Office for Health Improvement & Disparities

National Dental Epidemiology Programme

Oral health survey of adults aged 65 years and older living in care homes, 2024 to 2025: national protocol

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1. Introduction

The increasingly large number of older people in the population who are living longer and tending to have multiple medical conditions has led to increased interest in their oral health status and treatment needs. A survey of older people living in residential and nursing care homes was undertaken in Wales in 2006 but no national survey has been conducted in England. Hence there is a lack of standardised, comparable oral health data on this population group.

Local authorities in England are responsible for gathering information on the oral health needs of their local populations (reference 1; reference 2). The National Dental Epidemiology Programme of annual surveys enables local authorities to meet this responsibility and to fulfil the requirements of the Single Data List (reference 3).

Leadership and structures supporting the National Dental Epidemiology Programme sit with the Office for Health Improvement and Disparities (OHID) in the Department of Health and Social Care (DHSC). This national protocol forms part of the support that OHID provides. It provides a description of the standardised methods that fieldwork teams should use when undertaking this survey.

The population for the 2024 to 2025 survey is adults aged 65 years or older who are residing in a care setting irrespective of funding stream. This is the first survey of this population group to be commissioned and it will provide standardised, comparable oral health data for this important group.

The survey will include a clinical examination and questionnaire interview.

- Data from the survey will:
- enable local authorities to meet their responsibilities with regard to health needs assessments
- enable local authorities and integrated care boards to understand the needs of this population and inform their strategies and commissioning decisions
- inform oral health improvement strategies

2. Survey aim and objectives

The aim of the survey is to provide comparable, local level information on the oral health of adults aged 65 years or older residing in a care home setting to guide local service commissioning and enable geographical comparisons.

The objectives of the survey are:

- to sample and recruit people aged over 65 living in care home settings and undertake a clinical oral examination and questionnaire to estimate the prevalence of poor oral health amongst care home residents
- to estimate population oral health status through clinical examination
- to establish, by structured interview, reported experience of access to clinical treatment services, degree of dependency, the impact of poor oral health and need for mouth care support

3. Method

3.1 Survey population

The survey population is adults aged 65 years and older living in residential or nursing care homes and who have capacity to agree to participate in the survey.

3.1.1 Inclusion criteria

The inclusion criteria for the survey are:

- adults aged 65 or over residing in one of the sampled care homes
- adults who can understand the purpose and nature of the survey and are able to give informed agreement to participate

3.1.2 Exclusion criteria

The exclusion criteria for the survey are:

- adults unable to understand the information detailing the purpose and nature of the survey and who are therefore unable to give informed agreement to participate
- adults receiving end of life, respite or palliative care

3.2 Sampling unit

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

Where there is a need for smaller area estimates, statistical advice may need to be sought to agree a sampling method to allow for estimates of other geographical areas to be produced.

3.3 Sampling procedure

3.3.1 Sample size

Within each local authority a minimum number of 6 and a maximum of 10 care homes will be sampled. Within those sampled care homes all eligible residents will be approached with a target to aim to examine 100 residents aged over 65 years or over. If there are fewer than 6 care homes within a local authority area, the sample will need to be drawn using all care homes.

Due to the variation in the number of care homes at lower tier local authority level, for some areas, the sample will be small and not representative. The recommended minimum sample can be increased if local authorities require more detailed local information. This will need to be commissioned and arranged locally with advice from consultants in dental public health based regionally in NHS England.

3.3.2 Compiling the list of care homes for sampling

The national team will obtain a list of care homes for each local authority area from the Care Quality Commission and distribute to the dental epidemiology co-ordinators.

Working with consultants in dental public health the list should be validated with local authority staff who are familiar with the care homes in their area. Hospices and end of life residences should be excluded from the list. The validated list should be sent to fieldwork teams for sampling.

3.3.3 Sampling process

A random sample of care homes will be requested to participate in the survey. To sample, the list of care homes should be stratified into 6 groups according to:

- nursing or residential or mixed status
- number of beds (0 to 49 and 50 or more)

Care homes in each of the 6 groups (Table 1) should be allocated a random number starting at 1 within each care home group. A random number generator should be used to sample the care homes in a random order for each of the 6 groups. A random number for all the care homes in each stratification should be generated, ensuring there are no

duplicate random numbers and that the numbers are displayed in random and not sorted order. This should be repeated for each care home stratification.

Table 1: care home stratification groups

Size (number of beds)	Nursing	Residential	Mixed
0-49	1	1	1
50 or over	1	1	1

One care home should be selected for each of the 6 groups. Fieldwork teams, working with the local authority colleagues should contact the manager of each sampled care home to seek their cooperation with the survey. Where managers decline to take part, this should be recorded and the next sampled care home, from the same of the 6 groups, on the list approached.

Agreement to participate in the survey should be sought from every eligible resident in each of the 6 randomly selected care homes. If the total number of residents agreeing to participate is less than a hundred, select the next randomly sampled care home from the mixed stratification by order of random number. Select from the size category likely to yield the required number of participants outstanding. For example, if only a small number of additional participants is required, select from the smaller mixed group. If a larger number of additional participants in required, select from the larger mixed group. Continue this process until the minimum number of participants (100) or the maximum number of care homes (10) is reached. If there are not enough within the mixed stratification, select from any that will map for size.

This process of contacting sampled care homes, seeking cooperation of the manager and seeking agreement from all eligible residents will be continued until the minimum sample requirements have been met.

There is a large number of care homes across England and most local authorities will have sufficient numbers to generate the required sample. The status of the provider, that is whether it is state, charitable or independent, is not relevant to this survey.

3.3.4 Working in partnership with care homes

Sampled care homes should be approached in partnership with the local authority where possible. In many cases, the home will be known to the fieldwork team and additional support from the local authority may not be needed.

When a care home has agreed to participate in the survey, the contact details of the care home manager or a delegated care home lead for the survey will be requested to allow the next stage of communication.

The relationship with the care home manager or delegated lead that will support the survey is vital to delivery of this survey. Care homes will be involved in identifying eligible residents, socialising the survey and completion of the tracking form (Appendix J). The role of the care homes is detailed in section 5.2.1 and the process for preparing for the survey in partnership is given in section 6.2.

3.4 Support for sampling

Support for sampling may be requested from local dental epidemiology co-ordinators.

Contact details of dental epidemiology co-ordinators:

- East Midlands, Rizwana Lala, rizwana.lala@nhs.net
- East of England, Feema Francis, feema.francis@nhs.net
- London, Charlotte Klass, charlotte.klass1@nhs.net
- North East, Kamini Shah, kamini.shah4@nhs.net
- North West, Emma Hall-Scullin, emma.hall-scullin2@nhs.net
- South East, Jeyanthi John, jjohn@nhs.net
- South West, Reena Patel, reena.patel46@nhs.net
- West Midlands, Vicky Massey, vicky.massey@nhs.net
- Yorkshire and the Humber, Martin Ramsdale, martin.ramsdale@nhs.net

4. Responsibilities

4.1 Overarching responsibilities

The overarching responsibility for planning this survey and quality assuring the resulting products lies with the OHID national dental public health team, which is responsible for:

- initiating and managing the project

- ensuring that the design of the study meets appropriate standards
- making sure that arrangements are in place to ensure appropriate conduct and reporting

Responsibility for ensuring co-ordination and facilitation of the application of quality standards lies with the local dental epidemiology co-ordinators.

4.2 Commissioning responsibilities

The commissioning of the survey is the responsibility of local authorities, often in partnership with NHS dental commissioning teams and supported by local consultants in dental public health.

The local planning and organisation of the survey will be carried out by commissioned fieldwork teams, typically from community dental services. The delivery of the fieldwork to agreed national standards lies with the commissioned fieldwork teams.

4.3 Personnel

Fieldwork for the survey will be carried out by services commissioned by local authorities, sometimes in partnership with NHS organisations. The dental examinations will be carried out by registered dental clinicians who have been trained and standardised for the survey to national standards by regional standard examiners to ensure that they are familiar with the survey procedures, questionnaire and clinical criteria.

Examining clinicians should be accompanied by a data recorder. All fieldwork personnel should be trained in data protection, safeguarding and other relevant information governance issues. Disclosure and Barring Service certificates may be requested by care homes and all fieldwork team members must have valid certificates available, usually dated within the last 3 years.

5. Data sharing responsibilities

5.1 Information sharing and protection

The data collection, processing and sharing procedures for this survey have been designed in accordance with data protection principles, including those of data minimisation, fairness and transparency.

This section sets out the roles and responsibilities for sharing and protecting the information required for the National Dental Epidemiology Programme.

5.2 General Data Protection Regulations

Detail on UK General Data Protection Regulations (GDPR) and the lawful basis according to the Data Protection Act 2018 for the collection, processing and sharing of personal data about identifiable individuals is provided in section 5.2.2 of this document.

5.2.1 Role of care homes

Participating care homes will work in collaboration with fieldwork teams to complete the tracking form (Appendix J), which includes residents' details.

Care homes and fieldwork teams in partnership should be requested to ensure that all residents eligible to take part in the survey are provided with the written agreement form and information leaflet.

The tracking form (Appendix J) will be given to the fieldwork team ahead of the date of examination and the following should be completed:

- first name and surname, which is used to identify the adult and check that a written agreement for them to be examined has been received
- date of birth, which is used to confirm that the adult is the right age to take part in the survey and to distinguish between adults with the same name
- answers to questions Q1 to Q6

The list must be kept at the care home.

On the date of examination, floor and room numbers for participants should be requested as well as a care team member to facilitate approaching participating residents. Agreement to participate forms will be collected, reviewed and retained by the fieldwork team.

The care home will be requested to:

- collect the signed agreement forms from participants
- complete the tracking form and inform the fieldwork team of which residents have agreed to participate in the survey
- provide the signed agreement forms to the fieldwork team

The fieldwork team is responsible for:

- retaining the signed 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 as appropriate and in line with local protocols

5.2.2 Legal basis for care homes to share older adults' personal information with fieldwork teams

All local authorities in England have a statutory duty to undertake oral health surveys as part of a programme to help improve the oral 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 2012 (reference 2). Local authorities will usually commission a fieldwork team, which may include one or more qualified dentists, dental therapists and/or dental hygienists, from a local NHS trust to carry out the survey on their behalf.

The official authority for oral health surveys means that the lawful basis under the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018 for processing 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 oral health surveys means that care homes do not need to obtain the consent of residents to share their personal information with fieldwork teams. In addition, partners to the survey should be assured that the principles of the UK-GDPR (reference 4) have been adhered to in the designing of this protocol.

