Public Health England

Protecting and improving the nation's health

Dental public health epidemiology programme

Oral health survey of adults attending general dental practices 2017/18

National protocol

Final version amended December 2017

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1. Introduction

Local authorities have been responsible for gathering information on the health needs of their local populations since April 2013, following the white paper, Equity and Excellence; Liberating the NHS 2010.[1] This imperative is described in the Health and Social Care Act 2012, underpinned by Statutory Instrument 2012 number 3094,[2] and Commissioning Better Oral Health.[3]

The population group for scrutiny for the academic year 2017/18 will be adults attending general dental practices. This requires a new methodology but will produce oral health information about adults at local authority level and allow comparison at regional, NHS England (NHSE) and local authority level, as well as comparison with the findings of the 2009 Adult Dental Health Survey (ADHS). This will provide new insight for local authorities, the NHS and other partners as well as highlighting inequalities.

This protocol provides a description of the standardised methods that fieldwork teams should use when undertaking this survey.

IRAS number: 233971

Ethical approval for this study has been granted by on behalf of NHS Health Research Authority by London - Fulham Research Ethics Committee on Monday 9th October 2017, Ref 17/LO/1594.

2. Aim of the survey

The aims of the survey are to:

- collect information about oral health and service use from a representative sample of adults, drawn from those attending general dental practices, to provide local, relevant intelligence to local authorities and NHS commissioners about the populations they serve

- establish baseline learning about the feasibility of collecting routine information about the oral health of adults, using general dental practice patients and assess the validity and utility of this method

This information can be used to:

- Enable local authorities to meet their statutory responsibilities with assessment of oral health needs
- Inform part of a health needs assessment, particularly joint strategic needs assessments
- provide comparisons with adults examined in the ADHS, 2009 and 2018
- inform the local oral health improvement strategy
- provide standardised information for comparison, locally and regionally
- compare caries information recorded by general dental practitioners on claim forms with that provided by epidemiology examiners, to guide future use

3. Study stages

1. Consult with local authority dental leads regarding priorities for content of survey.
2. Establish a planning group for protocol development.
3. Formation of a population sampling frame of NHS / mixed / independent general dental practices.
4. Sampling to provide useful samples to the lowest possible geographical level.
5. Training for commissioned epidemiology fieldwork teams.
6. Recruitment of sampled practices and patients.
7. Recruitment of volunteer patients for self-completion questionnaire.
8. Brief clinical examination by trained epidemiology examiner.
9. Collection of DT MT FT information from FP17 forms.

10. Enter anonymised data onto secure tool, upload to secure central point, collate, check and clean data.

11. Analyse and compare with ADHS information.

12. Produce report and make recommendations.

4. Sample

The population sampling frame will be all general dental practices in England, NHS / mixed / independent, drawn from a list derived from the NHS Business Services Authority and from the Care Quality Commission. Practices offering only orthodontic care, specialist or paediatric care will be excluded.

Sampling will be undertaken by PHE Dental Public Health Epidemiology Team (PHE DPHET) using a standardised process which will meet the needs of the varying local government geographies and the varied distribution of practices.

The primary sampling unit will be local authority boundaries at unitary, metropolitan borough or lower-tier level. Practices will be randomly sampled such that larger practices are more likely to be selected.

For a standard minimum sample, fieldwork teams will contact all practices, in order of random selection, until they have visited a minimum of 10 practices, or all practices if there are fewer than 10. The aim will be to recruit and survey a minimum of 160 adults at these practices.

In a very small number of local authority areas there are insufficient practices to produce robust samples at lower-tier level. Where this is the case larger numbers of participants will be recruited at the existing practice. Alternatively discussion with the relevant Dental Epidemiology Coordinator (DEC) and Consultant in Dental Public Health (CDPH) who has local knowledge of usual groupings of small local authorities may suggest a way of grouping local authorities to allow a sample to be drawn which produces information at a local level.

Lists of sampled practices, grouped by local authority, along with contact details, will be sent to the nominated CDPH who is acting as the DEC for each PHE centre, for distribution to the relevant epidemiology fieldwork teams. The same lists, grouped by NHSE regional team will be sent to the teams to assist with communication.

4.1 Survey population

The survey population is defined as; all adults aged 16 and older, attending randomly sampled general dental practices for their dental care, who agree to participate in the survey and have capacity to consent to take part, on the agreed sessions.

5. Responsibilities

5.1 Overall and commissioning

The overall responsibility for planning this survey and quality assuring the resulting products lies with the national teams within PHE.

The study sponsor is Dr Sandra White for Public Health England who has the responsibility of initiating and managing the project, ensuring that the design of the study meets appropriate standards and that arrangements are in place to ensure appropriate conduct and reporting.

Responsibility for ensuring co-ordination and facilitation of the application of quality standards lies with the local PHE DECs.

The commissioning of the surveys will be the responsibility of the local authorities, often in partnership with NHS England dental commissioning teams and supported by local PHE Consultants in Dental Public Health.

The local planning and organisation of the survey will be carried out by commissioned fieldwork teams, typically from Community Dental Services (CDS), who will liaise with local NHSE teams and sampled general dental practices.

Responsibility for delivery of the fieldwork to agreed national standards lies with the commissioned fieldwork teams.

5.2 Personnel and working safely

Fieldwork for the survey will be carried out by services commissioned by the local authority, sometimes in partnership with NHS England. The self-completed questionnaires will be facilitated by support workers who will have received training in carrying out questionnaires to reduce bias. The clinical dental examinations will be carried out by registered dental clinicians who will be trained to apply the agreed

standards. Each team will comprise, as a minimum, one trained dentist and one trained support worker. It is likely that more adults will be recruited if there are two support workers, one in the surgery with the dentist and one in the waiting room recruiting and assisting with questionnaires.

The nature of the clinical measures being recorded precludes the use of therapists or hygienists for the full clinical examination.

Each fieldwork team will include, as a minimum:

- a qualified and registered dental surgeon[i], trained in the procedure for the survey clinical examination at a regional training event provided by PHE. Ideally the clinician should have experience of undertaking dental epidemiological surveys

- administrative support workers who have received training in carrying out the questionnaire at a regional training event provided by PHE. Ideally the administrative support worker should have experience of undertaking dental epidemiological surveys. At least one of the support workers will need to be fully trained with regard to decontamination in the surgery between patient volunteers

All team members will be required to have:

- criminal records bureau (CRB) or disclosure and barring service (DBS) certificates, obtained or updated in the previous three years

- vulnerable adult safeguarding training at a level commensurate with their role as clinicians, the majority of which will already be in place because of the clinical work they undertake on a daily basis and the vulnerable groups for whom they usually provide clinical care

- up-to-date training in data protection and other relevant information governance, infection control and safeguarding issues

All team members will abide with their employing organisations policies with regards to health and safety matters during their work, reporting accidents or safety issues including loss or theft of equipment. Particular attention should be paid to travelling safely, staying safe in public places, and maintaining personal safety while interviewing.

[i] In rare circumstances therapists can be used as clinical examiners, but the range of clinical measures that they can complete will be restricted.

Teams should familiarise themselves with fire exits at each practice.

The total resources involved in carrying out this clinical survey and the questionnaire are likely to be similar to that required for traditional child cohort surveys.

6. General conduct of the survey

The national dental public health team will compile a list of all general dental practices in England and use a random sampling process to provide ordered lists of practices at lower-tier local authority level and send these to fieldwork teams. Local fieldwork teams will contact the sampled practices to seek cooperation and arrange suitable times to visit. The teams will approach adults attending the practice on the agreed days and seek agreement for them to take part in the survey. The survey comprises a self-completed questionnaire and a simple clinical examination. The latter will take place in a surgery that is not being used.

The sampling unit will be lower tier local authorities. For each of these a sample of a minimum of 10 practices will be recruited in order from the sampling list, and a minimum of 16 adults will be recruited at each of these practices. There are a small number of local authorities where a different sampling model will be required and this will be agreed with Dental Epidemiology Coordinators and local CsDPH.

An overview of the survey is shown in plan form (Appendix D).

6.1 The national survey planning group, coordinated by PHE, will implement a communications strategy to ensure that local authority commissioners, NHS E teams, Local Dental Committees (LDCs), Local Dental Networks (LDNs), general dental practices, Dental Epidemiology Coordinator (DECs), Centre-based CsDPH, Regional epidemiology trainers and fieldwork teams are all aware of the purpose, principles and process of the survey.

6.2 Training will be provided at a regional level by members of the planning group. This will cover approaching sampled practices, involving adult patients, gaining consent, working around the practice schedule, supporting completion of the self-administered questionnaire, carrying out the standard clinical examination and gathering scores from the FP17 forms. Calibration on volunteers for all elements of the clinical examination is not indicated or feasible but additional training in recording caries in the permanent dentition will be given and a photographic calibration will be run at training events.

6.3 For this pilot survey honorariums will be paid to all NHS practices who host the survey. This will be no less than £185, paid by local Clinical Research Networks to support research in primary care and will recognise the minor inconvenience to the practice, the provision of an unused surgery and other facilities and the assistance of the administrative team in production of details from consented patient's FP17s.

7. Fieldwork

Fieldwork will take place in the practices, starting immediately after training and announcement of ethical approval and must be completed by the end of June 2018. This gives sufficient time for checking and cleaning of data, summing of numbers of practices and adults approached, recruited and completing the survey.

Following receipt of the list of practices for each local authority listed in randomly sampled order, the epidemiology fieldwork team will first send a letter to the practice owner of the first three or four practices. The letter will explain the purpose of the survey, explain what is being asked of the practices and ask for co-operation (Appendix Gi) and will complement communications via BDA, LDNs, LDCs, FGDP and NHS E prior to the start of the survey. A response section will be included which practices should complete and return to the fieldwork team in a reply paid envelope or by e-mail.

Where no response is received from sampled practices a follow-up telephone call should be made with the same purpose as the letter. If this approach also produces no agreement to assist then the next practice on the list should be approached.

It is pragmatic to send out introductory letters to the first three or four practices on the sampled list and then bring in substitute practices for those who decline to take part and progress incrementally until all practices up to a maximum of 10 have been included and a minimum of 160 adults have been surveyed.

A summarised explanation (Appendix C) is provided which may be used to give practices more detail about the purpose and nature of the survey. It also shows that the request for co-operation comes from a formal, legitimate NHS source.

7.1 Where practices indicate their willingness to support the survey, fieldwork teams will agree dates for visiting the practice to run the survey examination at a mutually convenient time and date.

A preliminary visit to each practice would be very helpful to allow for discussion to plan the survey day(s) or sessions.

In order to ensure a wide spread of patient ages consideration should be made about the best times of days to visit. In some cases a morning visit and an afternoon one may cover the various patients' daily routines. Visiting practices on varying days of the week can ensure the sample includes rare attenders and those attending with urgency. Evening sessions should also be considered as these may well attract people of working age. All adults should have the opportunity to take part and no individual or group will be excluded on grounds of race, gender, religious beliefs or sexual orientation.

7.2 Centrally produced posters and information cards should be offered to practices to display near to reception in the two weeks before the survey visit so that patients have some pre-warning of the nature and purpose of the survey.

7.3 A form indicating consent by the practice to use the premises and have access to FP17 forms should be completed prior to the start of data collection (Appendix Gii). Signed forms, with practice details, should be retained with tracking tables until the results of the survey are published.

7.4 Details of participating practices (Name of practice and address) will be required to be collected and retained to allow payment of honorariums

7.5 Practical suggestions for practice visits:

- when arranging a visit try to find out when would be the best time– a surgery needs to be available and you want to see people of a range of types and ages. In some cases it may be better to attend on two half days or even an evening session to be able to do this. If a practice has a pre-arranged time for those unexpectedly needing urgent care it may be helpful to arrange your visit to ensure you cover this

- a couple of weeks before the arranged visit go to the practice to introduce yourself and deliver a few posters about the planned survey and a pile of information postcards which have been completed to show local contact details. Ask the reception staff to display the posters and hand out information cards to anyone who might be booked to attend on the pre-arranged day

- prepare the paperwork for each practice ahead of time – print enough patient information sheets and consent letters and staple them together. Print the questionnaires and the clinical data collection sheets and staple them together. Print a tracking sheet so you can see who has reached each stage

- use differently coloured Foolscap document wallets (Appendix H) to collate paperwork at different stages of the data collection process

- if using a SatNav to find a practice use the full address, not just the postcode as this will be more accurate

- pack all the necessary equipment into smart cases so that you only need to do one trip from the car to the practice

- try to approach as many adults as possible in the waiting room but accept that some will refuse

- most local authority area teams are asked to visit a minimum of 10 practices and recruit a minimum of 16 adults at each. This is a minimum sample, not a target so see as many people as you can at each practice and make the most of the opportunity. The more volunteers we have the better the sample will be.

- the most efficient way to work is with two support workers and one dentist on the team. One support worker can recruit adults in the waiting room and assist them to complete the questionnaire then bring them through and record measures for clinical examination. The second can take over and repeat the process with other volunteers. At least one of the support workers will need to be fully trained with regard to decontamination in the surgery between patient volunteers.

- use the progress panel on the front of the questionnaire and the tracking sheet to record how each volunteer is progressing. Write in pencil for this part so that the initials or name can be deleted once the three sets of information have been captured.

- a flexible approach will be needed to ensure that the practice appointment schedule is not disrupted. Some volunteers can have their clinical examination first and complete the questionnaire second

7.6 Consent

The procedure for obtaining explicit, positive consent must involve:

- provision of posters and information cards for patients to see at recruited practices in the weeks prior to the survey visit

- giving potential adult volunteers an invitation letter which gives clear information explaining the nature and purpose of the dental survey in broad terms and simple language (Appendix J)

- provision of a form which reports explicit consent for the survey, and indicates that volunteers have read and understood the information letter (Appendix K)

Coercion to provide positive consent should not be used and would make the process illegal.

Respondents will be given clear explanations in writing, and verbally if necessary, of the purpose of the study, confidentiality issues and the way in which the data will be used (Appendix J). All of the interviews and clinical examinations will be conducted on a voluntary basis and fieldwork teams will not interview or examine someone who is unwilling to take part.

