



Public Health
England

Protecting and improving the nation's health

National dental epidemiology programme

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

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

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1. Introduction

Local authorities have been responsible for gathering information on the health needs of their local populations since April 2013, following the white paper, *Equity and Excellence; Liberating the NHS*.¹ This imperative is described in the *Health and Social Care Act 2012*², underpinned by Statutory Instrument 2012 number 3094³ and *Commissioning Better Oral Health*.⁴

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

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

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

2. Aim of the survey

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

This information can be used to:

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

3. Objectives

To examine 3-year-old children using caries diagnostic criteria and examination techniques based on those agreed by the British Association for the Study of Community Dentistry (BASCD), for caries prevalence surveys⁵ and using standardised sampling procedures.⁶

4. Sample

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

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

4.1 Survey population

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

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

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

4.2 Sampling procedure

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

Childcare sites include:

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

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

Sample size

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

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

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

Sampling procedure

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

Childcare sites are classified into 2 groups which are:

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

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

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

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

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

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

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

4.3 Calculation of a representative sample

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

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

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

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

Example of sampling method

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

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

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

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

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

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

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

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

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

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

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

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

4.4 Contact details of dental epidemiology co-ordinators

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

4.5 General Data Protection Regulations

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

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

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

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

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

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

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

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

GDPR and dental health surveys

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

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

ⁱⁱ <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/key-definitions/>

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

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

Informing parents

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

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

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

5. Responsibilities

5.1 Overall and commissioning

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

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

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

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

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

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

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

5.2 Personnel

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

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

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

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

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

6. General conduct of the survey

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

6.1 Planning and organisation of the survey

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

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

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

6.2 Contacting childcare sites

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

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

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

6.3 Seeking consent

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

The procedure for obtaining explicit, positive consent must involve:

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

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

6.3.1 Maximising consent rates

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

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

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

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

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

6.3.2 Recording consent

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

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

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

6.4 Feedback to parents

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

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

6.5 Safeguarding

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

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

7. Fieldwork

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

7.1 Equipment, instruments and materials

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

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

7.2 Examining position

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

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

7.3 Examination light

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

7.4 Instruments

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

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

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

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

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

8. Collection of data – general information

8.1 Training and calibration

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

8.2 Computer software

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

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

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

8.3 Information sharing and protection

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

8.3.1 Responsibilities of nurseries and playgroups

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

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

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

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

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

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

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

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

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

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

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

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

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

^{iv} www.legislation.gov.uk/ukxi/2012/3094/contents/made

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

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

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

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

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

8.3.4 Responsibilities of dental health teams

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

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

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

Dental health teams must:

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

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

8.3.5 Responsibilities of Public Health England

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

PHE is responsible for:

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

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

PHE is responsible for:

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

8.4 File management

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

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

9. Collection of non-clinical data

9.1 Recording of information to allow data linkage

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

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

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

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

9.2 Organisational boundary coding

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

9.3 Examiner

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

9.4 Examination date

The date of the examination will be recorded.

9.5 Childcare site name and postcode

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

9.6 Child identity number

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

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

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

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

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

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

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

9.7 Date of birth

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

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

9.8 Home address postcode

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

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

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

Postcodes should be entered with the first part (outward code) in the first box and the second part (inward code) in the second box, no spaces, in the Access data collection programme.

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

9.9 Sample group codes

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

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

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

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

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

9.10 Examination status

The type of examination will be recorded as follows:

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

9.11 Variable for ethnic code

Volunteer children will be coded for ethnic group/background to ensure the requirements of the Health and Social Care Act, 2012 are met. This act "...introduced the first specific legal duties on health inequalities, including duties on the Secretary of State for Health. All staff undertaking NHS and public health functions on behalf of the Secretary of State are responsible for ensuring compliance with these duties and this guidance is designed to help you do so." This would include a requirement to collect ethnicity data to be able to report any inequalities measured in dental health.

Reducing Health Inequalities and the Equality Act 2010

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

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

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

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

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

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

Further guidance and descriptions of ethnic groupings can be found from:

www.ethnicity-facts-figures.service.gov.uk/ethnic-groups

10. Collection of clinical data

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

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

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

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

10.1 Oral cleanliness: assessment of plaque

It is of interest for local surveys to include a variable about oral cleanliness because this provides a proxy for tooth brushing activity and likely exposure to fluoride toothpaste. A simple measure based on a modification of the Silness and Low Index⁷ will be used. A probe is not used for this part of the examination, which involves visual examination only of upper canine to upper canine. No disclosing should be done. Only easily visible plaque should be considered and recent debris (such as small pieces of food found in an otherwise clean mouth immediately after a lunchtime or break) should be ignored.

The coding to be used is:

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

10.2 Dentition status

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

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

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

10.3 Conventions

The conventions that will apply are:

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

10.4 Teeth present

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

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

10.5 Absent teeth

Tooth code 6 – extracted due to caries

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

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

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

Tooth Code 8 - Unerupted or missing other

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

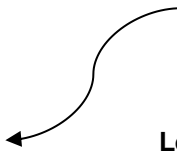
This code will be used **in the main chart** where there are missing primary incisors. This is the same convention as for 5-year-olds and will allow for comparison between the 2 age groups.

Missing incisors

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

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

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



				UPPER						
Right				6	6	6		Left		
E	D	C	B	A	A	B	C	D	E	
-	-	-	2	8	8	8	-	3	-	D
2	-	-	-	-	-	-	-	2	-	O
-	2	2	3	8	8	8	-	2	-	M

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

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

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

10.6 Obscured surfaces

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

10.7 Caries diagnostic criteria and codes

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

Surface code – sound

Criteria: a surface is recorded as 'sound' using a dashed mark ' – ' if it shows no evidence of treated or untreated clinical caries at the 'caries into dentine' threshold. The early stages of caries, as well as other similar conditions, are excluded. In the absence of other positive criteria, surfaces with the following defects should be coded as present and 'sound':

- white or chalky spots
- discoloured or rough spots
- stained pits or fissures in the enamel that are not associated with a carious lesion into dentine
- dark, shiny, hard, pitted areas of enamel showing signs of moderate-to-severe fluorosis

All questionable lesions should be coded as 'sound'.