However, as oral health surveys involve a physical examination, care homes and fieldwork teams must ensure that:

- written participant agreement is obtained for the examination to take place

- participants are provided with a copy of the 'Office for Health Improvement and Disparities National Dental Epidemiology Programme Oral Health Survey: Information for Participants' leaflet, which explains what the dental examination involves, the personal data processed and the organisations this personal data may be shared with

A note about the General Data Protection Regulations (GDPR) and care home oral health surveys is provided (Appendix E).

5.2.3 Responsibilities of fieldwork teams

Fieldwork teams are responsible for sending to the local dental epidemiology co-ordinator (DEC) the complete dental survey record for each participant. This electronic record will include the personal information of participants together with the results of the dental examination and the completed questionnaire.

This information must be sent to the DEC by secure email or uploaded to a secure folder accessible only by the fieldwork team and DEC.

No information for care home residents for whom written agreement to take part in the survey has not been received should be sent to the DEC.

Fieldwork teams must:

- retain a copy of the information they submit to the DEC 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 fieldwork team
- securely destroy this information at the end of this period in line with local protocols

The fieldwork team is also responsible for securely destroying at the earliest opportunity after the dental examinations have been completed in each care home the personal information of any care home residents for whom written agreement to take part has not been obtained.

5.2.4 Responsibilities of dental epidemiology co-ordinators

Dental epidemiology co-ordinators are responsible for liaising with local authority teams to validate the CQC care home lists and sending the validated lists to field work teams for sampling. DECs will also be responsible for checking and agreeing the sampling framework and sending the survey data and documentation securely to OHID once data collection is completed. These files will be uploaded to a region-specific secure Microsoft (MS) Teams channel accessible only to the relevant DEC and named OHID staff.

5.2.5 Responsibilities of the Office for Health Improvement and Disparities

The role of the Office for Health Improvement and Disparities (OHID) is to analyse the data collected by the fieldwork teams and to publish the results of the survey.

OHID is responsible for:

- obtaining CQC care homes lists
- ensuring that only staff from the OHID national Dental Public Health team have access to the personal data of the care home residents taking part in the survey
- ensuring this information is securely protected
- retaining the personal data of the residents taking part in the survey for 3 years and securely deleting this information at the end of this period

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

OHID is responsible for ensuring that any data it does share with third parties is de-personalised in accordance with the Information Commissioner's Office Anonymisation Code of Practice.

6. Preparation

An overview of the timelines is included in Appendix F and an overview of the survey is shown in plan form in Appendix G.

6.1 Planning and organisation of the fieldwork

The planning and organisation of the fieldwork will be carried out by commissioned fieldwork teams who will liaise with local authorities and care home managers. Reference to the Statutory Instrument 2012 No 3094 (Appendix A) and the letter from the national lead for the survey (Appendix C) should be made if difficulties are encountered. A letter of support from the local director of public health and/or the director of adult social care can be helpful and local consultants in dental public health can facilitate this.

The national team will obtain lists of all care homes, including nursing and residential homes, within each local authority from the Care Quality Commission and distribute to the DECs. The DECs will need to work with the consultants in dental public health and local authorities to validate the list of care homes to ensure this is as accurate as possible prior to sampling. This validated list will be sent to fieldwork teams for sampling (section 3.3). A letter (Appendix D) can be sent to all care homes to raise awareness of the survey.

6.2 Contacting care homes

Following the random sampling of care homes, the managers of the selected care homes will be contacted. This can be facilitated by local authority social care teams who know the care settings well. Previous research also shows better engagement if discussions are had over the phone or in person rather than solely by email. The aims and objectives of the survey will be explained, together with the role of the care home in the survey. The co-operation of the care home managers will be sought. A letter to care home managers (Appendix I) is provided and should be used to give care homes more detail about the purpose and nature of the survey.

Where a care home agrees to participate in the survey, the tracking from should be sent to the care home and the care home advised on how to assess residents for eligibility and how to obtain agreement to participate (Appendix J). Printed copies of patient information leaflets (Appendix K) and agreement to participate forms (Appendix L) should also be left with the home. A date should be set for follow up once the tracker is completed. Following completion of the tracker form, an examination date can be agreed. Ideally this should be a date where a care team member can facilitate your presence at the home.

6.3 Recruitment of participants

6.3.1 Agreement to participate

Care homes will present eligible participants with participant information leaflets and agreement to participate forms detailing the survey (Appendices K and L). Eligible residents should be given a minimum of a week to consider the information and fieldwork teams should be accessible in person, over the telephone or by email to answer any enquiries from care homes, residents or family members in line with the principles of ethical recruitment.

No resident should be coerced at any stage to participate, and information will be offered freely and without prejudice. Interviews and clinical examinations will be conducted on a voluntary basis and fieldwork teams will not interview or examine someone who is unwilling to take part. Individuals who agree to participate can opt out of the dental examination, to refuse to answer a particular question and to withdraw from either interview or examination at any time.

Survey documentation, including the participant information sheet and agreement to participate forms can only be amended by fieldwork teams in terms of the logo and details about their organisation.

6.3.2 Capacity

Some care home residents will have limited capacity to provide agreement to take part in the survey. Care home managers will facilitate fieldwork teams to only include those residents who they deem to have capacity to agree to participate in the survey. During the survey process, if any doubts about capacity arise, assumption will be made that capacity has been lost and that person will be excluded from the survey.

Appendix N outlines to interviewers how to review capacity. In addition, the process will be covered in the survey specific training provided to interviewers. In cases where it is judged that the potential participant does not have the capacity on that occasion to take part in the survey then the fieldwork team should not continue.

6.3.3 Seeking agreement to participate

Dental surveys involve a physical examination, so written agreement must be obtained from each participant.

Care home support will be needed to gain residents' agreement to participate in the survey. The inclusion criteria should be carefully explained to the care homes manager (Appendix I).

Care home teams should be advised to complete the information on the tracker form (Appendix J) and this will be completed in 3 parts:

1. List all residents in the care home and check the boxes for inclusion into the survey:
    - name
    - date of birth
    - capacity to agree to participate (Appendix J Q1)
    - NOT on end of life, respite or palliative care (Appendix J Q2)
2. To those that meet the inclusion criteria (Q3), distribute participant information leaflets (Appendix K) and agreement to participate forms (Appendix L), (Appendix J Q4).
3. For those that have agreed to participate, the care home team should complete the tracker form Appendix J Q5 and Q6.

6.3.4 Maximising agreement to participate

Care homes should be requested and supported to encourage and support their residents to agree to take part in the survey. Coercion to provide agreement to participate should not

be used and would make the process illegal. However, there are several approaches that local authorities and fieldwork teams can adopt.

It is important to send the letter from the senior responsible officer for the NDEP (Appendix C) to local authorities and to encourage directors of public health and their staff to contact care homes directly using the letter to care home managers (Appendix D). Local authorities can also support in publicising the survey and oral health promotion teams with existing links to local care homes may be able to support this.

Fieldwork teams can maximise agreement to participate through building good relationships with care homes. Visiting care homes in person early in the survey process is a recognised approach. Requesting each care home to designate a member of staff to liaise with the fieldwork team is likely to be helpful. Fieldwork teams should work closely with the care home manager or the named care home contact to optimise participation.

The time between recruitment and examination should be kept to a minimum. Capacity to agree to participate should always be verified on the day of examination.

6.3.5 Recording agreement to participate

Fieldwork teams must retain the original agreement form for those who agree to participate. Care home teams may also wish to make a copy for the resident's care record. Where agreement to participate has not been received, no further data on the care home resident is required.

Where agreement to participate has been received the fieldwork team will transcribe the participants' relevant details from the tracking form (Appendix J) to the survey team day sheet (Appendix O). The tracking form will be left with the care home as it contains details of residents who may not have agreed to participate.

7. Survey procedure

The collection of data via questionnaires and examinations in sampled care homes should commence after the training and standardisation of examiners and must be completed by the end of June 2025. This will allow sufficient time for checking and cleaning the data.

Only trained and standardised dental clinicians, along with appropriately trained assistants, will undertake the collection and recording of non-clinical and clinical data.

The survey interviews and examinations will take place in locations within care homes identified as suitable for the purpose and conducive to the smooth running of both the survey and the care home. Mobile surgeries or equivalent should not be used. The

participant should be fully informed about the interview and examination and have had the opportunity to ask questions, which have then been answered to their satisfaction.

The structured interview and clinical examination are expected to take no more than approximately 30 minutes for each adult. In some cases, this may take longer depending on the needs of the participant.

Questionnaire and clinical data may be entered either onto paper record sheets (Appendices P and Q) or directly onto computer, with safeguards for both methods. If collected on paper the information should be transferred onto the computer as soon as possible after the visit and not left until the end of the survey. If collected directly onto computer this should be immediately backed up. Both methods should then be backed up on the services' network.

7.1 Collection of questionnaire data

Distractions or extraneous noise should be tactfully removed to allow the interview responses to be heard by the recorder, for example the television sound turned off or down.

The information in this section is relevant to the questionnaire (Appendix P). Self-reported general and oral health questions have been validated in the National Adult Oral Health Surveys (reference 5).

The questionnaire interview will be completed face to face on the same day as the examination by the specifically trained fieldwork administrative supporter or dental clinician. This part of the survey is expected to take no longer than 10 to 20 minutes. A carer or someone who knows the participant well may assist with answering the questionnaire.

The questionnaire will cover the following areas:

- existing oral health care regime from the care home
- self-reported oral health status
- self-reported oral health-related quality of life, including the impact of oral health on eating and socialising
- self-reported oral dryness
- frequency of oral hygiene
- recent dental attendance

- barriers to dental attendance
- self-reported dental treatment need
- demographic questions: sex, age, ethnic group

7.1.1 Care home resident identity number

A unique identity number must be entered for each care home resident, which consists of a prefix from the lower tier local authority code and a suffix, which is a participant's identification number generated from the list of residents who have agreed to participate in the survey. The list of lower tier local authority codes is given in the fourth column in Appendix H.

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

Lower tier local authority code									**Number of sampled care home resident**			
E	0	7	0	0	0	0	0	4	0	0	0	3

The 15th care home resident to be sampled in Aylesbury Vale would have the following ID number:

Lower tier local authority code									**Number of sampled care home resident**			
E	0	7	0	0	0	0	0	4	0	0	1	5

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

7.1.2 Lower tier local authority name

The clinical data collection sheet for each care home resident examined requires completion of the name of the lower tier or unitary local authority within which the care home is sited. This is defined by the geographical position of the care home within local authority boundaries. A table of local authority codes and names is provided (Appendix H).

