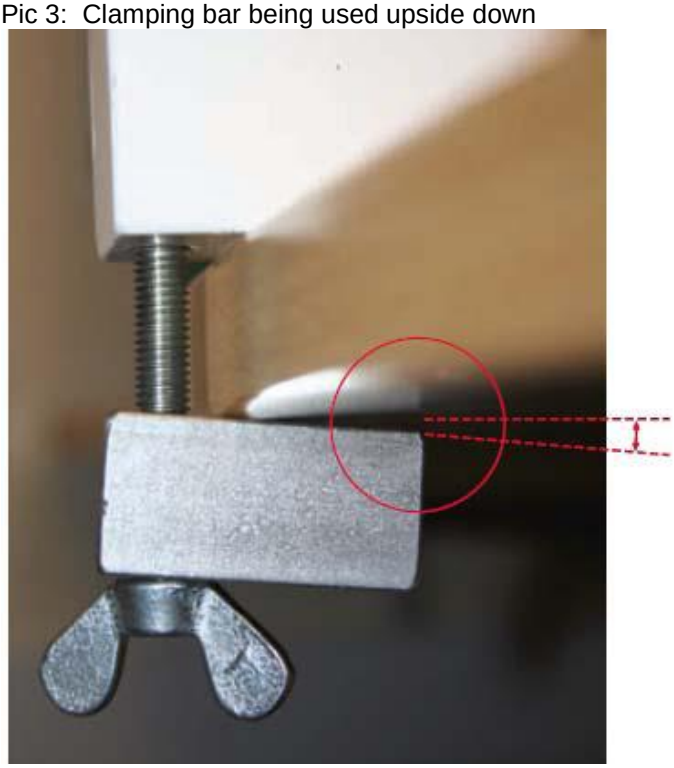
Pic 2: Correct fitting and use of the clamp

Note the surface contact along the length of the clamp

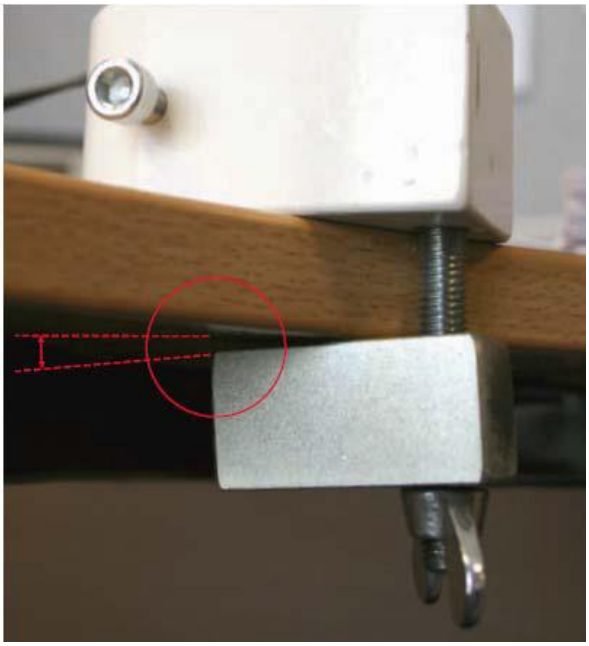


Incorrect use of clamp:

Pic 3: Clamping bar being used upside down



Pic 4: Clamping bar being used upside down



The moving arm should be able to move freely within the socket so that the lamp can be turned without moving the clamping mechanism. This may require the application of a little lubricant to the spigot.

Appendix I - Sources of information

- This national protocol, DSP2 format, guidance to data input and handling and feedback forms are all available from the NHS DEP website www.nwph.net/dentalhealth

- Contact details of Directors of Children's Services departments: www.adcs.org.uk/contacts/dcs.html

- Site to buy DSP2: http://usd.swreg.org/com/storefront/47803/product/478031

- Frequently asked questions about DSP2: www.computing.dundee.ac.uk/acprojects/dsp2

- Excel tables to help with calculation of weighted means, weighted proportions and weighted confidence intervals are available to download from: http://pcwww.liv.ac.uk/~gburnsid/bascd.htm

- Numbers of children using child care facilities – from Local Education Authority Department of Children's services. Consultants in dental public health or equivalent dental leads for each PCT may need to help with sourcing this information.

- If home postcodes cannot be obtained from schools, school nurses, school health clerks or local Child Health information services these can be obtained by cross referencing the volunteer's address in the relevant Royal Mail Postal Address Book: www.royalmail.com/address-book

  Alternatively, use the Royal Mail Postcodes on-line at: www.royalmail.com/portal/rm/postcodefinder.

- Light source if new unit required to replace a Daray Versatile (this is no longer produced)

  Either The Daray **X100** Halogen (£179 + VAT) with **Pivotd2** to allow desk-mounting (£37 + VAT)

  Contact: Hayley Blackburn at Daray Ltd
  Tel: 0333 321 0971
  hayley.blackburn@daray.co.uk
  www.daray.co.uk

  www.daray.co.uk/docs/X100.html

  Or The MT608BASCD (£310.32 + VAT incl clamp and bulb)
  Contact Brandon Medical Co. Ltd
  Tel: 0 1132 777393
  www.brandon-medical.com/products/medical-lighting/examination-lights/mt6008-examination-lamps

MT6008 Brochure.pdf

A list of codes for Local Authorities and PCTs follows. This is numbered and colour-coded to indicate how PCTs and LAs relate.