Surface code 1 – arrested dentinal decay

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

Surface code 2 – caries into dentine

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

Surface code 3 – decay with pulpal involvement

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

Surface code 4 – filled and decayed

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

Surface code 5 – filled with no decay

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

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

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

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

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

Surface code C – crown

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

Surface code T – trauma

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

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

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

10.8 Sealed surfaces

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

Surface code \$ – sealed surface, type unknown

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

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

Surface code N – obvious sealant restorations

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

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

10.9 Pufa

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

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

The coding to be used is:

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

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

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

11. Reporting of data

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Requestor to send an email to DentalPHIntelligence@phe.gov.uk providing:
 - name of individual to be allocated as 'super user'
 - local authority or LKIS
 - contact details
2. The nominated 'Super User' will be contacted by a member of the national dental public health team who will send a data-sharing agreement for signing.
3. Once the signed agreement has been received the super user will be sent their (anonymised) data along with a set of analysis guidance notes.

Other data requests

Any data requests that are for national data, or complex queries, should be emailed to DentalPHIntelligence@phe.gov.uk. The request will be considered by the national dental public health team and, if feasible, will either be sent to the appropriate DEC or super user for completion or conducted on a 'once for all' basis.

12. References

1. Department of Health (2010). Equity and excellence: Liberating the NHS. London, The Stationery Office. Accessed in June 2016 from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf
2. Health and Social care Act 2012. Accessed in June 2016 from: www.legislation.gov.uk/ukpga/2012/7/contents/enacted
3. National Health Service, England Social Care Fund, England Public Health, England. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Health watch) Regulations 2012. Accessed in June 2018 from: <http://origin-www.legislation.gov.uk/uksi/2012/3094/part/4/made>
4. Public Health England (2014). Local Authorities improving oral health for children and young people: An evidence-informed toolkit for local authorities. www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf
5. Pitts, N.B., Evans, D.J., Pine, C.M. (1997): British Association for the Study of Community Dentistry (BASCD) diagnostic criteria for caries prevalence surveys – 1996/97. Community Dental Health 14: (Supplement 1), 6-9.
6. Pine, C.M., Pitts, N.B., Nugent, Z.J. (1997a): British Association for the Study of Community Dentistry (BASCD) guidance on sampling for surveys of child dental health. A BASCD coordinated dental epidemiology programme quality standard. Community Dental Health 14: (Supplement 1), 10-17.
7. Pine, C.M., Pitts, N.B., Nugent, Z.J. (1997b): British Association for the Study of Community Dentistry (BASCD) guidance on the statistical aspects of training and calibration of examiners for surveys of child dental health. A BASCD co-ordinated dental epidemiology programme quality standard. Community Dental Health 14, (Supplement 1), 18-29.
8. Silness, J. and Loe, H. (1964). Periodontal disease in pregnancy. II Correlation between oral hygiene and periodontal condition. Acta Odontologica Scandinavica 22: 121–135.

13. Appendices

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[#] Documents will be available in pdf format from [K-Hub](#)

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Appendix A

Statutory Instrument 2012, No. 3094 - **extract**

STATUTORY INSTRUMENTS

2012 No. 3094

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

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

Made - - - 12th December 2012

Laid before Parliament 17th December 2012

Coming into force in accordance with regulation 1(2)

Extract from pages 8, 9, 26 and 27

PART 4

DENTAL PUBLIC HEALTH FUNCTIONS OF LOCAL AUTHORITIES

Interpretation

16. In this Part—

“oral health promotion programme” means a health promotion and disease prevention programme the underlying purpose of which is to educate and support members of the public about ways in which they may improve their oral health;

“oral health survey” means a survey to establish the prevalence and incidence of disease or abnormality of the oral cavity;

“water fluoridation programme” means fluoridation arrangements made under section 87(1) (fluoridation of water supplies at request of relevant authorities) of the Water Industry Act 1991(g)^v.

Exercise of functions of local authorities

17.—

(1) Each local authority (h)^{vi} shall have the following functions in relation to dental public health in England.

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

vi (h) See section 2B(5) of the 2006 Act for the definition of “local authority”, which is also applied to section 111 by virtue of section 111(3) of that Act.

(2) A local authority shall provide, or shall make arrangements to secure the provision of, the following within its area—

- (a) to the extent that the authority considers appropriate for improving the health of the people in its area, oral health promotion programmes;
- (b) oral health surveys to facilitate—
 - (i) the assessment and monitoring of oral health needs,
 - (ii) the planning and evaluation of oral health promotion programmes,
 - (iii) the planning and evaluation of the arrangements for provision of dental services as part of the health service, and
 - (iv) where there are water fluoridation programmes affecting the authority's area, the monitoring and reporting of the effect of water fluoridation programmes.

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

Revocations and transitional arrangements

18.—

(1) The Functions of Primary Care Trusts (Dental Public Health) (England) Regulations 2006(b)^{viii} ("the 2006 Regulations") are revoked.

(2) This paragraph applies where, in the exercise of its functions under the 2006 Regulations, a Primary Care Trust—

- (a) provided an oral health promotion programme or an oral health survey which was ongoing immediately prior to section 29 of the 2012 Act coming fully into force, or
- (b) participated in an oral health survey required by the Department of Health which was ongoing immediately prior to section 29 of the 2012 Act coming fully into force.

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

Signed by authority of the Secretary of State for Health.

Anna Soubry

Parliamentary Under-Secretary of State for Health,
Department of Health

12th December 2012

EXPLANATORY NOTE

(This note is not part of the Regulations)

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

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

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

vii (a) Paragraph 13 of Schedule 1 to the 2006 Act is substituted by section 17(2) and (13) of the 2012 Act.

viii (b) S.I. 2006/185.

Appendix B

Letter of support from programme lead for dental public health, Public Health England, to directors of public health



Dental Public Health
Wellington House
133-155 Waterloo Road
London SE1 8UG

T +44 (0)20 7654 8179

www.gov.uk/phe

To: Directors of public health
for forwarding to directors of children's services

8 August 2019

Dear Directors of Public Health and Directors of Children's Services,

Request for your support for the 2019/20 national dental survey of 3-year-old children^{ix}

I write to seek your support in delivering the above survey, which is part of the rolling programme of nationally coordinated dental surveys designed to provide quality assured local information on dental needs. The findings will be made widely available and shared with you and your colleagues as commissioners of the surveys.

A 3-year-old survey is taking place in response to the consultation exercise with local authorities on which population groups were of interest to them. The survey will measure the prevalence and severity of dental decay in 3-year-old children attending childcare sites in each local authority. The results of the survey will be compared with the findings of the previous survey of 3-year-olds in 2013, which found 12% had dental decay with each child having on average 3 decayed teeth.

The survey will provide benchmarking data for use by local authorities in joint strategic needs assessments to plan and commission oral health improvement interventions and evaluate them. PHE centre consultants in dental public health can support local authorities with this and evidence informed documents to assist local authorities with improving oral health and commissioning decisions were published in 2014 by NICEⁱ and PHEⁱⁱ. PHE has also published a return on investment modelling tool of population based oral health improvement programmes for children aged 0 to 5 years.

