Public Health England

Protecting and improving the nation's health

# National dental epidemiology programme

## Oral health survey of 3-year-old children 2019 to 2020: national protocol

This protocol aligns with the British Association for the Study of Community Dentistry (BASCD) diagnostic criteria for caries prevalence surveys and guidance on sampling for surveys of child dental health

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# Contents

# 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.[1] This imperative is described in the Health and Social Care Act 2012[2], underpinned by Statutory Instrument 2012 number 3094[3] and Commissioning Better Oral Health.[4]

Leadership and structures supporting the former NHS Dental Epidemiology Programme transferred into Public Health England (PHE) on 1 April 2013.This protocol forms part of the support that PHE provides.

The population group for scrutiny for the academic year 2019 to 2020 will be 3-year-olds attending childcare institutions. The findings will allow local authorities to monitor this age group and make comparison with the 2012 survey, inform oral health improvement strategies and indicate where resources should be targeted.

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

# 2. Aim of the survey

The aim of the survey is to measure the prevalence and severity of dental caries among 3-year-old children within each lower-tier local authority. The resulting reports give details of caries levels and other clinical measures and provide information for local authorities, the NHS and other partners.

This information can be used to:

- enable local authorities to meet their responsibilities regarding health needs assessments
- inform part of a health needs assessment, particularly joint strategic needs assessments
- provide comparisons with children of the same age in a previous study (2012)
- provide standardised information for comparison locally, regionally, between countries of the UK and internationally
- inform local oral health improvement strategies

# 3. Objectives

To examine 3-year-old children using caries diagnostic criteria and examination techniques based on those agreed by the British Association for the Study of Community Dentistry (BASCD), for caries prevalence surveys[5] and using standardised sampling procedures.[6]

# 4. Sample

The primary sampling unit will be local authority boundaries at unitary, metropolitan borough or lower-tier levels.

In a small number of cases it is not sensible for estimates to be provided for all lower-tier local authorities within a large upper-tier local authority. Where there is not a need for small area estimates there should be discussion between the regional PHE dental epidemiology coordinator (DEC), relevant consultants in dental public health and the BASCD statistical advisor to agree a reasonable sampling method to allow for estimates of other geographical areas to be produced.

## 4.1 Survey population

The survey population is defined as all those children attending childcare sites who have reached the age of 3 but have not had their fourth birthday on the date of examination and who attend that site for at least 3 hours per week. These sites will be nurseries, both state-funded and private, nursery classes attached to schools and playgroups.

Age eligible children will have dates of birth that fall within the widest range of dates of birth, September 2015 to June 2017.

Appendix K helps to identify the narrower ranges for examination dates in each month.

## 4.2 Sampling procedure

Discussion is required between local authority commissioners and consultants in dental public health in PHE centres to establish the size and type of sample that is required to meet local needs. For example, specific areas or population groups may be of interest, so enhanced samples may be required. Once this has been agreed the fieldwork team can undertake the sampling process.

Childcare sites include:

- nursery classes attached to primary schools
- children's centre childcare facilities for leaving children on a regular basis (not such things as Stay and Play sessions or occasional crèche sessions)
- nurseries and nursery schools not in children's centres
- private nurseries and nursery schools regardless of site
- playgroups

Sites designed exclusively for children with special needs will not be included, nor will purely before and after school sites or holiday clubs, leisure or study clubs.

## Sample size

A minimum of 250 examined children is required per local authority, from a minimum of 20 childcare sites. If there are fewer than 20 sites, all 3-year-old children in all the childcare sites should be invited to participate in the survey.

The minimum sample size of 250 children is unlikely to produce a sufficiently large sample to facilitate local planning for many areas, in which case larger samples will be required. Where larger samples are drawn, the children selected may need to be coded as additional sample A, B or C to allow for valid estimates to be calculated for the local authority area. Details of these requirements and the need for local stratification will be determined by local authorities with advice from DECs or consultants in dental public health in PHE centres, in liaison with dental managers/directors of the providers undertaking the surveys.

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

## Sampling procedure

A sampling procedure that stratifies for type of childcare site will be used to produce the sample. The stratification method is similar to that used for surveys of 5-year-old children but looks at type of provision rather than size of school. Detailed guidance on a stratified sampling procedure is given in 'British Association for the Study of Community Dentistry (BASCD) guidance on sampling for surveys of child dental health. A BASCD co-ordinated dental epidemiology programme quality standard'[6]. Advice can be requested from DECs.

Childcare sites are classified into 2 groups which are:

- Code 0 - playgroups
- Code 1 - nursery classes attached to primary schools
    - children's centre childcare facilities for leaving children on a regular basis (not such things as Stay and Play sessions or occasional crèche sessions)
    - nurseries and nursery schools not in children's centres
    - private nurseries and nursery schools regardless of site

A list of childcare sites has been provided by the national team in PHE, which derives from Ofsted and is grouped by region and local authority. This list will be distributed to the fieldwork teams by their DECs. It includes a listing of the number of places available at each site, but it cannot be known how many of these places are taken by a 3-year-old child.

The sites will include nursery classes attached to schools, children's centres, independent and local authority-controlled nurseries and playgroups.

For each local authority, the fieldwork team will need to examine the list and check websites and use local knowledge to be able to remove any sites which are:

- purely for before or after school care
- purely for holiday care
- study groups
- temporary or occasional provision for example crèches for one off events
- leisure groups for example Stagecoach
- hospital schools
- sites purely for children with special needs
- childminders

The fieldwork team will also need to identify which sites are playgroups and which are nurseries, nursery classes attached to schools and childcare facilities for regular use at children's centres. There may also be childcare sites missing from the list that will need to be added prior to sampling.

In local authority areas where there are more than 20 childcare sites a sampling procedure will be required which considers the distribution of 3-year-olds in different childcare sites. The aim will be to attend a minimum of 20 sampled sites and examine all willing children for whom parental agreement to participate in the survey has been received.

## 4.3 Calculation of a representative sample

A table should be constructed that shows the distribution of children in playgroups and other types of childcare (Table 1). Simply add together the number of children attending each type of childcare institution.

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

Each site should then be approached in the order in which they have been sampled. All age-eligible children at each site should be included and parental agreement to participate in the survey sought for each.

For example, in the fictitious local authority shown in Tables 1 and 2 the fieldwork team may need to go to the first 19 nurseries that were randomly selected to examine 240 children. If the first 19 sites do not yield enough children, the team should go onto select the 20th site. There may only be a need to visit one or 2 playgroups to examine the requisite 10 children. The fieldwork team should examine all consented and willing 3-year-olds at each sampled site.

### Example of sampling method

**Table 1: Distribution of 3-year-old children at childcare facilities in local authority X**

| Childcare type | A<br>Numbers of places regardless of age | B<br>Proportion of child places | C<br>Calculation if only a minimum 250 is to be sampled | D<br>Target number of children to see from each type of institution |
|---|---|---|---|---|
| Childcare sites that are not playgroups | 2836 | 96% | 250 x 0.96 = 240 | 240 |
| Playgroups | 118 | 4% | 250 x 0.04 = 10 | 10 |
| Total | 2,954 | 100% | | 250 |

**Table 2: Sampling of childcare institutions for target numbers to be seen**

| Name of institution | Allocated number | Order randomly sampled within each group | Target number of children to see from each type of institution |
|---|---|---|---|
| **Childcare sites that are not playgroups** | | | 240 |
| St Swithin's | 1 | 10th | |
| Brook Road | 2 | 1st | |
| Lowtown C Centre | 3 | 6th | |
| St Mary's | 4 | 2nd | |
| Broad Oak | 5 | 3rd | |
| Rowley Street | 6 | 8th | |
| High Green Nursery | 7 | 5th | |
| Busy Bees | 8 | 12th | |
| Station Rd CC | 9 | 11th | |
| Northern C Centre | 10 | 4th | |
| Kids Allowed | 11 | 7th | |
| Little Angels | 12 | 9th | |
| …… | and so on | | 240 |
| | | | |
| **Playgroups** | | | 10 |
| Ashes Lane playgroup | 1 | 2nd | |
| Luton Methodist Church playgroup | 2 | 1st | |
| | and so on | | 10 |

This is a suggested process for a sampling technique which can be applied to a minimum or a larger, simple sample. It is recognised that as the proportion of positive consenters reduces, the representativeness of the sample also reduces. A local decision will need to be made on the final sample size if there are difficulties achieving 250 examined children. An increased number of examined children will give greater precision to the data but will not affect the representativeness of the sample as it is unlikely the response rate will differ among a sample of 170 children from a sample of 500 children.