Relationship between geographies	
1	Multiple LAs within 1 PCT
2	1 LA to 1 PCT match
3	1 LA to multiple PCTs
4	1 LA wholly within non-co-terminous PCT
5	LA spans multiple PCTs

Geog Ref	Local Authority	Code	PCT	Code
2	Wigan	00BW	Ashton, Leigh and Wigan	5HG
2	Barking and Dagenham	00AB	Barking and Dagenham	5C2
2	Barnet	00AC	Barnet	5A9
2	Barnsley	00CC	Barnsley	5JE
2	Bassetlaw	37UC	Bassetlaw	5ET
2	Bath and North East Somerset	00HA	Bath and North East Somerset	5FL
1	Bedford	00KB	Bedfordshire	5P2
1	Central Bedfordshire	00KC	Bedfordshire	5P2
4	Bracknell Forest	00MA	Berkshire East	5QG
4	Slough	00MD	Berkshire East	5QG
4	Windsor and Maidenhead	00ME	Berkshire East	5QG
5	Runnymede	43UG	Berkshire East	5QG
1	West Berkshire	00MB	Berkshire West	5QF
1	Reading	00MC	Berkshire West	5QF
1	Wokingham	00MF	Berkshire West	5QF
2	Bexley	00AD	Bexley	TAK
3	Birmingham	00CN	Birmingham East and North	5PG
2	Blackburn with Darwen	00EX	Blackburn with Darwen Teaching	TAP
2	Blackpool	00EY	Blackpool	5HP
2	Bolton	00BL	Bolton Teaching	5HQ
1	Bournemouth	00HN	Bournemouth and Poole Teaching	5QN
1	Poole	00HP	Bournemouth and Poole Teaching	5QN
2	Bradford	00CX	Bradford and Airedale Teaching	5NY
2	Brent	00AE	Brent Teaching	5K5
2	Brighton and Hove	00ML	Brighton and Hove City	5LQ
2	Bristol, City of	00HB	Bristol	5QJ
2	Bromley	00AF	Bromley	5A7
5	Aylesbury Vale	11UB	Buckinghamshire	5QD
4	Chiltern	11UC	Buckinghamshire	5QD
4	South Bucks	11UE	Buckinghamshire	5QD
4	Wycombe	11UF	Buckinghamshire	5QD
5	South Oxfordshire	38UD	Buckinghamshire	5QD
2	Bury	00BM	Bury	5JX
2	Calderdale	00CY	Calderdale	5J6
1	Cambridge	12UB	Cambridgeshire	5PP
1	East Cambridgeshire	12UC	Cambridgeshire	5PP
1	Fenland	12UD	Cambridgeshire	5PP
1	Huntingdonshire	12UE	Cambridgeshire	5PP

Geog ref	Local Authority	Code	PCT	Code
1	South Cambridgeshire	12UG	Cambridgeshire	5PP
2	Camden	00AG	Camden	5K7
5	Cheshire East	00EQ	Central and Eastern Cheshire	5NP
5	Cheshire West and Chester	00EW	Central and Eastern Cheshire	5NP
1	Chorley	30UE	Central Lancashire	5NG
1	Preston	30UK	Central Lancashire	5NG
1	South Ribble	30UN	Central Lancashire	5NG
1	West Lancashire	30UP	Central Lancashire	5NG
1	City of London	00AA	City and Hackney Teaching	5C3
1	Hackney	00AM	City and Hackney Teaching	5C3
1	Cornwall	00HE	Cornwall and Isles of Scilly	5QP
1	Isles of Scilly	00HF	Cornwall and Isles of Scilly	5QP
2	County Durham	00EJ	County Durham	5ND
2	Coventry	00CQ	Coventry Teaching	5MD
2	Croydon	00AH	Croydon	5K9
1	Allerdale	16UB	Cumbria Teaching	5NE
1	Barrow-in-Furness	16UC	Cumbria Teaching	5NE
1	Carlisle	16UD	Cumbria Teaching	5NE
1	Copeland	16UE	Cumbria Teaching	5NE
1	Eden	16UF	Cumbria Teaching	5NE
1	South Lakeland	16UG	Cumbria Teaching	5NE
2	Darlington	00EH	Darlington	5J9
2	Derby	00FK	Derby City	5N7
4	Amber Valley	17UB	Derbyshire County	5N6
4	Bolsover	17UC	Derbyshire County	5N6
4	Chesterfield	17UD	Derbyshire County	5N6
4	Derbyshire Dales	17UF	Derbyshire County	5N6
4	Erewash	17UG	Derbyshire County	5N6
5	High Peak	17UH	Derbyshire County	5N6
4	North East Derbyshire	17UJ	Derbyshire County	5N6
4	South Derbyshire	17UK	Derbyshire County	5N6
1	East Devon	18UB	Devon	5QQ
1	Exeter	18UC	Devon	5QQ
1	Mid Devon	18UD	Devon	5QQ
1	North Devon	18UE	Devon	5QQ
1	South Hams	18UG	Devon	5QQ
1	Teignbridge	18UH	Devon	5QQ
1	Torridge	18UK	Devon	5QQ
1	West Devon	18UL	Devon	5QQ
2	Doncaster	00CE	Doncaster	5N5
1	Christchurch	19UC	Dorset	5QM
1	East Dorset	19UD	Dorset	5QM
1	North Dorset	19UE	Dorset	5QM
1	Purbeck	19UG	Dorset	5QM
1	West Dorset	19UH	Dorset	5QM
1	Weymouth and Portland	19UJ	Dorset	5QM
2	Dudley	00CR	Dudley	5PE
2	Ealing	00AJ	Ealing	5HX
1	Burnley	30UD	East Lancashire Teaching	5NH
1	Hyndburn	30UG	East Lancashire Teaching	5NH
1	Pendle	30UJ	East Lancashire Teaching	5NH
1	Ribble Valley	30UL	East Lancashire Teaching	5NH
1	Rossendale	30UM	East Lancashire Teaching	5NH
2	East Riding of Yorkshire	00FB	East Riding of Yorkshire	5NW
4	Eastbourne	21UC	East Sussex Downs and Weald	5P7
4	Lewes	21UF	East Sussex Downs and Weald	5P7