Results from previous dental surveys of children are encouraging but dental decay is still a significant public health problem. Toothache can cause pain, infection, difficulties with eating, sleeping and socialising and impact on school readiness and school absence. Extraction of teeth is still the most common reason for children to be admitted to hospital.

PHE is asking directors of public health to support local involvement in the 2019/20 survey. Gaining good local support for the surveys will be key to enabling high consent rates for participation in the

^{ix}Participation in the surveys is required by the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012: Part 4 Regulations,

surveys by both childcare sites and parents and carers of the children. This is essential for the survey results to be accurate and precise. The success of these surveys will be much increased if you could actively express your support to relevant colleagues, particularly heads of education and children and early years services. This may be achieved, in part, by forwarding a copy of this letter to these colleagues.

PHE has dental epidemiology co-ordinators (consultants in dental public health) across England based in PHE centres who will advise during the whole process, including commissioning of these surveys.

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

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

Yours sincerely,



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

National Lead for Dental Public Health

Email: Sandra.white@phe.gov.uk

ⁱ NICE 2014. Available from: www.nice.org.uk/guidance/ph55

ⁱⁱ PHE 2014. Available from: www.gov.uk/government/publications/improving-oral-health-an-evidence-informed-toolkit-for-local-authorities

Appendix C

Information about the purpose and nature of the survey.



Public Health England national dental epidemiology programme

Oral health survey of 3-year-old children 2019 to 2020

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

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

Fieldwork teams will contact randomly sampled nurseries and playgroups within a local authority area. They will ask for cooperation from the site and for access to lists of all children who may be included in the survey, showing dates of birth. From these lists they will identify children who will be the correct age on the day of examination. Explicit, written agreement to examine each child will then be sought via letters home to parents, which the team will provide. The ethnic classification and home postcode of children for whom parental agreement to have a dental examination has been received will be requested from site information.

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

The information relating to the dental examination is recorded without names, gender or complete dates of birth. All data is kept securely, and datasets are safely sent to regional centres for uploading via a secure web portal to the national coordinating centre. This centre collates data from all over England and produces reports on levels of dental health for England as a whole and at a variety of local government and health organisation levels. At no point is any individual identifiable, as the data is anonymised from the examination stage and only ever reported or published as grouped data.

It is hoped that all sites contacted will be able to assist the fieldwork teams in this national survey which local authorities have a responsibility to procure by law. The teams try to keep disruption to a minimum and ensure the children involved have a positive experience with the dental team.

Appendix D

Requirement for explicit, positive consent, 2007



Consent for School Dental Inspections and Dental Epidemiological Surveys

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

As both of the above stated processes inevitably involve physical contact between a dentist and a child, it is necessary to obtain consent from the child (if he/she is competent to give consent) or from a person with parental responsibility for the child, in accordance with the Department's guidance on consent to treatment¹. Whilst the risk of any proceedings² being brought against a dentist or PCT in relation to a school dental inspection or epidemiological survey might be considered low, in the event that there was, a dentist may not be able to prove that consent had been obtained simply on the basis that letter had been sent out to parents and no objection had been received.

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

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

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

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

¹ *Good practice in Consent* (HSC 2001/023)

http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/HealthServiceCircularsArticle/fs/en?CONTENT_ID=4003736&chk=OigZnc

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

² for battery/assault or negligence, or disciplinary proceedings

Appendix E

Letter from PHE regarding GDPR and health activities in childcare sites:



Protecting and improving the nation's health

PHE Yorkshire & the Humber Centre T +44 0113 855 7359
Blenheim House
Duncombe Street
Leeds, LS1 4PL
www.gov.uk/phe

19 August 2019

To whom it may concern

Advice on the General Data Protection Regulation and childcare sites health data collections

This letter provides advice on the lawful basis under the General Data Protection Regulation (GDPR) for children's personal information to be used for dental surveys.

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

GDPR and the lawful basis for the childcare sites health data collections

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

All processing of personal data – meaning all aspects of the collection, use and sharing of personal data about identifiable individuals^{xi} – must have a lawful basis under the GDPR. Article 6 of the GDPR sets out the range of purposes for which personal data

^x For further information on the GDPR can be found on the Information Commissioner's Office website: <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr>

^{xi} <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/key-definitions/>

can be lawfully processed. Article 9 sets out the associated conditions for the lawful processing of 'special categories' of personal data, including data about health.

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

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

No change is needed to the current ways in which parents are informed of childcare site health data collections for these to be lawful under the GDPR. A more detailed explanation is provided below.

GDPR and dental health surveys

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

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

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

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

Informing parents

Guidance on the management of dental surveys among 3-year-old children in childcare sites is published by Public Health England^{xiii}.

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

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

Summary

No change is needed to the current ways in which children's personal information is used and shared for childcare sites health data collection to be lawful under the GDPR.

The lawful basis under the GDPR for dental surveys of children in healthcare sites is not provided by consent – it is provided by varying combinations of 'compliance with a legal obligation', 'exercise of official authority', 'medical diagnosis or the provision of health care or treatment' and 'public interest in the area of public health'.

However, parents or persons with parental responsibility must still provide their written agreement for children to be included in a dental survey in a childcare site.