It would be better to focus resources on trying to increase the response rate if possible, than accepting a low response rate and increasing the sample size.

Discussion is required between commissioners, DECs, consultants in dental public health and the fieldwork team via their manager to decide for each local authority what they wish to gain from this survey and, therefore, the most appropriate sampling methods. Some areas may choose to undertake surveys of all childcare sites, others may choose to take enhanced samples to permit comparison between groups of interest and use the 'additional sample A, B, C' coding system to delineate mainstream samples and additional ones. Information should be recorded to show clearly how the samples have been formed and shown to the national team. A decision can them be

made about inclusion or exclusion of local additional groups to allow for analysis of a population representative sample.

Note that if ward-level estimates are required, sampling should be undertaken to ensure there is sufficient representation in each ward to be able to produce robust estimates. This does not mean that all sites need to be involved as there are alternative sampling methods which are far more efficient than this. Assistance is available regarding larger samples from DECs.

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

The completed tables and explanations of the proposed sampling method should be sent to DECs for agreement before any childcare sites are contacted.

Advice can also be requested from the regional DEC and from Girvan Burnside (g.burnside@liv.ac.uk).

## 4.4 Contact details of dental epidemiology co-ordinators

| PHE centre | Name of DEC | Email address |
|---|---|---|
| East Midlands | Jasmine Murphy<br>Allan Reid | jasmine.murphy@phe.gov.uk<br>allan.reid@phe.gov.uk |
| East of England | Linda Hillman<br>Charlotte Klass | linda.hillman@phe.gov.uk<br>charlotte.klass@phe.gov.uk |
| London | Desmond Wright<br>Rakhee Patel | desmond.wright@phe.gov.uk<br>rakhee.patel@phe.gov.uk |
| North East | Kamini Shah | kamini.shah@phe.gov.uk |
| North West | Melanie Catleugh | melanie.catleugh@phe.gov.uk |
| South East | Jenny Oliver | anna.ireland@nhs.net<br>jenny.oliver@phe.gov.uk |
| South West | Paul Harwood<br>Reena Patel | paul.harwood@phe.gov.uk<br>reena.patel@phe.gov.uk |
| West Midlands | Anna Hunt | anna.hunt@phe.gov.uk<br>annahunt@nhs.net |
| Yorkshire and The Humber | Sandra Whiston | sandra.whiston@phe.gov.uk |

## 4.5 General Data Protection Regulations

### A note about the General Data Protection Regulations (GDPR) (see Appendix E – Letter from PHE regarding GDPR and health activities in childcare sites)

The key message is that no change is needed to the current ways in which children's personal information is used and shared for these health data collections to be lawful under the GDPR.

### GDPR and the lawful basis for the childcare site health data collection

The GDPR became UK law on 25 May 2018. It updates and strengthens the ways in which personal data is protected[i]. The GDPR is an evolution in data protection legislation rather than a revolution.

All processing of personal data, meaning all aspects of the collection, use and sharing of personal data about identifiable individuals[ii] must have a lawful basis under the GDPR. Article 6 of the GDPR sets out the range of purposes for which personal data can be lawfully processed. Article 9 sets out the associated conditions for the lawful processing of 'special categories' of personal data, including data about health.

Consent is one of the lawful bases for processing personal data under the GDPR but is not the lawful basis for the dental data collections. Instead, this is provided by varying combinations of the GDPR articles that cover:

- compliance with a legal obligation
- the exercise of official authority
- medical diagnosis or the provision of healthcare or treatment
- public interest in public health

No change is needed to the current ways in which parents are informed of health data collections for these to be lawful under the GDPR.

### GDPR and dental health surveys

All local authorities in England are required to undertake dental surveys as part of a programme of work to help improve the oral health of people in their area.

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i Further information on the GDPR can be found on the Information Commissioner's Office website: https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr
ii https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/key-definitions/

The official authority for dental health surveys is provided by The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012[iii]. This official authority means that the lawful basis for processing children's personal data for this purpose is considered to be provided by:

- GDPR Article 6(1)(c) – processing is necessary for compliance with a legal obligation
- GDPR Article 6(1)(e) – processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority
- GDPR Article 9(2)(h) – processing is necessary for medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems

### Informing parents

Guidance on the management of dental surveys among 3-year-old children in childcare sites is published by PHE via a national protocol.

Dental surveys involve a physical examination so the guidance states that the written agreement of parents or persons with parental responsibility must be obtained for their children to be included in a survey.

No change is required to the way in which this written agreement is obtained. Childcare sites should continue to use the template information letter and agreement form provided by PHE. Only children for whom parental agreement has been received should be included in a survey.

# 5. Responsibilities

### 5.1 Overall and commissioning

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

The study sponsor is Dr Sandra White for PHE 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.

iii www.legislation.gov.uk/uksi/2012/3094/contents/made

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

The commissioning of the surveys is the responsibility of local authorities, often in partnership with NHS England dental commissioning teams and supported by local PHE consultants in dental public health. Many childcare sites will be unfamiliar with dental surveys or community dental services. This may lead to uncertainty about the sharing of data or co-operating with requests from fieldwork teams. It is therefore essential that colleagues within the local authority are approached to seek their support for the survey. If directors of public health, directors of education and directors of children's services are aware of the purpose and nature of the surveys, and can see the benefit of them, they can be supportive and ensure the childcare providers in their area feel confident to take part.

The local planning and organisation of the survey will be carried out by commissioned fieldwork teams, typically from community dental services.

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

## 5.2 Personnel

Fieldwork for the survey will be carried out by services commissioned by the local authority, sometimes in partnership with NHS England. The dental examinations will be carried out by registered dental clinicians who will be trained and calibrated to national standards by the regional standard examiners/trainers, using the approved BASCD training pack, to ensure that they are familiar with the examination method and criteria. Examiners must be calibrated following BASCD guidance on the statistical aspects of training and calibration of examiners for surveys of child dental health.[7] Examiners who do not conform to the accepted diagnostic standards will need to be retrained and recalibrated or replaced.

Where a therapist or hygienist will be carrying out examinations, the lead investigator, Sandra White (DentalPHIntelligence@phe.gov.uk), should be notified. Therapists and hygienists will need additional training on the clinical criteria for the survey prior to calibration if they are first time examiners. They will also need to be indemnified.

It is good practice for 2 support workers to accompany the examining dental clinician. One worker is required to record the codes that the examiner provides during the examination and the other will help support the process by liaising with staff, fetching the children, assisting with examination and encouraging co-operation.

Disclosure and Barring Service certificates may be requested by childcare sites. All members of the fieldwork teams will need to have up-to-date versions of these to hand in such cases.

Fieldwork personnel should have up-to-date training in infection control, safeguarding, data protection and other, relevant, governance issues.

# 6. General conduct of the survey

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

## 6.1 Planning and organisation of the survey

The planning and organisation of the survey will be carried out by commissioned fieldwork teams who will liaise with local authorities, childcare site managers, heads of nurseries attached to schools and leaders of playgroups. Reference to the Statutory Instrument 2012 No 3094 (Appendix A) [and the letter from the director of dental public health (Appendix B)] should be made if difficulties are encountered. A letter will be sent from the national lead for dental public health in PHE to directors of public health to ask for their explicit support and asking for directors of early years/education children's services to write to all their childcare providers to endorse the survey.

Centre based consultants in dental public health have been asked to liaise with directors of public health or other local authority contacts about this survey. If problems with site cooperation are encountered, then the regional DEC and local consultants in dental public health should be able to help by speaking with local authority colleagues.

An Ofsted derived database of pre-school childcare sites has been provided and fieldwork teams should use this to identify all childcare sites within each local authority area, including nurseries attached to schools, private and state funded nurseries and playgroups.

## 6.2 Contacting childcare sites

Following random sampling, the managers of the selected sites will be contacted. The aims and objectives of the survey will be explained and the co-operation of the managers sought. Dates for examination will be set at a mutually convenient time and date with relevant staff members at each site.