Geog ref	Local Authority	Code	PCT	Code
5	Wealden	21UH	East Sussex Downs and Weald	5P7
1	Ashford	29UB	Eastern and Coastal Kent	5QA
1	Canterbury	29UC	Eastern and Coastal Kent	5QA
1	Dover	29UE	Eastern and Coastal Kent	5QA
1	Shepway	29UL	Eastern and Coastal Kent	5QA
1	Swale	29UM	Eastern and Coastal Kent	5QA
1	Thanet	29UN	Eastern and Coastal Kent	5QA
2	Enfield	00AK	Enfield	5C1
2	Gateshead	00CH	Gateshead	5KF
1	Cheltenham	23UB	Gloucestershire	5QH
1	Cotswold	23UC	Gloucestershire	5QH
1	Forest of Dean	23UD	Gloucestershire	5QH
1	Gloucester	23UE	Gloucestershire	5QH
1	Stroud	23UF	Gloucestershire	5QH
1	Tewkesbury	23UG	Gloucestershire	5QH
1	Great Yarmouth	33UD	Great Yarmouth and Waveney	5PR
1	Waveney	42UH	Great Yarmouth and Waveney	5PR
2	Greenwich	00AL	Greenwich Teaching	5A8
1	Halton	00ET	Halton and St Helens	5NM
1	St. Helens	00BZ	Halton and St Helens	5NM
2	Hammersmith and Fulham	00AN	Hammersmith and Fulham	5H1
1	Basingstoke and Deane	24UB	Hampshire	5QC
1	East Hampshire	24UC	Hampshire	5QC
1	Eastleigh	24UD	Hampshire	5QC
1	Fareham	24UE	Hampshire	5QC
1	Gosport	24UF	Hampshire	5QC
1	Hart	24UG	Hampshire	5QC
1	Havant	24UH	Hampshire	5QC
1	New Forest	24UJ	Hampshire	5QC
1	Rushmoor	24UL	Hampshire	5QC
1	Test Valley	24UN	Hampshire	5QC
1	Winchester	24UP	Hampshire	5QC
2	Haringey	00AP	Haringey Teaching	5C9
2	Harrow	00AQ	Harrow	5K6
2	Hartlepool	00EB	Hartlepool	5D9
4	Hastings	21UD	Hastings and Rother	5P8
4	Rother	21UG	Hastings and Rother	5P8
5	Wealden	21UH	Hastings and Rother	5P8
2	Havering	00AR	Havering	5A4
3	Birmingham	00CN	Heart of Birmingham Teaching	5MX
2	Herefordshire, County of	00GA	Herefordshire	5CN
1	Broxbourne	26UB	Hertfordshire	5QV
1	Dacorum	26UC	Hertfordshire	5QV
1	East Hertfordshire	26UD	Hertfordshire	5QV
1	Hertsmere	26UE	Hertfordshire	5QV
1	North Hertfordshire	26UF	Hertfordshire	5QV
1	St Albans	26UG	Hertfordshire	5QV
1	Stevenage	26UH	Hertfordshire	5QV
1	Three Rivers	26UJ	Hertfordshire	5QV
1	Watford	26UK	Hertfordshire	5QV
1	Welwyn Hatfield	26UL	Hertfordshire	5QV
2	Rochdale	00BQ	Heywood, Middleton and Rochdale	5NQ
2	Hillingdon	00AS	Hillingdon	5AT
2	Hounslow	00AT	Hounslow	5HY
2	Kingston upon Hull, City of	00FA	Hull Teaching	5NX
2	Isle of Wight	00MW	Isle of Wight National Health Service	5QT
2	Islington	00AU	Islington	5K8

