Supervised Toothbrushing (STB) Toolkit - to support local authorities with implementation of STB programmes in London

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Background

Good oral health is important for children's overall well-being. Tooth decay is one of the most prevalent oral diseases affecting 1 in 4 children aged 5 in London (NDEP, 2024). Poor oral health can result in difficulties eating, speaking, socialising, sleeping and can lead to school absenteeism compromising their educational and social development.

Tooth decay experience varies by deprivation and ethnicity in England, highlighting oral health inequalities. Children living in the most deprived areas experience significantly worse oral health than those in more affluent areas. Some ethnic groups, particularly children from Asian and other ethnic backgrounds are more likely to experience higher levels of tooth decay.

The Core20PLUS5 highlights those residing in the most socioeconomically deprived areas consistently exhibit the poorest health outcomes, with oral health inequalities being a prominent concern. Tooth decay being largely preventable, it is important that every child is given the best start in life in line with Marmot principles.

Commissioning better oral health for children and young people (PHE, 2014) is a comprehensive toolkit for local authorities with recommended interventions which include supervised tooth brushing (STB), healthy food policies, and oral health training for health, education and social care professionals. NICE guidance (2014) for supervised toothbrushing programmes in early years has highlighte that it can be effective in reducing the burden of oral diseases in children.

Evidence has shown that children from the most deprived areas in Glasgow who participated in the Childsmile programme for over three years had lower odds of experiencing dental caries. The intervention had a notably greater impact among children from the 40% most deprived areas (Kidd et al., 2015; Anopa et al 2020).

Good oral health can be maintained by reducing sugar intake, brushing twice a day with a fluoride toothpaste and visiting the dental team. Nurseries and schools are encouraged to adopt healthy eating and snack policies and implementing water only schools to create supportive environments for children.

In March 2025, the government prioritised child oral health and has committed to supporting supervised toothbrushing initiatives in early years settings and schools as part of broader efforts to improve child oral health and reduce inequalities. All London local authorities (except for City of London) have received funding to implement STB in their localities in late April 2025. The funding for local authorities has been confirmed for 2025-2026.

Colgate will donate the toothbrush and toothpaste packs for the next 5 years for the STB programme as well as take home packs.

National guidance for supervised toothbrushing was recently updated in March 2025 (OHID, 2025), which is found here.

What is supervised toothbrushing?

Supervised toothbrushing is a classroom based daily activity where children brush their teeth with fluoride toothpaste under the supervision of an adult, usually a teacher, teaching assistant, or school health worker who has been trained on oral health and the STB protocol. It usually takes 10-15 minutes per session including preparation, brushing, cleaning up and storage.

Use of fluoride toothpaste

Daily application of fluoride toothpaste to teeth reduces the risk of tooth decay in children. Fluoride strengthens the enamel (outer layer of teeth) when teeth are forming and it also prevents tooth decay from forming and progressing to dental cavities.

Aim of the toolkit

This comprehensive implementation toolkit for London was developed to support local authorities in London in planning the implementation of the programme from May 2025. It is recommended that local authorities work with the Community Dental Services and early years and schools to implement the programme in the 20% most deprived areas with support from the consultants in dental public health.

This is a live document; it will be updated and re-circulated as new information emerges.

Recommended Process: Implementing a Supervised Toothbrushing Programme

This section outlines a structured and collaborative approach for local authorities to implement a high-quality supervised toothbrushing (STB) programme for children aged 3 to 5 years. The process is designed to support effective use of national DHSC funding, ensure equitable access and maximise impact—particularly for children living in the most deprived areas in your borough.

The steps below provide a framework, from initial planning and stakeholder engagement through to implementation, monitoring, and promotion. They are intended to promote consistency across London while allowing for local flexibility.

We also recommend integrating the STB programme as part of wider local public health initiatives in line with Healthy Early Years London and Health Schools London. Supporting the implementation of healthy food and snack policies and water only schools alongside the STB programme will maximise outcomes for children's oral health and the wider healthy weight agenda (Every Child a Healthy Weight).

Local authorities are encouraged to work across Integrated Care Board (ICB) footprints to reduce duplication and share learning for greater efficiency. Considering the current situation across systems, resources are limited within NHS England, ICBs dental commissioning teams and community dental services. Therefore, it might be difficult to engage with 32 local authorities separately to implement the STB programme and may be beneficial to set up a regional steering groups based on ICB footprints.

1. **Steering Group:** Set up a multi-disciplinary local steering group with a representative from early years, schools, public health, providers (Community Dental Service /Oral Health Promotion team), dental public health, ICBs, commissioners. Consider doing this at the ICB footprint which will promote engagement and learning from each other. This saves duplication and resources.