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

Lists of all age-eligible children to be included in the survey should be obtained prior to the examination. These lists should include the following information: name, date of birth, residential postcode and ethnicity. Using these lists, children who will be age-eligible on the planned day of examination will be identified (see Appendix K). A list of these children, along with their home postcodes will be formed into a table. Agreement to participate should be sought from the parents/carers of each of these children.

## 6.3 Seeking consent

Explicit consent for undertaking dental examination of children in an epidemiological survey is required following the guidance by the Department of Health in 2007 (Appendix D).

The procedure for obtaining explicit, positive consent must involve:

- giving parents of sampled children an invitation letter, which gives clear information explaining the nature and purpose of dental surveys and how the resulting data will be used in broad terms and simple language (Appendix L, and M where indicated)
- provision of a form which reports parental agreement for the survey, indicates that parents have read and understood the information leaflet and includes a signature and date of this (Appendix L or M where indicated)
- recording on a form (Appendix N) which children have returned the signed agreement form and which have not
- distribution of a second letter with agreement to participate form, ideally on differently coloured paper, to those who do not respond to the first
- acceptance of, and respect for, the decision of a parent or a child to decline an examination

In some sites, parents are asked to agree to their child's participation in a range of activities for the forthcoming year or term. It is acceptable for agreement to participate in the survey to be included in this block-consent session if an invitation letter is provided.

### 6.3.1 Maximising consent rates

It is very important that all efforts are made to maximise the proportion of agreement to participate forms that are returned from parents. Appendix O gives details of a range of approaches that fieldwork teams and local authority partners can take.

Various strategies may be necessary to maximise the number of agreement to participate forms returned. These include:

- identifying sites where consent return is likely to be poor and providing additional support
- recruiting a named person at a site who can speak with parents and follow up when forms are not forthcoming. This might be a nursery nurse, family liaison worker, pastoral-care worker, nursery assistant or parent volunteer
- providing completed lists that show which children have been sent agreement to participate forms and a column for sites to record which ones have returned them (Appendix N).
- giving parents prior warning of the survey and seeking their support via posters, an insertion in the newsletter, postcards or attendance at parents' evening
- liaising with the childcare sites on how they best keep in touch with parents, for example through WhatsApp groups
- posting letters and consents to home addresses with stamped, addressed envelopes for return
- handing letters and agreement to participate forms directly to parents at pick up time

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

The support of the PHE lead for dental public health will be shown in a letter to directors of public health (Appendix B) and explicit support is being sought locally from heads of children's services, where possible. The letter and any local support letters can be used to seek the support of site managers and expedite co-operation.

### 6.3.2 Recording consent

Fieldwork teams must keep a record of the number of all children approached, the numbers with parental consent, parental refusal and no consent (Appendix Q), so that the form in Appendix R can be completed. Appendix R and Appendix Q should be completed electronically and submitted securely along with data files to DECs.

All consented children should be examined where the child is willing to co-operate with this.

It is good practice to double check the examination sheet to identify clearly those children for whom consent has been provided. Children whose parents have not returned an agreement to participate form must not be examined.

## 6.4 Feedback to parents

It is good practice to inform parents/guardians if a clinical condition requiring closer investigation is seen during examination, for example, sepsis. This should be couched in terms that respect any existing patient-clinician relationship. If there is no intention to provide this information, the consent letter (Appendix L) should be modified to reflect this. The DEC can provide advice and support.

Feedback letters should be placed in individual envelopes directed to the child's parent or guardian and posted to the child's home or distributed by the childcare site.

## 6.5 Safeguarding

Any safeguarding concerns suspected by the fieldwork teams should be managed according to local safeguarding procedures.

Safeguarding concerns should be captured in appendix R if they have been acted on in line with local safeguarding procedures.

# 7. Fieldwork

Examinations will take place in childcare sites, starting immediately after training and calibration of examiners and must be completed by the end of June 2020. This gives sufficient time for checking and cleaning of data, summing of numbers of children identified, those consented and not consented, numbers examined and reporting of these.

## 7.1 Equipment, instruments and materials

To ensure standardisation, no mobile surgeries or equivalent should be used, neither should loupes be worn by the examiner.

The dental examinations will take place in childcare sites in a location identified as being suitable for that purpose and convenient for the smooth running of both the survey and the site.

## 7.2 Examining position

A table with a mat or suitable fully reclining chair will be used for examination, with the examiner seated behind the child, not the side. If a reclining chair is used, an

assessment should be made of the safety of it for both the examiner and the volunteer. Some chairs can tip backwards as smaller children move upwards in them if there is no support underneath.

### 7.3 Examination light

An inspection light yielding approximately 4,000 lux at one metre will be used for illumination. (A Daray X100 HD (goose neck) lamp with Halogen bulb or a Brandon Medical MT6008 are suitable if a replacement is needed. Do not use a lamp with an LED bulb). If using the Daray Versatile, it should be set to the brighter of the 2 settings. A spare halogen bulb will be carried in case of failure. Daray lamps must be firmly secured to a rigid surface before use and the attachment mechanism correctly orientated to ensure it cannot topple over (see Appendix H). See Appendix I for supplier contact details.

### 7.4 Instruments

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

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

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 and a new pair of examination gloves will be used for each volunteer.

Cotton wool rolls, cotton buds, or pledgets of cotton wool will be used to clear teeth of debris and moisture.

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

# 8. Collection of data – general information

### 8.1 Training and calibration

Only trained and calibrated dental clinicians, assisted by appropriately trained assistants, will undertake the collection and recording of non-clinical and clinical data.

## 8.2 Computer software

Data should be collected using the Access data collection tool with a specific format for this survey (3yr 2019 Data Collection.accdb), which can be downloaded from K-Hub.

The format contains several free fields for local use at the end. If these are insufficient for local information requirements, please discuss this with your DEC.

Data may be entered either onto paper record sheets (Appendix P) or directly onto computer, with safeguards for both methods (see 8.3 and 8.4).

## 8.3 Information sharing and protection

This section sets out the roles and responsibilities for sharing and protecting the information required for the national dental survey programme.

### 8.3.1 Responsibilities of nurseries and playgroups

For all 3-year-old children on their roll, nurseries and playgroups are required to provide:

- first name and surname - this is used to identify the child and check that written parental agreement for them to be examined has been received
- date of birth – this is used to confirm that the child is the right age to take part in the survey
- gender – this is used to help confirm the identity of the child and to enable national and local analyses of gender differences in dental health
- ethnic group – this is used to enable national and local analyses of ethnic group differences in dental health
- home postcode – this is used to enable national and local analyses of socio-economic and geographic differences in dental health

The list containing this information must be provided to the dental health team appointed by the local authority to carry out the survey. The list must be sent using secure email, or, if provided in hard copy, sent to the dental health team by registered post or handed over in person.

### 8.3.2 Legal basis for nurseries and playgroups to share children's personal information with dental health teams

All local authorities in England have a statutory duty to undertake dental surveys as part of a programme to help improve the dental health of people in their area. The

official authority for these surveys is provided by The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012iv. Local authorities will usually commission a dental health team, which may include one or more qualified dentist, dental therapist and/or dental hygienist, from a local NHS Trust to carry out the survey on their behalf.

The official authority for dental surveys means that the lawful basis under the General Data Protection Regulation (GDPR) and Data Protection Act 2018 for processing children's personal information for this purpose is considered to be provided by:

- GDPR Article 6(1)(c) – processing is necessary for compliance with a legal obligation
- GDPR Article 6(1)(e) – processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority
- GDPR Article 9(2)(h) – processing is necessary for medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems

This lawful basis for dental surveys means that nurseries and playgroups do not need to be obtain the consent of parents or guardians to share their children's personal information with dental health teams.

However, as dental surveys involve a physical examination, nurseries and playgroups and the dental health teams must ensure that:

- written parental agreement is obtained for the examination to take place
- parents are provided with a copy of the 'Public Health England National Dental Health Survey: Information for Parents' leaflet, which explains what the dental examination involves, the personal data processed about each child, and the organisations this personal data may be shared with

### 8.3.3 Responsibilities for obtaining parental agreement for children to take part in dental surveys

Nurseries and playgroups are responsible for ensuring that the parents of all children eligible to take part in the dental survey are provided with the parental agreement form and the 'Information for Parents' leaflet.

iv www.legislation.gov.uk/uksi/2012/3094/contents/made

Usually, it will be the responsibility of the nursery or playgroup to provide the agreement form and information leaflet to the parents of eligible children, although the dental health team may undertake this on their behalf.