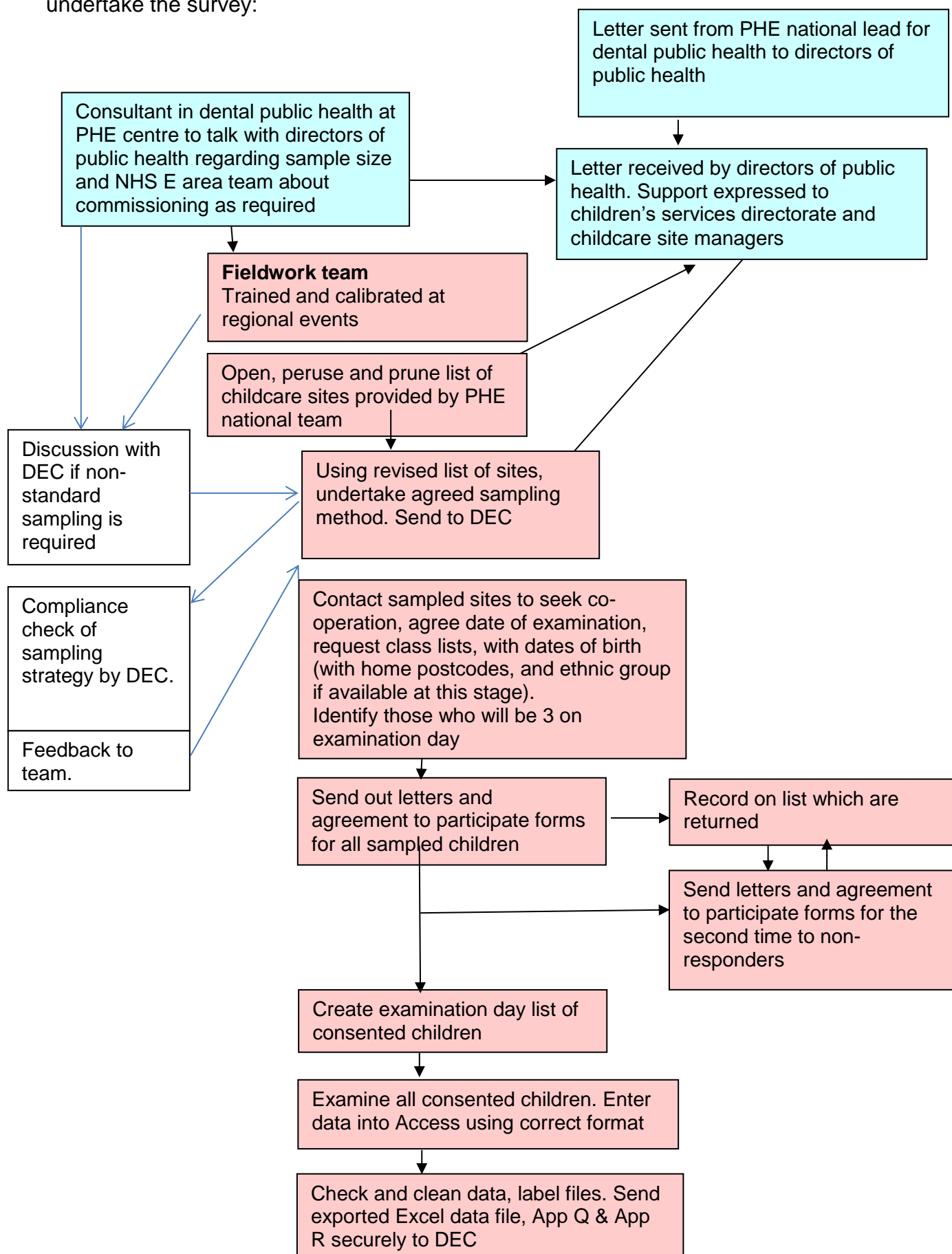
Yours faithfully



Dr Andrew Furber
Lead Centre Director for Dental Public Health

xiii The national protocol for the 2019/20 survey of 3-year-old children can be found at: www.gov.uk/government/collections/oral-health

Appendix F Stages for PHE dental public health epidemiology programme teams to undertake the survey:



Appendix G

Operational timetable

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

Appendix H

Safe use of Daray lights for dental epidemiology fieldwork

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

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

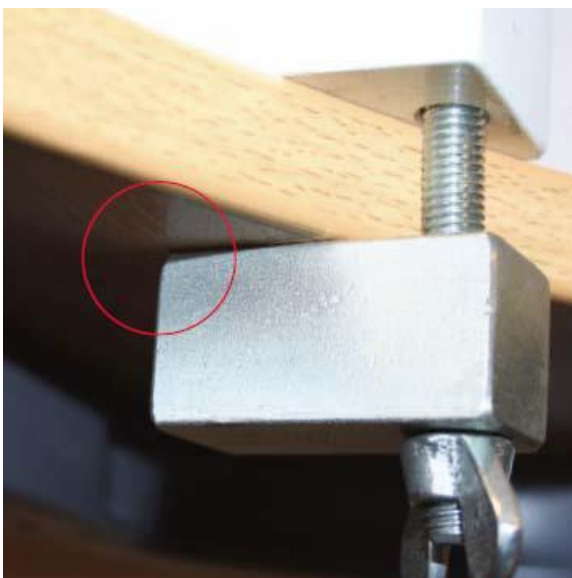
The clamps should be fitted and used correctly and checked to ensure they are firmly fixed to a work surface. For this reason, it is best practice to establish a set examination site at a venue and avoid moving around from one room to another.

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

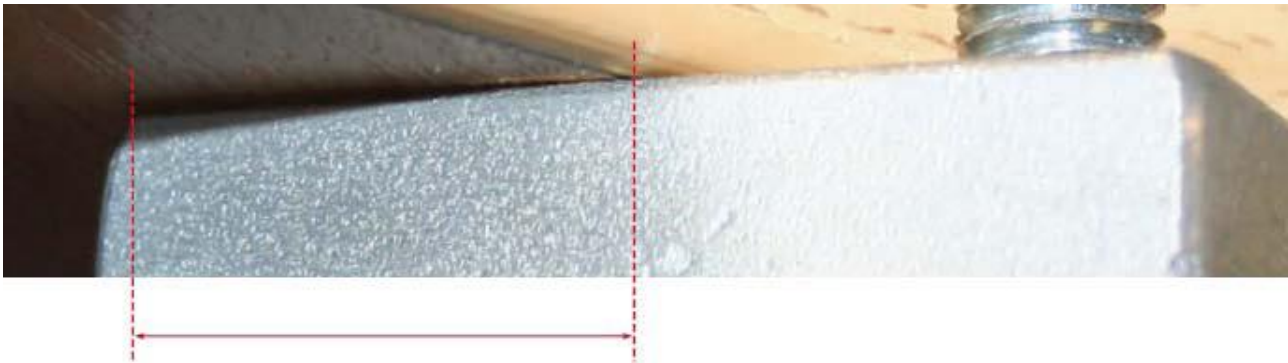
The pictures below show how the clamp with a silver clamping bar should be fitted to ensure that the block of the clamp is in full contact with the base of the desk or table surface (pictures 1 and 2). If the wedge-shaped bar is fitted upside down, it will not be stable (pictures 3 and 4).