7.1.3 Examiner

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

7.1.4 Care home name

Care must be taken to record each care home with a single method of spelling and punctuation to avoid erroneously creating care homes that the computer programme

recognises as distinct. For example, a single care home recorded as 'St Mary's' in 5 records and 'St. Marys' in 10 others will appear to be 2 care homes when the data entry checks are undertaken.

7.1.5 Care home postcode

The care home postcode will be recorded. If a postcode is not provided, it may be found on the care home's website or the Royal Mail website: www.royalmail.com/find-a-postcode.

Note that computer programmes can only read postcodes if they are entered in the correct format (A = alphabetic N = numeric). Format examples:

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

Postcodes should be entered in the Access data collection programme with the first part (outward code) in the first box and the second part (inward code) in the second box, without spaces. Care should be taken to ensure the correct postcode is entered, as an incorrect postcode means that care home resident's record may be excluded from the final analyses.

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

7.1.6 Care home type

The type of care home will be recorded as follows:

0 - Residential

1 - Nursing

2 - Mixed

7.1.7 Date of examination

The date of the examination will be recorded dd/mm/yyyy.

7.1.8 Sample group code

Care home residents 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 particular concern, it is important that additional care home residents sampled for this purpose are identifiable. This allows for deeper local analysis. It is therefore necessary to code these care home residents so 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 who will then advise the national dental public health team.

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

0 - Main sample

1 - Additional sample A

2 - Additional sample B

3 - Additional sample C

4 - Additional sample D

5 - Special care home

7.1.9 Questions for completion by face-to-face interview with the participant

A member of the fieldwork team will complete the questionnaire with the participant following the script in the questionnaire. All questions should be completed if possible, including the demographic information at the end of the questionnaire.

Participants should be asked to indicate their sex and ethnic group. This should not be selected by the interviewer.

Collection of ethnicity data is required under the Health and Social Care Act, 2012 to enable reporting of inequalities in oral health. Further information is available in Reducing Health Inequalities and the Equality Act 2010 (reference 6). This survey is using the 19 ethnic groups recommended for use by the government (reference 7).

Care home residents 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 to A5 or lower code X if the lower ethnicity is not provided. If lower code B3 is used, then the higher code must be 'B mixed'.

Codes F, G and H may be defined for local use and should allow for additional lower ethnic groups not listed in the table below. If these are used the relevant higher ethnic group must also be used. For example, if locally it has been agreed to distinguish information for Eastern Europeans, the relevant higher ethnic code should be used followed by the locally defined lower ethnic code, that is, 'A white' and 'F Eastern European'. This allows the data to be included in the relevant national higher ethnic analysis and the national lower ethnic ‘other’ analysis, with the ability to perform local level analysis for the extra defined group. The locally defined group codes and descriptions used must be sent to the DEC when the data is submitted.

Table 2: ethnic groups

Higher ethnicity code	Higher ethnicity description	Lower ethnicity code	Lower ethnicity description
A	White	A1	English, Welsh, Scottish, Northern Irish or British
		A2	Irish
		A3	Gypsy or Irish traveller
		A4	Roma
		A5	Any other white background
B	Mixed or multiple ethnic groups	B1	White and black Caribbean
		B2	White and black African
		B3	White and Asian
		B4	Any other mixed or multiple ethnic background
C	Asian or Asian British	C1	Indian
		C2	Pakistani
		C3	Bangladeshi
		C4	Chinese
		C5	Any other Asian background
D	Black, black British, Caribbean or African	D1	African
		D2	Caribbean
		D3	Any other black background
E	Other ethnic group	E1	Arab
		E2	Any other ethnic group
A, B, C, D or E		F	Specific other ethnic group – locally defined
		G	Specific other ethnic group – locally defined
		H	Specific other ethnic group – locally defined
X	Information on ethnic group not provided	X	Information on ethnic group not provided

In the final part of the questionnaire, indicate whether or not the questionnaire was completed and update the survey day sheet (Appendix O).

7.1.10 Local questionnaire content

If local authorities wish to add additional questions as part of the questionnaire interview, a bespoke questionnaire and data collection tool will need to be agreed with the national team and the extra data will need to be analysed locally. Please contact the national dental public health team to request this on dentalphintelligence@dhsc.gov.uk.

7.2 Collection of clinical data

Once the questionnaire has been completed, the clinical examination (Appendix Q) will be undertaken. It is good practice to double check the survey day sheet (Appendix O) to clearly identify those care home residents for whom agreement to participate has been provided. All care home residents with agreement to participate should be examined where the care home resident is willing to co-operate.

7.2.1 Identification numbers

Record each participant's unique identification number (section 7.1.1) to allow linking of their questionnaire and clinical data. This must be recorded identically on the questionnaire and clinical data collection sheets to enable data linkage.

7.2.2 Preparing for data collection

The dental instruments should be laid out on a clean tissue on a hard surface out of sight of the participant, if possible, but allowing easy access. A head torch will be used for the examination as it likely that some participants will not be able to sit upright. To ensure good lighting, batteries should be replaced frequently.

Distractions or extraneous noise should be tactfully removed to allow the examiner calls to be heard by the recorder, for example the television sound turned off or down.

The examination should only proceed once the participant is comfortably positioned and the oral cavity can be viewed by the examiner.

7.2.3 Medical screening

There is no need to ask participants about any medical conditions prior to examination as no probing is used. This does not pose a risk to participant with a previous history of rheumatic fever or other cardiac disorders, according to clinical guideline 64 from the National Institute for Health and Care Excellence (NICE) (reference 8).

7.2.4 Examination position

The participant should be seated in a comfortable chair that has good head support, and to which the examiner can get access. This may be in their bedroom or a private area in a communal space. Individual examiner’s preferences vary. There may be some instances where a participant is bed bound. Although attempts to examine all participants who have agreed to take part should be made, it is at the examiner's discretion if a suitable position for examination is attainable. If the examiner feels a suitable position is not possible, the examination should be coded '3 - no examination possible - suitable examining position

not attained'. If a participant needs to be moved, contact a member of the care home team. On no account must you attempt to reposition them yourselves.

7.2.5 Examination light

A head lamp of specified type will be used instead of a fixed lamp to avoid the problems of positioning of the usual lamp, the availability of power points and the risk of the clamp damaging surfaces. Suitable headlamps are listed in Appendix M.

7.2.6 Instruments and materials

Infection control will be a priority and will comply with local protocols. Each examining team will carry sufficient sets of pre-sterilised instruments to ensure that there are a fresh set of sterilised instruments for every examination. Examiners will wear a new, clean pair of gloves for each examination.

The following equipment will be required by each examiner:

- head torch (Appendix M)
- No. 4 plane mouth mirrors
- straight probes (CPITN or standard probe blunted to 0.3mm)
- paper covers and trays for instruments
- latex and powder free gloves
- cleaning and disinfection wipes for surfaces
- alcohol-based handrub for hands
- yellow bags for disposal of waste
- extension lead and circuit breaker – only if a laptop is being taken into the field
- protective spectacles for participant

The attachment of the mirror head to the stem and the stem to the handle should be checked for security. Mirror heads will be replaced when they become scratched or otherwise damaged.

Appropriate personal protective equipment should be worn by the examiner and assistant as detailed in the relevant national guidance. National and local policies and arrangements

will be applied to maintain infection prevention and control and avoidance of allergic reactions to latex and glove powder.

Following the examination, dirty instruments will be placed in a sealed container for transport back to the clinical base or designated clinic where the instruments will be sterilised according to local procedures. Gloves will be disposed of into a standard yellow bag with any tissues and wipes after the exam. This will be disposed of on return to the clinic along with normal clinical waste.

7.2.7 Examination process

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

If the participant wants to brush their teeth prior to the dental examination, allow them to do so. Where visibility is obscured, debris or moisture should be removed gently from individual sites with cotton wool rolls, cotton buds or pledgets of cotton wool. Compressed air should not be used.

Probes must only be used for cleaning debris from tooth surfaces to enable satisfactory visual examination, for confirming the presence of tooth-coloured restorations and for gently running over root caries to establish if arrested or active. Radiographic or fibre-optic transillumination examination will not be undertaken.

Loupes will not be worn as these would affect standardisation of the examination process and, therefore, the comparability of the data.

The sequence of examination is:

1. Denture assessment.
2. Plaque, tooth and caries assessment.
3. Soft tissue and PUFA.
4. Assessment of treatment requirements.
5. Degree of urgency for dental care.

7.2.8 Denture assessment

A visual inspection of any dentures will be carried out, whether they are used by the participant or not. Dentures should be removed to enable inspection. If the participant does not wish to remove their denture(s), assessment will be undertaken with them in place.

The dentures will be examined separately for the upper and lower arches for the following features:

- denture absent or present and type (partial or full)
- denture material
- denture status
- denture cleanliness
- denture marked with participant's name
- whether the dentures are worn

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

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

If the denture is in need of repair due to, for example, cracked, fractured or teeth missing, then the status should be code 1 - needs repair.

If the denture is no longer functional for chewing or appearance and could not be repaired, then the status should be code 2 - needs replacement.

For both upper and lower dentures the following codes should be used for each element of the denture examination:

Denture present:

0 - no denture

1 - partial

2 - full

Note: if there is no denture present, the rest of the denture section of the form does not need to be completed.