The **nursery or playgroup** is also responsible for:

- receiving the signed agreement forms from parents
- informing the dental health team of which children have parental agreement to receive a dental examination
- providing the signed agreement forms to the dental health team

The **dental health team** is responsible for:

- retaining the signed parental agreement forms for 1 year
- keeping these forms in a secure location, such as a lockable filing cabinet
- securely destroying these forms at the end of this period

### 8.3.4 Responsibilities of dental health teams

Dental health teams are responsible for sending to PHE the complete dental survey record for each child taking part. This record will include the personal information of each child provided by the nursery or playgroup together with the results of the dental examination.

This information must be handed directly in person to the PHE Dental Epidemiology Coordinator on a removable storage device, such as a memory stick, or sent to the Coordinator by secure email.

No information for children for whom parental agreement to take part in the survey has not been received should be sent to PHE.

Dental health teams must:

- retain a copy of the information they submit to PHE for 1 year
- ensure this information is securely protected, for example by storing it on a secure computer network that can only be accessed by the dental health team
- securely destroy this information at the end of this period

The dental health team is also responsible for securely destroying at the earliest opportunity after the dental examinations have been completed in each nursery and playgroup the personal information of any children for whom parental agreement to take part has not been obtained.

### 8.3.5 Responsibilities of Public Health England

The role of PHE is to analyse the information provided by the dental health teams and publish the results of these analyses in a national report on children's dental health.

PHE is responsible for:

- ensuring that only staff from the PHE Dental Public Health team have access to the personal data of the children taking part in the survey
- ensuring this information is securely protected
- retaining the personal data of the children taking part in the survey for 3 years and securely deleting this information at the end of this period

PHE may also share data from the dental health survey with local authorities and academic researchers so that they can use it to improve dental health, care and services through research and planning.

PHE is responsible for:

- ensuring that any data it does share with third parties is de-personalised in accordance with the ICO's Anonymisation Code of Practice
- managing any third party data sharing through its Office for Data Release and publishing a description of this sharing in its data release register

## 8.4 File management

Files should be labelled to indicate the population group to which they refer. It is insufficient to simply label files with the age group and year of survey. The name of the local authority is required, according to the guidance.

Data handling guidance instructions on the checking, cleaning and labelling of data files will be available from K-Hub.

# 9. Collection of non-clinical data

## 9.1 Recording of information to allow data linkage

The PHE national dental public health team intends to use the data from this year's survey to investigate the difference in dental caries prevalence and severity between 3 year olds and 5 year olds. To link caries information at individual level with the next 5-

year-old dataset 2020/21, it is essential that a list is formed of all children, with their survey unique ID number (as formed in 9.6 below), their first and second names, date of birth (dd/mm/yyyy) and postcode. This information will be kept separate from the caries data.

All fieldwork teams should complete an electronic copy of Appendix Q to provide these details for all children.

Appendix Q is a password-protected workbook. When you try to open it, you will be asked for a password. This password will be sent to fieldwork teams by the DECs. The word should start with a capital E and have no punctuation or spaces.

## 9.2 Organisational boundary coding

The clinical data collection sheet for each child examined requires entry of the name of the lower-tier or unitary local authority within which the childcare site sits. This is defined by the geographical position of the site within local authority boundaries. This should be clear, as the local authority is given on the Ofsted derived list which has been provided. A table of names for lower-tier local authority is provided in Appendix J along with their codes.

## 9.3 Examiner

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

## 9.4 Examination date

The date of the examination will be recorded.

## 9.5 Childcare site name and postcode

The site name and postcode will be entered. Care must be taken to record each site with a single method of spelling and punctuation to avoid erroneously creating sites that the computer programme recognises as distinct. For example, a single site recorded as St Mary’s in 5 records and St. Marys in 10 others will appear to be 2 sites when the central computer checks entries.

## 9.6 Child identity number

A unique identity number must be entered for each child, which consists of a prefix from the lower-tier local authority code and a suffix, which numbers participants from

class lists. The list of lower-tier local authority codes is given the fourth column in Appendix J.

For example, the third child to be sampled in Aylesbury Vale would have the following ID number:

| Lower-tier local authority code | | | | | | | | | Number of sampled child | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| E | 0 | 7 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | 0 | 0 | 3 |

The 190th child to be sampled in Aylesbury Vale would have the following ID number:

| Lower-tier local authority code | | | | | | | | | Number of sampled child | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| E | 0 | 7 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | 1 | 9 | 0 |

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

## 9.7 Date of birth

Full dates of birth are required to enable sampling from class lists but use of just the month and year of birth increases anonymity for purposes of recording on the clinical data collection sheet. So, all children will be recorded onto these and onto the computer data collection system as being born on the 15th of the month. The Access data collection system will automatically indicate when a child is possibly too old or too young for inclusion. In these cases, a double check should be run on the actual date of birth to ensure that they are in fact 3-years-old on the day of examination.

Age eligible children will have dates of birth that fall within the widest range of dates of birth September 2015 to June 2017 (see Appendix K, which also helps to identify the narrower ranges for examination dates in each month).

## 9.8 Home address postcode

Home postcodes will be recorded for all children for whom parental consent is provided. This should be sought from the childcare site or, in the rare instances when this is refused, from parents via the agreement to participate form, or lists from child health databases can be requested.

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, in the Access data collection programme.

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

## 9.9 Sample group codes

Children examined as part of the minimum standard sample should be coded as 0 – Main sample.

To facilitate the identification of samples that are taken in addition to the minimum requirement, separate coding is required to assist in the calculation of valid, local population level estimates. For example, if an additional sample is required for an area of concern, it is important that additional children sampled for this purpose are identifiable. This allows for deeper local analysis. It is therefore necessary to code these children in order that they can be identified and included or excluded from analyses accordingly.

All ‘additional’ samples, if used, should be defined locally and descriptions communicated to DECs.

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

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

## 9.10 Examination status

The type of examination will be recorded as follows:

0 Examined
1 Repeat examination for intra-examiner reliability
2 Training examination
3 Child absent
4 Child refused examination

## 9.11 Variable for ethnic code

Volunteer children will be coded for ethnic group/background to ensure the requirements of the Health and Social Care Act, 2012 are met. 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.

### Reducing Health Inequalities and the Equality Act 2010

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

Ethnic group will be collected from parents using the agreement to participate form.

The ethnicity code set reflects categories used in the 2011 national population census, which are:

| Higher ethnicity code | Higher ethnicity description | Lower ethnicity code | Lower ethnicity description |
|---|---|---|---|
| A | White | A1 | English/Welsh/Scottish/Northern Irish/British |
| | | A2 | Irish |
| | | A3 | Gypsy or Irish traveller |
| | | A4 | Any other White background |
| B | Mixed/Multiple ethnic groups | B1 | White and Black Caribbean |
| | | B2 | White and Black African |
| | | B3 | White and Asian |
| | | B4 | Any other Mixed/Multiple ethnic background |
| C | Asian/Asian British | C1 | Indian |
| | | C2 | Pakistani |
| | | C3 | Bangladeshi |
| | | C4 | Chinese |
| | | C5 | Any other Asian background |
| D | Black/African/Caribbean/Black British | D1 | African |
| | | D2 | Caribbean |
| | | D3 | Any other Black/African/Caribbean background |
| E | Other ethnic group | E1 | Arab |
| | | E2 | Any other ethnic group |
| F | Other ethnic group – locally defined | I | Ethnic group not provided |
| G | Other ethnic group – locally defined | I | Ethnic group not provided |
| H | Other ethnic group – locally defined | I | Ethnic group not provided |
| I | Information on ethnic group not provided | I | Ethnic group not provided |

Children can only be classified at a lower ethnicity descriptor from the list given for their higher-level descriptor. For example, A – White must have a lower code A1-A4 only. If you use lower code B3, then the higher code must be B – Mixed.

The penultimate 3 groups may be defined for local use and should allow for additional ethnic groups not listed in the table above.

Further guidance and descriptions of ethnic groupings can be found from: www.ethnicity-facts-figures.service.gov.uk/ethnic-groups

# 10. Collection of clinical data

To ensure standardisation, no mobile surgeries or equivalent should be used, neither should loupes be worn by the examiner as these would affect the examination process and, therefore, the comparability of the data.