Geog ref	Local Authority	Code	PCT	Code
2	Kensington and Chelsea	00AW	Kensington and Chelsea	5LA
2	Kingston upon Thames	00AX	Kingston	5A5
2	Kirklees	00CZ	Kirklees	5N2
2	Knowsley	00BX	Knowsley	5J4
2	Lambeth	00AY	Lambeth	5LD
2	Leeds	00DA	Leeds	5N1
2	Leicester	00FN	Leicester City	5PC
1	Rutland	00FP	Leicestershire County and Rutland	5PA
1	Blaby	31UB	Leicestershire County and Rutland	5PA
1	Charnwood	31UC	Leicestershire County and Rutland	5PA
1	Harborough	31UD	Leicestershire County and Rutland	5PA
1	Hinckley and Bosworth	31UE	Leicestershire County and Rutland	5PA
1	Melton	31UG	Leicestershire County and Rutland	5PA
1	North West Leicestershire	31UH	Leicestershire County and Rutland	5PA
1	Oadby and Wigston	31UJ	Leicestershire County and Rutland	5PA
2	Lewisham	00AZ	Lewisham	5LF
5	North Lincolnshire	00FD	Lincolnshire Teaching	5N9
4	Boston	32UB	Lincolnshire Teaching	5N9
4	East Lindsey	32UC	Lincolnshire Teaching	5N9
4	Lincoln	32UD	Lincolnshire Teaching	5N9
4	North Kesteven	32UE	Lincolnshire Teaching	5N9
4	South Holland	32UF	Lincolnshire Teaching	5N9
4	South Kesteven	32UG	Lincolnshire Teaching	5N9
4	West Lindsey	32UH	Lincolnshire Teaching	5N9
2	Liverpool	00BY	Liverpool	5NL
2	Luton	00KA	Luton	5GC
2	Manchester	00BN	Manchester Teaching	5NT
2	Medway	00LC	Medway	5L3
5	Braintree	22UC	Mid Essex	5PX
4	Chelmsford	22UF	Mid Essex	5PX
4	Maldon	22UK	Mid Essex	5PX
2	Middlesbrough	00EC	Middlesbrough	5KM
4	Milton Keynes	00MG	Milton Keynes	5CQ
5	Aylesbury Vale	11UB	Milton Keynes	5CQ
2	Newcastle upon Tyne	00CJ	Newcastle	5D7
2	Newham	00BB	Newham	5C5
1	Breckland	33UB	Norfolk	5PQ
1	Broadland	33UC	Norfolk	5PQ
1	King's Lynn and West Norfolk	33UE	Norfolk	5PQ
1	North Norfolk	33UF	Norfolk	5PQ
1	Norwich	33UG	Norfolk	5PQ
1	South Norfolk	33UH	Norfolk	5PQ
1	Colchester	22UG	North East Essex	5PW
1	Tendring	22UN	North East Essex	5PW
4	North East Lincolnshire	00FC	North East Lincolnshire	TAN
5	North Lincolnshire	00FD	North East Lincolnshire	TAN
1	Fylde	30UF	North Lancashire Teaching	5NF
1	Lancaster	30UH	North Lancashire Teaching	5NF
1	Wyre	30UQ	North Lancashire Teaching	5NF
5	North Lincolnshire	00FD	North Lincolnshire	5EF
2	North Somerset	00HC	North Somerset	5M8
4	Newcastle-under-Lyme	41UE	North Staffordshire	5PH
5	Staffordshire Moorlands	41UH	North Staffordshire	5PH
2	North Tyneside	00CK	North Tyneside	5D8
1	York	00FF	North Yorkshire and York	5NV
1	Craven	36UB	North Yorkshire and York	5NV
1	Hambleton	36UC	North Yorkshire and York	5NV

Geog ref	Local Authority	Code	PCT	Code
1	Harrogate	36UD	North Yorkshire and York	5NV
1	Richmondshire	36UE	North Yorkshire and York	5NV
1	Ryedale	36UF	North Yorkshire and York	5NV
1	Scarborough	36UG	North Yorkshire and York	5NV
1	Selby	36UH	North Yorkshire and York	5NV
1	Corby	34UB	Northamptonshire Teaching	5PD
1	Daventry	34UC	Northamptonshire Teaching	5PD
1	East Northamptonshire	34UD	Northamptonshire Teaching	5PD
1	Kettering	34UE	Northamptonshire Teaching	5PD
1	Northampton	34UF	Northamptonshire Teaching	5PD
1	South Northamptonshire	34UG	Northamptonshire Teaching	5PD
1	Wellingborough	34UH	Northamptonshire Teaching	5PD
2	Northumberland	00EM	Northumberland	TAC
2	Nottingham	00FY	Nottingham City	5EM
1	Ashfield	37UB	Nottinghamshire County Teaching	5N8
1	Broxtowe	37UD	Nottinghamshire County Teaching	5N8
1	Gedling	37UE	Nottinghamshire County Teaching	5N8
1	Mansfield	37UF	Nottinghamshire County Teaching	5N8
1	Newark and Sherwood	37UG	Nottinghamshire County Teaching	5N8
1	Rushcliffe	37UJ	Nottinghamshire County Teaching	5N8
2	Oldham	00BP	Oldham	5J5
4	Cherwell	38UB	Oxfordshire	5QE
4	Oxford	38UC	Oxfordshire	5QE
5	South Oxfordshire	38UD	Oxfordshire	5QE
5	Vale of White Horse	38UE	Oxfordshire	5QE
1	West Oxfordshire	38UF	Oxfordshire	5QE
2	Peterborough	00JA	Peterborough	5PN
2	Plymouth	00HG	Plymouth Teaching	5F1
2	Portsmouth	00MR	Portsmouth City Teaching	5FE
2	Redbridge	00BC	Redbridge	5NA
2	Redcar and Cleveland	00EE	Redcar and Cleveland	5QR
2	Richmond upon Thames	00BD	Richmond and Twickenham	5M6
2	Rotherham	00CF	Rotherham	5H8
2	Salford	00BR	Salford	5F5
2	Sandwell	00CS	Sandwell	5PF
2	Sefton	00CA	Sefton	5NJ
2	Sheffield	00CG	Sheffield	5N4
2	Shropshire	00GG	Shropshire County	5M2
2	Solihull	00CT	Solihull	TAM
1	Mendip	40UB	Somerset	5QL
1	Sedgemoor	40UC	Somerset	5QL
1	South Somerset	40UD	Somerset	5QL
1	Taunton Deane	40UE	Somerset	5QL
1	West Somerset	40UF	Somerset	5QL
3	Birmingham	00CN	South Birmingham	5M1
1	Southend-on-Sea	00KF	South East Essex	5P1
1	Castle Point	22UE	South East Essex	5P1
1	Rochford	22UL	South East Essex	5P1
2	South Gloucestershire	00HD	South Gloucestershire	5A3
1	Cannock Chase	41UB	South Staffordshire	5PK
1	East Staffordshire	41UC	South Staffordshire	5PK
1	Lichfield	41UD	South Staffordshire	5PK
1	South Staffordshire	41UF	South Staffordshire	5PK
1	Stafford	41UG	South Staffordshire	5PK
1	Tamworth	41UK	South Staffordshire	5PK
2	South Tyneside	00CL	South Tyneside	5KG
1	Thurrock	00KG	South West Essex	5PY