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

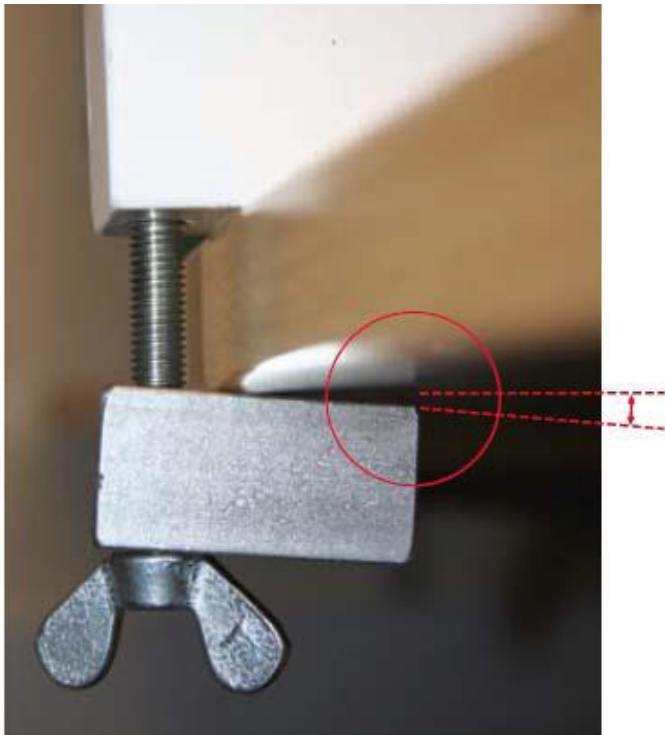
Pic 1. Correct fitting and use of the clamp



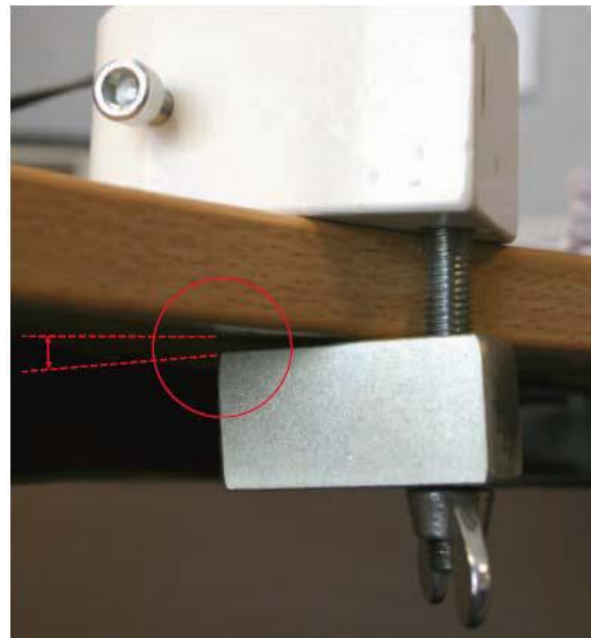
Pic 2. Correct fitting and use of the clamp. Note the surface contact along the length of the clamp



Incorrect use of clamp



Pic 3. Clamping car being used upside down



Pic 4. Clamping bar being used upside down

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

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

Appendix I

Sources of information

This national protocol, Access data collection format and appendices are all available from [K-Hub](#).

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

www.royalmail.com/address-book

Alternatively, use the Royal Mail postcodes on-line at:

www.royalmail.com/portal/rm/postcodefinder

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

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

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

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

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

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

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

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

Appendix J

List of codes for local authorities

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Barking and Dagenham	E09000002	Barking and Dagenham	E09000002
Barnet	E09000003	Barnet	E09000003
Barnsley	E08000016	Barnsley	E08000016
Bath and North East Somerset	E06000022	Bath and North East Somerset	E06000022
Bedford	E06000055	Bedford	E06000055
Bexley	E09000004	Bexley	E09000004
Birmingham	E08000025	Birmingham	E08000025
Blackburn with Darwen	E06000008	Blackburn with Darwen	E06000008
Blackpool	E06000009	Blackpool	E06000009
Bolton	E08000001	Bolton	E08000001
Bournemouth, Christchurch and Poole	E06000058	Bournemouth, Christchurch and Poole	E06000058
Bracknell Forest	E06000036	Bracknell Forest	E06000036
Bradford	E08000032	Bradford	E08000032
Brent	E09000005	Brent	E09000005
Brighton and Hove	E06000043	Brighton and Hove	E06000043
Bristol, City of	E06000023	Bristol, City of	E06000023
Bromley	E09000006	Bromley	E09000006
Buckinghamshire	E10000002	Aylesbury Vale	E07000004
		Chiltern	E07000005
		South Bucks	E07000006
		Wycombe	E07000007
Bury	E08000002	Bury	E08000002
Calderdale	E08000033	Calderdale	E08000033
Cambridgeshire	E10000003	Cambridge	E07000008
		East Cambridgeshire	E07000009
		Fenland	E07000010
		Huntingdonshire	E07000011
		South Cambridgeshire	E07000012
Camden	E09000007	Camden	E09000007
Central Bedfordshire	E06000056	Central Bedfordshire	E06000056
Cheshire East	E06000049	Cheshire East	E06000049
Cheshire West and Chester	E06000050	Cheshire West and Chester	E06000050
City of London	E09000001	City of London	E09000001
Cornwall	E06000052	Cornwall	E06000052
County Durham	E06000047	County Durham	E06000047
Coventry	E08000026	Coventry	E08000026
Croydon	E09000008	Croydon	E09000008

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Cumbria	E10000006	Allerdale	E07000026
		Barrow-in-Furness	E07000027
		Carlisle	E07000028
		Copeland	E07000029
		Eden	E07000030
		South Lakeland	E07000031
Darlington	E06000005	Darlington	E06000005
Derby	E06000015	Derby	E06000015
Derbyshire	E10000007	Amber Valley	E07000032
		Bolsover	E07000033
		Chesterfield	E07000034
		Derbyshire Dales	E07000035
		Erewash	E07000036
		High Peak	E07000037
		North East Derbyshire	E07000038
		South Derbyshire	E07000039
Devon	E10000008	East Devon	E07000040
		Exeter	E07000041
		Mid Devon	E07000042
		North Devon	E07000043
		South Hams	E07000044
		Teignbridge	E07000045
		Torridge	E07000046
		West Devon	E07000047
Doncaster	E08000017	Doncaster	E08000017
Dorset	E06000059	Dorset	E06000059
Dudley	E08000027	Dudley	E08000027
Ealing	E09000009	Ealing	E09000009
East Riding of Yorkshire	E06000011	East Riding of Yorkshire	E06000011
East Sussex	E10000011	Eastbourne	E07000061
		Hastings	E07000062
		Lewes	E07000063
		Rother	E07000064
		Wealden	E07000065
Enfield	E09000010	Enfield	E09000010
Essex	E10000012	Basildon	E07000066
		Braintree	E07000067
		Brentwood	E07000068
		Castle Point	E07000069
		Chelmsford	E07000070
		Colchester	E07000071
		Epping Forest	E07000072
		Harlow	E07000073