Volunteer children will be examined lying down on a table with a mat or in a suitable chair that is reclined to fully supine. The examiner will be seated behind the subject. The examination will be visual, without loupes, aided by mouth mirrors and the standardised light source only as described in 7.3.

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

Probes must only be used for cleaning debris from the tooth surfaces to enable satisfactory visual examination and for defining fissure sealants as indicated below (10.8). Radiographic or fibre-optic transillumination examination will not be undertaken.

## 10.1 Oral cleanliness: assessment of plaque

It is of interest for local surveys to include a variable about oral cleanliness because this provides a proxy for tooth brushing activity and likely exposure to fluoride toothpaste. A simple measure based on a modification of the Silness and Low Index[7] will be used. A probe is not used for this part of the examination, which involves visual examination only of upper canine to upper canine. No disclosing should be done. Only easily visible plaque should be considered and recent debris (such as small pieces of food found in an otherwise clean mouth immediately after a lunchtime or break) should be ignored.

The coding to be used is:

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

## 10.2 Dentition status

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

The condition of each tooth surface will be recorded using the BASCD standardised criteria (BASCD) Diagnostic Criteria for Caries Prevalence Surveys.[5] The application of these criteria will be taught using the BASCD teaching pack, available from K-Hub.

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

## 10.3 Conventions

The conventions that will apply are:

- 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
- the presence of supernumerary teeth will not be recorded. If a tooth and a supernumerary exactly resemble one another, the distal of the 2 will be regarded as the supernumerary
- missing primary incisors are assumed exfoliated and assigned tooth Code 8 in the main chart (also see 10.5 for more detail on recording these)
- caries takes precedence over non-carious defects, for example hypoplasia
- retained roots following extraction or gross breakdown should be recorded as code 3
- discoloured, non-vital incisors, without caries or fractures should be scored T for trauma on all surfaces
- surfaces which are obscured, for example unerupted surfaces, should be assumed to be sound and coded ‘-‘ on paper charts

## 10.4 Teeth present

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

a) the teeth present or absent are described as such: mirror only
b) tooth surface examination: mirror + cotton wool (for drying)

## 10.5 Absent teeth

### Tooth code 6 – extracted due to caries

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

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

All missing primary canines and primary molars will be considered to have been extracted (code 6) unless there is unquestionable evidence that a tooth has been extracted or lost for other reasons.

### Tooth Code 8 - Unerupted or missing other

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

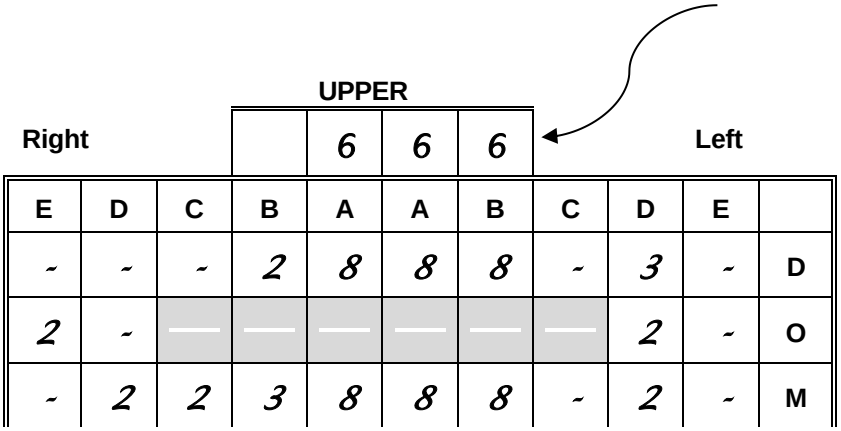
This code will be used **in the main chart** where there are missing primary incisors. This is the same convention as for 5-year-olds and will allow for comparison between the 2 age groups.

**Missing incisors**

To capture the real number of incisors that have been extracted, 2 additional rows have been added to the chart. These boxes are for the recording of missing incisors that have probably been extracted because of caries.

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

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




Among 3-year-olds it is likely that most missing incisors will have been extracted because of caries, so the Code 6 should be placed in the additional box unless there is overwhelming evidence that the tooth is missing for another reason.

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

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

## 10.6 Obscured surfaces

All obscured surfaces are assumed sound (surface code ‘-‘ 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.

## 10.7 Caries diagnostic criteria and codes

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

## Surface code – 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. In the absence of other positive criteria, surfaces with the following defects 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 showing signs of moderate-to-severe fluorosis

All questionable lesions should be coded as ‘sound’.

## Surface code 1 – arrested dentinal decay

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

## Surface code 2 – caries into dentine

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

## Surface code 3 – decay with pulpal involvement

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

## Surface code 4 – filled and decayed

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

## Surface code 5 – filled with no decay

Criteria: surfaces which contain a satisfactory permanent restoration of any material will be coded under this category (except for obvious sealant restorations which are coded separately as code N).

## Surface code R – filled, needs replacing (not carious)

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

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

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

## Surface code C – crown

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

## Surface code T – trauma

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

Where a tooth is missing through trauma, all surfaces should be coded T.

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

## 10.8 Sealed surfaces

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

### Surface code $ – sealed surface, type unknown

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

Where a clear sealant is in place and there appears to be a lesion showing through the material, the surface should still be coded code $ – sealed surface, type unknown.

### Surface code N – obvious sealant restorations

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

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

## 10.9 Pufa

All children should be examined for the presence or absence of the pufa signs listed below. The mouth should be examined in the same order as before (upper right, upper left, lower left, lower right), ensuring that the lips or cheeks are gently retracted to allow the soft tissues to be examined. The lesions to be looked for are:

- (p) open pulp primary dentition
- (u) traumatic ulceration in primary dentition
- (f) fistula in primary dentition
- (a) abscess in primary dentition

The coding to be used is:

- 0 – no lesions evident
- 1 – a single lesion present
- 2 – two or more lesions present

### 10.10 Optional spare variables for assessment of treatment need or other local requirement

Spare variables have been provided, as usual, to allow collection of further data which may be analysed locally, and this should accommodate descriptors of ward, locality or other unit. If these are insufficient for local needs, the national format can be amended to add in additional variables at the end. The new format should be renamed to distinguish it from the standard format.

## 11. Reporting of data

Data should be input into a secure computer with the Access format for the 2019 to 2020 survey (3yr 2019 data collection.accdb) as soon as possible after visiting the childcare site. Data should not be left to be entered as a batch when all fieldwork is completed.

Prior to sending on completed data files, each fieldwork team is responsible for checking their data for inaccuracies. Step-by-step guidance to the whole data-handling process is available from K-Hub. The main areas for error occur with incorrect dates of birth and/or ages, duplicate entries for children or childcare sites and entry of clinical data for children coded as being absent.

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

The information that will be reported for each lower-tier local authority using Appendix R is:

- start and finish dates of the period of examinations (dd/mm/yyyy to dd/mm/yyyy)
- total number of sites providing childcare/education for 3-year olds
- total number of 3-year-old children attending listed sites

- number of sites visited providing childcare/education for 3-year olds
- number of 3-year-old children from whom consent was initially sought
- number of 3-year-old children with parental consent, parental consent refused and agreement to participate form not returned
- number of 3-year-old consented children examined, absent and refused examination
- number of safeguarding concerns encountered during the survey (see section 6.5).

Data will be submitted as cleaned Excel survey files exported from the Access data collection database and summary reports submitted as completed Excel documents

All returns should be made to DECs as soon as possible after completion of the survey and no later than 31 July 2020 and should include:

- the completed appendix R summary worksheet for each upper-tier local authority including information for each lower-tier local authority on separate rows
- the Excel survey data file for each lower-tier local authority labelled to indicate which local authority it refers to

DECs will upload the data files received from fieldwork teams into the shared DEC network folder relevant for their area.

The national report will be provided by the PHE national dental public health team. Responsibility for governance of the data lies with this team.

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

1. Requestor to send an email to DentalPHIntelligence@phe.gov.uk providing:

    - name of individual to be allocated as ‘super user’
    - local authority or LKIS
    - contact details

2. The nominated ‘Super User’ will be contacted by a member of the national dental public health team 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.