2. **Mapping of current supervised toothbrushing programme and DHSC data:** review current STB activity by location, setting, age groups and Index of Multiple Deprivation (IMD).

   Check the number of 3-, 4- and 5-year-olds for the Local authority and by IMD 1 and 2. Cross check with numbers of children provided by DHSC

3. **Collaboration:** Work in collaboration with education/children's services, draft a database of eligible nurseries and schools (location, headteacher/ director of settings, number of children by age) providing education for 3- to 5-year-olds ranked by IMD 1

and 2 using the setting's postcodes (extend to IMD 3,4 and 5 if existing programmes are already targeting IMD 1 and 2)

a. Identity the number of children per setting by age and any children with additional needs
b. Number of staff who will need training on STB
c. Cross check existing STB programme within the setting
d. Consider supporting the implementation of health food and snack policies and water only schools to align with Healthy Early Years London and Healthy Schools London.

4. **Commissioning, Service Specification and KPIs**: Use and adapt the attached Service specification with the CDS with KPI's and monitoring framework. Please see template in appendix 1.

The Dental Commissioning teams hosted by NEL ICB will be working with the Consultant in Dental Public Health and the local authorities to draft a Memorandum of Understanding using the attached service specification. It is recommended that each local authority also seek advice from their commissioning teams.

5. **Work plan:** Work with the Community Dental Service and oral health promotion teams to plan delivery of the programme. Develop a work plan in a staggered approach recruiting settings in stages. Develop a planning chart for recruitment of settings that identifies settings and timelines.

6. **Promotion of the STB programme:** Promote the programme with public/parents and key stakeholders and consider developing an engagement plan. It is recognised that there will be barriers and facilitators to recruiting settings. Potential engagement approaches include:

a. Early Years Forum/Head teacher's forum
b. Health visiting and school nursing teams
c. Newsletters
d. Stay and play sessions
e. Family hubs
f. PTA (Parent Teaching Association)
g. Community groups

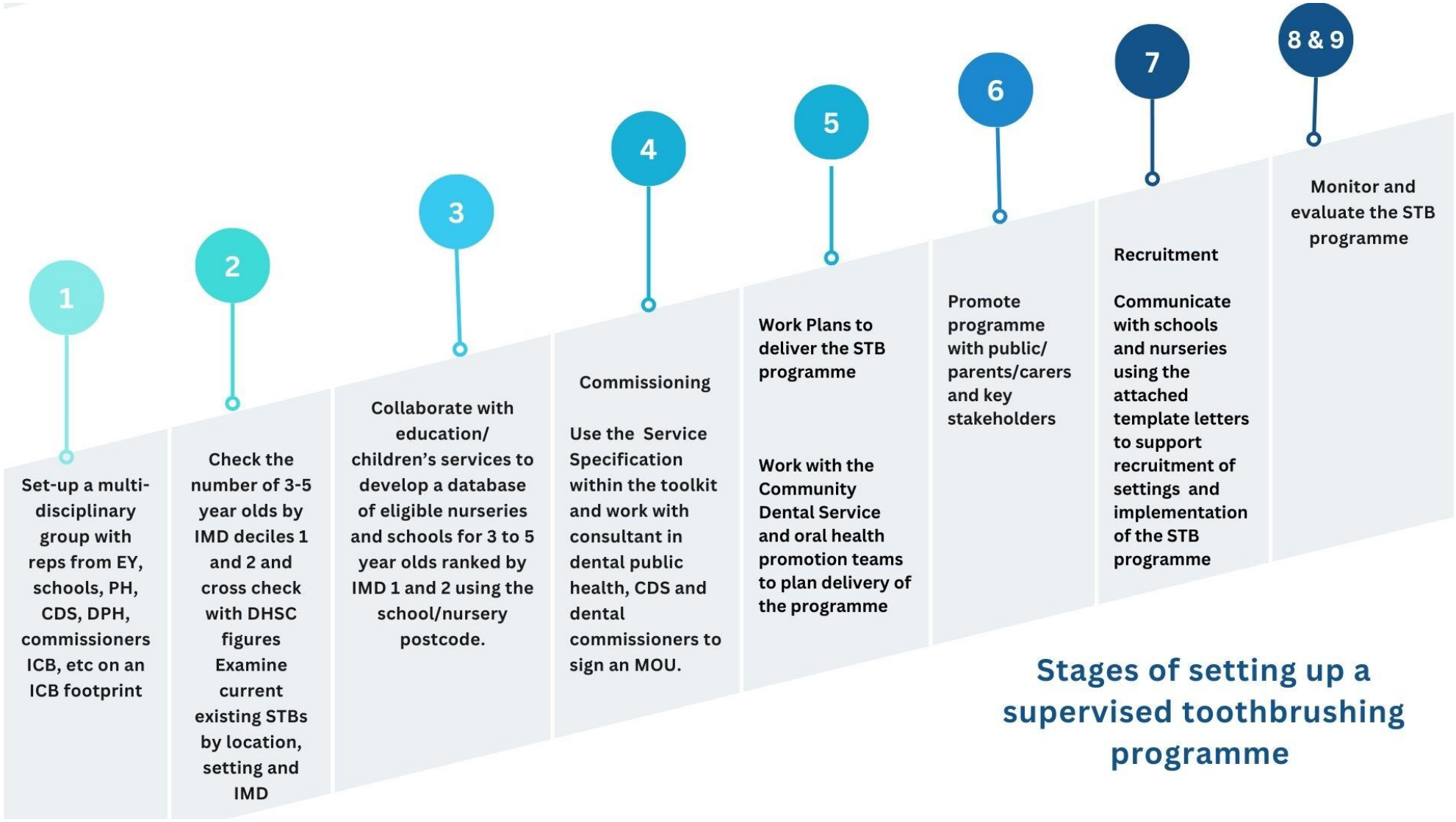
7. Recruitment of early years settings and children. Communicate with schools and nurseries to support recruitment of settings: Email a letter to headteacher/early years stetting leads and parents (explaining that child oral health is a priority, benefits of STB and support and resources that will be provided, meeting Healthy Early Years London) ready