The steps taken to ensure informed consent, without pressure or inducements, are described here which is to be read in conjunction with the principles of ethical recruitment (Box 1).

Each fieldwork team will adapt all survey documents only in terms of the logo and contact details about their organisation.

Individuals who agree to participate will still have the opportunity to opt out of the dental examination, to refuse to answer a particular question and to withdraw from either interview or examination at any time. In some circumstances the examination or the questionnaire may not be completed and this should be recorded using the coding system provided. The number of part-completed questionnaire and clinical examinations will be reported.

Where neither the clinical examination nor the questionnaire is completed a further randomly sampled and consented person should be substituted.

Dental epidemiology fieldwork teams will comply closely with the principles of ethical recruitment (Box 1).

Box 1. Principles of ethical recruitment

- All prospective volunteers will be approached in a sensitive manner and asked if they would be willing to take part in a survey of adult dental health
- No coercion, inducement or financial reward will be provided
- the provision of dental treatment will be unaffected by the participation or non-participation of potential volunteers and this will be made clear to them
- information sheets will be provided for all potential volunteers. A core information sheet is provided (Appendix J) and fieldwork teams should make minor amendments only to show their organisation details
- the information sheet should be read out to those who have difficulties reading English
- in circumstances where mental capacity or understanding is limited the survey team should explain the purpose and nature of the survey, in terms which are appropriate
- potential volunteers should be given time to consider whether or not they wish to take part
- positive consent should be obtained prior to commencement of the questionnaire or clinical survey. This should be written using the agreed consent form (Appendix K) which should be completed with a unique ID number of each volunteer. Where only verbal consent can be obtained this should be recorded and witnessed
- in cases where an adult is unable to give consent because of mental incapacity no other adult can consent on their behalf. In such cases the adult will not be recruited into the survey but recorded among all those approached
- respondents will be provided with repeat opportunities to opt-out of participating in the survey, and those that do will be regarded as survey non-responders. It is expected that there will always be non-responders to voluntary sample surveys, but it is important to try to minimise non-response to maximise the confidence in the reliability of the survey estimates

- it is important that all steps are followed in the sampling and recruitment process to ensure maximum compliance whist upholding the ethical principles listed above

7.7 Capacity to provide informed consent

Some adults may have limited capacity to provide consent. Members of the fieldwork team should use their knowledge relating to this area to make their assessment of the ability of individuals to give consent. In addition, the process will be covered in the survey specific training provided to interviewers. In cases where it is judged that the potential volunteer does not have the capacity on that occasion to take part in the survey then the fieldwork team should not continue. Assent will not be sought.

Fieldwork teams must keep a record of the number of all adults approached, the number giving consent, and the number refusing so that Appendix N can be completed and submitted along with data files. A box is provided on the tracking sheet to allow a tally to be kept of the number approached at each practice.

8. Collection of data – general information

8.1 Training

Only trained dental surgeons[ii], assisted by appropriately trained assistants, will undertake the collection and recording of non-clinical and clinical data, using this protocol.

Regional training events will give details of the procedure of undertaking the questionnaire and the clinical examination.

Objectives of regional training:

- to train DECs, epidemiology trainers and fieldwork teams to be able to work through the relevant processes of, approaching, recruiting and surveying adults attending general dental practices according to this protocol

[ii] In rare circumstances therapists can be used as clinical examiners but the range of clinical measures that they can complete will be restricted.

- to train support staff to ask questions of volunteers from the questionnaire and record response data accurately
- to train clinical examiners to undertake reproducible examinations for the study
- to train support staff to record clinical codes correctly
- to ensure fieldwork personnel know how to enter the data and handle it according to data protection guidelines

8.2 Computer software

Data should be collected using the Microsoft Access data collection tool with specific formats for this survey. The tool can be downloaded from www.nwph.net/dentalhealth/ [AdultsiP 2018 Data Collection.accdb].
The formats contain several free fields at the end for local use. If these fields are insufficient for local information requirements it is requested that additional fields are added to the end of the national format.

8.3 Confidentiality

Fieldwork teams will ensure that all data is handled with full regard to confidentiality and the data protection legislation. Access to all data files will be controlled and protected by passwords.

Fieldwork teams will only retain anonymous, processed data files for purposes of verification. These files should be retained until the national data is published.

Consent forms will carry personal information and so are confidential. Therefore they must be collected, transported and stored with due regard and with all steps taken to avoid any details being disclosed to unauthorised personnel.

As personal data processed for purposes of research and statistics falls within the scope of the Data Protection Act (but may be exempt from subject access) each provider team will register their data collection according to local procedures.

All confidential information relating to this survey should be kept securely until the results are published and then disposed of in a secure way.

8.4 Security

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

If data are collected onto paper sheets in the field, transfer onto computer will occur with the minimum of delay. It is good practice for data to be entered on the same day as examination takes place. 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.

8.5 File management

Files should be labelled to indicate the population group and local authority to which they refer. It is insufficient to simply label files with the population group and year of survey.

Data handling guidance instructions on the checking, cleaning and labelling of data files will be provided via DECs and published on www.nwph.net/dentalhealth/

8.6 File transfer

Data files will only be transferred on disk or stick by hand delivery from the fieldwork team to the DEC or by sending as an email attachment from an nhs.net address to the DEC's nhs.net address.

9. Collection of non-clinical data

In order to respect the dentist-patient professional relationship it is important that no-one in the survey team makes any comment about the oral health status of volunteers, nor about past or current treatment. Similarly no oral health advice should be given except to suggest to the patient that they speak to their own dentist if they have any concerns or questions. If examining teams come across anything that gives concern about a safeguarding issue or a lesion giving concern then they should speak directly with the volunteer's dentist in the first instance.

Fieldwork teams will need to take:

- epidemiology paperwork packs comprising

  - information sheets with consent forms attached
  - blank questionnaires and clinical data collection sheets attached together
- clipboards
- coloured folders to keep
  - blank epidemiology paperwork packs
  - part completed questionnaires and clinical data collection sheets
  - completed questionnaires and clinical data collection sheets that require FP17 information to be added
  - fully completed questionnaires and clinical data collection sheets, including FP17 data
- pens and pencils
- the tracking table (Appendix I)
- centrally produced ‘Thank you’ cards

9.1 Recording of background information

9.1.1 Organisational boundary coding

The clinical data collection sheet for each adult examined requires entry of the code number of the lower-tier local authority within which the practice is sited. This is defined by the geographical position of the practice within local authority boundaries. This should be clear, as the National Team will have provided lists of sampled practices with this information. A table of names and codes for lower-tier local authorities is provided in Appendix F.

9.1.2 Volunteer identity number

A unique identity number must be entered for each volunteer, which consists of a prefix from the lower-tier local authority code and a suffix, which starts with the number of the practice and ends in the number of the volunteer.

For example, the third volunteer to take part in the fourth practice involved in Aylesbury Vale would have the following ID number:

Lower-tier local authority									Number of volunteer				
E	0	7	0	0	0	0	0	4	0	4	0	0	3

The 185th volunteer to be sampled in the ninth practice in Aylesbury Vale would have the following ID number:

Lower-tier local authority									Number of volunteer				
E	0	7	0	0	0	0	0	4	0	9	1	8	5

The use of identity numbers instead of names improves anonymity of the data and should reduce the chance of duplicate data entries.

The use of an identifier for practices will allow provision of individual feedback for practices that request this.

9.2 Recording of questionnaire information

The questionnaire will enquire into demographic details, past attendance, barriers to seeking dental care, impact of oral health, provision of preventive messages and ability to pay for treatment.

The questionnaire can be self-completed by the volunteers as this increases privacy, however, should they require help then the interviewer can provide this. Assistance can be given with individual questions if the volunteer requires clarification or, if requested, the interviewer can read the questions to the volunteer and record their answers. Interviewers must avoid leading the volunteer to answer questions in any particular way, but rather allow them to make their own choices. No judgments about patient responses should be expressed, nor should any advice on clinical care be given.

9.2.1 Ethnic code

Volunteers will be asked to provide a response about their ethnic origin to ensure the requirements of the Health and Social Care Act, 2012.[iii] This act "…introduced the first specific legal duties on health inequalities, including duties on the Secretary of State for Health. All staff undertaking NHS and public health functions on behalf of the Secretary of State are responsible for ensuring compliance with these duties and this guidance is designed to help you do so." This would include a requirement to collect ethnicity data to be able to report any inequalities measured in dental health.

The options for response are drawn from the list given on the FP17 form but the volunteer should be asked to provide this information as part of the questionnaire.

9.2.2 Home address postcode

Home postcodes will be recorded for volunteer adults who are willing to give this. Admin supporters should ensure it is clear which entries are meant to be letters, and which are numbers. The most common data entry faults are the substitution of the letters I and O for the numbers 1 and 0.

Care is also needed with postcodes when it comes to entering these data into the computer. Note that 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 box, no spaces.

[iii] See: phenet.phe.gov.uk/Our-Organisation/Directorates/Health-and-Wellbeing/Documents/Reducing%20health%20inequalities%20and%20equality%20act%2027%20March.pdf

10. Collection of clinical data

The dental examination will be carried out on consenting respondents. The following data will be collected by the specifically trained dental clinician and recorded onto the data collection sheet:

- the number of natural teeth present, along with their caries status
- the presence of bleeding on probing
- an assessment of the number of posterior segments with one or more tooth-to-tooth or tooth-to-replacement contacts
- presence and condition of dentures
- the need for treatment and degree of urgency
- the PUFA index

The dental examination is likely to take 15 minutes on average, depending on the number of natural teeth and the ability of the respondent to cooperate. Respondents with both natural teeth and dentures may have a slightly longer examination than those with just natural teeth. The clinical examination will be well within the normal competence of a qualified dental surgeon.[iv]

10.1 Equipment, instruments and materials

10.1.1 Examinations should take place in a surgery which is not being used for clinical treatment on the agreed sessions. Volunteer patients should be examined supine in the dental chair with the examiner seated behind them on a clinician's chair. The examination will be visual only, aided by mouth mirrors and the clinical light.

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.

[iv] In rare circumstances therapists can be used as clinical examiners but the range of clinical measures that they can complete will be restricted.

Probes must only be used for cleaning debris from the tooth surfaces to enable satisfactory visual examination and for assessing bleeding on probing (see 10.4). Radiographic or fibre-optic trans-illumination examination will not be undertaken.

10.1.2 Fieldwork teams will provide the instruments required which are:

- No.4 plain mouth mirrors, good quality disposable mirrors can be used
- 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 immediately prior to use
- paper covers and trays for instruments
- ball ended CPITN/BPE probes or blunt or ball ended probes (0.5mm)
- disposable cups for patients to rinse if they want to
- latex and powder free gloves
- paper liners for instrument trays
- rigid boxes for transporting of clean and dirty instruments
- yellow bags for disposal of waste
- protective spectacles for participant

Used instruments and disposables should be safely removed from the practice and decontaminated or safely disposed of at the fieldwork base. The practice equipment, other than the dental chair and light, and the clinician's and assistant's chairs, will not be used.

10.1.3 Local policies and arrangements will be applied to maintain infection control and avoidance of allergic reactions to latex and glove powder. A fresh set of autoclaved instruments or disposable instruments and a new pair of latex-free examination gloves will be used for each volunteer.

10.1.4 Cotton wool rolls or cotton buds will be used to clear teeth of debris and moisture, not the surgery triple syringe.

10.1.5 Suitable shaded spectacles will be used to protect the volunteer's eyes from the light and accidental contact.

10.1.6 Data may be entered either onto paper record sheets (Appendix M) or directly onto computer, with safeguards for both methods (see 8.4).

10.2 Medical screening

There is no need to ask volunteers about any medical conditions prior to examination, as probing for assessment of gingival bleeding does not pose a risk to patients with a previous history of Rheumatic Fever or other cardiac disorders, according to recent guidance from NICE.

In order to respect the dentist-patient professional relationship it is important that no-one in the survey team makes any comment about the oral health status of volunteers, nor about past or current treatment. Similarly, no oral health advice should be given except to suggest to the patient that they speak to their own dentist if they have any concerns or questions. If examining teams come across anything that gives concern about a safeguarding issue or a lesion giving concern then they should speak directly with the volunteer's dentist in the first instance.

10.3 Stage 1 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 will be recorded using the BASCD standardised criteria (BASCD) Diagnostic Criteria for Caries Prevalence Surveys.5 The application of these criteria will be taught using the BASCD teaching pack.

Some modifications to the coding have been made to allow for reporting on adults when there is less clarity about reasons for extraction.

Data will be recorded at tooth level but all surfaces will be examined. The worst condition seen on any of the tooth surfaces will be the one that is assigned to that tooth.

10.3.1 Conventions

The following conventions will apply:

a) Only permanent teeth will be included in the examination.

b) 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.

c) 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.

d) Caries takes precedence over non-carious defects, eg hypoplasia.

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

f) Surfaces which are obscured, eg banded teeth, should be assumed to be sound.

10.3.2 Teeth present, absent and replaced

It may be useful to start by identifying which teeth are present and which are absent, and which have been replaced by fixed or removable means.

Tooth code 6 – extracted for any reason with no replacement. If there has been an extraction and root remains have been left in place, code 3 should be used.

Tooth code F – extracted tooth, replaced by a fixed tooth – either an implant or bridge pontic.

Tooth code D – extracted tooth, replaced by a removable tooth – a denture.

10.3.3 Obscured surfaces

All obscured surfaces are assumed 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.

10.3.4 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 tooth, the worst condition any surface being applied to denote this.

These codes, which are mutually exclusive, are as follows:

Code - – sound
Criteria - a surface is recorded as 'sound' using a dashed mark '–' 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
- 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'.

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.

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.

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.

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.

Code 5 – filled with no decay
Criteria – surfaces which contain a satisfactory permanent restoration of any material will be coded under this category.

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.