Denture base material:

1 - metal

2 - acrylic

Denture status:

0 - intact

1 - needs repair

2 - needs replacement

Denture cleanliness:

0 - clean

1 - dirty with soft debris

2 - dirty with hard debris (calculus with or without soft debris)

Denture marked with participant name:

0 - no

1 - yes

Dentures worn:

0 – never

1 – sometimes (for eating/socialising)

2 – all the time

7.2.9 Coding conventions

The following coding conventions will apply:

- a tooth is deemed to have erupted when any part of it is visible in the mouth. Unerupted or obscured surfaces (for example by calculus) of an erupted tooth are assumed sound and coded U = Natural tooth present unrestored

- supernumerary teeth are not recorded. If a tooth and a supernumerary resemble one another, the distal of the two is regarded the supernumerary. If the supernumerary tooth takes place of a missing permanent tooth, score as for the tooth it replaces
- for a retained deciduous tooth, score as for the permanent tooth it replaces
- the threshold for recording lesions as caries is active dentine involvement
- where doubt exists about the classification of any condition, the lower category should always be recorded, that is, if in doubt, score low, such as least disease. If there are 2 carious lesions on the crown or root score the worst

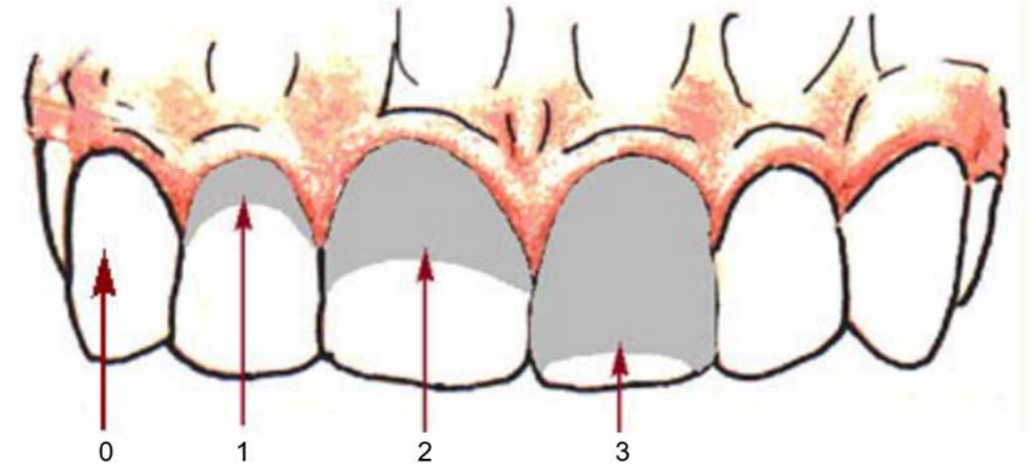
7.2.10 Plaque, tooth and caries assessment

After the denture assessment, plaque presence and the presence and condition of teeth will be assessed. Dentures should be left out for this part of the examination. If a participant refuses to remove their dentures, score '9 = Assessment cannot be made', should be used for any teeth where visual assessment is not possible. The examination should be done in the following order: upper right, upper left, lower left, lower right.

Note that data for these 3 assessments should not be collected for a tooth at the same time, you will need to do 3 sweeps of the mouth.

Plaque will be recorded at sextant level using the Malmö University Oral Health Country/Area Project (reference 9). Easily visible debris found on the buccal or labial and lingual or palatal surfaces of the 3 segments of each dental arch should be included, 6 in total. Score the dirtiest tooth per sextant, both buccal or labial and lingual or palatal surfaces. Calculus is not recorded. If there is no tooth in the sextant or only retained roots, leave the box blank. Do not score '9 = Assessment cannot be made' for this situation.

Figure 1. Plaque assessment



Source: Malmö University Oral Health Country/Area Project (reference 9).

Figure 1 shows the appropriate coding for line 1 of the dental chart. There should be 2 codings for each tooth selected per sextant:

0 = No debris present

1 = Soft debris covering not more than one-third of the exposed tooth surface

2 = Soft debris covering more than one-third, but not more than two-thirds of the exposed tooth surface

3 = Soft debris covering more than two-thirds of the exposed tooth surface

For each tooth in the mouth, the following should be recorded on the clinical examination form:

- presence/absence of tooth
- coronal caries
- root caries

On line 2 of the dental chart, tooth presence should be coded as:

U = Natural tooth present unrestored

F = Natural tooth present restored

M = Tooth missing, no replacement

R = Tooth replaced (bridge pontic, implant pontic, implant, denture)

X = Retained root (restored or unrestored)

Teeth with defective, lost or temporary restorations should be scored 'F = Natural tooth present restored'. Similarly, temporary crowns, bridges or abutments will be scored as 'F = Natural tooth present restored'. As the survey intends to collect data about future needs for maintenance of restorations, any restoration for trauma repair, wear, bridge abutments, wings, veneers or shims will be scored as 'F = Natural tooth present restored'.

Treatment need will be picked up later in 'Assessment of treatment requirements', and caries is reported separately.

If a tooth is coded 'M = Tooth missing, no replacement' or 'R = Tooth replaced' in line 2, there should be no code recoded for that tooth in lines 3 (coronal caries) and 4 (root caries) of the dental chart.

If a tooth is coded 'X = Retained root' in line 2, there should be no code recorded for that tooth code in line 3 (coronal caries) of the dental chart.

If a denture covers a retained root, score as 'X = Retained root', do not use 'R = tooth replaced'. Note that code 'R' is different from the British Association for the Study of Community Dentistry (BASCD) code 'R'.

On lines 3 and 4 of the dental chart, active dentine coronal and root caries should be coded as:

0 = no active caries present (this coding would include arrested dentine caries)

1 = active caries present

If in doubt, score low, such as least disease. If there are 2 carious lesions on the crown or root score the worst.

For the root caries assessment, anything exposed apical to the cemento-enamel junction is regarded as root surface, and any unexposed root surfaces are assumed sound, coded '0 - No active caries present or unexposed root'.

A tactile as well as visual assessment may be required for assessment of root caries, to assist in the decision as to whether the caries is active or arrested, and the gentle use of a ball-ended probe can be used.

Table 1: Colour change, consistency, appearance and texture in active and inactive root caries

	Active	**Inactive**
Colour change	Yellow or light brown	Darkly stained or black
Consistency	Soft or leathery	Hard
Appearance	Opaque or matte	Shiny
Texture	Rough	Smooth

7.2.11 PUFA

All participants should be examined for the presence or absence of PUFA signs. 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. Only score one PUFA sign per tooth. The following signs of the consequences of untreated dental caries are scored:

(P) open pulp

(U) traumatic ulceration

(F) fistula

(A) abscess

Record the number of teeth with one or more PUFA signs. Do not record the number of PUFA signs per teeth or per mouth.

Code 0 = No teeth PUFA signs

Code 1 = 1 tooth PUFA signs

Code 2 = 2 or more teeth PUFA signs

7.2.12 Soft tissue pathology

Examiners should examine the soft tissues and record the presence and absence of lesions. The mouth should be examined in the same order as for the teeth. The lips and cheeks should be gently retracted to allow for the soft tissues to be examined. Examples of soft tissue pathology are:

- fistula
- sinus
- swelling
- ulcer including denture ulcer
- white or red patch
- periodontal disease
- denture stomatitis
- candidal infection
- denture induced hyperplasia

- angular cheilitis

The soft tissues should be coded as:

0 = No pathology present

1 = Pathology present

2 = Suspicious lesion present, requiring urgent referral

The protocol for dealing with a suspicious lesion is detailed in 7.3 Feedback to participants. The situation is unlikely as incidence of these lesions is low, and the survey examination is not a cancer screening exercise.

7.2.13 Examination completion status

Having completed the examination, the completion status should also be recorded. This should be coded as follows:

1 = No examination possible – participant withdrew agreement to take part

2 = No examination possible – participant unable to co-operate

3 = No examination possible – suitable examining position not attained

4 = Full examination completed

5 = Partial examination completed – participant withdrew agreement to take part

6 = Partial examination completed – participant could not co-operate

The survey day sheet (Appendix O) should also be updated.

7.2.14 Assessment of treatment requirements

The purpose of this part of the examination is to permit a general assessment to be made about both the nature of dental treatment need and accessibility requirements of older people living in care. It is not possible to lay out criteria for the treatment need for all conditions that might be found and it would not be appropriate in all cases to treat all oral diseases and conditions.

Instead, examiners are asked to consider the needs of each participant to achieve a stable oral and dental condition, free of discomfort and enabling them to eat, speak and socialise without restriction because of problems with their mouth or teeth. It is also appreciated that

the brief examination in domiciliary conditions may leave some conditions undiagnosed so the examiner can only base their assessment on what they can see at the time.

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

The options for items of treatment are:

- no treatment indicated
- examination with or without further diagnostic tests
- prevention, for example oral hygiene advice, dietary advice, additional fluoride
- removal of calculus
- minor restoration, for example simple direct fillings
- major restoration, for example crowns, bridges, veneers, inlays, with or without endodontic treatment
- extraction(s) or other minor surgery
- minor prosthetic care, for example repair of existing denture
- major prosthetic care, for example provision of one or more new partial or complete dentures
- treatment or referral for soft tissue pathology
- other treatment, to be described by the clinician

7.2.15 Degree of urgency for dental care

The information derived from this section will be used to make broad statements about the proportion of adults aged 65 or over living in care homes who are in urgent need of clinical dental care.

Examples of need for urgent dental care include:

- overt malignancy
- lesions that arouse suspicions of malignancy

- uncontrolled swelling
- uncontrollable bleeding
- uncontrollable pain

This list is not exhaustive.

Most other dental conditions would not require urgent care but could be dealt with through a routine dental appointment.

The degree of urgency for dental care should be classified as urgent or routine, based on the clinician's judgement.

If urgent care is required the participant can be advised to contact their own dentist, follow local arrangements or call 111.

This information can be shared with the care home and their family with participant agreement.

7.2.16 Setting for the provision of treatment which would best meet the needs of the participant

This section allows an overall assessment to be made of the types of care that commissioners might need to commission in the future to meet the needs of this population.

The coding should not be influenced by the current availability of dental healthcare in the care home area. Rather it should be coded under the assumption that care in each type of setting is currently available without limit. This will allow free and unfettered choice of the correct type of care to meet the needs of each participant at the time of examination, considering their general health, mobility, dependency and compliance.

Examiners should not select a type of care for convenience or to meet participant preference but on what the examiner feels each participant needs according to their limitations.

Examples of participant eligibility for community dental services (CDS) provision are those who would require a hoist, wheelchair tipper or bariatric chair. Examples of participant eligibility for wholly domiciliary care are those who are bed-bound or who require an ambulance or specialist transport for hospital appointments.

The options for treatment settings are:

- attendance in general dental care setting
- attendance in community dental care setting for compliance or mobility reasons
- wholly as a domiciliary care case as the participant cannot leave the care home

7.2.17 Optional spare variable

An optional spare variable has been provided to allow collection of further data, which may be analysed locally. If this is insufficient for local needs, the national format can be amended to create a bespoke format. Please contact the national dental public health team to request this on dentalphintelligence@dhsc.gov.uk.

7.3 Feedback to participants

In line with current ethical practice, feedback can be provided to each person who takes part in the examination. The procedure will follow that used in the 2023 national adult oral health survey for England. The administrator is permitted to say, when contacting potential participants, that the clinical examiner may be able to offer them some advice on the best way of looking after their mouth or teeth. If, after the examination, the participant wishes to know about the general condition of their dental health then the examiner can give an indication of whether there is room for improvement in terms of the general oral hygiene or cleanliness using one of 5 statements, which generally categorise a participant's oral health and treatment needs. The DEC can provide advice and support.