to be sent alongside consent forms for parents and carers. We have provided a template please see appendix 2.

Recruitment: Start recruitment of settings and ask each setting to identify an oral health champion.

8. Monitor: We have provided a monitoring framework. It is recommended that during the initial stages may need to monitor activities monthly and then progress to quarterly monitoring.

9. Evaluation: It is recommended that programmes are evaluated to assess their impacts and intended oral health outcomes but also assess the processes of a programme with the aim of additional adjustments and improvements. An evaluation framework is here.



Supervised toothbrushing packs

Colgate will be donating tooth brushing packs for the next 5 years for both in-setting brushing and packs for the children to take home. It is a local decision whether to accept the donated products.

Local authorities need to accept the product using the online form accessed via link in the letter from DHSC to directors of public health. **The deadline for accepting donated products in 2025/26 is 26 May 2025.**

The first deliveries will begin in June 2025 and will continue until mid-July. The second deliveries are expected to take place in the first two weeks of December 2025. Upon receipt of goods, local authorities will be responsible for subsequent storage and onward distribution as determined locally.

In-setting brushing pack

The setting-facing resources include a toothbrush for each child per term and toothpaste to be used during the supervised toothbrushing sessions. The dimensions of in setting toothbrushes are 16cm in length, 1.4cm width and 0.5cm depth.

Take-home brushing pack

Each child has been allocated two home tooth brush and toothpaste packs per year. The home toothbrushing packs contain a “Little teeth” toothbrush and paste along with a leaflet for parents and toothbrushing chart. These packs are not pre-prepared so you may wish to plan for your supervised toothbrushing provider or oral health promotion team to do this prior to onwards distribution to settings.

An example of the supplied Colgate toothbrush stored in a Health Foundation rack (needs to be purchased). A permanent marker should be used to identify the brush and slot.

Storage racks are not included in the donation. Colgate does not manufacture toothbrushing racks. There are several suitable racks available on the market. A non-exclusive list includes:

1) Oral Health Foundation BrushBox lidded option which stores 12 brushes): BrushBox - Supervised Toothbrushing Storage

2) Clever Deko available via amazon (NB we would advise use of alternative slots to avoid toothbrushes coming into contact, so to store 25 toothbrushes): https://amzn.eu/d/48YdQ2T

3) BEC plastics are designing a range of racks which will be purchasable from Amazon in the next few weeks. It is expected that these will be in two sizes (10 and 20 brushes) with numbered slots and the option to purchase a compatible lid.

The above is provided for information only, to try and assist local authorities with their own enquiries and arrangements as needed. For the avoidance of doubt, please be advised that DHSC is not in any way endorsing or promoting the above products or services.

London local authority allocations are available in appendix 3.