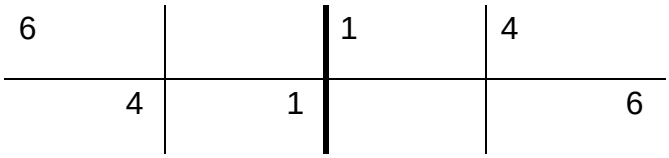
Lesions or cavities containing a temporary dressing, or cavities from which a restoration has been lost will be regarded as 'filled, needs replacing' unless there is also evidence of caries into dentine, in which case they will be coded in the appropriate category of 'decayed'.

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. Note that code C also applies to pre-formed and stainless steel crowns.

When doubt exists about the classification of any surface condition, the lower category should always be recorded. However the worst condition of any surface of the tooth should be the one that is recorded for the tooth.

10.4 Stage 2 Gingival condition

It is of interest to have a measure about gingival condition which relates to the point at which a general dental practitioner would be prompted to consider action and at which patients may be aware of a problem if they see bleeding when brushing. Bleeding on probing will be recorded for the six index teeth shown on the chart:



The CPITN/BPE probe will be gently inserted into the gingival margin sulcus no more than 2mm deep at an angle between 45 to 60 degrees to the longitudinal axis of the tooth on the buccal and palatal surfaces[6]. The probe should be continuously swept around the gingival sulcus and the presence or absence of bleeding at least 30 seconds from initial probing of the site should be recorded.

The coding to be used is:

0	No bleeding on probing
1	Some bleeding on probing
9	Unscorable

10.5 Stage 3 Functional occlusal contacts (line 3 on chart)

The assessment of occlusal contacts refers to occlusal contacts between **upper and lower natural teeth and between natural teeth and denture or bridge replacements.** This short examination examines only the posterior (premolar and molar) regions. The examination is conducted with dentures in place if they are normally worn.

10.5.1 Procedure

A contact is the same as an occlusal stop. For the purposes of this examination you should get the subject to close together normally on the back teeth (sometimes the phrase “clench your back teeth together” is the most effective) and then, using a mirror to hold back the cheek, look at the lower arch from the side and record the distribution of contacts.

In the posterior region we are looking for tooth to tooth contact involving one or more lower natural or artificial molars making contact with an upper natural tooth or artificial replacement. Similarly in the premolar region we look for a contact involving one or more lower premolars and a natural or replacement tooth in the upper arch. The presence of a contact is determined by the lower tooth.

Just look at each side in turn and work out whether or not there is a contact between a lower molar and another natural or artificial tooth in the upper arch, then between a lower premolar and another natural or artificial tooth in the upper arch.

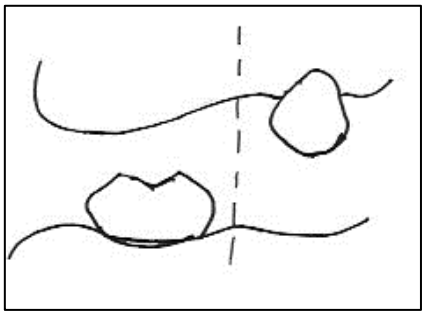
The scoring is quite easy, obviously if there is NO lower tooth or denture or bridge pontic in the area you are looking at there cannot possibly be a contact. Record contact between premolars (1 or 0), then between molars on the right and repeat on the left.

10.5.2 Codes and criteria: Posterior functional contacts

0 = No posterior functional contact

1 = Posterior functional contact present

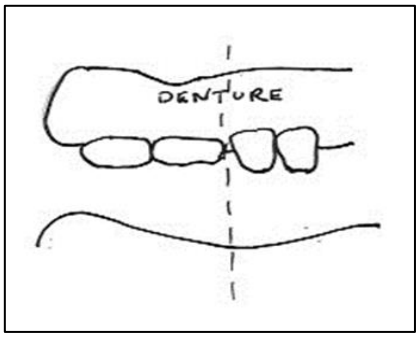
Illustrative examples:



Molar area – no contact in upper for lower right molar, so no PFC

Premolar area – no premolar in lower so no PFC

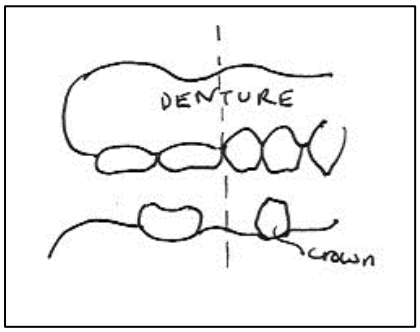
3	Segments containing teeth with functional contacts against natural or replacement teeth	0	0	



Molar area - no molar in lower so no PFC

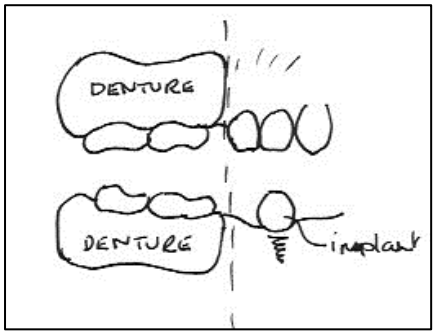
Premolar area – no premolar in lower so no PFC

3	Segments containing teeth with functional contacts against natural or replacement teeth	0	0	



Molar area – lower natural tooth has functional contact with denture tooth in upper so there is a PFC
Premolar area – lower fixed replacement tooth has functional contact with denture tooth in upper so there is a PFC

3	Segments containing teeth with functional contacts against natural or replacement teeth	1	1	



Molar area – lower denture teeth have functional contact with denture teeth in upper so there is a PFC
Premolar area – lower implant retained crown has functional contact with natural upper teeth – there is a PFC.

3	Segments containing teeth with functional contacts against natural or replacement teeth	1	1	

10.6 Stage 4 Dentures

It is essential that any dentures are now removed for the rest of the examination.

10.6.1 Codes and criteria: dentures

You will now have, to hand, any dentures the participant may have. The dentures, including full dentures opposed by natural teeth or partial dentures should be examined separately, upper and lower, for the following features.

Denture absent or present and type, material and condition recorded separately for upper and lower arches.

The material type should relate to the major structure of the denture:

- if the denture has a cast metal base then it should be recorded as being metal
- if the denture is mostly acrylic with metal clasps or rests then it should be coded as acrylic

If the denture is unequivocally in need of repair or relining or additions then this should be coded although it should be borne in mind that many people manage very well with incomplete, old or broken dentures.

If the denture is no longer functional for chewing or appearance and could not be significantly improved by relining or repair or addition then it should be coded for replacement.

10.7 Stage 5 PUFA

Examiners will ask the patient the following question:

Do you have any pain or discomfort in your mouth at the moment?

0 = No pain

1 = Yes pain

If “No” do not ask the further question but do carry out an examination to look for PUFA lesions.

If “Yes”, then ask

Do you think the pain is related to your teeth?

0 = No

1 = Yes

Examiners will then examine the soft tissues by gently retracting lips and cheeks to allow the soft tissues to be examined and record the presence or absence of any of the lesions listed below. The lesions to be looked for are:

- open pulp in permanent dentition
- traumatic ulceration in permanent dentition
- abscess in permanent dentition
- fistula in permanent dentition

10.7.1 Codes and criteria: PUFA

0 = No lesions evident

1 = A single lesion present

2 = Two or more lesions present

10.8 Stage 6 Assessing general dental treatment need

The purpose of this section is to allow general assessments to be made about the types of treatment adults have. It is not possible to lay out criteria for treatment need for all conditions that might be found and the aim of this recording is not to list all possible treatment that might be needed to achieve a perfect dental state that might meet the expectations of a specialist. Instead examiners are asked to consider the needs of each individual volunteer to achieve a stable oral and dental condition, free of discomfort and able to eat, speak and socialise without restriction because of problems with their mouth or teeth. It is also appreciated that the brief, visual examination may leave some conditions undiagnosed so the examiner can only base their assessment on what they can see at the time.

The information from this section can only be analysed to make broad statements about need.

10.8.1 Items of treatment

Using the knowledge gained from the brief examination the examiner should record all the treatment, if any, that they consider the individual volunteer requires to maintain, stabilise or improve their oral condition so that it can remain or become stable, free of important progressive disease and allowing comfortable function.

The options are:

- No treatment
- Prevention advice – oral health, diet, additional fluoride
- Removal of calculus
- Minor restoration – simple direct fillings

- Major restoration – crowns/bridges/veneers/inlays, with or without endodontic treatment
- Extraction(s) or other minor surgery
- Prosthetic care – repair, reline, addition, copy for existing denture or provision of one or more new partial or complete dentures
- Other treatment

One or more options can be selected.

10.8.2 Degree of urgency

The information derived from this section will be used to make broad statements about the proportion adults who are in need of urgent clinical dental care.

Examples of a need for urgency would include overt malignancy, lesions that arouse suspicions of malignancy, uncontrolled swelling and uncontrolled bleeding. This list is not exhaustive.

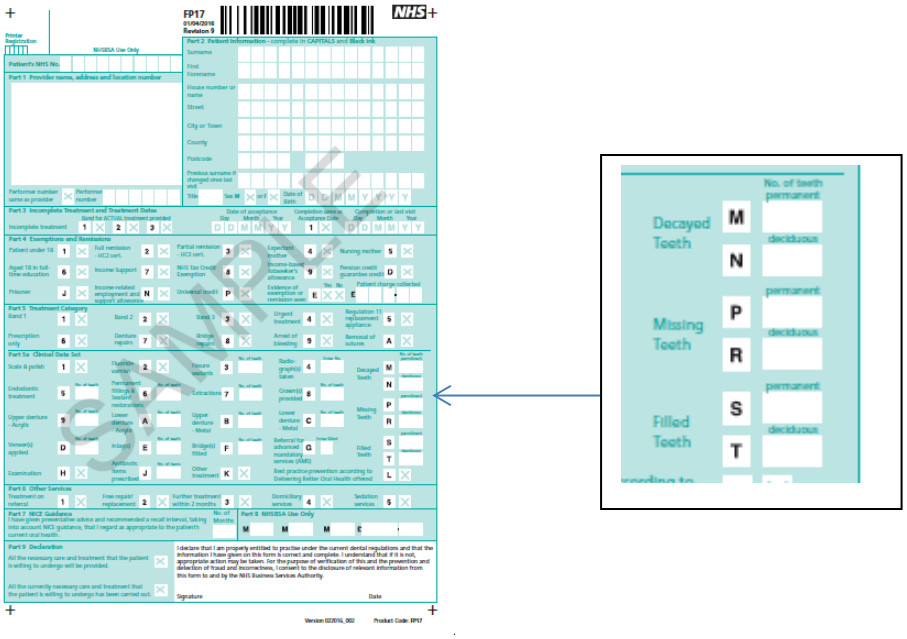
Most other dental conditions would not require urgent care but can be dealt with during routine care.

10.9 Stage 7 Retrieval of DT MT FT data from patients' FP17 claim forms

Since April 2017 general dental practitioners (GDPs) have been required to provide counts of the number of decayed, missing and filled teeth on all NHS treatment claims forms (FP17s). This data is entered in section 5a, the clinical data set, and is often carried out automatically by computer systems. Volunteers for the survey will have been asked to give consent to their FP17 data being shared and a variety of methods may be necessary for teams to capture these data.

Survey teams should ask for help from practice staff to capture this data as only they will have access to the hard copy or electronic FP17 forms. Good relations with reception desk staff and the practice manager will be essential to facilitate access to this information.

Where the practice uses hard copies of the FP17 it may be possible to simply ask for the practice staff to look at the form and provide the details to the survey team once the patient has been examined by the GDP.



In others the information is entered automatically onto electronic claim forms and the FP17 DT MT FT data may not be available until the patient has finished their course of treatment. For these it will be necessary to keep a record so they can be followed up. Use the tracking sheet to indicate the need to follow up the volunteers' records, keep their names on the front of the questionnaire temporarily and phone back to the practice after a few weeks to capture the detail you need.

If a volunteer is attending the practice for urgent care the FP17 DT MT FT may not be completed. If a previous course of care occurred within the last three months then the DT MT FT can be used from then, if not, record the reason for the missing data.

Volunteers who are attending private practices or who are having private treatment at an NHS practice will not have FP17 DT MT FT data to collect. The reason for this should be coded on the data collection sheet.

Different IT systems need different approaches to retrieve the FP17 data and the process may not be familiar to practice staff. Instructions follow for the main IT systems.

10.9.1 How to view the DT MT FT data on a patient's FP17 form on Exact-Software of Excellence.

You can only view information on a patient's FP17 form once the patient has finished their course of treatment and the dentist has noted this on the patient's record. To view the FP17 form:

1) Go on to the appointment book for the day and double click on the patient that you have examined.

2) Click on the £ icon, this will bring up the patient's payment account.

3) Click on the FP17 icon on the patient's payment account, the DMFT score for this patient is then available in this format.

Look for this:

	DT	MT	FT
Permanent	0	22	3
Deciduous – not needed for this survey			

If the patient has not yet finished their treatment this information will not be present, these details will need to be collected at the end of their course of treatment (follow-up table needed to allow this).

10.9.2 How to view the DT MT FT data on a patient's FP17 form using R4 and R4 Clinical +

1) Go on to the appointment book for the day and click on the patient you require so their name is highlighted.

2) Click on the view patient's file icon (three heads symbol).

3) Click on the treatment tab.

4) Click the box which says "show old plans".

5) Click on the correct course of treatment.

6) Click NHS claim button, the DT MT FT score for this patient is then available in this format:

DMF	Decayed	Missing	Filled
Permanent tooth assessment	12	11	2
Deciduous – not needed for this survey			

The DMF indicators displayed show the state of the mouth at the date of acceptance (exam) not the completion, this shows no indication of the treatment carried out in this course of treatment.

If the patient has not yet finished their treatment this information will not be present, these details will need to be collected at the end of their course of treatment (follow-up table needed to allow this).