Below are the scripts that should be used for each category of participant, depending on the clinical findings.

The categories are:

- category 1 - no obvious oral problems
- category 2 - minor oral disease requiring a dental check-up (used for anyone with obvious disease requiring further assessment)
- category 3 - obvious oral disease requiring a dental examination within one month (used for anyone who scores 1 on the PUFA index and or soft tissue assessment)
- category 4 - urgent dental care needed
- category 5 - suspected serious pathology (used if the examining dental clinician notices a lesion which they consider may be serious and potentially life threatening, such as a suspected malignancy)

The feedback given should use the wording provided. If the participant asks about their dental treatment need, or if questions related to the standard of previous dental care arise, the response will be that the survey is not designed to collect the sort of information on which a treatment can be planned, and that visiting a general dental practitioner (GDP) is the best way of ensuring a thorough dental check-up. This is not only a way of deflecting potentially difficult questions, it is also true.

Category 1 - no obvious oral problems

This code may be used for anyone with no obvious disease requiring further assessment. Suggested wording is as follows:

“Thank you for taking part in this survey, the information that we collect is important. I am able to give you some feedback about the examination if you would like.

“It is important that you understand that the survey is not designed to collect the sort of information on which dental treatment can be planned so this examination is not the same as visiting a high street dentist which is the best way of ensuring a thorough dental check-up. We cannot check the teeth as thoroughly as a dentist in a surgery and we cannot take x-rays.

“However, having looked at your mouth today it does appear overall to be healthy. There are no teeth that obviously require urgent attention. However, current evidence-based guidance suggests that you should see a dentist for a complete check-up at least once every 2 years. If you have not seen a dentist within the last 2 years you should do so in the coming months.”

Category 2 - minor issues requiring a dental check up

This code may be used for anyone with obvious disease requiring further assessment. Suggested wording is as follows:

“Thank you for taking part in this survey, the information that we collect is important. I am able to give you some feedback about the examination if you would like.

“It is important that you understand that the survey is not designed to collect the sort of information on which dental treatment can be planned so this examination is not the same as visiting a high street dentist which is the best way of ensuring a thorough dental check-up. We cannot check the teeth as thoroughly as a dentist in a surgery and we cannot take x-rays.

“Having looked at your mouth today there are no teeth that require urgent attention, but I think you would benefit from a thorough check-up. I would recommend that you organise an appointment for a check-up in the next couple of months.”

Category 3 - obvious or progressive oral disease requiring a check-up within 1 month

This category is appropriate for anyone who scored 1 on the PUFA index. Suggested wording is as follows:

“Thank you for taking part in this survey, the information that we collect is important. I am able to give you some feedback about the examination if you would like.

“It is important that you understand that the survey is not designed to collect the sort of information on which dental treatment can be planned, we are not in a dental surgery and we do not have access to air (to dry the teeth) or x-rays (to help us see beyond a clinical examination in some areas). This examination is not the same as visiting a general dental practitioner, which is the best way of ensuring a thorough dental check-up.”

Then either:

“On the basis that you said you were having pain from your mouth you should arrange to see a dentist in the next couple of weeks to help you.”

Or:

“Having looked at your mouth there are some teeth that would benefit from a closer inspection, and I would recommend that you make an appointment to see your dentist in the next couple of weeks.”

If the participant does not have a dentist, you will have available a local contact telephone number in order for them to find a dentist.

If you are asked to comment on specific aspects of oral hygiene, we would suggest that you respond, if appropriate, by identifying areas for improvement but say that they will need more specific advice from a dentist or dental hygienist since there are many ways of achieving this. It is very important that you are not too prescriptive and that you adhere to general principles as there should be no scope for oral hygiene advice being given that conflicts with previous hygiene advice. You could preface this by saying:

"What I generally tell people is…"

If you are asked to comment on specific aspects of past treatment, you need to say:

"This survey is limited and you need to see your (or a) dentist for specific advice and/or treatment."

Category 4 - urgent dental care need

If a participant needs urgent dental care then advise the participant or care home team to follow local arrangement procedures.

Category 5 - protocol for dealing with a suspected serious pathology

In the unlikely event that the examining clinician notices a lesion that they consider may be serious and potentially life threatening, such as a suspected malignancy, they are obliged to follow this set protocol. Established local referral protocols should be used to make an immediate referral and the participant's general medical practitioner (GMP) and dentist (if they have one) should be informed. There should be no delay for this referral, it should be made on the same day or within 24 hours. To ensure safeguarding, the service lead clinician should have oversight of all referrals sent and take responsibility for taking appropriate action on any report of serious pathology.

It should be noted that examiners are highly unlikely to encounter such serious pathology in this survey because:

- the incidence of such lesions is low
- the examination is not a screening exercise for such lesions
- the examination does not involve detailed examination of all the oral soft tissues

The wording below is suggested to communicate the finding to the participant.

“Thank you for taking part in this survey, the information that we collect is important. Before I discuss the findings with you it is important that you understand that the survey is not as thorough as a normal examination with your own dentist, and it is difficult to examine all areas of the mouth in the same way. In this survey our policy is to inform your family doctor of any ulcers or inflamed areas. There is an area like this in your mouth and because I am not sure exactly what it is I would like to arrange for your dentist or doctor to look at this for you. Are you happy for me to do that?”

For participants agreeing to be referred, the following steps should be carried out:

1. The examiner should complete a participant consent form for serious pathology referral (Appendix S) with the agreement box ticked and signed by the participant.
2. The examiner should complete a mouth map (Appendix T), recording details of the lesion(s).
3. Copies of Appendices S and T should be left with the participant and a copy should be retained with the survey paperwork and archived following local protocol.

4. A referral should be made using established local referral protocols.

For participants who refuse the referral, the following steps should be carried out:

1. The examiner should complete a participant consent form for serious pathology referral (Appendix S) with the refusal box ticked and signed by the participant.

2. The examiner should complete a mouth map (Appendix T), recording details of the lesion(s).

3. Copies of Appendices S and T should be left with the participant and a copy should be retained with the survey paperwork and archived following local protocol.

4. The participant should be given an information letter urging them to pursue an examination (Appendix U).

5. None of the referral conversation should be shared with care home staff or family members as this would breach the residents' right to confidentiality.

The Dental Protection Society has agreed this is an acceptable line of approach.

The service lead clinician should follow up any referral to GMP or GDP to ensure it has been actioned urgently and follow up within a week any participants who refuse the referral to encourage them to change their mind.

7.3.1 Dealing with further questions

Examining clinicians cannot be specific about dental treatment need or on the standard of previous dental treatment because the examination is not designed to collect the information required to make these assessments. If the participant requests more detail on their oral health, dental examiners will respond, if appropriate, by using general principles to identify areas for improvement, but say that the participant will need more specific advice from a registered dental professional through a full dental assessment.

7.4 Safeguarding

Any safeguarding concerns suspected by the fieldwork teams should be managed according to local safeguarding procedures. All staff involved in fieldwork should have completed vulnerable adult safeguarding training at a level commensurate with their role as clinical staff.

8. Data submission

8.1 Data collection tool

The MS Access data collection tool with the specific format for this survey should be used to input the non-clinical and clinical survey data as soon as possible after visiting the care home. This is available from the survey toolkit (reference 10). Data should not be left to be entered as a batch when all fieldwork is completed. The data collection tool contains several free fields for local use at the end. If these are insufficient for local information requirements, bespoke requirements can be arranged by contacting dentalphintelligence@dhsc.gov.uk.

Prior to sending on completed data files, each fieldwork team is responsible for checking their data for inaccuracies. Common errors include duplicate entries for care home residents or care homes and clinical data for care home residents coded as being absent. Step by step guidance on the checking, cleaning and labelling of data files is available in the 'Guidance for handling data', available from the survey toolkit (reference 10).

8.2 File transfer

Once the data has been checked and any identified errors corrected, files should be correctly labelled according to the guidance and sent securely to the relevant DEC to upload. Extracted Excel files should be labelled to indicate the survey group, year and local authority to which they refer. Data files must only be transferred via secure email from an nhs.net address to a DEC's nhs.net address or via a secure MS Teams site.

The following will be reported for each lower tier local authority in the data summary worksheet (Appendix R):

- start and finish dates of the period of examinations (dd/mm/yyyy to dd/mm/yyyy)
- total number of care homes
- number of care homes sampled and contacted
- number of care homes where managers agreed to assist
- total number of beds and residents in care homes where the managers agreed to assist
- number of eligible residents for whom agreement to participate was initially sought

- number of residents with agreement to participate in both parts of the survey; questionnaire only; clinical examination only

- number of care home residents who agreed to take part and who completed both parts of the survey; questionnaire only; clinical examination only

- number of care home residents who agreed to take part and no suitable examining position was attained; who were unable to co-operate, absent or withdrew agreement to take part on the day of the survey

The above information must be accurate to enable the calculation of participation rates for the survey at both national and local levels.

Data will be submitted as cleaned Excel survey files, exported from the Access data collection database. The summary worksheet will be submitted as a completed Excel document.

All returns should be made to DECs as soon as possible after completion of the survey and no later than 31 July 2025. Returns should include:

- the completed Appendix R summary worksheet for each upper tier and lower tier local authorities within it

- the Excel survey data file for each local authority, labelled to indicate which local authority it refers to

DECs will upload the data files received from fieldwork teams to the DEC MS Teams folder for the appropriate region.

9. Data publication

A national report will be produced by the national dental public health team and published on the Oral Health Collections page (GOV.UK) (reference 11).

Local authority and NHS England personnel can apply to become super users to access the raw, anonymised data for specific purposes by contacting dentalphintelligence@dhsc.gov.uk with the following information:

- name and contact details of staff member to become a super user

- name of relevant upper tier local authority

The new super user will be sent a data-sharing agreement for signing. Once the signed agreement has been returned, they will be sent the relevant anonymised data and accompanying guidance notes.

9.1 Data requests

Other data requests should be emailed to dentalphintelligence@dhsc.gov.uk.