Geog ref	Local Authority	Code	PCT	Code
1	Basildon	22UB	South West Essex	5PY
1	Brentwood	22UD	South West Essex	5PY
2	Southampton	00MS	Southampton City	5L1
2	Southwark	00BE	Southwark	5LE
2	Stockport	00BS	Stockport	5F7
2	Stockton-on-Tees	00EF	Stockton-on-Tees Teaching	5E1
4	Stoke-on-Trent	00GL	Stoke on Trent	5PJ
5	Staffordshire Moorlands	41UH	Stoke on Trent	5PJ
1	Babergh	42UB	Suffolk	5PT
1	Forest Heath	42UC	Suffolk	5PT
1	Ipswich	42UD	Suffolk	5PT
1	Mid Suffolk	42UE	Suffolk	5PT
1	St Edmundsbury	42UF	Suffolk	5PT
1	Suffolk Coastal	42UG	Suffolk	5PT
2	Sunderland	00CM	Sunderland Teaching	5KL
4	Elmbridge	43UB	Surrey	5P5
4	Epsom and Ewell	43UC	Surrey	5P5
4	Guildford	43UD	Surrey	5P5
4	Mole Valley	43UE	Surrey	5P5
4	Reigate and Banstead	43UF	Surrey	5P5
5	Runnymede	43UG	Surrey	5P5
4	Spelthorne	43UH	Surrey	5P5
4	Surrey Heath	43UJ	Surrey	5P5
4	Tandridge	43UK	Surrey	5P5
4	Waverley	43UL	Surrey	5P5
4	Woking	43UM	Surrey	5P5
1	Merton	00BA	Sutton and Merton	5M7
1	Sutton	00BF	Sutton and Merton	5M7
4	Swindon	00HX	Swindon	5K3
5	Vale of White Horse	38UE	Swindon	5K3
5	High Peak	17UH	Tameside and Glossop	5LH
4	Tameside	00BT	Tameside and Glossop	5LH
2	Telford and Wrekin	00GF	Telford and Wrekin	5MK
2	Torbay	00HH	Torbay	TAL
2	Tower Hamlets	00BG	Tower Hamlets	5C4
2	Trafford	00BU	Trafford	5NR
2	Wakefield	00DB	Wakefield District	5N3
2	Walsall	00CU	Walsall Teaching	5M3
2	Waltham Forest	00BH	Waltham Forest	5NC
2	Wandsworth	00BJ	Wandsworth	5LG
2	Warrington	00EU	Warrington	5J2
1	North Warwickshire	44UB	Warwickshire	5PM
1	Nuneaton and Bedworth	44UC	Warwickshire	5PM
1	Rugby	44UD	Warwickshire	5PM
1	Stratford-on-Avon	44UE	Warwickshire	5PM
1	Warwick	44UF	Warwickshire	5PM
5	Braintree	22UC	West Essex	5PV
4	Epping Forest	22UH	West Essex	5PV
4	Harlow	22UJ	West Essex	5PV
4	Uttlesford	22UQ	West Essex	5PV
1	Dartford	29UD	West Kent	5P9
1	Gravesham	29UG	West Kent	5P9
1	Maidstone	29UH	West Kent	5P9
1	Sevenoaks	29UK	West Kent	5P9
1	Tonbridge and Malling	29UP	West Kent	5P9
1	Tunbridge Wells	29UQ	West Kent	5P9

Geog ref	Local Authority	Code	PCT	Code
1	Adur	45UB	West Sussex	5P6
1	Arun	45UC	West Sussex	5P6
1	Chichester	45UD	West Sussex	5P6
1	Crawley	45UE	West Sussex	5P6
1	Horsham	45UF	West Sussex	5P6
1	Mid Sussex	45UG	West Sussex	5P6
1	Worthing	45UH	West Sussex	5P6
5	Cheshire East	00EQ	Western Cheshire	5NN
5	Cheshire West and Chester	00EW	Western Cheshire	5NN
2	Westminster	00BK	Westminster	5LC
2	Wiltshire	00HY	Wiltshire	5QK
2	Wirral	00CB	Wirral	5NK
2	Wolverhampton	00CW	Wolverhampton City	5MV
1	Bromsgrove	47UB	Worcestershire	5PL
1	Malvern Hills	47UC	Worcestershire	5PL
1	Redditch	47UD	Worcestershire	5PL
1	Worcester	47UE	Worcestershire	5PL
1	Wychavon	47UF	Worcestershire	5PL
1	Wyre Forest	47UG	Worcestershire	5PL

Source: NWPHO from ONS Population Estimates and ONS Geographical Lookups.