10.9.3 How to view the DT MT FT data on a patient's FP17 form using Pearl Dental Software

Short version:

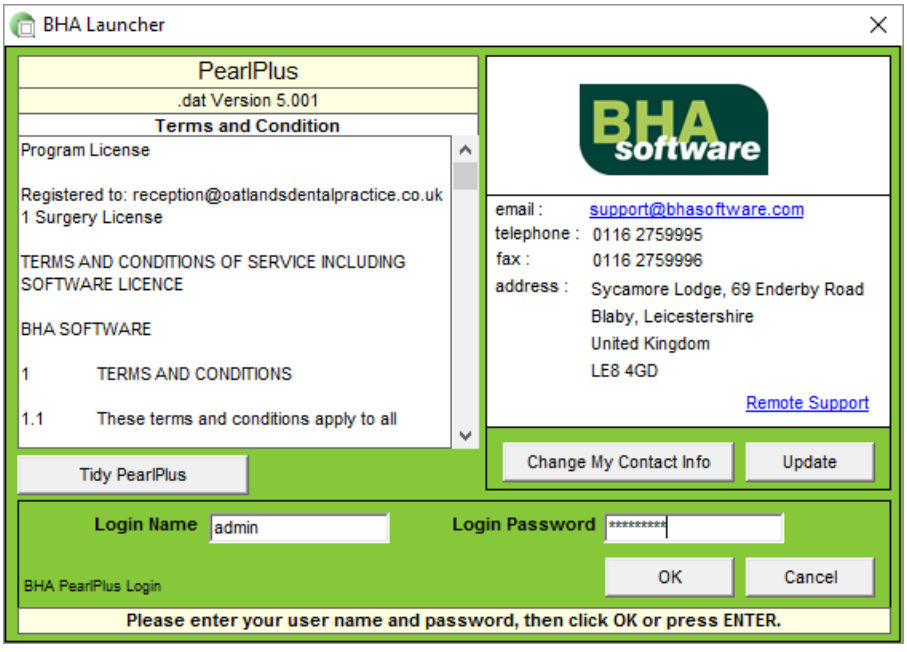
1) From the patients record click the "NHS" button in bottom right.

2) From NHS window press the NHS button again this will view the most recent form.

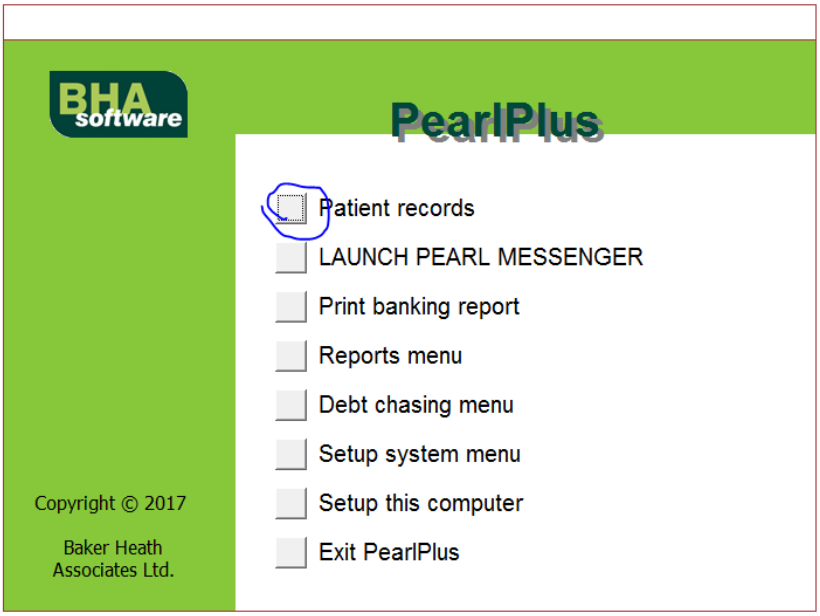
3) Scroll down on the most recent form and it will show you the DMF.

Long version:

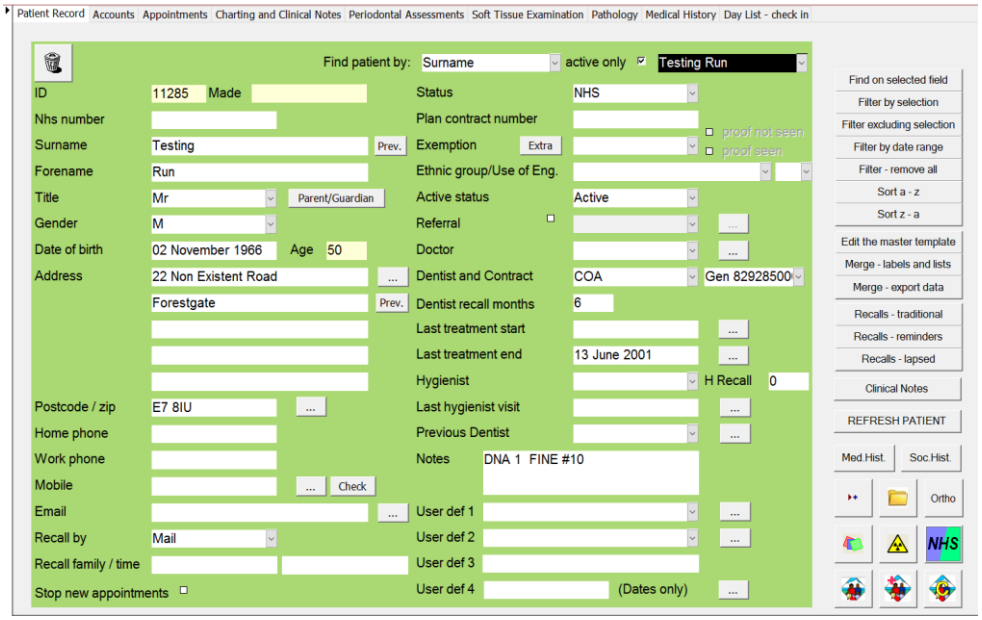
1) Login to system



2) Go to “Patient Records”

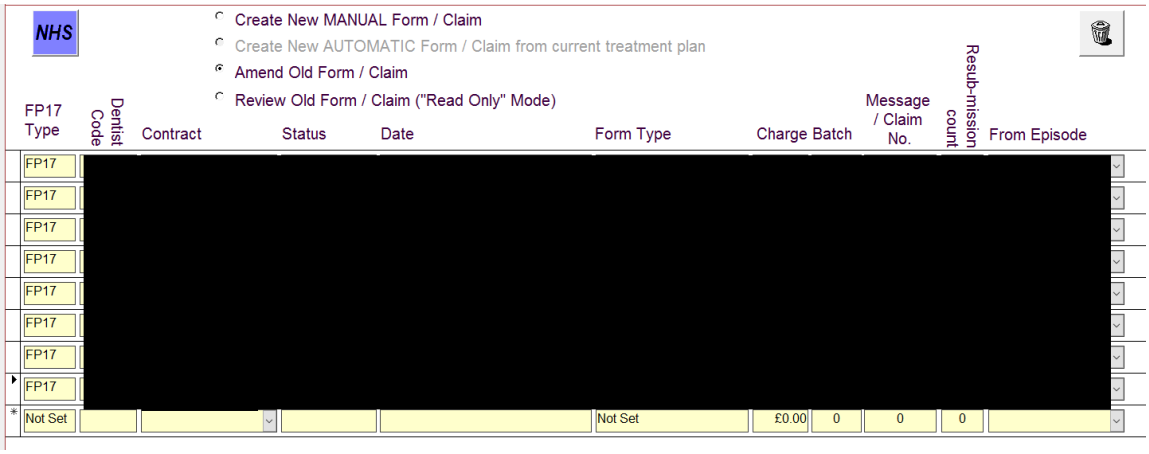


3) Go to Specific Patient (search using combo in top right)



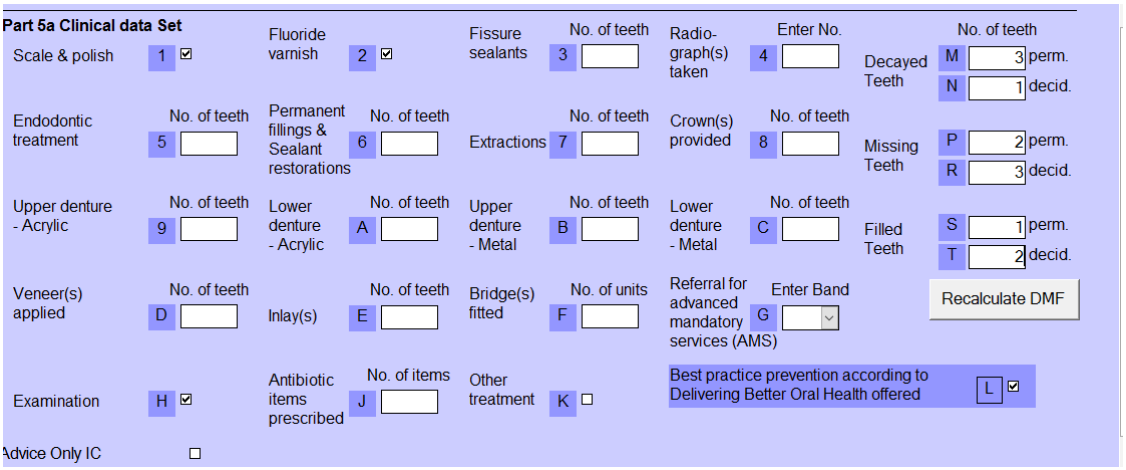
4) Press the NHS button (Located in bottom right)

5) This will give you a list of FP17s for the current patient.



6) Click on a specific form you want to view the DMF for and then press the NHS button in top left.

7) This will bring up an FP17 on screen. Scroll down and the DMF is visible.



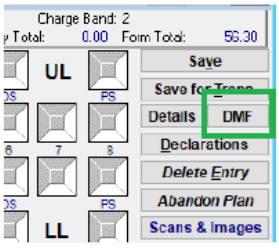
This will show you the DMF that was transmitted within a certain course of treatment. Any issues call the support line 0116 275 9995 and they will be able to assist.

10.9.4 How to view the DT MT FT figures using the Paragon and Edge Software system from Dentsys

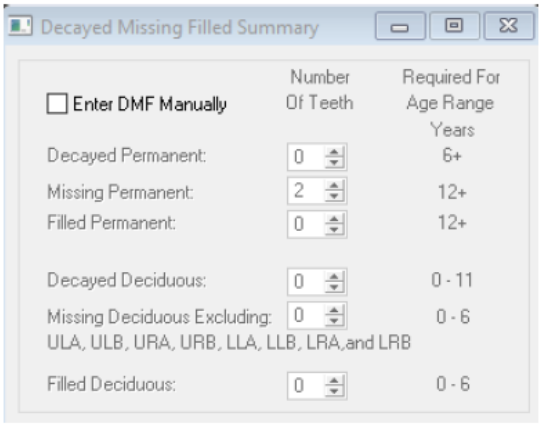
DMF Calculation and Capture for the Paragon and Edge Software Systems

The DMF data is captured in one of two ways; Automatically or Manually.

When within a Treatment Plan, the clinician can display the DMF screen by clicking the 'DMF' button.



This displays the following screen:



The details within this screen represent the state of the mouth at the start of treatment. The system will inspect the Hard Tissue chart that was created on examination (if one was created) and populate the figures as relevant. In the above example, the clinician would have charted on the Hard Tissue chart that two Permanent teeth were missing, but none were decayed or filled.

These figures then do not change during or after treatment, as they represent the state of the mouth before treatment.

11. Reporting of data

Data should be entered into a secure computer with the Microsoft Access format for the **2017-18 survey** as soon as possible after visiting each practice. Data should not be left to be entered as a batch when all fieldwork is completed.

Prior to sending on data files, each fieldwork team is responsible for checking their data for inaccuracies. The main areas for error occur with duplicate entries for volunteers and postcodes.

Guidance will be provided which will give a step-by-step guide to the whole data handling process. This will be available from your DEC.

Once data has been checked and errors corrected, files should be correctly labelled according to the guidance and sent on to the relevant DEC to upload. Files can be passed by hand on password-protected memory sticks or disks directly to the DEC or they can be sent as email attachments from an nhs.net address to an nhs.net address. Separate files should be formed for each local authority and labelled to indicate the age group and local authority to which they refer.

The following will be reported using Appendix N:

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

2. Total number of sampled practices contacted.

3. Number of practices agreeing to host the survey and visited.

4. Total number of adults approached from whom consent was initially sought.

5. Number of adults who agreed to take part in the survey and gave consent.

6. Number of adults who completed the questionnaire.

7. Number of adults who completed the clinical examination.

8. Number of adults who completed both the questionnaire and examination.

Data will be submitted as cleaned Excel sheets exported from Access survey files and summary reports submitted as completed Excel documents. Separate guidance on data handling will be provided.

All returns should be made to DECs as soon as possible after completion of the survey and **no later than 31 July 2018**. These must only be made by direct handing over of a password-protected memory stick or disc or by email attachments from an nhs.net address to an nhs.net address and should include:

- the completed Appendix N summary worksheet for each upper-tier local authority – one line for each lower-tier, where these exist

- the Excel sheet exported from the Access survey file for each local authority labelled to indicate which local authority it refers to

DECs will upload the data files received from fieldwork teams to the national dental public health team, via a secure portal.

The national report will be provided by the national dental public health team and the Risk Factors Intelligence function of the Health Improvement directorate.

Cleaned and verified copies of the raw, anonymised data will be available to DECs as soon as practicable after the publication of the main report. This will enable DECs and colleagues working in PHE centres to make maximum use of their data if further analysis is required for local use.

Local authority personnel can apply to become a super-user and access the raw, anonymised data for specific purposes via this process:

1. Local authority requestor to send an email to DentalPHIntelligence@phe.gov.uk providing the following information:

    - Name of individual to be allocated as ‘super user’

    - Local Authority

    - Contact details

2. The nominated ‘Super User’ will be contacted by a member of the DPHET who will send a data sharing agreement for signing.

3. Once the signed agreement has been received the super user will be sent their (anonymised) data along with a set of analysis guidance notes.

11.1 Other data requests

Any data requests that are for national data, or complex queries, should be emailed to DentalPHIntelligence@phe.gov.uk. The request will be considered by the Risk Factors Intelligence function and the national dental public health team and, if feasible, will

either be sent to the appropriate DEC or Super User for completion or conducted on a 'once for all' basis.