10. References

1. Department of Health (2012). Health and Social Care Act 2012. London, The Stationery Office. Accessed in June 2016 from: https://www.legislation.gov.uk/ukpga/2012/7/contents

2. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 (SI No. 2012/3094). Regulation 17 Statutory Instrument 2012 No 3094. Available from: https://www.legislation.gov.uk/uksi/2012/3094/regulation/17/made

3. Government Single Data List. Available from: https://www.gov.uk/government/publications/single-data-list

4. The Information Commissioner's Office website: Guide to the UK General Data Protection Regulation (UK GDPR). Available from: https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

5. Adult oral health survey 2021: self-reported health and oral impacts. Available from: https://www.gov.uk/government/statistics/adult-oral-health-survey-2021/adult-oral-health-survey-2021-self-reported-health-and-oral-impacts

6. Reducing Health Inequalities and the Equality Act 2010. Available from: www.gov.uk/guidance/equality-act-2010-guidance#public-sector-equality-duty

7. List of ethnic groups - GOV.UK (ethnicity-facts-figures.service.gov.uk). Available from: www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups

8. National Institute for Clinical Excellence. Clinical Guideline 64 (CG64). Prophylaxis against infective endocarditis: antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures. Accessed September 2024 from: https://www.nice.org.uk/guidance/cg64

9. Malmö University. Oral Health Country/Area Profile Project. Accessed July 2020 from: https://capp.mau.se/methods-and-indices/

10. Oral health survey of adults in care homes 2024 to 2025: toolkit. Available from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit

11. GOV.UK Oral health collections page. Available from: www.gov.uk/government/collections/oral-health

11. Appendices

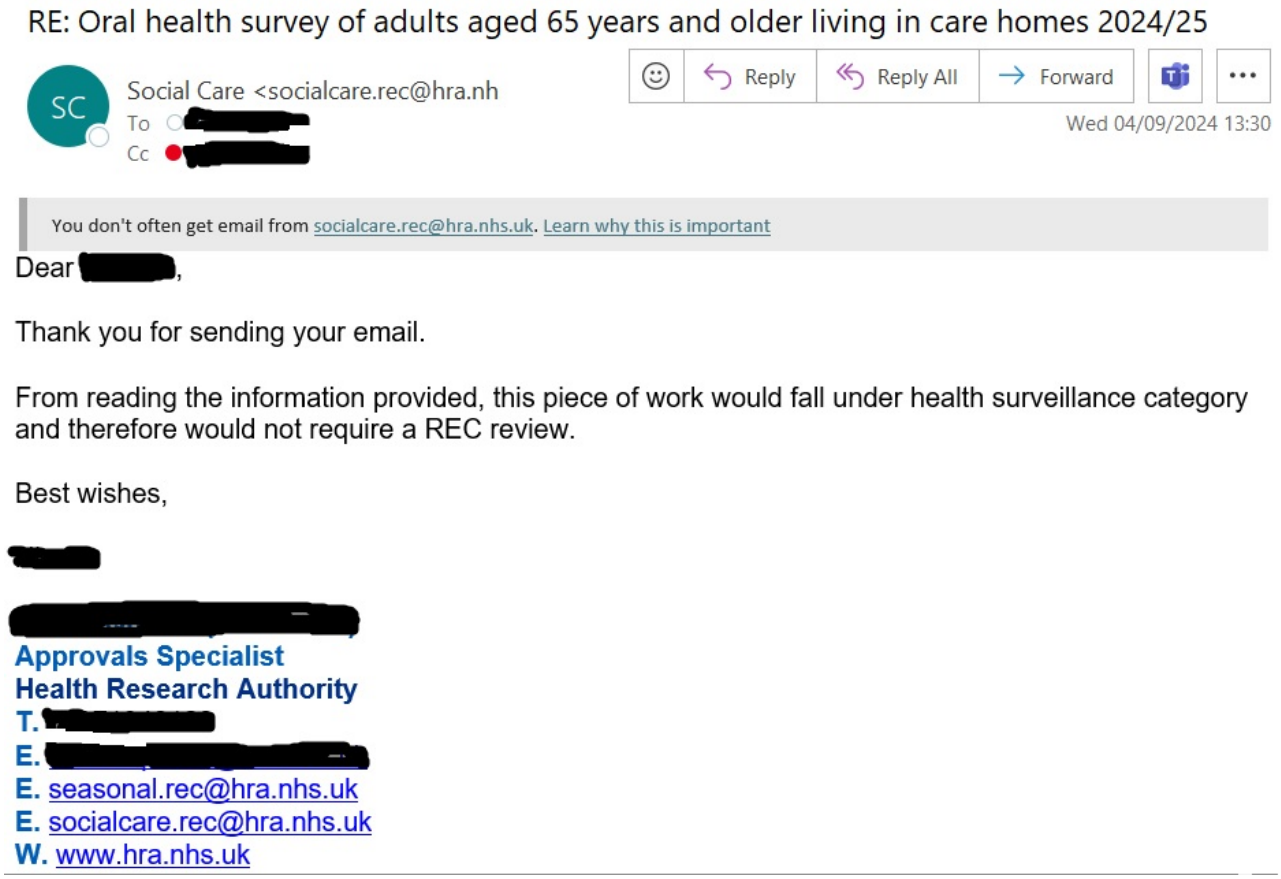
Appendix	Title
A	Statutory Instrument 2023, No. 3094 – extract
B	Ethical approval letter
C	Letter of support, survey of residents, 2024 to 2025
D	Letter to all care home managers
E	Lawful basis for data under GDPR DPA 2018
F	Operational timetable
G	Stages of the programme (flow chart)
H	Local authority names and codes
I	Letter to sampled care homes 2024 to 2025
J	Care homes tracking form example
K	Participant information leaflet 2024 to 2025
L	Agreement to participate form
M	List of suitable headlamps
N	Protocol for assessing capacity to provide agreement to participate
O	Survey team day sheet example
P	Survey questionnaire
Q	Examination data collection sheet
R	Data summary example
S	Participant consent form for serious pathology referral
T	Mouth map example
U	Letter for participant in case of serious pathology

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

If needed this is available to print from:
https://www.legislation.gov.uk/uksi/2012/3094/regulation/17/made (reference 2).

Appendix B: ethical approval letter

Below is an illustration of the email received stating that the survey does not require a Research Ethics Committee (REC) review.



RE: Oral health survey of adults aged 65 years and older living in care homes 2024/25

SC Social Care <socialcare.rec@hra.nh

To [redacted]

Cc [redacted]

Reply | Reply All | Forward

Wed 04/09/2024 13:30

You don't often get email from socialcare.rec@hra.nhs.uk. Learn why this is important

Dear [redacted],

Thank you for sending your email.

From reading the information provided, this piece of work would fall under health surveillance category and therefore would not require a REC review.

Best wishes,

[redacted]

[redacted]

Approvals Specialist
Health Research Authority
T. [redacted]
E. [redacted]
E. seasonal.rec@hra.nhs.uk
E. socialcare.rec@hra.nhs.uk
W. www.hra.nhs.uk

Appendix C: letter of support

This appendix is a letter of support for the Oral health survey of adults aged 65 years and older living in care homes 2024 to 2025, from the senior responsible officer for NDEP to directors of public health and is available to download from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Appendix D: letter to all care home managers

This appendix is a letter to care home managers providing details of the upcoming survey of eligible adults in care homes and is available to download from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Appendix E: lawful basis for data under GDPR DPA 2018

This appendix contains information on the lawful basis for processing dental survey data under the GDPR and DPA 2018 and is available to download from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Appendix F: care homes survey 2024 to 2025 operational timetable

Action	Timeline
Discuss survey with DECs and workforce	May 2024
Local consultants to liaise with directors of public health and adult social care teams to socialise the survey	June to July 2024
National training	5 September 2024
Regional fieldwork teams training and online standardisation	September to October 2024
National team to download care homes lists from CQC website	September 2024
Verify CQC care homes lists with local authorities	October 2024
Fieldwork team to sample care homes	October 2024
Fieldwork team to contact sampled care settings to socialise the survey	November 2024
Book visits and recruit residents to survey	January to June 2025
Undertake fieldwork	February to June 2025
Submit fieldwork data to DECs	31 July 2025
Submission of fieldwork data to Office for Health Improvement and Disparities	31 August 2025
Publication of final report	Early 2026
Directors of public health and adult social care teams to liaise with colleagues to raise profile of the survey	June to July 2024

Appendix G: stages in the National Dental Epidemiology Programme

This gives an overview of the steps in the dental survey.

1. A letter is sent from the senior responsible officer for NDEP to local authority directors of public health telling them about the survey and what is the survey population.

2. The directors of public health cascade this information to directors of adult social care in local authorities to gain support for the survey.

3. Consultants in dental public health at regional level support commissioning of the survey and agree local sample sizes with local authorities and NHS England and Improvement.

4. Regional consultants in dental public health discuss sampling with their local dental epidemiology co-ordinator if additional sampling is requested in a local authority.

5. Dental epidemiology co-ordinators working with the national team obtain a current list of care homes from the CQC and liaise with local authorities' teams to 'clean' the lists.

6. Local authority teams working with local dental public health consultants raise awareness of the survey though relevant channels and forums.

7. Fieldwork teams are trained and standardised for the survey at regional events.

8. The fieldwork teams get ratified care home lists from the DECs.

9. Using these lists, the fieldwork teams sample the care homes to take part in the survey and the sampling is checked and confirmed by the local dental epidemiology co-ordinator.

10. Sampled care homes are contacted by the fieldwork teams to take part in the survey. Tracking form is sent to care homes for completion with support from the fieldwork team.

11. Information letters and forms requesting agreement to participate in the survey are distributed to the participants meeting the inclusion criteria at the sampled care homes.

12. Lists of care home residents to be examined are drawn up between the care home and fieldwork team.

13. All care home residents who are present in the care home on the day of examination for whom agreement to participate has been received are administered the questionnaire and examined.

14. All the data collected is entered into a computer and checked for errors. It is then sent securely to the local dental epidemiology co-ordinator.