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Essex	E10000012	Maldon	E07000074
		Rochford	E07000075
		Tendring	E07000076
		Uttlesford	E07000077
Gateshead	E08000020	Gateshead	E08000020
Gloucestershire	E10000013	Cheltenham	E07000078
		Cotswold	E07000079
		Forest of Dean	E07000080
		Gloucester	E07000081
		Stroud	E07000082
		Tewkesbury	E07000083
Greenwich	E09000011	Greenwich	E09000011
Hackney	E09000012	Hackney	E09000012
Halton	E06000006	Halton	E06000006
Hammersmith and Fulham	E09000013	Hammersmith and Fulham	E09000013
Hampshire	E10000014	Basingstoke and Deane	E07000084
		East Hampshire	E07000085
		Eastleigh	E07000086
		Fareham	E07000087
		Gosport	E07000088
		Hart	E07000089
		Havant	E07000090
		New Forest	E07000091
		Rushmoor	E07000092
		Test Valley	E07000093
		Winchester	E07000094
Haringey	E09000014	Haringey	E09000014
Harrow	E09000015	Harrow	E09000015
Hartlepool	E06000001	Hartlepool	E06000001
Havering	E09000016	Havering	E09000016
Herefordshire, County of	E06000019	Herefordshire, County of	E06000019
Hertfordshire	E10000015	Broxbourne	E07000095
		Dacorum	E07000096
		East Hertfordshire	E07000097
		Hertsmere	E07000098
		North Hertfordshire	E07000099
		St Albans	E07000240
		Stevenage	E07000101
		Three Rivers	E07000102
		Watford	E07000103
		Welwyn Hatfield	E07000241
Hillingdon	E09000017	Hillingdon	E09000017
Hounslow	E09000018	Hounslow	E09000018

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Isle of Wight	E06000046	Isle of Wight	E06000046
Isles of Scilly	E06000053	Isles of Scilly	E06000053
Islington	E09000019	Islington	E09000019
Kensington and Chelsea	E09000020	Kensington and Chelsea	E09000020
Kent	E10000016	Ashford	E07000105
		Canterbury	E07000106
		Dartford	E07000107
Kent	E10000016	Dover	E07000108
		Gravesham	E07000109
		Maidstone	E07000110
		Sevenoaks	E07000111
		Folkestone and Hythe (was Shepway)	E07000112
		Swale	E07000113
		Thanet	E07000114
		Tonbridge and Malling	E07000115
		Tunbridge Wells	E07000116
Kingston upon Hull, City of	E06000010	Kingston upon Hull, City of	E06000010
Kingston upon Thames	E09000021	Kingston upon Thames	E09000021
Kirklees	E08000034	Kirklees	E08000034
Knowsley	E08000011	Knowsley	E08000011
Lambeth	E09000022	Lambeth	E09000022
Lancashire	E10000017	Burnley	E07000117
		Chorley	E07000118
		Fylde	E07000119
		Hyndburn	E07000120
		Lancaster	E07000121
		Pendle	E07000122
		Preston	E07000123
		Ribble Valley	E07000124
		Rossendale	E07000125
		South Ribble	E07000126
		West Lancashire	E07000127
		Wyre	E07000128
Leeds	E08000035	Leeds	E08000035
Leicester	E06000016	Leicester	E06000016
Leicestershire	E10000018	Blaby	E07000129
		Charnwood	E07000130
		Harborough	E07000131
		Hinckley and Bosworth	E07000132
		Melton	E07000133
		North West Leicestershire	E07000134
		Oadby and Wigston	E07000135
Lewisham	E09000023	Lewisham	E09000023

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Lincolnshire	E10000019	Boston	E07000136
		East Lindsey	E07000137
		Lincoln	E07000138
		North Kesteven	E07000139
		South Holland	E07000140
		South Kesteven	E07000141
		West Lindsey	E07000142
Liverpool	E08000012	Liverpool	E08000012
Luton	E06000032	Luton	E06000032
Manchester	E08000003	Manchester	E08000003
Medway	E06000035	Medway	E06000035
Merton	E09000024	Merton	E09000024
Middlesbrough	E06000002	Middlesbrough	E06000002
Milton Keynes	E06000042	Milton Keynes	E06000042
Newcastle upon Tyne	E08000021	Newcastle upon Tyne	E08000021
Newham	E09000025	Newham	E09000025
Norfolk	E10000020	Breckland	E07000143
		Broadland	E07000144
		Great Yarmouth	E07000145
		King's Lynn and West Norfolk	E07000146
		North Norfolk	E07000147
		Norwich	E07000148
		South Norfolk	E07000149
North East Lincolnshire	E06000012	North East Lincolnshire	E06000012
North Lincolnshire	E06000013	North Lincolnshire	E06000013
North Somerset	E06000024	North Somerset	E06000024
North Tyneside	E08000022	North Tyneside	E08000022
North Yorkshire	E10000023	Craven	E07000163
		Hambleton	E07000164
		Harrogate	E07000165
		Richmondshire	E07000166
		Ryedale	E07000167
		Scarborough	E07000168
		Selby	E07000169
Northamptonshire	E10000021	Corby	E07000150
		Daventry	E07000151
		East Northamptonshire	E07000152
		Kettering	E07000153
		Northampton	E07000154
		South Northamptonshire	E07000155
		Wellingborough	E07000156
Northumberland	E06000048	Northumberland	E06000048
Nottingham	E06000018	Nottingham	E06000018

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Nottinghamshire	E10000024	Ashfield	E07000170
		Bassetlaw	E07000171
		Broxtowe	E07000172
		Gedling	E07000173
		Mansfield	E07000174
		Newark and Sherwood	E07000175
		Rushcliffe	E07000176
Oldham	E08000004	Oldham	E08000004
Oxfordshire	E10000025	Cherwell	E07000177
		Oxford	E07000178
		South Oxfordshire	E07000179
		Vale of White Horse	E07000180
		West Oxfordshire	E07000181
Peterborough	E06000031	Peterborough	E06000031
Plymouth	E06000026	Plymouth	E06000026
Portsmouth	E06000044	Portsmouth	E06000044
Reading	E06000038	Reading	E06000038
Redbridge	E09000026	Redbridge	E09000026
Redcar and Cleveland	E06000003	Redcar and Cleveland	E06000003
Richmond upon Thames	E09000027	Richmond upon Thames	E09000027
Rochdale	E08000005	Rochdale	E08000005
Rotherham	E08000018	Rotherham	E08000018
Rutland	E06000017	Rutland	E06000017
Salford	E08000006	Salford	E08000006
Sandwell	E08000028	Sandwell	E08000028
Sefton	E08000014	Sefton	E08000014
Sheffield	E08000019	Sheffield	E08000019
Shropshire	E06000051	Shropshire	E06000051
Slough	E06000039	Slough	E06000039
Solihull	E08000029	Solihull	E08000029
Somerset	E10000027	Mendip	E07000187
		Sedgemoor	E07000188
		South Somerset	E07000189
		Somerset West and Taunton	E07000246
South Gloucestershire	E06000025	South Gloucestershire	E06000025
South Tyneside	E08000023	South Tyneside	E08000023
Southampton	E06000045	Southampton	E06000045
Southend-on-Sea	E06000033	Southend-on-Sea	E06000033
Southwark	E09000028	Southwark	E09000028
St. Helens	E08000013	St. Helens	E08000013