12. References

1. Department of Health (2010). Equity and excellence: Liberating the NHS. London, The Stationery Office. Accessed in June 2016 from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

2. Statutory Instrument 2012 No 3094. National Health Service, England Social Care Fund, England Public Health, England. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Health watch) Regulations 2012. Accessed in June 2016 from: http://origin-www.legislation.gov.uk/uksi/2012/3094/part/4/made

3. Public Health England (2014). Local Authorities improving oral health for children and young people : An evidence-informed toolkit for local authorities. www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf

4. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012.

5. 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.

6. Greater Manchester Local Dental Network. Healthy Gums DO Matter. Periodontal Management in Primary Dental Care. Practitioner's toolkit. 2014

13. Table of appendices

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

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

~ Document will be available in Excel format from www.nwph.net/dentalhealth/

Appendix A. Statutory Instrument 2012, No. 3094 - extract

S T A T U T O R Y I N S T R U M E N T S

2012 No. 3094

NATIONAL HEALTH SERVICE, ENGLAND SOCIAL CARE FUND, ENGLAND PUBLIC HEALTH, ENGLAND

The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012

Made - - - - 12th December 2012
Laid before Parliament 17th December 2012
Coming into force in accordance with regulation 1(2)

Extract from pages 8, 9, 26 and 27

PART 4

DENTAL PUBLIC HEALTH FUNCTIONS OF LOCAL AUTHORITIES

Interpretation

16. In this Part—

"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;

"water fluoridation programme" means fluoridation arrangements made under section 87(1) (fluoridation of water supplies at request of relevant authorities) of the Water Industry Act 1991(**g**)[v].

Exercise of functions of local authorities

17.—

V (**g**) 1991 c.56. Section 87(1) is substituted by section 58(1) and (2) of the Water Act 2003 (c.37).

(1) Each local authority (**h**)[vi] shall have the following functions in relation to dental public health in England.
(2) A local authority shall provide, or shall make arrangements to secure the provision of, the following within its area—

(a) to the extent that the authority considers appropriate for improving the health of the people in its area, oral health promotion programmes;

(b) 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 arrangements for provision of dental services as part of the health service, and
(iv) where there are water fluoridation programmes affecting the authority's area, the monitoring and reporting of the effect of water fluoridation programmes.

(3) The local authority shall participate in any oral health survey conducted or commissioned by the Secretary of State under paragraph 13(1) of Schedule 1 to the 2006 Act (powers in relation to research etc)(**a**)[vii] so far as that survey is conducted within the authority's area.

Revocations and transitional arrangements

18.—

(1) The Functions of Primary Care Trusts (Dental Public Health) (England) Regulations 2006(**b**)[viii] ("the 2006 Regulations") are revoked.

(2) This paragraph applies where, in the exercise of its functions under the 2006 Regulations, a Primary Care Trust—
(a) provided an oral health promotion programme or an oral health survey which was ongoing immediately prior to section 29 of the 2012 Act coming fully into force, or
(b) participated in an oral health survey required by the Department of Health which was ongoing immediately prior to section 29 of the 2012 Act coming fully into force.

(3) Where paragraph (2) applies, each local authority whose area fell wholly or partly within the area of the Primary Care Trust shall continue to carry out the oral health promotion programme or oral health survey, to the extent that the programme or survey relates to persons in the local authority's area.

Signed by authority of the Secretary of State for Health.
Anna Soubry
Parliamentary Under-Secretary of State for Health,
Department of Health

12th December 2012

EXPLANATORY NOTE
(This note is not part of the Regulations)

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vi (**h**) *See* section 2B(5) of the 2006 Act for the definition of "local authority", which is also applied to section 111 by virtue of section 111(3) of that Act.
vii (**a**) Paragraph 13 of Schedule 1 to the 2006 Act is substituted by section 17(2) and (13) of the 2012 Act.
viii (**b**) S.I. 2006/185.

These Regulations make provision in relation to the designation of certain NHS bodies as Care Trusts, the public health functions of local authorities and Local Healthwatch organisations.

Part 4 specifies the functions to be exercised by local authorities in relation to dental public health in England.

The functions to be exercised by local authorities in relation to dental public health in England as specified in Part 4, relate to the provision of oral health promotion programmes and oral health surveys. In the case of oral health surveys, local authorities must make their own arrangements for oral health surveys and must also participate in any such surveys conducted or commissioned by the Secretary of State.

Appendix Bi. Letter of support from programme lead for dental public health, Public Health England, to directors of public health and NHS E dental leads

Public Health England

Dental Public Health
Skipton House
80 London Road
London SE1 6LH

T +44 (0)20 7654 8179

www.gov.uk/phe

To: Directors of Public Health

27th September 2017
Gateway number: 210350

Dear Director of Public Health,

Re: Forthcoming oral health survey of adults in practices 2017/18

Local authorities are appreciative of the information that is produced about the oral health of children via the PHE Dental Public Health Epidemiology programme. They note that, in contrast, there is limited information about the oral health needs of adults and this shortcoming restricts their ability to plan for oral health improvement and to oversee the provision of clinical services. In order to respond to this need PHE will coordinate a national survey which will focus on adults and provide information on needs and clinical service use at local authority level.

A multi-agency planning group, with representation from Local Government Association, has developed and piloted the method and will produce a national protocol to allow commissioned fieldwork teams to run standardised surveys of adults encountered in general dental practices. The resources required for this will be roughly the same as those required for a standard, minimum sample survey of caries in school children. Regional training events will be provided in September and October.

The national surveys provide benchmarking data that may be used by local authorities in joint strategic needs assessments to both plan and commission oral health improvement interventions and evaluate them. The surveys also inform national policy.

I would like to take this opportunity to thank local authorities and particularly directors of public health for their support.

Local authorities have had responsibility for improving health and reducing inequalities, including oral health, since April 2013. Participation in the surveys is required by the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012: Part 4 Regulations, which specify the functions to be exercised by local authorities in relation to dental public health and oral health surveys in England. Local authorities should provide or secure the provision of oral health surveys to: assess and monitor oral health needs, plan and evaluate oral health promotion programmes, plan and evaluate arrangements for provision of dental services and monitor and report on the effect of water fluoridation programmes. In addition, local authorities should participate in any oral health survey conducted or commissioned by the Secretary of State so far as that survey is conducted within the authority's area.

PHE is asking directors of public health to support local involvement in the 2017/18 survey. PHE has dental epidemiology co-ordinators (consultants in dental public health) across England based in PHE centres who will advise during the whole process, including commissioning of these surveys.

As PHE co-ordinates the National Dental Epidemiology Programme we are keen to hear how surveys can continue to respond to the needs of users so I would be happy to receive feedback.

Yours sincerely,

Sandra White BDS, FDSRCS, MPH, FDS(DPH)RCS, FFPH, MBA, PCMedEd

National Lead for Dental Public Health
Email: Sandra.white@phe.gov.uk

Appendix Bii. Letter of support from programme lead for dental public health, Public Health England, to NHS E dental leads

Public Health England

Dental Public Health
Skipton House
80 London Road
London SE1 6LH

T +44 (0)20 7654 8179

www.gov.uk/phe

To: NHS E Leads for dental services

27th September 2017
Gateway number: 210350

Dear NHS E Leads for dental services,

Re: Forthcoming oral health survey of adults in practices 2017/18

NHS England teams are appreciative of the information that is produced about the oral health of children via the PHE Dental Public Health Epidemiology programme. They note that, in contrast, there is limited information about the oral health needs of adults and this shortcoming restricts their ability to plan the provision of clinical services. In order to respond to this need PHE will coordinate a national survey which will focus on adults and provide information on needs and clinical service use at local authority level.

A multi-agency planning group, with representation from NHS England, has developed and piloted the method and will produce a national protocol to allow commissioned fieldwork teams to run standardised surveys of adults encountered in general dental practices. The resources required for this will be roughly the same as those required for a standard, minimum sample survey of caries in school children. Regional training events will be provided in September and October.

The national surveys provide benchmarking data that may be used by commissioners and also to inform national policy.

I would like to take this opportunity to thank NHS England for their support for these surveys.

PHE is asking NHS England to support local involvement in the 2017/18 survey. PHE has dental epidemiology co-ordinators (consultants in dental public health) across England based in PHE centres who will advise during the whole process, including commissioning of these surveys.

As PHE co-ordinates the National Dental Epidemiology Programme we are keen to hear how surveys can continue to respond to the needs of users so I would be happy to receive feedback.

Yours sincerely,

S White

Sandra White BDS, FDSRCS, MPH, FDS(DPH)RCS, FFPH, MBA, PCMedEd
National Lead for Dental Public Health
Email: Sandra.white@phe.gov.uk

Appendix C. Information about the purpose and nature of the survey

Public Health England dental public health epidemiology programme
Oral health survey of adults 2017-2018

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

This year the survey will focus on adults (aged 16+) and will access them when they attend general dental practices. The survey aims to provide information about the oral health status of adults and their use of treatment services at a local level. This will assist NHS England to arrange services to meet the needs of the population and local authorities to plan health improvement programmes where they are needed.

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. Regional training will be 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 randomly sampled general dental practices within a local authority area. They will ask for cooperation from the practice and, where this is given, arrange a suitable time to visit the practice when a surgery is not being used. Information about the survey will be provided for the practice to pass on to patients so that they know what is being planned.

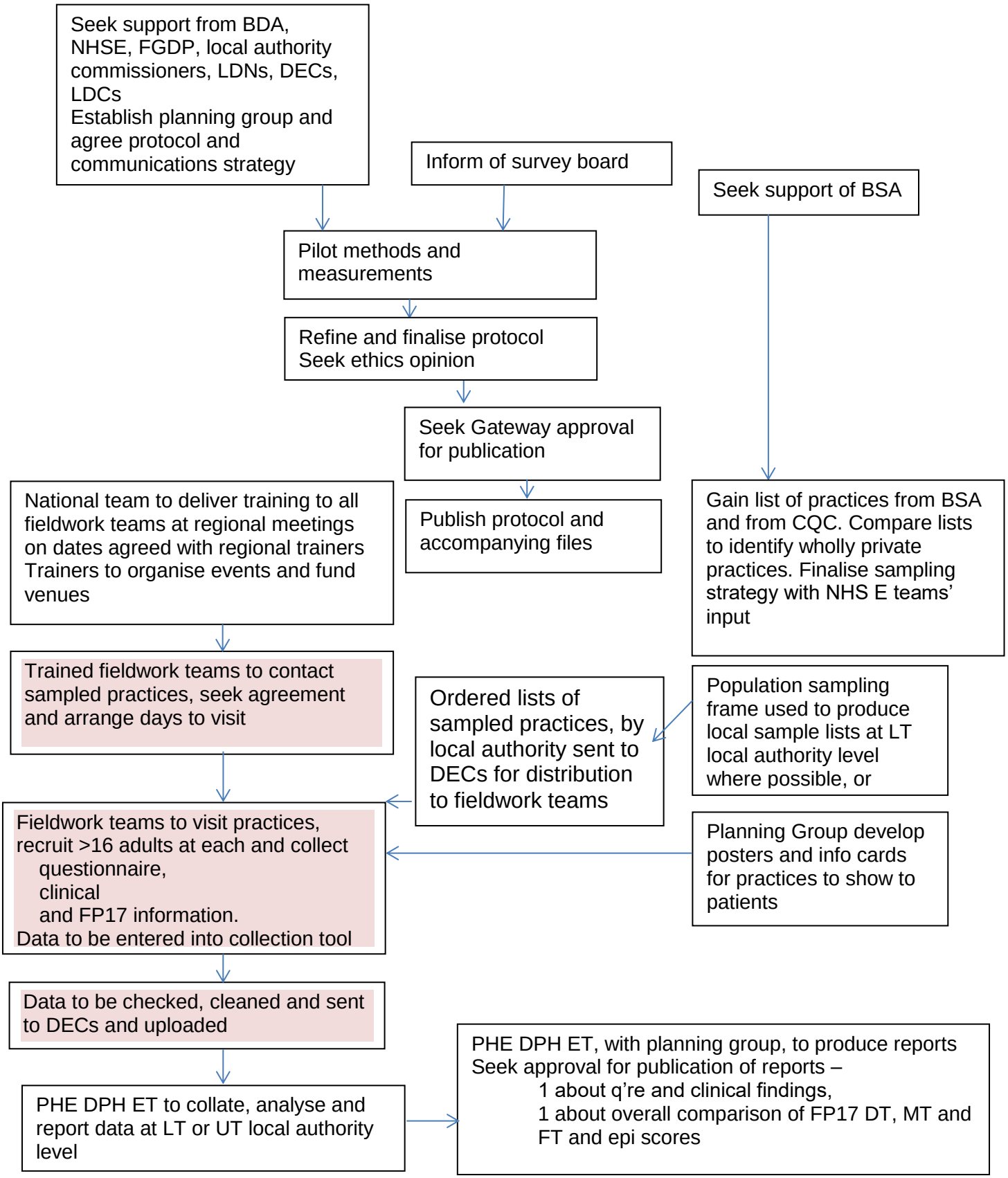
On the day(s) when the fieldwork team visit the practice they will aim to keep disruption to a minimum and ensure that appointments can run normally. One of the team members will approach adults who come to the practice and explain the nature and purpose of the survey, answer any questions the potential participants may have and ask them to take part. Volunteers will be asked to self-complete a questionnaire which takes about 10 minutes and have a brief, simple clinical examination by a dental surgeon on the epidemiology team at the practice, which also takes about 10 minutes. These activities will be fitted around treatment appointments.

The information relating to the questionnaire and dental examination is recorded anonymously; no names or dates of birth are recorded for this purpose. All data is kept securely and datasets are securely sent to regional centres for uploading via a secure 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 a variety of local government and health organisation levels. At no point will any individual practice, performer or patient be identifiable, as the data is anonymised from the examination stage and only reported or published as grouped data. **Because of this, participating practices can be assured that data will not be used for performance management purposes.**

At no point will the epidemiology fieldwork team make any comment to the patient volunteers about their health status or the treatment they have had. Any questions about clinical care that might arise will be referred to the responsible dentist at the practice. It is hoped that all the practices contacted will be able to assist the fieldwork teams in this national survey which local authorities have a responsibility to procure by law. The teams will keep disruption to a minimum and ensure the volunteers have a positive experience with the dental team.