## 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 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. Health and Social care Ac 2012.Accessed in June 2016 from: www.legislation.gov.uk/ukpga/2012/7/contents/enacted

3. 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 2018 from: http://origin-www.legislation.gov.uk/uksi/2012/3094/part/4/made

4. 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

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. Pine, C.M., Pitts, N.B., Nugent, Z.J. (1997a): British Association for the Study of Community Dentistry (BASCD) guidance on sampling for surveys of child dental health. A BASCD coordinated dental epidemiology programme quality standard. Community Dental Health 14: (Supplement 1), 10-17.

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

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

# 13. Appendices

## Table of appendices



# Documents will be available in pdf format from K-Hub
* Documents will be available in Word format from K-Hub
~ Document will be available in Excel format from K-Hub

Appendix A. **Statutory Instrument 2012, No. 3094 – extract** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

Appendix B. **Letter of support from programme lead for dental public health, Public Health England, to directors of public health** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

Appendix C. **Information about the purpose and nature of the survey** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

# Appendix D. **Requirement for explicit, positive consent, 2007**

DH Department of Health

**Consent for School Dental Inspections and Dental Epidemiological Surveys**

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

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

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

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

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

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

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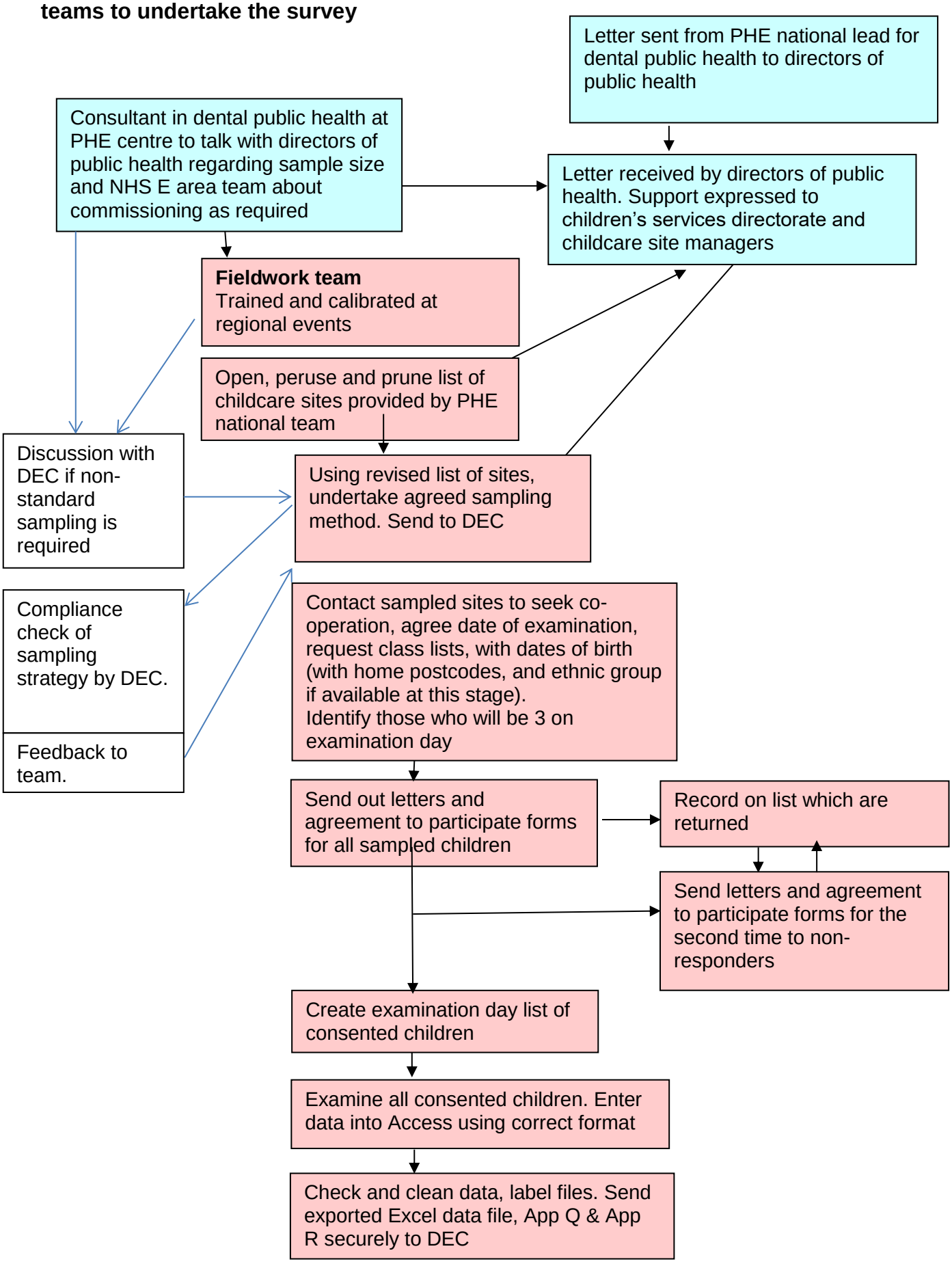
[1] *Good practice in Consent* (HSC 2001/023)
http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/HealthServiceCircularsArticle/fs/en?CONTENT_ID=4003736&chk=OigZnc

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

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

Appendix E. **Letter from PHE regarding GDPR and health activities in childcare sites** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

## Appendix F. **Stages for PHE dental public health epidemiology programme teams to undertake the survey**



# Appendix G. **Operational timetable**

| | |
|---|---|
| Training for dental epidemiology coordinators (DECs) – national protocol | July 2019 |
| National clinical training and calibration for standard examiners | |
| Regional training and calibration for fieldwork teams | September 2019 |
| Data collection and ongoing data entry | To start immediately after regional training and calibration and completed by 30 June 2020 |
| Completion of data checking and labelling of local authority data files.<br>Secure forwarding of cleaned data files to DECs as soon as possible before deadline. | By 31 July 2020 |
| DECs to upload summaries and copies of local authority data files to the national dental public health team | To be uploaded as and when they have been checked, completed by 31 August 2020 |
| National DPH team- Checking of data, returning errors for clarification by fieldwork teams via DECs, and collation of clean, verified data | As and when data files arrive. |
| National DPH team – compute estimates for local authorities | From September 2020 |
| Publication of results on website www.gov.uk/government/collections/oral-health#related-intelligence | January 2021 or 4 months after receipt of last data set dependent upon PHE gateway. |
| Feedback of cleaned anonymised data | January 2021 or 4 months after receipt of last data set. |

## Appendix H. **Safe use of Daray lights for dental epidemiology fieldwork**

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

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

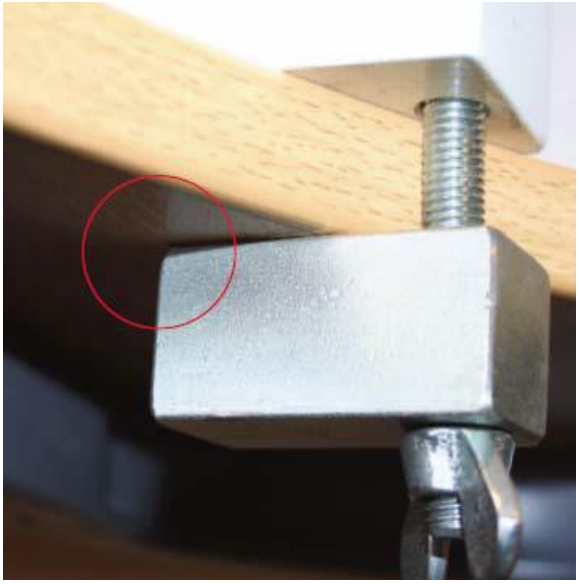
The clamps should be fitted and used correctly and checked to ensure they are firmly fixed to a work surface. For this reason, it is best practice to establish a set examination site at a venue and avoid moving around from one room to another.

The Pivot D2 clamp has replaced the Pivot D clamp and can be sourced from Daray Ltd.