Monitoring Framework for Supervised Toothbrushing Programmes

Monitoring is the systematic process of data collection and analysis during project implementation to establish whether an intervention is moving towards the set objectives or project goals. We intend to include two types:

- Process Monitoring: what has been done so far, where and how it is done
- Financial monitoring: programme expenditure and compare it with the budgets set

It is important to monitor the STB programme to ensure that the programme is delivered as planned and targeting children in the most deprived areas. While DHSC has not published a monitoring blueprint, based on previous programmes it is expected that local authorities undertake monitoring activities to support implementation of the STB programme. Therefore, as a region, we have developed a monitoring framework to support local authorities with monitoring their STB programmes. The provider should ideally meet with the cluster of local authorities and reports should be collated and shared on a quarterly basis, if possible. This will help identify facilitators and barriers to programme delivery as well as assessing progress over time.

Process Monitoring

Key performance indicators will be used to monitor the programme as well as local intelligence on any facilitators and challenges in programme implementation.

Key Performance Indicators

Staff Training

- Number of staff eligible for training in each setting
- Number and proportion of staff who have been trained in each setting

Recruitment of settings and children

- Number of eligible settings by IMD (IMD deciles 1 and 2, if there are existing STB programmes, then IMD 3,4 and 5)
- Number and proportion of eligible settings by IMD (IMD 1 and 2, if there are existing STB programmes, then IMD 3,4 and 5) who have **signed up** to the STB programme
- Number and proportion of settings who have declined participation and reason

- Number of eligible children within each setting (3-5 year olds)
- Number and proportion of children with consent to participate

Programme Fidelity

- Number and proportion of eligible settings by IMD (IMD 1 and 2, if there are existing STB programmes, then IMD 3,4 and 5) who are taking part in the STB programme
- Number and proportion of eligible children within each setting (3-5 year olds) who are taking part in the STB programme
- How often is supervised brushing taking place (e.g. 5 days per week, 3 days per week) per setting
- Narrative report from provider on encouraging settings to take part and what has been done to address the challenges

Maintenance

- Number and proportion of eligible settings by IMD (IMD 1 and 2, if there are existing STB programmes, then IMD 3,4 and 5) who are maintaining the programme

Quality assurance

- Number of quality audits undertaken in participating settings and method (in person, virtual, self-assessment).
- Number of suspended settings and reasons stated.

Monitoring Framework

Staff Training	Recruitment of settings & children	Programme Fidelity	Maintenance	Quality Assurance
• Number of staff targeted for the STB programme who are eligible for training in each setting • Number and proportion of staff who have been trained in each setting	• Number of eligible settings by IMD (IMD 1and 2, if there are existing programmes then IMD 3,4 and 5) • Number and proportion of eligible settings who have **signed up** to the programme by IMD • Number and proportion of settings who have declined to participate and reasons • Number of eligible children within each setting (3-5 year olds) • Number and proportion of children with consent to participate in the STB programme	• Number and proportion of eligible settings who are **actively participating** in the STB programme by IMD • Number and proportion of eligible children (3-5 year olds) within each settings **who are taking part** in the STB programme • The frequency of supervised toothbrushing (e.g. 5 days per week) • Narrative report from the provider on encouraging settings to take part and what has been done to address the challenges	• Number and proportion of eligible settings by IMD who are maintaining the programme • Number and proportion of children participating in the programme	• Number of quality audits undertaken in participating settings and method • Number of suspended settings and reasons

Evaluation framework for Supervised Toothbrushing Programmes

Local evaluation can be conducted to assess the success of the programme at a borough level and identify future improvements and learning. We have developed an evaluation framework to support local authorities with conducting their local evaluation. Local authorities can adapt the template according to their local contexts. Considering the programme is planned for five years, it is recommended that evaluation takes place locally to support implementation and maintenance of the STB programme in the short- and long-term.

Aim

To evaluate the implementation of supervised toothbrushing schemes for 3-5 years olds funded by the DHSC in London local authorities.

Objectives

- To assess the number of settings and children taking part in supervised toothbrushing schemes by age, IMD, and ethnicity.
- To explore the barriers and facilitators to implementation of the programme.
- To assess the acceptability of the scheme to staff, parents and children.
- To assess changes in oral health knowledge and behaviours of early years and school staff.