As this is a pilot survey financial recognition in the form of an honorarium will be made by local Clinical Research Networks to NHS practices who host the survey.

Appendix D. Stages for PHE dental public health epidemiology programme teams to undertake the survey



Appendix E. Operational timetable

Regional training for fieldwork teams	September and October 2017
Data collection and ongoing data entry	To start immediately after regional training and granting of ethical approval and **completed by 30 June 2018**.
Completion of data checking and labelling of local authority data files. Secure forwarding of cleaned data files to DECs as soon as possible before deadline.	By 31 July 2018.
DECs to upload summaries and copies of local authority data files to the dental public health epidemiology team (DPHET) via the web portal www.nwph.net/dentalhealthupload/login.aspx	To be uploaded as and when they have been checked, completed by 31 August 2018.
DPHET - Checking of data, returning errors for clarification by fieldwork teams via DECs, and collation of clean, verified data	As and when data files arrive.
Risk factors intelligence/DPHET – compute estimates for local authorities	From September 2018.
Publication of results on website www.nwph.net/dentalhealth	January 2019 or four months after receipt of last data set dependent upon PHE gateway.
Return of cleaned anonymised data to DECs	January 2019 or five months after receipt of last data set.

Appendix F. List of codes for local authorities

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Barking and Dagenham	E09000002	Barking and Dagenham	E09000002
Barnet	E09000003	Barnet	E09000003
Barnsley	E08000016	Barnsley	E08000016
Bath and North East Somerset	E06000022	Bath and North East Somerset	E06000022
Bedford	E06000055	Bedford	E06000055
Bexley	E09000004	Bexley	E09000004
Birmingham	E08000025	Birmingham	E08000025
Blackburn with Darwen	E06000008	Blackburn with Darwen	E06000008
Blackpool	E06000009	Blackpool	E06000009
Bolton	E08000001	Bolton	E08000001
Bournemouth	E06000028	Bournemouth	E06000028
Bracknell Forest	E06000036	Bracknell Forest	E06000036
Bradford	E08000032	Bradford	E08000032
Brent	E09000005	Brent	E09000005
Brighton and Hove	E06000043	Brighton and Hove	E06000043
Bristol, City of	E06000023	Bristol, City of	E06000023
Bromley	E09000006	Bromley	E09000006
Buckinghamshire	E10000002	Aylesbury Vale	E07000004
		Chiltern	E07000005
		South Bucks	E07000006
		Wycombe	E07000007
Bury	E08000002	Bury	E08000002
Calderdale	E08000033	Calderdale	E08000033
Cambridgeshire	E10000003	Cambridge	E07000008
		East Cambridgeshire	E07000009
		Fenland	E07000010
		Huntingdonshire	E07000011
		South Cambridgeshire	E07000012
Camden	E09000007	Camden	E09000007
Central Bedfordshire	E06000056	Central Bedfordshire	E06000056
Cheshire East	E06000049	Cheshire East	E06000049
Cheshire West and Chester	E06000050	Cheshire West and Chester	E06000050
City of London	E09000001	City of London	E09000001
Cornwall	E06000052	Cornwall	E06000052
County Durham	E06000047	County Durham	E06000047
Coventry	E08000026	Coventry	E08000026
Croydon	E09000008	Croydon	E09000008
Cumbria	E10000006	Allerdale	E07000026
		Barrow-in-Furness	E07000027
		Carlisle	E07000028

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Cumbria	E10000006	Copeland	E07000029
		Eden	E07000030
		South Lakeland	E07000031
Darlington	E06000005	Darlington	E06000005
Derby	E06000015	Derby	E06000015
Derbyshire	E10000007	Amber Valley	E07000032
		Bolsover	E07000033
		Chesterfield	E07000034
		Derbyshire Dales	E07000035
		Erewash	E07000036
		High Peak	E07000037
		North East Derbyshire	E07000038
		South Derbyshire	E07000039
Devon	E10000008	East Devon	E07000040
		Exeter	E07000041
		Mid Devon	E07000042
		North Devon	E07000043
		South Hams	E07000044
		Teignbridge	E07000045
		Torridge	E07000046
		West Devon	E07000047
Doncaster	E08000017	Doncaster	E08000017
Dorset	E10000009	Christchurch	E07000048
		East Dorset	E07000049
		North Dorset	E07000050
		Purbeck	E07000051
		West Dorset	E07000052
		Weymouth and Portland	E07000053
Dudley	E08000027	Dudley	E08000027
Ealing	E09000009	Ealing	E09000009
East Riding of Yorkshire	E06000011	East Riding of Yorkshire	E06000011
East Sussex	E10000011	Eastbourne	E07000061
		Hastings	E07000062
		Lewes	E07000063
		Rother	E07000064
		Wealden	E07000065
Enfield	E09000010	Enfield	E09000010
Essex	E10000012	Basildon	E07000066
		Braintree	E07000067
		Brentwood	E07000068
		Castle Point	E07000069
		Chelmsford	E07000070

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Essex	E10000012	Colchester	E07000071
		Epping Forest	E07000072
		Harlow	E07000073
		Maldon	E07000074
		Rochford	E07000075
		Tendring	E07000076
		Uttlesford	E07000077
Gateshead	E08000020	Gateshead	E08000020
Gloucestershire	E10000013	Cheltenham	E07000078
		Cotswold	E07000079
		Forest of Dean	E07000080
		Gloucester	E07000081
		Stroud	E07000082
		Tewkesbury	E07000083
Greenwich	E09000011	Greenwich	E09000011
Hackney	E09000012	Hackney	E09000012
Halton	E06000006	Halton	E06000006
Hammersmith and Fulham	E09000013	Hammersmith and Fulham	E09000013
Hampshire	E10000014	Basingstoke and Deane	E07000084
		East Hampshire	E07000085
		Eastleigh	E07000086
		Fareham	E07000087
		Gosport	E07000088
		Hart	E07000089
		Havant	E07000090
		New Forest	E07000091
		Rushmoor	E07000092
		Test Valley	E07000093
		Winchester	E07000094
Haringey	E09000014	Haringey	E09000014
Harrow	E09000015	Harrow	E09000015
Hartlepool	E06000001	Hartlepool	E06000001
Havering	E09000016	Havering	E09000016
Herefordshire, County of	E06000019	Herefordshire, County of	E06000019
Hertfordshire	E10000015	Broxbourne	E07000095
		Dacorum	E07000096
		East Hertfordshire	E07000097
		Hertsmere	E07000098
		North Hertfordshire	E07000099
		St Albans	E07000240
		Stevenage	E07000101
		Three Rivers	E07000102

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Hertfordshire	E10000015	Watford	E07000103
		Welwyn Hatfield	E07000241
Hillingdon	E09000017	Hillingdon	E09000017
Hounslow	E09000018	Hounslow	E09000018
Isle of Wight	E06000046	Isle of Wight	E06000046
Isles of Scilly	E06000053	Isles of Scilly	E06000053
Islington	E09000019	Islington	E09000019
Kensington and Chelsea	E09000020	Kensington and Chelsea	E09000020
Kent	E10000016	Ashford	E07000105
		Canterbury	E07000106
		Dartford	E07000107
		Dover	E07000108
		Gravesham	E07000109
		Maidstone	E07000110
		Sevenoaks	E07000111
		Shepway	E07000112
		Swale	E07000113
		Thanet	E07000114
		Tonbridge and Malling	E07000115
		Tunbridge Wells	E07000116
Kingston upon Hull, City of	E06000010	Kingston upon Hull, City of	E06000010
Kingston upon Thames	E09000021	Kingston upon Thames	E09000021
Kirklees	E08000034	Kirklees	E08000034
Knowsley	E08000011	Knowsley	E08000011
Lambeth	E09000022	Lambeth	E09000022
Lancashire	E10000017	Burnley	E07000117
		Chorley	E07000118
		Fylde	E07000119
		Hyndburn	E07000120
		Lancaster	E07000121
		Pendle	E07000122
		Preston	E07000123
		Ribble Valley	E07000124
		Rossendale	E07000125
		South Ribble	E07000126
		West Lancashire	E07000127
		Wyre	E07000128
Leeds	E08000035	Leeds	E08000035
Leicester	E06000016	Leicester	E06000016
Leicestershire	E10000018	Blaby	E07000129
		Charnwood	E07000130
		Harborough	E07000131

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Leicestershire	E10000018	Hinckley and Bosworth	E07000132
		Melton	E07000133
		North West Leicestershire	E07000134
		Oadby and Wigston	E07000135
Lewisham	E09000023	Lewisham	E09000023
Lincolnshire	E10000019	Boston	E07000136
		East Lindsey	E07000137
		Lincoln	E07000138
		North Kesteven	E07000139
		South Holland	E07000140
		South Kesteven	E07000141
		West Lindsey	E07000142
Liverpool	E08000012	Liverpool	E08000012
Luton	E06000032	Luton	E06000032
Manchester	E08000003	Manchester	E08000003
Medway	E06000035	Medway	E06000035
Merton	E09000024	Merton	E09000024
Middlesbrough	E06000002	Middlesbrough	E06000002
Milton Keynes	E06000042	Milton Keynes	E06000042
Newcastle upon Tyne	E08000021	Newcastle upon Tyne	E08000021
Newham	E09000025	Newham	E09000025
Norfolk	E10000020	Breckland	E07000143
		Broadland	E07000144
		Great Yarmouth	E07000145
		King's Lynn and West Norfolk	E07000146
		North Norfolk	E07000147
		Norwich	E07000148
		South Norfolk	E07000149
North East Lincolnshire	E06000012	North East Lincolnshire	E06000012
North Lincolnshire	E06000013	North Lincolnshire	E06000013
North Somerset	E06000024	North Somerset	E06000024
North Tyneside	E08000022	North Tyneside	E08000022
North Yorkshire	E10000023	Craven	E07000163
		Hambleton	E07000164
		Harrogate	E07000165
		Richmondshire	E07000166
		Ryedale	E07000167
		Scarborough	E07000168
		Selby	E07000169
Northamptonshire	E10000021	Corby	E07000150
		Daventry	E07000151
		East Northamptonshire	E07000152

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Northamptonshire	E10000021	Kettering	E07000153
		Northampton	E07000154
		South Northamptonshire	E07000155
		Wellingborough	E07000156
Northumberland	E06000048	Northumberland	E06000048
Nottingham	E06000018	Nottingham	E06000018
Nottinghamshire	E10000024	Ashfield	E07000170
		Bassetlaw	E07000171
		Broxtowe	E07000172
		Gedling	E07000173
		Mansfield	E07000174
		Newark and Sherwood	E07000175
		Rushcliffe	E07000176
Oldham	E08000004	Oldham	E08000004
Oxfordshire	E10000025	Cherwell	E07000177
		Oxford	E07000178
		South Oxfordshire	E07000179
		Vale of White Horse	E07000180
		West Oxfordshire	E07000181
Peterborough	E06000031	Peterborough	E06000031
Plymouth	E06000026	Plymouth	E06000026
Poole	E06000029	Poole	E06000029
Portsmouth	E06000044	Portsmouth	E06000044
Reading	E06000038	Reading	E06000038
Redbridge	E09000026	Redbridge	E09000026
Redcar and Cleveland	E06000003	Redcar and Cleveland	E06000003
Richmond upon Thames	E09000027	Richmond upon Thames	E09000027
Rochdale	E08000005	Rochdale	E08000005
Rotherham	E08000018	Rotherham	E08000018
Rutland	E06000017	Rutland	E06000017
Salford	E08000006	Salford	E08000006
Sandwell	E08000028	Sandwell	E08000028
Sefton	E08000014	Sefton	E08000014
Sheffield	E08000019	Sheffield	E08000019
Shropshire	E06000051	Shropshire	E06000051
Slough	E06000039	Slough	E06000039
Solihull	E08000029	Solihull	E08000029
Somerset	E10000027	Mendip	E07000187
		Sedgemoor	E07000188
		South Somerset	E07000189
		Taunton Deane	E07000190
		West Somerset	E07000191

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
South Gloucestershire	E06000025	South Gloucestershire	E06000025
South Tyneside	E08000023	South Tyneside	E08000023
Southampton	E06000045	Southampton	E06000045
Southend-on-Sea	E06000033	Southend-on-Sea	E06000033
Southwark	E09000028	Southwark	E09000028
St. Helens	E08000013	St. Helens	E08000013
Staffordshire	E10000028	Cannock Chase	E07000192
		East Staffordshire	E07000193
		Lichfield	E07000194
		Newcastle-under-Lyme	E07000195
		South Staffordshire	E07000196
		Stafford	E07000197
		Staffordshire Moorlands	E07000198
		Tamworth	E07000199
Stockport	E08000007	Stockport	E08000007
Stockton-on-Tees	E06000004	Stockton-on-Tees	E06000004
Stoke-on-Trent	E06000021	Stoke-on-Trent	E06000021
Suffolk	E10000029	Babergh	E07000200
		Forest Heath	E07000201
		Ipswich	E07000202
		Mid Suffolk	E07000203
		St Edmundsbury	E07000204
		Suffolk Coastal	E07000205
		Waveney	E07000206
Sunderland	E08000024	Sunderland	E08000024
Surrey	E10000030	Elmbridge	E07000207
		Epsom and Ewell	E07000208
		Guildford	E07000209
		Mole Valley	E07000210
		Reigate and Banstead	E07000211
		Runnymede	E07000212
		Spelthorne	E07000213
		Surrey Heath	E07000214
		Tandridge	E07000215
		Waverley	E07000216
		Woking	E07000217
Sutton	E09000029	Sutton	E09000029
Swindon	E06000030	Swindon	E06000030
Tameside	E08000008	Tameside	E08000008
Telford and Wrekin	E06000020	Telford and Wrekin	E06000020
Thurrock	E06000034	Thurrock	E06000034
Torbay	E06000027	Torbay	E06000027

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Tower Hamlets	E09000030	Tower Hamlets	E09000030
Trafford	E08000009	Trafford	E08000009
Wakefield	E08000036	Wakefield	E08000036
Walsall	E08000030	Walsall	E08000030
Waltham Forest	E09000031	Waltham Forest	E09000031
Wandsworth	E09000032	Wandsworth	E09000032
Warrington	E06000007	Warrington	E06000007
Warwickshire	E10000031	North Warwickshire	E07000218
		Nuneaton and Bedworth	E07000219
		Rugby	E07000220
		Stratford-on-Avon	E07000221
		Warwick	E07000222
West Berkshire	E06000037	West Berkshire	E06000037
West Sussex	E10000032	Adur	E07000223
		Arun	E07000224
		Chichester	E07000225
		Crawley	E07000226
		Horsham	E07000227
		Mid Sussex	E07000228
		Worthing	E07000229
Westminster	E09000033	Westminster	E09000033
Wigan	E08000010	Wigan	E08000010
Wiltshire	E06000054	Wiltshire	E06000054
Windsor and Maidenhead	E06000040	Windsor and Maidenhead	E06000040
Wirral	E08000015	Wirral	E08000015
Wokingham	E06000041	Wokingham	E06000041
Wolverhampton	E08000031	Wolverhampton	E08000031
Worcestershire	E10000034	Bromsgrove	E07000234
		Malvern Hills	E07000235
		Redditch	E07000236
		Worcester	E07000237
		Wychavon	E07000238
		Wyre Forest	E07000239
York	E06000014	York	E06000014

Source: ONS Geographical Lookups.