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Staffordshire	E10000028	Cannock Chase	E07000192
		East Staffordshire	E07000193
		Lichfield	E07000194
		Newcastle-under-Lyme	E07000195
		South Staffordshire	E07000196
		Stafford	E07000197
		Staffordshire Moorlands	E07000198
		Tamworth	E07000199
Stockport	E08000007	Stockport	E08000007
Stockton-on-Tees	E06000004	Stockton-on-Tees	E06000004
Stoke-on-Trent	E06000021	Stoke-on-Trent	E06000021
Suffolk	E10000029	Babergh	E07000200
		West Suffolk	E07000245
		Ipswich	E07000202
		Mid Suffolk	E07000203
		East Suffolk	E07000244
Sunderland	E08000024	Sunderland	E08000024
Surrey	E10000030	Elmbridge	E07000207
		Epsom and Ewell	E07000208
		Guildford	E07000209
		Mole Valley	E07000210
		Reigate and Banstead	E07000211
		Runnymede	E07000212
		Spelthorne	E07000213
		Surrey Heath	E07000214
		Tandridge	E07000215
		Waverley	E07000216
		Woking	E07000217
Sutton	E09000029	Sutton	E09000029
Swindon	E06000030	Swindon	E06000030
Tameside	E08000008	Tameside	E08000008
Telford and Wrekin	E06000020	Telford and Wrekin	E06000020
Thurrock	E06000034	Thurrock	E06000034
Torbay	E06000027	Torbay	E06000027
Tower Hamlets	E09000030	Tower Hamlets	E09000030
Trafford	E08000009	Trafford	E08000009
Wakefield	E08000036	Wakefield	E08000036
Walsall	E08000030	Walsall	E08000030
Waltham Forest	E09000031	Waltham Forest	E09000031
Wandsworth	E09000032	Wandsworth	E09000032
Warrington	E06000007	Warrington	E06000007

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

Source: From ONS Geographical Lookups.

Appendix K

Guide for date-of-birth bands for survey of 3-year olds September 2019 to June 2020

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

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

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

Appendix L

Parental agreement form and information sheet



Public Health England

National Dental Health Survey, 2019/20

I agree to my child receiving a dental examination as part of the National Dental Health Survey, 2019/20.

I have received and understood the information about this provided in the Public Health England National Dental Health Survey: Information for Parents leaflet.

My child's name (if you have more than one child aged 3 in the nursery or playgroup, please provide all their names)

.....

.....

My child's (or children's) ethnic group (please tick one box which best describes your child's ethnic group or background)

Ethnicity		Please tick:
White	English/Welsh/Scottish/Northern Irish/British	
	Irish	
	Gypsy or Irish Traveller	
	Any other White background	
Mixed/Multiple ethnic groups	White and Black Caribbean	
	White and Black African	
	White and Asian	
	Any other Mixed/Multiple ethnic background	
Asian/Asian British	Indian	
	Pakistani	
	Bangladeshi	
	Chinese	
	Any other Asian background	
Black/African/Caribbean/Black British	African	
	Caribbean	
	Any other Black/African/Caribbean background	
Other ethnic group	Arab	
	Any other ethnic group	
Prefer not to say		

My child's (or children's) nursery or playgroup name

.....

My name

My signature

Date

Please return this form to your child's nursery or playgroup



Protecting and improving the nation's health

Public Health England National Dental Health Survey: Information for Parents

What is the survey about?

Each year, Public Health England undertakes a national survey of dental health. This year's survey is looking at 3-year-olds and aims to find out how healthy their teeth and gums are.

Your child's nursery or playgroup is taking part in the survey so the parents of all 3-year olds are being asked to agree to their child taking part.

What does the survey involve?

Your child will be asked to have a very simple and quick dental examination with a dental team. The examination will be carried out at your child's nursery or playgroup by a dental professional, who may be a dentist, dental therapist or dental hygienist.

No child will be forced to take part on the day of the examination if they don't want to. You are welcome to accompany your child to the examination if you wish.

The dental professional will do a simple visual examination that only takes a few minutes. No treatment will be provided. They will use fresh disposable gloves and sterilised mirrors for each child. They will let you know if they find anything wrong.

A short film has been produced showing what happens at the examination. You can watch this film at <https://youtu.be/BzrjK8HRpD8>

The examination will not be as thorough as the one done by your family dentist so it's important that you still take your child for full and regular check-ups.

If you are happy for your child to take part, please complete and sign the attached agreement form and return it to your child's nursery or playgroup.

Why your help is important

The national survey of children's dental health will produce much better information if as many children as possible take part.

It doesn't matter what your child's dental health is like for them to be involved. We want to include children with perfect teeth, those with not-so-perfect teeth, those who regularly visit a dentist, and those who don't. This will help us build a much better picture of what the dental health of 3-year-olds is like currently, and whether it is getting better or worse.

The knowledge gained from the survey will be used to help improve dental health, care and services across England through research and planning.

What information will the dental team collect about my child?

To run the survey, your child's nursery or playgroup will provide personally identifiable information about your child to the dental team carrying out the examination.

The dental team usually works for the NHS and undertakes the dental examination on behalf of your local authority as all local authorities in England are required to carry out these surveys.

The information provided to the dental team will include your child's name, gender and date of birth. This information is needed so that the dental team can check that you have agreed to your child taking part and that your child is the right age.

The dental team will also be provided with your child's home postcode.

The dental team will then add to this information details of what they find when they examine your child's teeth and gums. For example, they will record whether your child has any decayed, missing or filled teeth.

All this information will then be sent by the dental team to Public Health England.

What happens if the dental team finds anything wrong?

If you accompany your child to the examination, the dental professional will tell you if they find anything wrong with your child's teeth and gums and advise you what to do next.

If you don't accompany your child to the examination, the dental team will write you a letter telling you what they've found and advising you what to do. The dental team will ask the nursery or playgroup to pass this letter on to you.

What will Public Health England do with my child's information?

The personally identifiable information about your child and their dental health will be sent by the dental team to Public Health England.

Public Health England is the executive agency of the Department of Health & Social Care responsible for protecting the public's health, addressing health inequalities and promoting the health and wellbeing of the nation. Part of its role is to help improve children's dental health across the country.