Appendix J - Guide for date of birth bands for survey of three-year-olds 2012/13

For this month of exam ↓	Children born within these ranges will definitely be three years old		There may also be a few more in these ranges
	Earliest birth month and year	Latest birth month and year	Birth Month / Year Check Day of Birth * and **
September 2012	October 2008	August 2009	September 2008 and 2009*
October 2012	November 2008	September 2009	October 2008 and 2009*
November 2012	December 2008	October 2009	November 2008 and 2009*
December 2012	January 2009	November 2009	December 2008 and 2009*
January 2013	February 2009	December 2009	January 2009 and 2010**
February 2013	March 2009	January 2010	February 2009 and 2010**
March 2013	April 2009	February 2010	March 2009 and 2010**
April 2013	May 2009	March 2010	April 2009 and 2010**
May 2013	June 2009	April 2010	May 2009 and 2010**
June 2013	July 2009	May 2010	June 2009 and 2010**
July 2013	August 2009	June 2010	July 2009 and 2010**
August 2013	September 2009	July 2010	August 2009 and 2010**
September 2013	October 2009	August 2010	September 2009 and 2010**

* If born 2008 birth day should be later than day of exam, if born 2009 birth day should be same day or before day of exam.

** If born 2009 birth day should be later than day of exam, if born 2010 birth day should be same day or before day of exam.

Appendix K – Consent letter and form

To be added to headed notepaper - minor modifications are acceptable, local details to be added.

Dear Parent,

Dental survey of three-year-old children

Please will you help us to plan better dental services? To do this we are preparing to look at the teeth of groups of three-year-old children as part of a national survey. We can then compare dental health in the local area and with other areas of the country.

Please give your consent to your child taking part in this year's survey by signing the attached form and returning it to your child care site. The survey is planned to take place on …….. The children taking part will have a simple examination at their nursery/Children's Centre / playgroup when a dentist and assistant who are trained to do this work will visit. The dentist will use fresh disposable gloves and sterilised mirrors for each child. The check takes only a few minutes and we will let you know if we find anything wrong. We would be pleased to see you at the child care site if you would like to be present.

No treatment will be provided, just a quick examination. All children still need to visit their own dentist for regular check-ups.

As part of the survey we will be asking the child care site to share some information they already have, for example postcode or ethnic group. The information about your child will be anonymised and stored in a computer file which will be password protected and only dental staff will have access to it. The anonymised results will be sent to the regional centre so that they can be compared with all Primary Care Trusts in England. The findings may be published in a scientific journal but no individual will be identifiable and the analysis and reporting will be carried out on groups.

Thank you for reading this information sheet. If you have any questions please contact ……

Yours sincerely

Clinical Director

CONSENT FORM

I have read and understood the information in the invitation letter about the dental survey.

My child's name is (insert name)…….. Class ……

Please tick appropriate box below:

Yes, I agree to my child taking part in the dental survey	☐	No, I do not want my child to be included	☐	My child has already taken part in this survey at another child care site	☐

Signed……(parent or guardian) Date ……

Name (block capitals) ……

Optional statements for consent letter:

Please give your home postcode | | | | | | |

Please write the name of your child's doctor or medical practice

……..

Appendix L - Tracking list for child care sites to record return of consent letters – optional use

National Dental Epidemiology Programme Survey of three-year-olds

Return of consent forms - Class ……

Child's name	Tick when form returned	Notes

Appendix M – Data Collection Form

1. LA code |__|__|__|__|__|__| 2. 2006 PCT code |__|__|__|__|__|__|

3. Examiner _____ 4. Site name _____

5. Site Postcode |__|__|__|__| |__|__|__| 6. Site code |__|

0 – LA Nursery class attached to a primary school
1 – LA Children's Centre child care facility
2 – LA funded nursery not in Children's Centre
3 – Private nursery regardless of site
4 – Playgroup regardless of funding or site

7. Date of examination |__|__|__|__|__|__|

8. Child identity number |__|__|__|__|__|__|__|__|__|__| 9. Date of birth |1|5|_m_|_m_|_y_|_y_|_y_|_y_|

10. Home postcode |__|__|__|__| |__|__|__|

11. Sample group code |__| 0 - Main sample 1 - Additional sample A 2 - Additional sample B 3 - Additional sample C 4 - Additional sample D 5 - Additional sample E

12. Examination type |__| 0 - Examined 1- Repeat exam 2 - Training 3 - Absent 4 - Child refused

13. Plaque measurement |__| 0 - Teeth appear clean 1- Little plaque visible 2 - Substantial amount of plaque visible 9 – No assessment possible

UPPER

Right **Left**

E	D	C	B	A	A	B	C	D	E	
										D
		■	■	■	■	■	■			O
										M
										B
										L

Right **LOWER** **Left**

E	D	C	B	A	A	B	C	D	E	
										D
		■	■	■	■	■	■			O
										M
										B
										L

Extra Box

Missing incisors :
probably extracted for caries ……..…6
unerupted or missing other ……..…8