Appendix Gi. Letter to send to sampled practices

Note: To be topped and tailed by local team and sent with topped and tailed Appendix C

Local letter head and logo

Dear Practice Principal,

Re: Asking for your help with Public Health England epidemiological study of adults' oral health 2017/18

You may well have heard about the study of adults that is taking place during 2017/18 from the BDA, LDN or FGDP. Your practice has been randomly sampled and this letter is to ask if you would be willing to consider assisting with the study.

We would not require a great deal of your time, or that of your staff, as the study will be conducted by our epidemiology team. However, we would need the use of one surgery for a day or so (or half days) at your convenience and your permission to approach patients who have an appointment in your practice on the day. Any study activities will be fitted around treatment appointments so that they can run normally and the research team will do their best to be as unobtrusive as possible. There is more detail in the accompanying factsheet.

Someone from the local epidemiology fieldwork team will contact the practice soon to discuss the survey, answer any questions you may have and ask if you will help.

You are probably aware that regular surveys of child oral health take place in schools and nurseries which provide locally relevant information which is vital for the planning of health improvement programmes and dental services. However, adults are much harder to reach and there is no current source of locally relevant information about their oral health needs. This study aims to provide this information from dental practice patients.

For this pilot survey honorariums will be paid to all practices who host the survey, whether NHS or private. This will be no less than £185, paid by local Clinical Research Networks to support research in primary care and will recognise the minor inconvenience to the practice, the provision of an unused surgery and other facilities and the assistance of the administrative team in production of details from consented patient's FP17s.

If you agree to assist, and we certainly hope you will, I would be very grateful if you could respond to this request to be a host practice by e-mailing, telephoning or posting the information overleaf to:

……(name and contact details of epidemiology team)

Name of practice : ……..……..

I have received the letter asking if this practice is willing to host the local epidemiology team to carry out the Adults in Practices survey with adults who attend the practice.

Please tick:

☐ The practice is pleased to agree to assist with the survey, please contact us to arrange this

☐ There are questions I would like to ask before the practice can agree to assist with the survey, please contact us to discuss it.

☐ The practice declines to assist with the national survey.

Yours faithfully,

Appendix Gii. Recording of consent and access to records from GDPs

Note: To be topped and tailed by local team
To be completed prior to the start of data collection and retained with the tracking sheet for each practice.

Name of practice _____

Address (or practice stamp)

_____

_____

_____

I …… (name of responsible registrant) agree to a trained dental epidemiology fieldwork team running the National Dental Public Health Epidemiology Programme survey in the practice detailed above and approaching adult patients for this purpose.

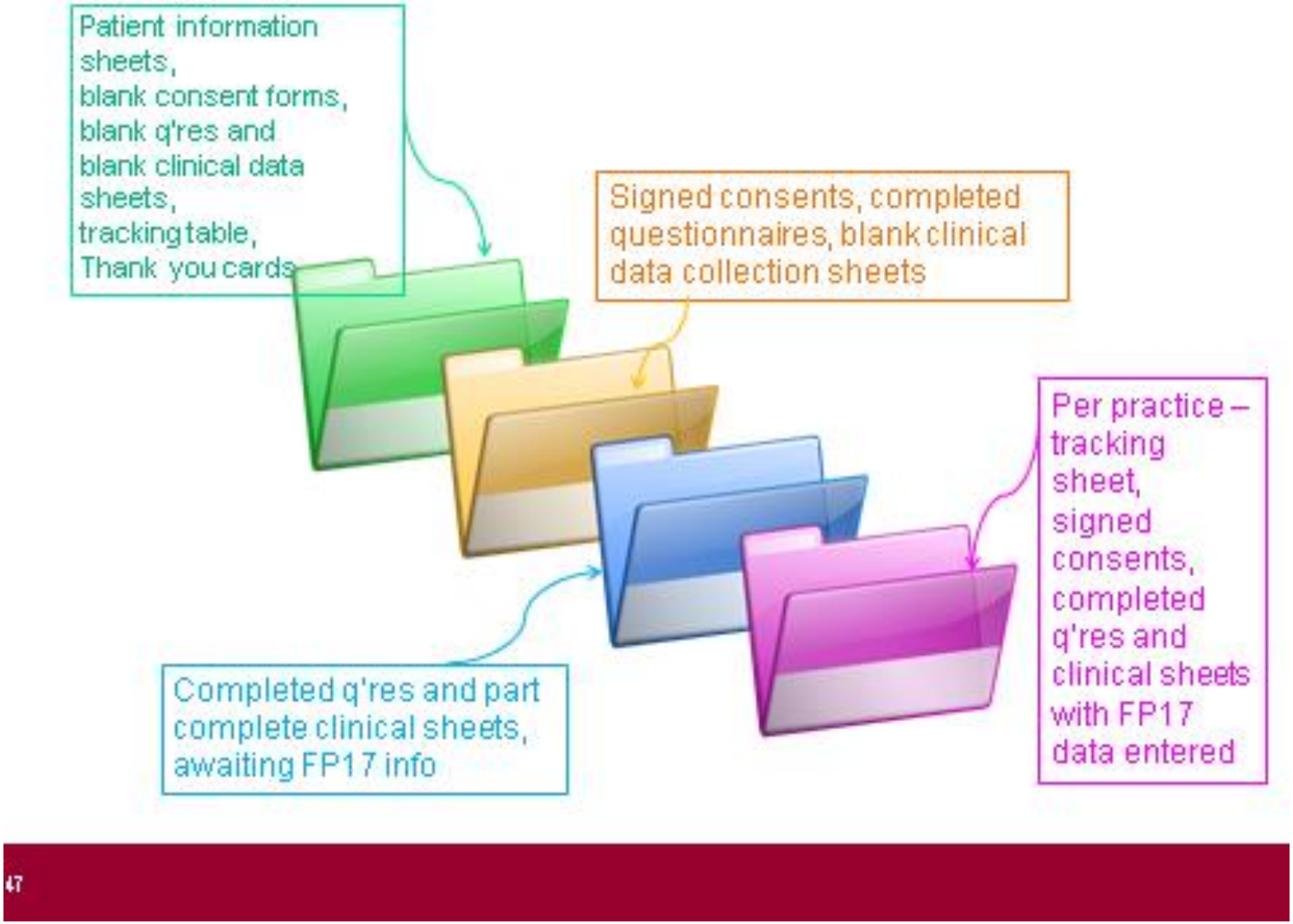
For practices working under NHS contract:

I also agree to details from the patients' FP17 Treatment claim form being observed and recorded as part of this survey, where patient consent has been given.

Signed _____ Date _____

Position in practice: _____

Appendix H. Diagram of suggested folders to keep paperwork organised during practice visits



Appendix I. Volunteer tracking table and capture of practice details

Name of principal at host practice .....

Address of host practice :	Local authority number									Keep a count of the number of potential volunteers you approach here

Patient name (to be removed as soon as data collection is complete)	Volunteer number - last 5 digits					Consent given Yes / No	Questionnaire completed Yes / No	Examination completed Yes / No	FP17 data captured Yes / No / NA	DT from FP17	MT from FP17	FT from FP17

Appendix J. Volunteer information sheet

Public Health England
Dental Public Health Epidemiology Programme
Dental health survey of adults 2017-2018

Please will you help with the survey of adult dental health?

We are asking patients who are at this practice today to volunteer to take part in this survey. There is more information on this sheet but, in summary, you are being asked to complete a short questionnaire and have a brief examination of your teeth by the survey dentist while you are at the practice today. This can be fitted around your appointment and should take about 20 minutes. We will also ask if we can copy some information down from your NHS treatment form.

The aim of the survey is to provide information about the dental health needs of adults in this area so that the NHS can make sure the right services are provided for them. If lots of people take part then the information is more accurate.

Your dental care now or in the future will not be affected in any way if you choose to take part in the survey or prefer to decline the request.

If you have any questions about the survey please ask the survey team or have a look at the questions below.

Q What is the survey about?

This year surveys are being carried out all across England to find out more about oral health among adults and their use of dental treatment services. The information will be used to plan local dental health services in the future.

Adults attending this practice will be asked if they would take part in the survey while they are at the practice. Participation is voluntary, although the success of the survey depends on the goodwill and cooperation of those invited to take part.

Q Why your help is important

The survey will produce much better information if lots of adults agree to take part. It is important that all sorts of people agree – and it doesn't matter what your dental condition is like, we need to include those with no natural teeth of their own, those with big and little problems, those with perfect teeth and those with not-so-perfect teeth, those who attend private dentists and NHS ones.

The examiners are not looking for bad teeth or for healthy mouths – they just want to record what they find. The results will help to estimate the local and national needs for dental treatment rather than just your own.

Q Who is running the survey?

An NHS dental team, including a fully qualified dentist, who are trained and experienced in carrying out surveys of dental health which are carried out every year with different groups in the population. The survey is being coordinated by Public Health England.

Q Who is being asked to participate?

Your dentist's practice has been selected at random from a list of all practices and they have very kindly agreed to host the survey team.

Adult patients attending for dental care on the day of the study at sampled practices are being asked to participate.

Q What are volunteers being asked to do?

Either before or after your dental appointment today you will be asked to complete a short questionnaire which asks about your general and dental health and use of treatment services. One of the survey team can provide help if you need it.

You will also be asked to have a brief dental examination today, at a time to avoid any problems with appointments and not interfere with your normal dental care. The trained dentist who does the examination will only use routine check-up instruments to look at teeth and cotton wool rolls to dry them. No X-rays will be taken for this survey.

This examination cannot be as thorough as the one done by your own dentist so the survey examiner cannot give any feedback about the condition of your teeth or gums, nor about the treatment being provided. The questionnaire and check-up will take about 20 minutes.

Volunteers receiving NHS care will also be asked if they would agree to very limited information being copied by the survey team from the NHS treatment form that is used for every course of treatment.

Your decision to take part will make no difference to the dental treatment you receive now or in the future.

Other than the extra time today there are no individual advantages or disadvantages to taking part.

Q Can I withdraw from the study at any time?

You are free to withdraw your consent at any stage today and you do not need to give a reason for withdrawing. Withdrawing from the study will not affect the treatment you receive. As the study is anonymous we will not be able to identify your information, so you can't withdraw it later on.

Q Who will use the results?

The results will be grouped together by PHE and then shared with a range of people who will use the information to help with their work. This will include the NHS, to help with local planning of treatment services, to support local authorities with their responsibility for monitoring the health, including oral health, of their local population and the Department of Health.

A number of other government departments and agencies may also use the results. Survey information may also be shared with researchers who are viewed by PHE as fit to carry out suitable research.

Publications based on the data will be made available on PHE website and might be published in journals from the end of 2018.

Q Is the survey confidential?

Yes, the information you give us will be treated as strictly confidential as directed by the Code of Practice adopted by the NHS and the Data Protection Act, and will only be used for statistical research purposes.

No names or addresses will be recorded on the survey forms – just a number and a postcode.

The information will be used to produce statistics that will not identify any individuals; instead information about groups of people will be reported. Survey information is also provided to other approved organisations for statistical purposes only. All such statistics produced are subject to similar codes and the same standards of protection are applied to your information at all times.

The consent forms and all other data will be securely transported and held by the survey team who will be the only people who will have access to it. As soon as the survey results are published the consent forms and other data will be securely disposed of by survey teams who are used to dealing with such information.

Who has reviewed this study?

Ethical approval for this study has been granted by on behalf of NHS Health Research Authority by London - Fulham Research Ethics Committee on Monday 9th October 2017, Ref 17/LO/1594.

If you have questions, comments or complaints contact:

Thank you for your help.

Appendix K. Consent form

Local Trust logo here

Dental Public Health Epidemiology Programme
Dental health survey of adults 2017-2018

CONSENT TO TAKE PART

To be completed by interviewer and participant who should initial the boxes or delete statements accordingly :

ID Number :

Lower-tier local authority code									Number of volunteer adult				

1. I have read and understood the information in the leaflet for the above survey.

   I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I consent to take part in a questionnaire as part of this survey ☐

3. I consent to a dental examination of my teeth and dentures ☐

4. I consent to the survey team copying some information from the claim form (FP17) for my NHS treatment. ☐

5. I have agreed to take part in this study but understand that my participation is voluntary and that I am free to withdraw without giving any reason, without my treatment or legal rights being affected ☐

6. I understand that my information will be treated in strict confidence by the survey team ☐

Signed _____ ***Date*** _____
(To be signed by participant)

Signed _____ _____ ***Date*** _____
(To be signed by person collecting consent)

Name of person collecting consent: _____
If a participant wants a copy a second form should be completed and this copy left with them.