The information about your child will be sent securely by computer. The details of all the children taking part will be collected together and analysed by Public Health England to understand more about:

- the overall dental health of 3-year-olds and whether it is getting better, getting worse or staying the same across England
- whether there are any differences in children's dental health between groups in the population and the places where they live

If your child takes part in another dental survey in future, Public Health England may also link this information together.

The findings will be published in a report on the GOV.UK website. No information that could identify any child will ever be published.

Your child's personally identifiable information will be protected by Public Health England at all times. It will be held on secure computers and only used by a small team of dental health experts, all of whom are trained to protect confidentiality.

Your child's personally identifiable information will be held by Public Health England for 3 years. At the end of this period, your child's name, date of birth and postcode will be permanently deleted from Public Health England's computers.

You can find out more about Public Health England and the information it uses to do its job at <https://www.gov.uk/government/organisations/public-health-england>

Will my child's information be shared with anyone else?

The information collected about the children taking part in the national survey may be shared by Public Health England with other organisations. However, only de-personalised information will be shared – in other words, names, dates of birth and postcodes will be removed so that no child can be identified.

The organisations that Public Health England may share information with are your local authority and academic researchers so that they can use it to improve dental health, care and services through research and planning.

Who can I contact if I have any questions or concerns?

If you have any questions about the national dental health survey, you can contact:
[add local contact details]

You can also contact Public Health England by email at DentalPHIntelligence@phe.gov.uk or by writing to:

Dental Public Health
Public Health England
5th floor North, Wellington House
133-155 Waterloo Road
London SE1 8UG.

If you have any concerns about how your child's personally identifiable information is being used for the dental survey, you can contact the Public Health England Data Protection Officer by email at dataprotectionofficer@phe.gov.uk or by writing to:

Public Accountability Unit
Public Health England
7th Floor North, Wellington House
133-155 Waterloo Road
London SE1 8UG

You can also contact the Information Commissioner's Office if you have any concerns by calling 0303 123 1113 or via a live chat at ico.org.uk/make-a-complaint

V01.00 September 2019

Appendix M

Information letter and agreement form enhanced with pictures

Dear Parent

Checking children's teeth

Every year we check over 100,000 children's teeth to help make dentist services better for all children.



This year we would like your child to take part.

We plan to do the checks on

.....

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

This letter has some information about the checks and a form to fill in, so you can say yes or no.

1. Why do we check children's teeth?

We check to see if they have any decay. This lets us find out if different groups of children or children in other areas have better or worse teeth. Our reports are then used to help plan a better dentist service in all areas.





All of our reports are put up on a website:
www.gov.uk/government/collections/oral-health#related-intelligence

We keep all the information about your child private.



2. Why we chose your child


First of all, we pick out some playgroups and nurseries in an area. This could be any play group or nursery.

Then we ask all the 3-year-old children to take part.

3. We have to ask you if we can check your child's teeth

It is up to you to say yes or no.



If you are happy for your child to take part, you need to tick  **yes** on the form.

You can also change your mind at any time - please let us or the play group or nursery know if you do.

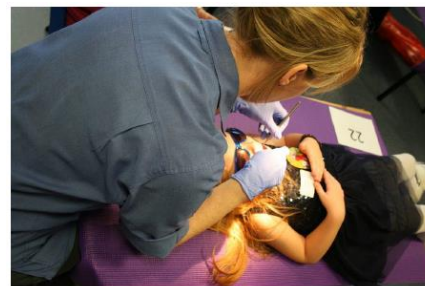
4. What happens in the check

We are happy for you to come along if you want to.

A dental clinician and assistant will visit the nursery or playgroup. They will make sure everything is clean.

We don't do any treatment, just a quick check. The check only takes a few minutes, and we will let you know if we find anything wrong.

All children still need to visit their own dentist for check-ups.

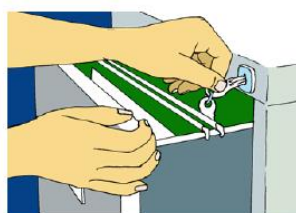


5. How we use the information

We ask the nursery or playgroup for names, dates of birth, ethnicity and home postcode.

This information and the results of the checks are sent to Public Health England who put it all together.

They keep it all safe and secret.



When they have done that, all the personal information will be destroyed.

6. How to find out more

Thank you for reading this letter.

Please feel free to email or call if you have any questions.

Call:

Email:



Form to send back to nursery or playgroup, please



My child's name is:

They are in playgroup:

Checking my child's teeth

I understood the information about teeth checks and I agree to have my child's teeth checked

☐

Yes

☐

No

Signed
(Parent or Guardian)

Date:

Full Name:
(Please print)

Appendix N. Tracking list for childcare sites to record which children have returned agreement to participate forms

PHE dental public health epidemiology programme, 2019-20

Return of agreement to participate forms – Childcare group

[illegible]

Appendix O

Maximising consent returns (amended excerpt from 'The good practice guide for dental epidemiology. Advice and guidance for local authorities, fieldwork teams and other stakeholders').

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

What can local authorities do?

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

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

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

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

non-participation by parents and guardians include non-receipt of information, issues with language or literacy and low engagement with dental services in general.

What can fieldwork teams do?

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

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

Planning and resourcing the effort

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

Communication with childcare sites

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

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

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

Example text in relation to Ofsted

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

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

Administering the forms

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

Key actions

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

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

- consider whether posting letters and agreement forms to home addresses with stamped, addressed envelopes may help if sites feel unable to directly support the process themselves
- consider handing letters and agreement forms directly to parents at pick-up time
- consider aligning with signing for other health issues by parents
- encourage parents to look at the short film about dental surveys:
<https://youtu.be/BzrjK8HRpD8>

Optional measures				
15. Spare variable	<input type="checkbox"/>	0 -	1 -	2 - 3 -
16. Spare variable	<input type="checkbox"/>	0 -	1 -	2 - 3 -

79

Appendix R

Excel worksheet for summary information

Appendix R : Dental Public Health Epidemiology Programme for England, Oral Health Survey of 3yr olds 2019-20

Upper Tier LA Code	Upper Tier LA Name	Lower Tier LA Code	Lower Tier LA Name	Name of examiner	Start date of examinations dd/mm/yyyy	End date of examinations dd/mm/yyyy	Childcare sites listed by local authority				Number of children with :			Number of children WITH parental consent :			Number of episodes when safeguarding issues arose
							Total number of sites	Total number of 3-year-olds attending	Number of sites visited	Number of children from whom consent sought (sample size)	Parental consent supplied	Parental consent refused	Form not returned	Examined	Child absent	Child refused	