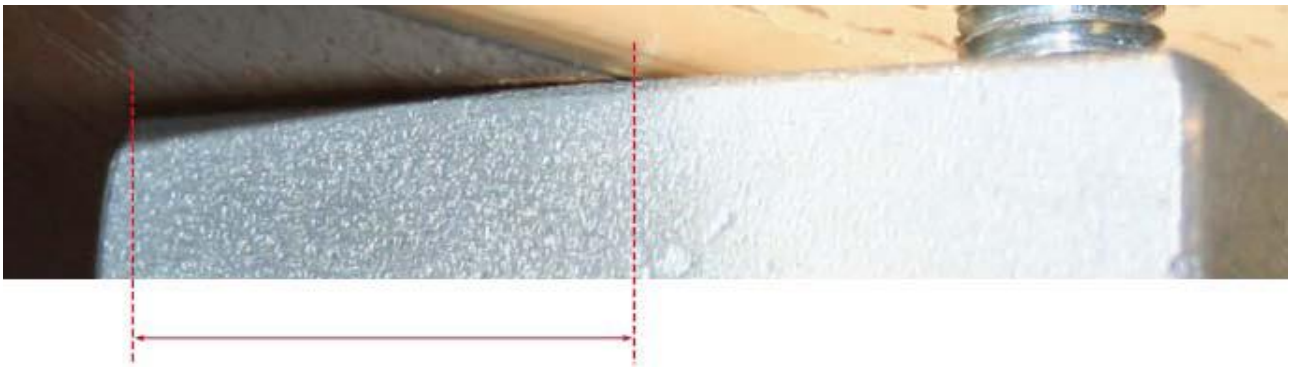
The pictures below show how the clamp with a silver clamping bar should be fitted to ensure that the block of the clamp is in full contact with the base of the desk or table surface (pictures 1 and 2). If the wedge-shaped bar is fitted upside down, it will not be stable (pictures 3 and 4).

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

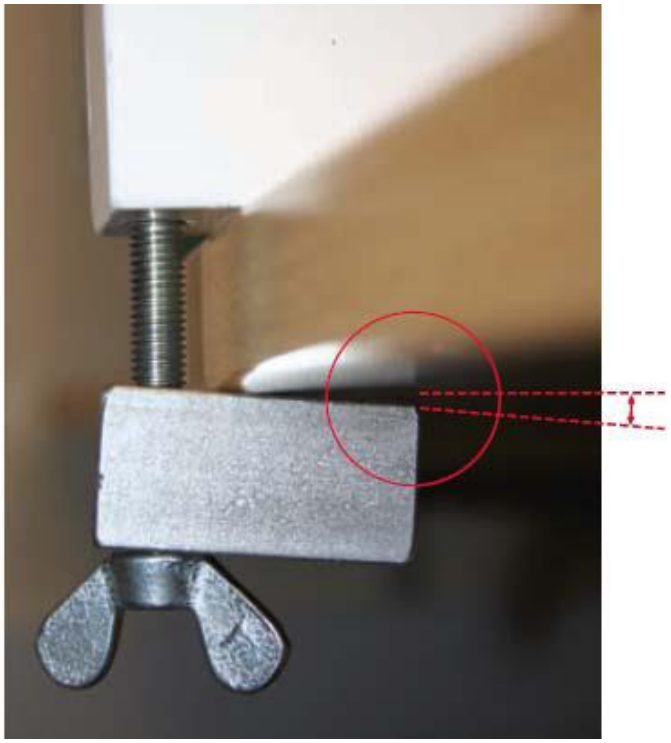
**Pic 1. Correct fitting and use of the clamp**



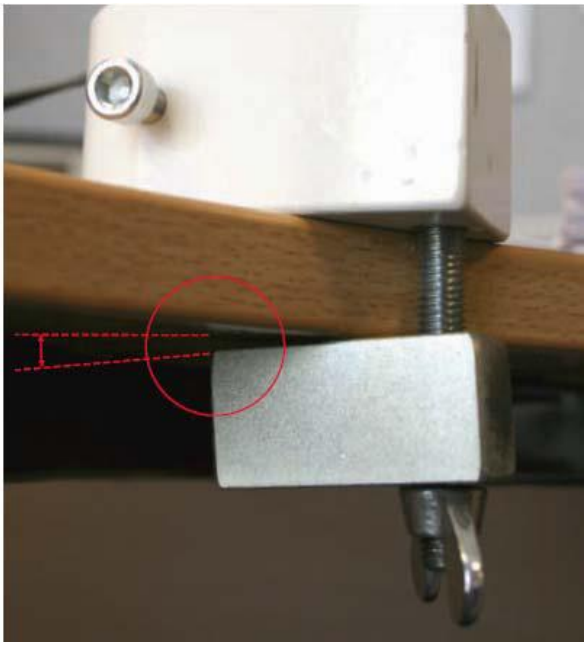
**Pic 2. Correct fitting and use of the clamp. Note the surface contact along the length of the clamp**



## Incorrect use of clamp



**Pic 3. Clamping car being used upside down**



**Pic 4. Clamping bar being used upside down**

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

It should be noted that Daray Ltd also manufacture lamps with LED bulbs. These are unsuitable for dental examination as they are too bright for eye safety and they provide a level of light that is too intense for diagnosis and recording of caries. Only the dental survey lamps with **halogen** bulbs should be used.

## Appendix I. **Sources of information**

This national protocol, Access data collection format and appendices are all available from K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

If home postcodes cannot be obtained from childcare sites, nursery nurses, nursery health clerks or local child health information services, these can be obtained by cross referencing the volunteer's address in the relevant Royal Mail postal address book: www.royalmail.com/address-book

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

Light source. If a new unit is required to replace a Daray Versatile, which is no longer produced, alternatives are:

- Daray X100 HD Halogen, with various options for desk-mounting, (£280 plus VAT) which is made specially for dental epidemiology examinations, so does not appear in the products on the website

Daray Ltd
Edison House
Robian Way
Swadlincote
Derbyshire
DE11 9DH
www.daray.co.uk

Sales Team:
Tel: 0800 804 8384
Tel: 0333 321 0971
Fax: 0333 321 0973
E-mail: sales@daray.co.uk

- Brandon medical examination halogen light with desk mounting option MT6008D (£395.95 plus VAT) - replacement bulb: LF12V2W (£14.95 plus VAT)

Brandon Medical Co Ltd
Elmfield Road
Morley
Leeds
LS27 0EL
www.brandon-medical.com

Tel: 0113 277 7393
Fax: 0113 272 8844
Email: enquiries@brandon-medical.com

Please note that on the Brandon lamp the clamp involves physically screwing it with a screw driver onto table.

# Appendix J. **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, Christchurch and Poole | E06000058 | Bournemouth, Christchurch and Poole | E06000058 |
| 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 |

| Upper-tier local authority | Upper code | Lower-tier local authority | Lower code |
|---|---|---|---|
| Cumbria | E10000006 | Allerdale | E07000026 |
| | | Barrow-in-Furness | E07000027 |
| | | Carlisle | E07000028 |
| | | 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 | E06000059 | Dorset | E06000059 |
| 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 |
| | | Colchester | E07000071 |
| | | Epping Forest | E07000072 |
| | | Harlow | E07000073 |

| Upper-tier local authority | Upper code | Lower-tier local authority | Lower code |
|---|---|---|---|
| Essex | E10000012 | 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 |
| | | Watford | E07000103 |
| | | Welwyn Hatfield | E07000241 |
| Hillingdon | E09000017 | Hillingdon | E09000017 |
| Hounslow | E09000018 | Hounslow | E09000018 |

| Upper-tier local authority | Upper code | Lower-tier local authority | Lower code |
|---|---|---|---|
| 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 |
| Kent | E10000016 | Dover | E07000108 |
| | | Gravesham | E07000109 |
| | | Maidstone | E07000110 |
| | | Sevenoaks | E07000111 |
| | | Folkestone and Hythe (was 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 |
| | | Hinckley and Bosworth | E07000132 |
| | | Melton | E07000133 |
| | | North West Leicestershire | E07000134 |
| | | Oadby and Wigston | E07000135 |
| Lewisham | E09000023 | Lewisham | E09000023 |

| Upper-tier local authority | Upper code | Lower-tier local authority | Lower code |
|---|---|---|---|
| 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 |
| | | Kettering | E07000153 |
| | | Northampton | E07000154 |
| | | South Northamptonshire | E07000155 |
| | | Wellingborough | E07000156 |
| Northumberland | E06000048 | Northumberland | E06000048 |
| Nottingham | E06000018 | Nottingham | E06000018 |

| Upper-tier local authority | Upper code | Lower-tier local authority | Lower code |
|---|---|---|---|
| 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 |
| 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 |
| | | Somerset West and Taunton | E07000246 |
| 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 |

| Upper-tier local authority | Upper code | Lower-tier local authority | Lower code |
|---|---|---|---|
| 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 |
| | | West Suffolk | E07000245 |
| | | Ipswich | E07000202 |
| | | Mid Suffolk | E07000203 |
| | | East Suffolk | E07000244 |
| 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 |
| 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 |

| Upper-tier local authority | Upper code | Lower-tier local authority | Lower code |
|---|---|---|---|
| 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: From ONS Geographical Lookups.