Appendix L. Questionnaire

Public Health England Dental Public Health Epidemiology Programme

Oral health survey of adults 2017-2018

Initials *pencil only*		*Delete initials when survey completed*
Stage	Done?	Notes
Q're		
Clin		
FP17		

Questionnaire

Unique ID code

Lower-tier local authority code									**Number of volunteer adult**				

First some questions about you and your dental health, then others about using dental treatment services.

Please tick the boxes for your answers:

1 Are you?

☐ Male

☐ Female

☐ Prefer not to answer

2 Which age band are you in?

☐ 16 – 24

☐ 25 – 34

☐ 35 – 44

☐ 45 – 54

☐ 55 – 64

☐ 65 – 74

☐ 75– 84

☐ 85 or over

☐ Prefer not to answer

Some questions about your health and lifestyle.

3 Do you have any disability or long standing illness that limits your ability to attend a dental practice for a check-up or treatment?

☐ Yes (go to question 4)

☐ No (go to question 5)

☐ Prefer not to answer (go to question 5)

4 How are you limited to what you can do and where you can get to?

TICK ALL THAT APPLY

☐ I can't sit in a dentist's chair

☐ I can't climb stairs so need a downstairs surgery

☐ I have difficulty leaving the house so I usually need a dentist to come to me

☐ Other (please specify) _____

☐ Prefer not to answer

Now some questions about your mouth and teeth

HOW OFTEN during the last year …	Never, or hardly ever	Occasionally	Fairly often or very often	Prefer not to answer or N/A
5… have you had **painful aching** in your mouth?	☐	☐	☐	☐
6… have you had trouble **pronouncing any words** because of problems with your teeth, mouth, or dentures?	☐	☐	☐	☐
7… have you found it **difficult to eat any foods** because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐
8… have you been **self-conscious or embarrassed** because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐
9… have you felt that your **general health or wellbeing has been affected by** problems with your teeth, mouth or dentures?	☐	☐	☐	☐
10… have you had to **take time off work** because of problems with your teeth, mouth or dentures?	☐	☐	☐	☐
11… have you **needed urgent dental care**?	☐	☐	☐	☐

Next – some questions about advice about smoking and alcohol

12 Do you use tobacco?

☐ Yes I am a current smoker

☐ No, I have never smoked

☐ No, I'm an ex-smoker

☐ I chew tobacco / paan / gutkha

☐ Prefer not to answer

13 How many days last week did you drink alcohol? (0-7) ☐

Prefer not to answer ☐

Have you ever been given advice from a dentist or a member of a dental team about…

	Yes	No	Don't know
14… how oral health affects general health?	☐	☐	☐
15… the effect of alcohol on oral or general health?	☐	☐	☐
16… the effect of smoking on oral or general health?	☐	☐	☐
17… considering what you eat and drink to keep your mouth and body healthy?	☐	☐	☐
18… using fluoride toothpaste to help control dental decay?	☐	☐	☐
19… improving your oral hygiene to help keep gums healthy?	☐	☐	☐

Now some questions about going to the dentist.

20 Roughly how long has it been since you last saw a dentist, before this course of treatment?

- ☐ Within the last 12 months
- ☐ More than 1, but less than 2 years ago

If you answer either of these times go to question 22

- ☐ More than 2 years ago
- ☐ More than 5 years ago
- ☐ More than 8 years ago
- ☐ More than 10 years ago

If you answer any of these times go to question 21

- ☐ Prefer not to answer go to question 22

21 What are the reasons why you have not seen a dentist in the last two years or more?

TICK ALL THAT APPLY

- ☐ No need to see the dentist / nothing wrong with my teeth / no natural teeth
- ☐ I can't find an NHS dentist
- ☐ I can't afford the NHS charges
- ☐ I haven't got the time to see a dentist
- ☐ I am afraid of dentists / I don't like seeing the dentist
- ☐ Keep forgetting / Haven't got round to it
- ☐ It's difficult to get to and from the dentist
- ☐ I've had a bad experience with a dentist
- ☐ Dentist stopped doing NHS work
- ☐ Other (please specify) _____
- ☐ Prefer not to answer

22 You may know of people living near you who have had difficulties getting dental treatment. Which are the 3 main barriers to getting NHS dental care among the people you know nearby?

TICK UP TO 3 THAT APPLY

- ☐ I am not aware of any real problems in getting NHS dental care
- ☐ Long travelling distances to reach an NHS dentist
- ☐ High costs of NHS dental care
- ☐ Hardly any dentists in the area that are accepting new patients for NHS care
- ☐ Problems contacting an NHS dentist
- ☐ Long waiting lists for NHS dental care
- ☐ Having to take time off work to get to the dentist
- ☐ Language or communication problems with NHS dental practices
- ☐ Particular problems that older and disabled adults may have
- ☐ Other reason – please give brief details

  _____
- ☐ Prefer not to answer

Now some questions about paying for dental treatment

23 When it comes to paying for dental treatment which description best fits your situation?

- ☐ I attend a private dentist and pay for my dental treatment – either as the bills come in or as part of an insurance scheme
- ☐ I pay the full NHS charges for my dental treatment
- ☐ I pay the full NHS charges and I pay for some extras privately
- ☐ I don’t know if I am exempt from paying NHS dental charges
- ☐ I get some exemption for my NHS dental charges because of my financial situation
- ☐ I get my NHS dental treatment free because I am exempt from all charges
- ☐ Not sure
- ☐ Other – please give brief details _____
- ☐ Prefer not to answer

24 If you were told you need to pay a charge of £56 for a course of NHS dental treatment would you be able to pay this?

- ☐ Yes, quite easily
- ☐ Yes, but it would be a struggle
- ☐ Yes, but only if I could pay a bit at a time
- ☐ No, this would be too much for me to afford
- ☐ This doesn't apply as I have my dental treatment free
- ☐ Prefer not to answer

25 If you were told you need to pay a charge of £244 for a course of NHS dental treatment would you be able to pay this?

- ☐ Yes, quite easily
- ☐ Yes, but it would be a struggle
- ☐ Yes, but only if I could pay a bit at a time
- ☐ No, this would be too much for me to afford
- ☐ This doesn't apply as I have my dental treatment free
- ☐ Prefer not to answer

26 If you are attending a private practice or having private treatment could you say why you choose to do this, please?

- ☐ This doesn't apply to me as I am not attending a private practice or having private treatment
- ☐ I prefer to have private dental treatment instead of from the NHS as I think it is better
- ☐ There aren't any dentists offering NHS treatment near to me
- ☐ My dentist went private and I chose to stay with them
- ☐ My dentist will see my children on the NHS but adults have to go privately
- ☐ Some other reason _____
- ☐ Prefer not to answer

27 What is your ethnic group? Please choose ONE selection from this list to indicate your ethnic group

White British		**Black or black British Caribbean**	
White Irish		**Black or black British African**	
Other white background		**Other black background**	
White and black Caribbean		**Asian or Asian British Indian**	
White and black African		**Asian or Asian British Pakistani**	
White and Asian		**Asian or Asian British Bangladeshi**	
Other mixed background		**Other Asian background**	
Oriental / Chinese		**Any other ethnic group**	
Prefer not to answer			

28 We don't want your name or address details on this form, but would you write your postcode here, please.

Home postcode | | | | | | | | |

Prefer not to answer ☐

29 We have asked you a lot of questions. Is there anything you would like to say that we haven't asked you about dental health and dentistry, and how satisfied you are with the care you receive?

☐ No

☐ Yes – record these below

☐ _____

_____

Thank you for completing the questionnaire.

Someone from the survey team will answer these last questions:

This questionnaire was ……

☐ Completed in its entirety

☐ Not started as the volunteer did not consent to take part in the questionnaire

☐ Not completed as the volunteer decided not to continue

☐ Not completed as the volunteer found it too hard to take part

Size of practice

☐ Single practice owned by dentist (s)

☐ Practice owned by Corporate in group of fewer than 5 practices

☐ Practice owned by Corporate in group of 5 or more practices

Type of practice

☐ Nearly all NHS

☐ Mixed NHS and private

☐ Wholly private

Practice postcode | | | | | | | | | |

Appendix M. Clinical data collection sheet

Public Health England Dental Public Health Epidemiology Programme
Oral health survey of adults 2017-2018 Examination data recording sheet

	Lower-tier local authority code	Number of volunteer adult
Unique ID code		

Home postcode ☐☐☐☐ ☐☐☐☐ Prefer not answer ☐

Clinical examination completion status ☐

1 = No examination possible – volunteer did not consent
2 = No examination possible – volunteer unable to co-operate or changed their mind
3 = Full examination completed
4 = Partial examination completed – volunteer withdrew consent
5 = Partial examination completed – volunteer could not co-operate

		Right								UPPER								Left
2	Index teeth with gingival bleeding on probing																	
1	Tooth condition																	
		8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	

		Right								LOWER								Left
		8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
1	Tooth condition																	
2	Index teeth with gingival bleeding on probing																	
3	Segments containing teeth with functional contacts against natural or replacement teeth																	

Line 1 Codes :	0 or - = Natural tooth present and sound
	1 = Natural tooth present with arrested caries
	2 = Natural tooth present with caries into dentine
	3 = Natural tooth present with caries into the pulp
	4 = Natural tooth present with filling(s) and caries
	5 = Natural tooth present with filling(s)
	R = Natural tooth present with filling(s) need replacing
	6 = Natural tooth missing, any reason, with no replacement
	C = Natural tooth with a crown
	F = Natural tooth replaced by bridge pontic, implant pontic or implant
	D = Natural tooth replaced by denture tooth
Line 2 Codes :	0 = No bleeding on probing
	1 = Some bleeding on probing
	9 = Unscorable
Line 3 Codes :	0 = No posterior functional contact
	1 = Posterior functional contact present

Presence or absence of dentures

	Denture present 0 - no denture 1 - partial 2 - full 3 - overdenture 4 - implant retained	**Denture material** 1 - metal base 2 - acrylic base	**Status** 0 - intact 1 - needs repair 2 - needs replacement
Upper			
Lower			

PUFA index

Ask the question - Do you have any pain or discomfort in your mouth at the moment?

0 = No – do not ask next question
1 = Yes – ask next question ☐
9 = Not answered – do not ask next question

Do you think that this pain is related to your teeth? ☐

0 = No / don't know
1 = Yes
9 = Not answered

Number of PUFA conditions ☐

0 = No lesions evident
1 = Single lesion present
2 = Two or more lesions present

The four PUFA lesions are: Open pulp, traumatic ulceration, abscess, sinus or fistula

Items of treatment this volunteer requires in the opinion of the epidemiological examiner, on visual examination alone. TICK ALL THAT APPLY

a	No treatment indicated	
b	Prevention advice – oral hygiene or diet, additional fluoride	
c	Removal of calculus	
d	Minor restoration – simple direct fillings	
E	Major restoration – crowns/bridges/veneers/inlays, with or without endodontic treatment	
F	Extraction(s) or other minor surgery	
g	Prosthetic care – repair, reline, addition, copy for existing denture or provision of new partial or complete dentures	
h	Other treatment :	

Degree of urgency for any treatment - in the opinion of the epidemiological examiner, on visual examination alone

1	Urgent	
2	Routine	
3	No treatment required	

Information from section 5 of FP17:

DT ☐☐

MT ☐☐

FT ☐☐

N/A (private care) ☐ Not available yet - will be followed up ☐ Not available - other reason ☐

Size of practice

Single practice owned by dentist (s)	
Practice owned by Corporate in group of fewer than 5 practices	
Practice owned by Corporate in group of 5 or more practices	

Type of practice

Nearly all NHS	
Mixed NHS and private	
Wholly private	

Practice postcode ☐☐☐☐ ☐☐☐☐

Appendix N. Illustration example of Excel worksheet for summary information

Summary information will be reported using the Appendix N Excel datasheet, example shown:

Appendix N : Dental Public Health Epidemiology Programme for England, Oral Health Survey of Adults in Practice 2017-18

											Number of adults who :		
Upper Tier LA Code	Upper Tier LA Name	Lower Tier LA Code	Lower Tier LA Name	Name of examiner	Start date of examinations dd/mm/yyyy	End date of examinations dd/mm/yyyy	Total number of sampled practices contacted	Number of practices agreeing to host & visited	Total number of adults approached	Number of adults agreeing to take part & giving consent	Took part in the questionnaire	Took part in the clinical examination	Took part in both the questionnaire and examination
E01000007	Derbyshire	E07000032	Amber Valley	A.N.Other	12/10/2017	03/04/2018	20	15	205	200	190	160	150
E01000007	Derbyshire	E07000033	Bolsover	A.N.Other	06/11/2017	02/03/2018	10	10	250	180	165	160	145
E01000007	Derbyshire	E07000034	Chesterfield	A.N.Other	10/01/2018	03/05/2018	15	12	245	225	220	215	210
E01000007	Derbyshire	E07000035	Derbyshire Dales	A.N.Other	23/02/2018	20/06/2018	50	10	180	175	175	170	170

Appendix O. Contact details of dental epidemiology co-ordinators

PHE centre	Name of DEC	Email address (use nhs.net address to send data)
East Midlands	Sandra Whiston	sandra.whiston@phe.gov.uk sandra.whiston@nhs.net
East of England	Feema Francis (Linda Hillman)	feema.francis@phe.gov.uk feema.francis@nhs.net (linda.hillman@phe.gov.uk) (linda.hillman3@nhs.net)
London	Desmond Wright	desmond.wright@phe.gov.uk desmondwright@nhs.net
North East	Kamini Shah	kamini.shah@phe.gov.uk Kamini.shah1@nhs.net
North West	Gill Davies	gill.davies@phe.gov.uk gill.davies3@nhs.net
South East	Anna Ireland	anna.ireland@phe.gov.uk anna.ireland@nhs.net
South West	Paul Harwood	paul.harwood@phe.gov.uk paul.harwood2@nhs.net
West Midlands	Anna Hunt	anna.hunt@phe.gov.uk annahunt@nhs.net
Yorkshire and The Humber	Swarngit Shahid	swarngit.shahid@phe.gov.uk swarngit.shahid@nhs.net