Tooth Codes

Extracted caries.....	**6**
Unerupted or missing other.....	**8**

Surface Codes

Sound..... Blank, '-' , Or	**0**
Hard, arrested caries.....	**1**
Decayed.....	**2**
Decay + pulpal involvement.....	**3**
Roots only remaining…….	**3**
Filled and decayed.....	**4**
Filled.....	**5**
Filled, needs replacement.....	**R**
Obvious sealant rest'n.....	**N**
Sealed surface	**$**
Crown	**C**
Trauma.....	**T**

Extra Box

Missing incisors :
probably extracted for caries ……..…6
unerupted or missing other ……..…8

15. Abscess / Sepsis present |__| 0 - Absent 1 - Present

Optional measures

16. Higher Ethnicity |__| See 12.10.1 **17. Lower Ethnicity** |__| See 12.10.1

18. Spare variable |__| 0 - 1 - 2 - 3 –

19. Spare variable |__| 0 - 1 - 2 - 3 -

20. Spare variable |__| 0 - 1 - 2 - 3 -

Appendix N - Examination sheet – essential and should be retained securely if longitudinal surveys are intended

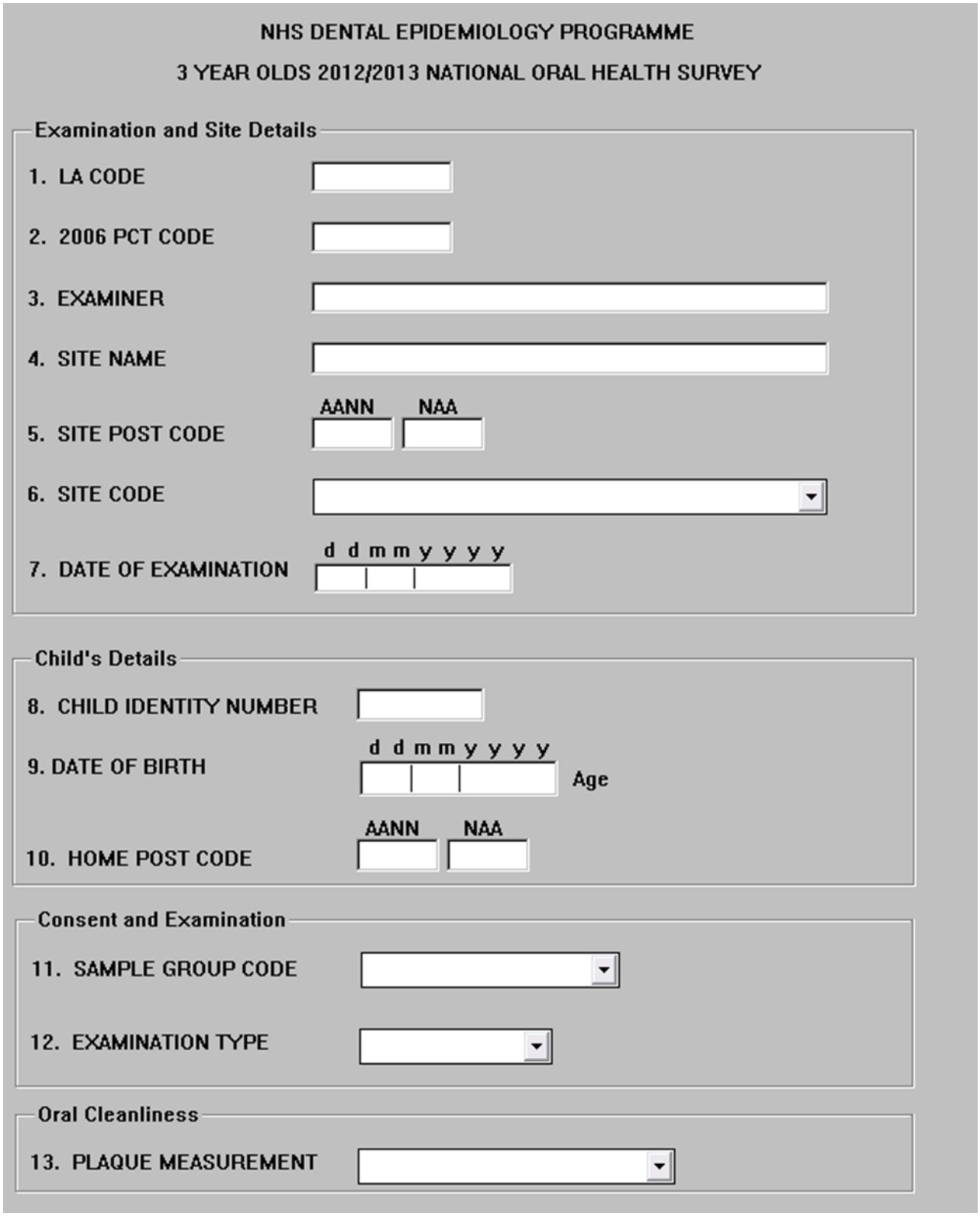
National Dental Epidemiology Programme - Survey of three-year-olds 2012/13