Appendix H: local authority names and codes

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	E06000060	Buckinghamshire	E06000060
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
Cumberland	E06000063	Cumberland	E06000063
Darlington	E06000005	Darlington	E06000005
Derby	E06000015	Derby	E06000015
Derbyshire	E10000007	Amber Valley	E07000032
		Bolsover	E07000033
		Chesterfield	E07000034
		Derbyshire Dales	E07000035
		Erewash	E07000036

Upper tier local authority	Upper code	Lower tier local authority	Lower code
		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
		Maldon	E07000074
		Rochford	E07000075
		Tendring	E07000076
		Uttlesford	E07000077
Gateshead	E08000037	Gateshead	E08000037
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

Upper tier local authority	Upper code	Lower tier local authority	Lower code
		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	E07000242
		Hertsmere	E07000098
		North Hertfordshire	E07000099
		St Albans	E07000240
		Stevenage	E07000243
		Three Rivers	E07000102
		Watford	E07000103
		Welwyn Hatfield	E07000241
Hillingdon	E09000017	Hillingdon	E09000017
Hounslow	E09000018	Hounslow	E09000018
Isle of Wight	E06000046	Isle of Wight	E06000046
Isles of Scilly	E06000053	Isles of Scilly	E06000053
Islington	E09000019	Islington	E09000019
Kensington and Chelsea	E09000020	Kensington and Chelsea	E09000020
Kent	E10000016	Ashford	E07000105
		Canterbury	E07000106
		Dartford	E07000107
		Dover	E07000108
		Folkestone and Hythe	E07000112
		Gravesham	E07000109
		Maidstone	E07000110
		Sevenoaks	E07000111
		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

Upper tier local authority	Upper code	Lower tier local authority	Lower code
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
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

Upper tier local authority	Upper code	Lower tier local authority	Lower code
		Norwich	E07000148
		South Norfolk	E07000149
North East Lincolnshire	E06000012	North East Lincolnshire	E06000012
North Lincolnshire	E06000013	North Lincolnshire	E06000013
North Northamptonshire	E06000061	North Northamptonshire	E06000061
North Somerset	E06000024	North Somerset	E06000024
North Tyneside	E08000022	North Tyneside	E08000022
North Yorkshire	E06000065	North Yorkshire	E06000065
Northumberland	E06000057	Northumberland	E06000057
Nottingham	E06000018	Nottingham	E06000018
Nottinghamshire	E10000024	Ashfield	E07000170
		Bassetlaw	E07000171
		Broxtowe	E07000172
		Gedling	E07000173
		Mansfield	E07000174
		Newark and Sherwood	E07000175
		Rushcliffe	E07000176
Oldham	E08000004	Oldham	E08000004
Oxfordshire	E10000025	Cherwell	E07000177
		Oxford	E07000178
		South Oxfordshire	E07000179
		Vale of White Horse	E07000180
		West Oxfordshire	E07000181
Peterborough	E06000031	Peterborough	E06000031
Plymouth	E06000026	Plymouth	E06000026
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	E06000066	Somerset	E06000066
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

Upper tier local authority	Upper code	Lower tier local authority	Lower code
St. Helens	E08000013	St. Helens	E08000013
Staffordshire	E10000028	Cannock Chase	E07000192
		East Staffordshire	E07000193
		Lichfield	E07000194
		Newcastle-under-Lyme	E07000195
		South Staffordshire	E07000196
		Stafford	E07000197
		Staffordshire Moorlands	E07000198
		Tamworth	E07000199
Stockport	E08000007	Stockport	E08000007
Stockton-on-Tees	E06000004	Stockton-on-Tees	E06000004
Stoke-on-Trent	E06000021	Stoke-on-Trent	E06000021
Suffolk	E10000029	Babergh	E07000200
		East Suffolk	E07000244
		Ipswich	E07000202
		Mid Suffolk	E07000203
		West Suffolk	E07000245
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
Warwickshire	E10000031	North Warwickshire	E07000218
		Nuneaton and Bedworth	E07000219
		Rugby	E07000220
		Stratford-on-Avon	E07000221

Upper tier local authority	Upper code	Lower tier local authority	Lower code
		Warwick	E07000222
West Berkshire	E06000037	West Berkshire	E06000037
West Northamptonshire	E06000062	West Northamptonshire	E06000062
West Sussex	E10000032	Adur	E07000223
		Arun	E07000224
		Chichester	E07000225
		Crawley	E07000226
		Horsham	E07000227
		Mid Sussex	E07000228
		Worthing	E07000229
Westminster	E09000033	Westminster	E09000033
Westmorland and Furness	E06000064	Westmorland and Furness	E06000064
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: www.ons.gov.uk/methodology/geography/geographicalproducts/namescodesandlookups/lookups

Appendix I: letter to sampled care homes

This appendix is a letter to sampled care homes inviting them to take part in the survey and is available to download from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Appendix J: care home tracking form

Below is an illustration example of the tracking form for care homes to record which residents are eligible and which have agreed to participate. This appendix is available to download and print from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Care home tracking form

National Dental Epidemiology Programme, oral health survey of adults aged 65 years and older living in care homes, 2024 to 2025

Care home name: Ravenscroft Residential Home

Care home postcode: FY4 3VG

Care home contact name and number: Mrs Bond 01253 422653

Total Number of beds: 34

Total number of current residents: 30

Number of eligible residents: 25

Q1 to Q6 codes: Y = Yes; N = No (Q3 criteria - if younger than 65 years old ie: born after 01/02/1960, then Q3=N; if Q1=N then Q3=N; if Q2=Y then Q3=N)

First name	Surname	Date of birth	Q1. Capacity to agree to participate?	Q2. On end of life, respite or palliative care?	Q3. Eligible to participate? (see criteria above)	If Q3 = Y then: Q4. Resident given survey information and participation letter?	Q5. Agreement to participate in questionnaire received?	Q6. Agreement to participate in clinical examination received?
Margaret	Jones	24/05/1944	Y	N	Y	Y	Y	N
Violet	Harrison	23/09/1952	Y	Y	N			
Henry	Smith	06/07/1949	Y	N	Y	Y	Y	Y
Brenda	Wright	25/12/1959	N	N	N			
Barbara	Smith	09/08/1937	Y	N	Y	Y	Y	Y
Terry	Lund	03/05/1963	Y	N	N			

Appendix K: information for prospective participants

This appendix is survey information for eligible care home residents and is available to download from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Appendix L: agreement to participate

This appendix is an agreement to participate form for eligible care home residents and is available to download and print from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Appendix M: list of suitable types of headlamps

The clinical examination is not so exacting that a specialist head torch is required. A list of suppliers follows for assistance, but this is not exhaustive.

Cotswold outdoor: www.cotswoldoutdoor.com/equipment/torches-lanterns/head-torches

Go outdoors: www.gooutdoors.co.uk/walking/equipment/lighting/head-torches

Decathlon: www.decathlon.co.uk/Head_Torches

Millets: www.millets.co.uk/HeadTorches

Torch direct: www.torchdirect.co.uk/head-torches.html

Blacks: www.blacks.co.uk › Equipment › Torches & Lighting

Appendix N: protocol for assessing capacity to provide agreement to participate

The meaning of 'capacity' to provide agreement to participate

'Capacity' refers to the person's mental capacity.

Mental capacity refers to a person's ability to make a decision.

This refers to any decision whether to get up in the morning, what to wear or whether to go to the doctor when feeling ill – as well as more serious or significant decisions, for example, decisions that have legal consequences, like having medical treatment, buying goods or making a will.

For our purpose it relates to making an informed decision about whether to participate in the survey.

The meaning of 'lacking capacity' and why it is important

Section 2(1) of the Mental Capacity Act 2005 (MCA) states that:

"For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."

This means that a person lacks capacity if they meet both of the following criteria:

- they have an impairment or disturbance (for example, a disability, condition or trauma) that affects the way their mind or brain works
- the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made

It should be noted that the impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

- the loss of capacity is partial
- the loss of capacity is temporary
- their capacity changes over time

How to assess if a respondent lacks capacity to provide informed agreement to participate

You should assess whether the respondent lacks capacity before starting the interview.

The MCA states that the starting point must be to assume the respondent has the capacity to make a specific decision. Some people may require help to be able to make or communicate a decision. However, this does not necessarily mean that they lack capacity to do so. What matters is their ability to carry out the processes involved in making the decision.

The MCA also states that an assessment on whether a person lacks capacity should never be based simply on:

- their age
- their appearance
- assumptions about their condition
- any aspect of their behaviour

The word 'appearance' is used because it covers all aspects of the way that people look, for example it includes the physical characteristics of certain conditions (scars, features linked to Down's syndrome or muscle spasms caused by cerebral palsy) as well as aspects of appearance like skin colour, tattoos, body piercings, or the way people dress (including religious dress).

The word 'condition' is also wide-ranging. It includes physical disabilities, learning difficulties and disabilities, illness related to age, and temporary conditions (for example drunkenness or unconsciousness). Aspects of behaviour might include extrovert (for example shouting or gesticulating) and withdrawn behaviour (for example talking to yourself or avoiding eye contact).

The emphasis on this guidance is about treating everybody equally.

There are 2 stages in assessing whether a respondent lacks capacity. If the conditions of both stages are met, then you should consider the respondent to lack capacity.

Stage 1: does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

Examples of an impairment or disturbance in the functioning of the mind or brain may include the following:

- conditions associated with some forms of mental illness
- dementia
- significant learning disabilities
- the long-term effects of brain damage
- physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- delirium
- concussion following a head injury
- the symptoms of alcohol or drug abuse

Stage 2: does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make the specific decision when they need to. But first people must be given all practical and appropriate support to help them make the decision for themselves. This support might include the use of non-verbal communication such as signers (for sign language) or perhaps the use of an interpreter.

Stage 2 can only apply if all practical and appropriate support to help the person make the decision has failed.

What the Act means by 'inability to make a decision'

A person is unable to make a decision if they cannot do any one of the following tasks:

- understand information about the decision to be made

It is important not to assess someone's understanding before they have been given relevant information about a decision. You should provide respondents with information about the survey. You should make every effort to provide this information in a way that is most appropriate to help the respondent to understand. For example, a respondent with a learning difficulty may need you to read the purpose leaflet to them.

- retain that information in their mind

The respondent must be able to hold the information in their mind long enough to make an effective decision.

- use or weigh that information as part of the decision making process

For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. Sometimes people can understand information but an impairment or disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given.

For example, some respondents who have serious brain damage might make impulsive decisions regardless of information they have been given or their understanding of it.

- communicate their decision by talking, using sign language or any other means

According to the MCA, if a respondent cannot communicate their decision in any way at all, they should be treated as if they are unable to make that decision. As mentioned previously, before arriving at this conclusion you should ensure that all practical efforts to make communication have been explored, for example the use of signers.

If a respondent is unable to perform any one of these 4 tasks, then they are unable to make a decision. If this is the case, you should treat them as being unable to provide agreement to participate in the survey.

If a respondent meets the criteria under stage 1 and stage 2 then you should classify them as lacking capacity to provide informed agreement to participate and kindly exclude them from the survey. Assent should not be sought.