## Appendix K. **Guide for date-of-birth bands for survey of 3-year olds September 2019 to June 2020**

| **For this month of exam** ↓ | **(Children born within these ranges will definitely be 3 years old)** | | **(There may also be a few more in these ranges)** |
|---|---|---|---|
| | **Earliest birth month and year** | **Latest birth month and year** | **Birth month/year Check day of birth * and ** |
| September 2019 | October 2015 | August 2016 | September 2015 and 2016* |
| October 2019 | November 2015 | September 2016 | October 2015 and 2016* |
| November 2019 | December 2015 | October 2016 | November 2015 and 2016* |
| December 2019 | January 2016 | November 2016 | December 2015 and 2016* |
| January 2020 | February 2016 | December 2016 | January 2016 and 2017** |
| February 2020 | March 2016 | January 2017 | February 2016 and 2017** |
| March 2020 | April 2016 | February 2017 | March 2016 and 2017** |
| April 2020 | May 2016 | March 2017 | April 2016 and 2017** |
| May 2020 | June 2016 | April 2017 | May 2016 and 2017** |
| June 2020 | July 2016 | May 2017 | June 2016 and 2017** |
| July 2020 | August 2016 | June 2017 | July 2015 and 2016** |

* If born 2015, birth day should be later than day of exam. If born 2016, birth day should be same day or before day of exam.

** If born 2016, birth day should be later than day of exam. If born 2017, birth day should be same day or before day of exam.

Appendix L. **Parental agreement form and information sheet** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

Appendix M. **Information letter and agreement form enhanced with pictures** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

Appendix N. **Tracking list for childcare sites to record which children have returned agreement to participate forms** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

## Appendix O. **Maximising consent returns** (amended excerpt from ‘The good practice guide for dental epidemiology. Advice and guidance for local authorities, fieldwork teams and other stakeholders’).

The value of epidemiological surveys is maximised if high proportions of potential participants agree to take part. Dental surveys of 3-year-old children in England require parents to provide written agreement and there are varied levels of response for each childcare site and each local authority. Non-return of agreement forms is far more prevalent than parents refusing to agree so action by a range of agencies should focus on encouraging parents to return completed forms. Local authorities, fieldwork teams and childcare site staff all have a role here.

### What can local authorities do?

Local authorities can play a key role in engagement with childcare sites via the directorate responsible for early years or schools and education. A letter of support for the survey from the relevant director and director of public health outlining the purpose of the survey, details of data-sharing arrangements in place and encouraging general support for the survey can usefully alert site owners and managers to the survey before fieldworkers attempt initial contact. This should ideally be addressed by name to the head of each site a week or 2 in advance of contact being made by fieldwork teams.

Local authorities could ensure information about the surveys is published on their websites and is visible in community and health centres local to childcare sites taking part in the survey. If a member of the public health team in the local authority leads on oral/dental health, this person should be well informed about the purpose and general running of the survey and be able to answer any related queries or forward these to the relevant fieldwork team.

Many local authorities contract an oral health improvement worker or team and these should be included in discussions with the fieldwork team as early as possible as they are likely to have useful links within the community. Finally, with school nurses and health visitors now falling under the remit of local authorities there may be opportunities in the future for involvement of these groups in maximising agreement returns.

Efforts to maximise agreement returns should be at the childcare site level (requiring co-operation from heads of these sites and from all staff involved in the delivery of agreement to participate forms) and at the level of parents and guardians of children to be surveyed. Reasons for non-participation at the site level include non-receipt of information by decision makers, concerns or confusion over data-sharing agreements, high workload of staff and lack of clarity over what the survey involves. Reasons for non-participation by parents and guardians include non-receipt of information, issues with language or literacy and low engagement with dental services in general.

## What can fieldwork teams do?

Whilst there is no single solution that can overcome issues associated with poor agreement return levels, several strategies have been found to positively impact on the response. Improvements of 12–22% in overall agreement returns have been achieved by implementing some of the points below.

One of the principal reasons for reduced agreement rates is due to non-return of forms irrespective of whether parents have chosen to agree to the survey or not. Practical experience has shown that on-site administrative processes and even individual staff within sites can make the difference between success and failure in getting forms back from parents. Evidence has also shown that sites in some of the most deprived areas can achieve high levels of agreement and the reverse seems to hold equally true. Developing a working relationship between the fieldwork team and the childcare site is essential.

## Planning and resourcing the effort

Where feasible, advanced agreement should be sought to ensure sufficient fieldwork staff are available to resource the process. It may be more efficient to concentrate resources over a short pre-determined period, within which forms will be distributed and collected. A timetable of when each stage of the agreement process will be undertaken could be used to allocate staff for shorter periods of time.

**Communication with childcare sites**
Agreement rates from previous surveys can be used to determine low-participating sites and those with historically low returns. A separate plan can then be devised to target these sites with additional administrative support. This has been shown to increase agreement by up to 22% through developing a named point(s) of contact with whom regular communication is maintained. Experience suggests that meeting staff in person, rather than over the phone, is more likely to lead to a good working relationship.

The information sheet included in the protocol can be used and enhanced by adding in what steps the fieldwork team will take to support the site to optimise the return of agreement forms. If a nursery attached to a school which has been sampled previously it may help to show the previous agreement level in comparison with others.

It may be helpful for fieldwork teams to make reference to Ofsted’s statement that applies:

**Example text in relation to Ofsted**
"School attainment and health are closely linked. Children's health and wellbeing is an important area of Ofsted inspections and inspectors will continue to monitor this as part of the common inspection framework.

"Working with health providers, including through measuring and screening, can be an important way of demonstrating a focus on child health and wellbeing and can be used to inform parents and local communities about how successful the childcare site is. This then has the potential to impact positively on the Ofsted inspection."

**Administering the forms**
Persistence is crucial as follow-up of non-responding and poor agreement return sites will yield increased responses. Competing priorities in childcare sites may mean forms are forgotten, left undistributed or are collected at the class level but not returned to the administrative office. Experience has shown that splitting the locality into areas and targeting each area in turn can be helpful in scheduling delivery and follow up.

**Key actions**
A number of simple tips can also assist sites in supporting the agreement process. Some are more resource intensive than others, but again the important points are persistence and working to lessen the administrative impact on the site. Tips include:

- ask the site for a named point of contact with whom to liaise on matters relating to consent
- recruit a named person at each site who can speak with parents and chase up non-returns, for example, a nursery nurse, family liaison worker or parent volunteer
- provide materials in suitable format to publicise the survey to parents in newsletters, emails or posters on display in the nursery or playgroup
- ask the site to use their text reminder system to prompt parents to return signed agreement forms
- use a table like that provided in the protocol to provide sites with written checklists of children's names already divided by groups for ease of use. This should show which children have been sent agreement letters and have a column to record returns
- provide a clearly labelled, large collection envelope for returned forms with simple step-by-step instructions on it
- ask sites about parent evenings or similar events where parents could be asked to agree
- provide sites with spare forms and take copies along when visiting them, delivering by hand whenever possible
- consider whether posting letters and agreement forms to home addresses with stamped, addressed envelopes may help if sites feel unable to directly support the process themselves

- consider handing letters and agreement forms directly to parents at pick-up time
- consider aligning with signing for other health issues by parents
- encourage parents to look at the short film about dental surveys: https://youtu.be/BzrjK8HRpD8

Appendix P. **Data collection sheet 2019/20 survey of 3-year olds** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

**Appendix Q. Excel worksheet for overview list and examination day sheet** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health

## Appendix R. **Excel worksheet for summary information** : Available on K-Hub via the Oral Health Collections page www.gov.uk/government/collections/oral-health