Name of Site ……
Date of examination _ _ / _ _ / _ _ _ _

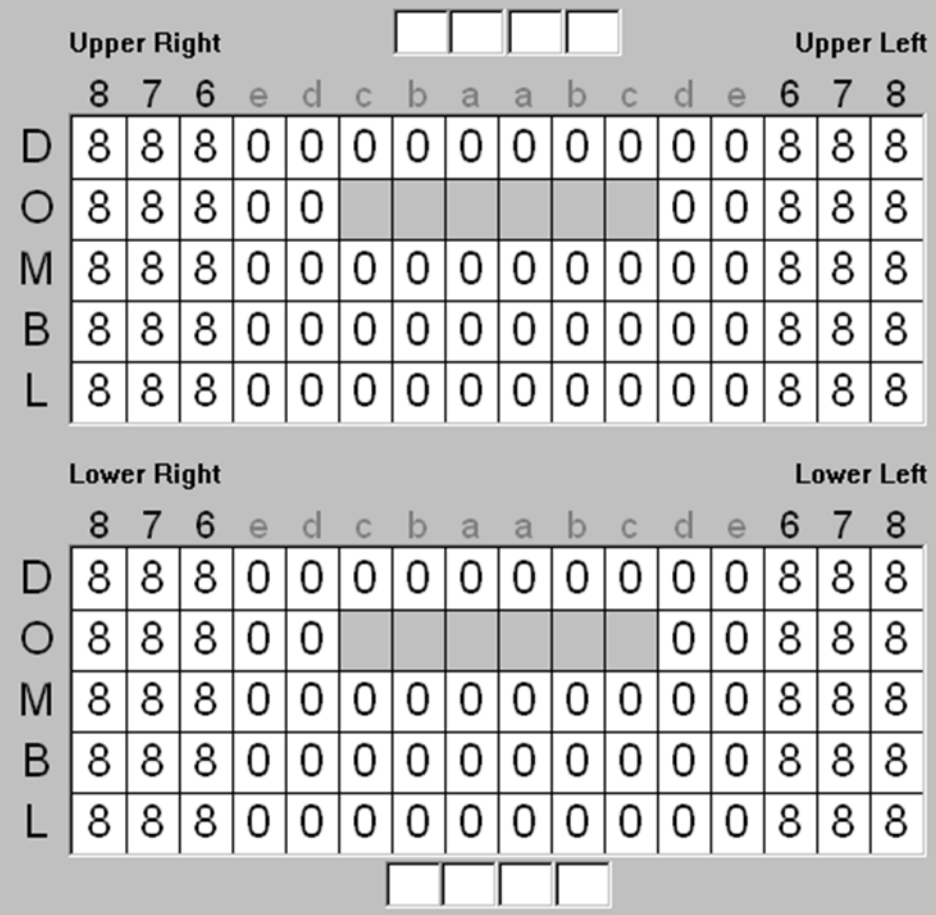
Site postcode …… ….
Name of site contact……
Telephone number……

				Examination status					
							Consent provided		
Child's name	ID Number	Date of Birth	Postcode	Parent refused	Consent given	No form returned	Examined	Absent	Child refused

Appendix O – Format for Dental Survey Plus 2 – download from www.nwph.net/dentalhealth



14.



Other Details

15. ABSCESS / SEPSIS PRESENT

Optional Details

Ethnicity Details

16. HIGHER ETHNICITY

17. LOWER ETHNICITY

Spare Details

18. SPARE 1

19. SPARE 2

20. SPARE 3

Appendix P - Summary information sheet and questionnaire recording experiences of consent collection – one form to be completed per LA and PCT

National Dental Epidemiology Programme Survey
three-year-old children 2012/13

Local Authority .....

Primary Care Trust .....

Name of examiner(s) .....

Start - finish date of examinations (dd/mm/yyyy – dd/mm/yyyy) ..... - .....

Total number of child care sites listed by LA/PCT [ ] Number of sites visited [ ]

Total number of three-year-old children attending listed child care sites [ ]

Number of children sampled [ ]

Number of children with : parental consent supplied [ ] parental consent refused [ ] consent form not returned [ ]

Number of children with parental consent : examined [ ] child absent [ ] child refused [ ]

In the site with the lowest response rate what proportion of children had parental consent? [ ]

In the site with the highest response rate what proportion of children had parental consent? [ ]

What do you think are the key factors for the success of gaining high levels of consent from pre-school sites?

.....

.....

.....

.....

What do you think are the key factors that can lead to low levels of consent from pre-school sites?

.....

.....

.....

.....

Appendix P cont. – Reporting of non-BASCD standard sampling methods – additional, augmented or 'census' samples, use of additional codes for ethnic groups.

Name of PCT(s) _____

Name of LA(s) _____

Were 'additional' samples taken for local purposes?	
Yes	
No	

If yes – please explain the formation of the additional sample(s):
A
B
C
D
E

Will it be necessary for weighting to be applied when The Dental Observatory calculates PCT or LA estimates?	
Yes	
No	

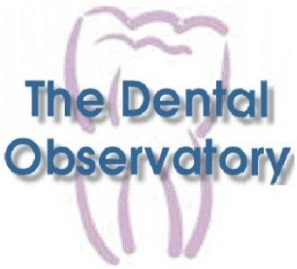
If weighting is required then please complete the table below

Label of sub-group	Number of age group in population	Number examined
A		
B		
C		
D		
E		

Were codes F, G or H in variable 15 used for additional ethnic groups in this PCT / LA?	
Yes Please give details of these in the table below	
No	

If codes F, G or H were used for additional ethnic groups in this PCT / LA please give details of the specific group coding (E.g. Code F – Polish, or Code G – Roma, or Code H – Somali)

	Description of ethnic group
Code F	
Code G	
Code H	



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Published October 2012