Appendix O: survey team day sheet

Below is an illustration example of the survey team day sheet. This can later be used to help calculate the summary information for Appendix R data summary sheet. This appendix is available to download from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Survey team day sheet

National Dental Epidemiology Programme, oral health survey of adults aged 65 years and older living in care homes, 2024 to 2025

Local authority name: Blackpool

Care home name: Ravenscroft Residential Home

Care home postcode: FY4 3VG

Care home contact name and number: Mrs Bond 01253 422653

Total Number of beds: 34

Total number of current residents: 30

Number of eligible residents: 25

Survey status S1 and S2: Y = Yes; A = Absent; W = Withdrew agreement to take part; N = No suitable examining position was attained
U = Unable to cooperate; N/A = Not applicable as did not agree to participate

Date of survey: 15/02/2025

Sample Number	First name	Surname	Date of birth	Q5. Agreement to participate in questionnaire received?	Q6. Agreement to participate in clinical examination received?	Survey status	
						S1. Questionnaire undertaken (whether full or partial)	S2. Clinical examination undertaken (whether full or partial)
0001	Margaret	Jones	24/05/1944	Y	N	Y	N/A
0002	Henry	Smith	06/07/1949	Y	Y	A	A
0003	Barbara	Smith	09/08/1937	Y	Y	Y	W

Appendix P: survey questionnaire

This appendix is the questionnaire to be administered to eligible residents for whom agreement to participate has been received and is available to download and print from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Appendix Q: examination data collection sheet

This appendix is the clinical examination data collection sheet used to record data from examined eligible residents for whom agreement to participate has been received and is available to download and print from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

Appendix R: data summary

Below is an illustration example of the data summary spreadsheet for mainstream care homes, which needs to be completed accurately to enable the calculation of response rates. This appendix is available to download from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10). It also includes separate spreadsheets to report on additional surveys and special care homes if required.

Data summary part 1, National Dental Epidemiology Programme, oral health survey of adults aged 65 years and older living in care homes, 2024 to 2025

MAIN SAMPLE SURVEY

Upper tier LA Code	Upper tier LA Name	Lower tier LA Code	Lower tier LA Name	Name(s) of examiner(s)	Start date of examinations dd/mm/yyyy	End date of examinations dd/mm/yyyy	Total number of care homes	Number of care homes sampled & contacted	Number of care homes where managers agreed to assist	Total number of beds	Total number of residents
E10000007	Derbyshire	E07000032	Amber Valley	A N Other	12/01/2025	03/06/2025	25	10	10	325	250
E10000007	Derbyshire	E07000033	Bolsover	A N Other X Y Other	06/01/2025	02/05/2025	60	12	11	300	300
E10000007	Derbyshire	E07000034	Chesterfield	A N Other	25/01/2025	03/05/2025	30	11	10	380	350
E10000007	Derbyshire	E07000035	Derbyshire Dales	X Y Other Y Z Other	05/02/2025	19/06/2025	10	10	8	160	160

At care homes where managers agreed to assist:				Number of residents who agreed to take part and:						
Number of eligible residents for whom agreement to participate was initially sought	Number of residents with agreement to participate in both parts of the survey	Number of residents with agreement to participate in the questionnaire only	Number of residents with agreement to participate in the clinical examination only	completed both the questionnaire and clinical examination (wholly or partially)	completed only the questionnaire (wholly or partially)	completed only the clinical examination (wholly or partially)	no suitable examining position was attained (N)	were unable to co-operate on the day (U)	were absent on the day (A)	withdrew agreement to take part on the day (W)
115	103	11	0	98	11	2	0	0	1	2
125	109	5	2	102	6	4	1	1	0	2
130	110	7	0	93	12	7	0	0	0	5
100	88	3	0	65	16	5	0	0	2	3

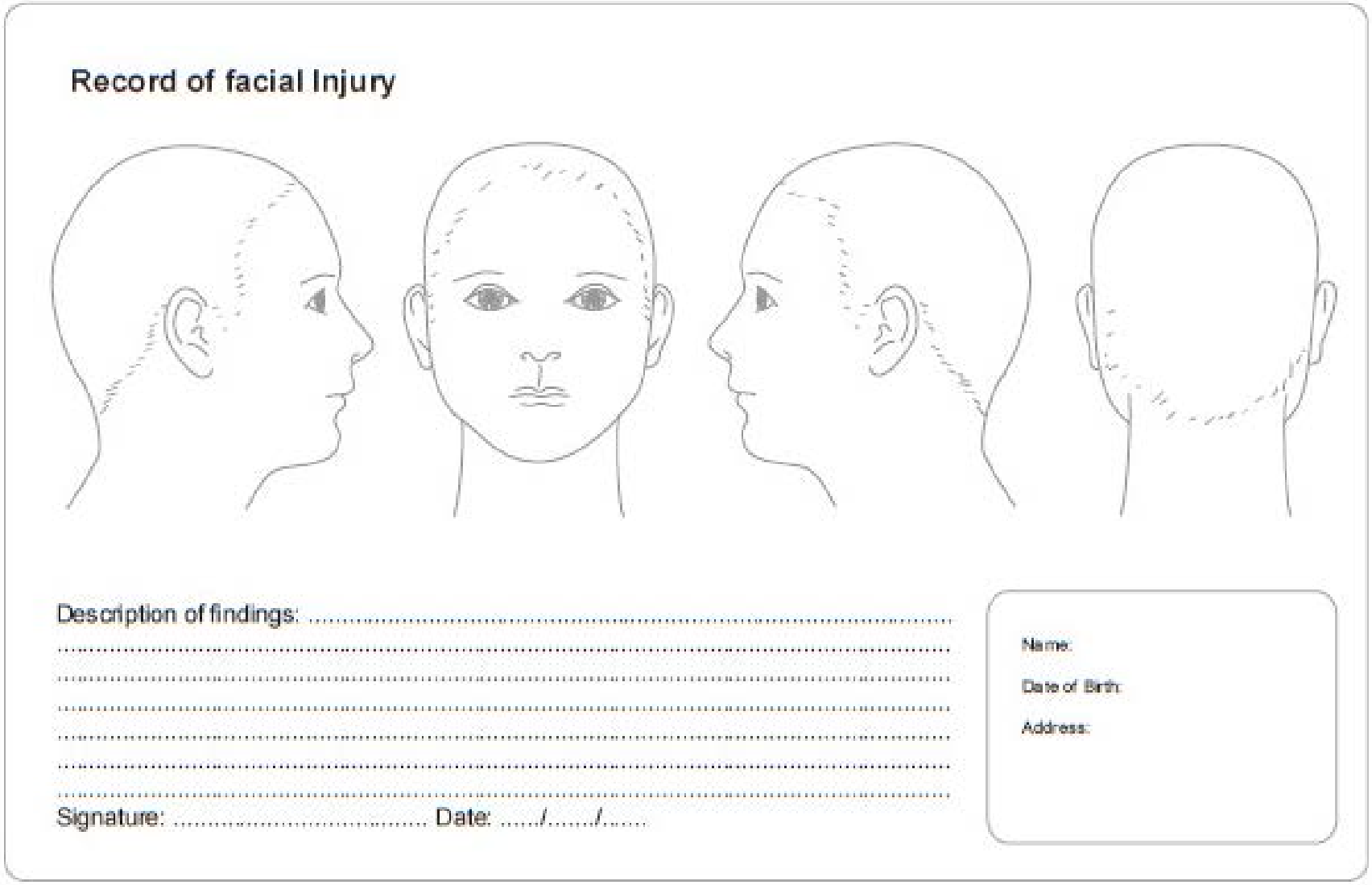
Main sample | Additional sample | Special care homes

Appendix S: participant consent form for serious pathology referral

This appendix is a form to be used for participants' consent for serious pathology referral and is available to download and print from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).

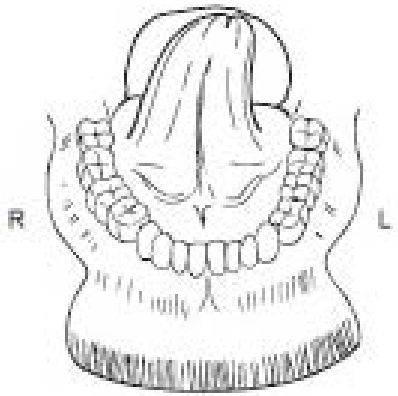
Appendix T: mouth map example

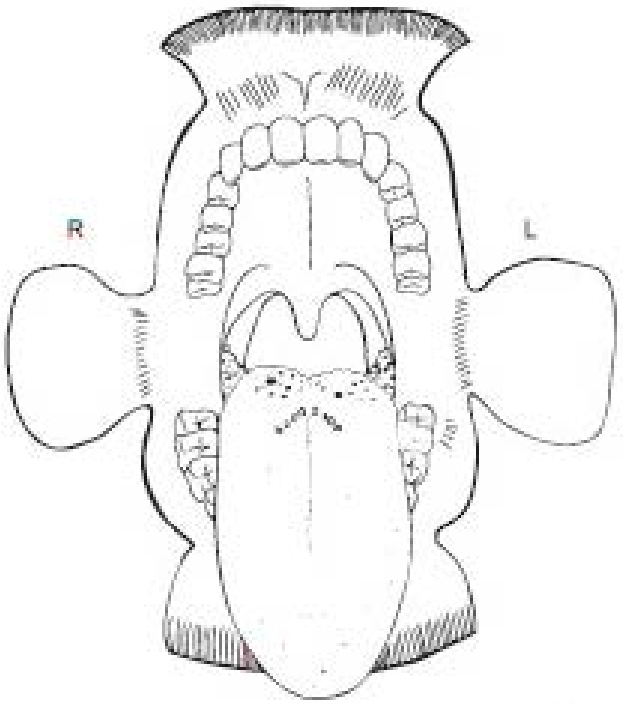
Below is an illustration example of a mouth map used for referrals.



Source: Dental Illustration Unit Cardiff University School of Dentistry Heath Park Cardiff 2011

Oral Assessment Chart





Description of findings: .....

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Signature: ..... Date: ...../...../.....

Name:

Date of Birth:

Address:

Source: Dental Illustration Unit Cardiff University School of Dentistry Heath Park Cardiff 2011

Appendix U: letter for participant refusal in case of serious pathology

This appendix is a letter for participants who refuse referral in cases of serious pathology and is available to download from: www.gov.uk/government/publications/oral-health-survey-of-adults-in-care-homes-2024-to-2025-toolkit (reference 10).