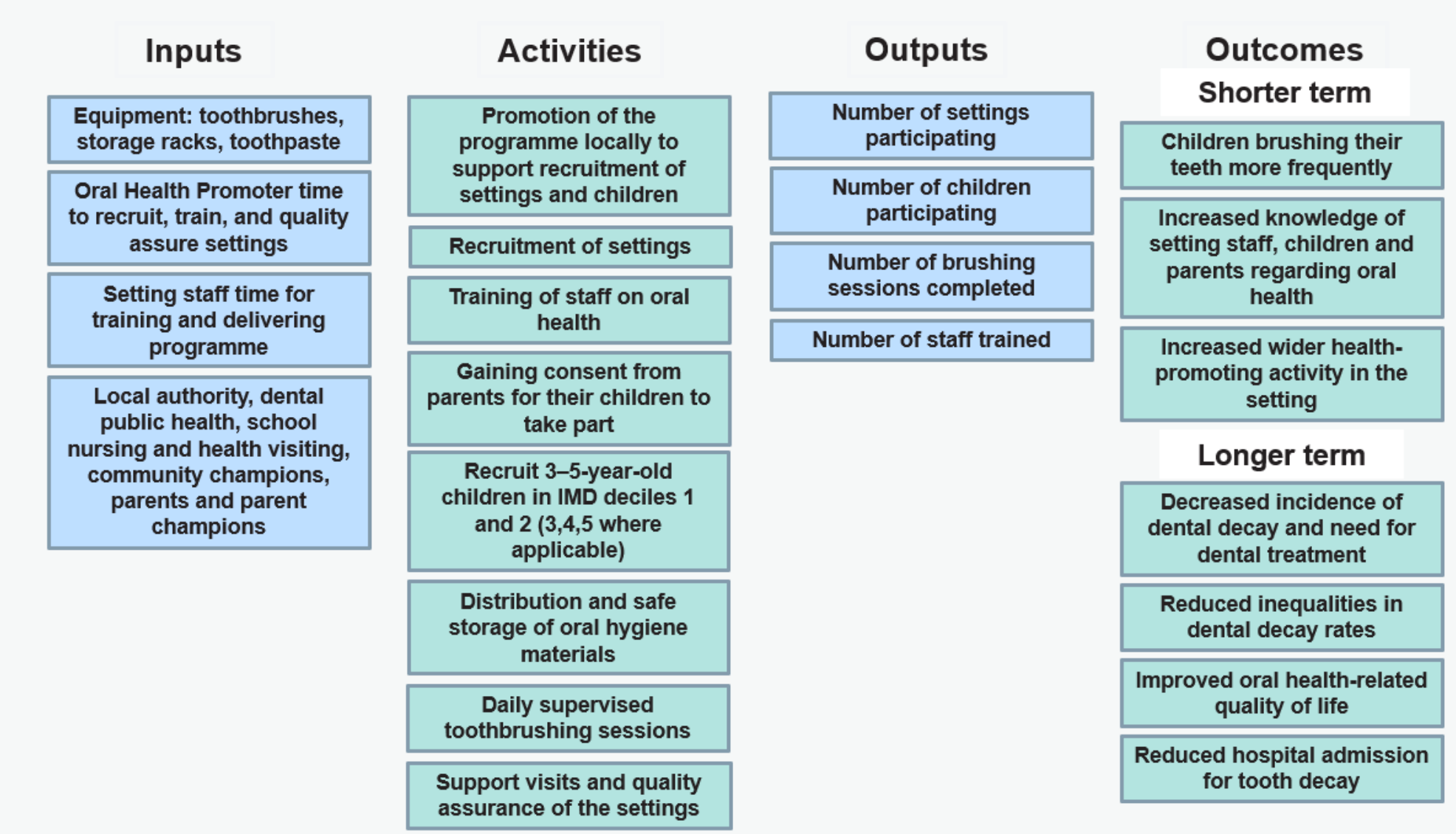
An example staff questionnaire can be found at appendix 4.

An example parent questionnaire can be found at appendix 5.

RE-AIM is a framework to guide the planning and evaluation of programs according to the 5 key RE-AIM outcomes: Reach, Effectiveness, Adoption, Implementation, and Maintenance. This framework has been utilised to evaluate public health interventions and is aligned to the evaluation of the STB programme.

Framework	RE-AIM				
Domain	**Reach (R)**	**Effectiveness (E)**	**Adoption (A)**	**Implementation (I)**	**Maintenance (M)**
Metrics	Number of children who have consented as a percentage of total number of 3–5-year-olds by setting's IMD Consent rate Reasons for non-consent	Early years staff oral health knowledge and behaviours	Number and proportion of settings participating in the programme Number and proportion of settings by IMD declined and reasons	Number and proportion of children participating in the programme Frequency of brushing Time taken to do the supervised toothbrushing Quality assurance visits and audit results Barriers and facilitators Costs	Number and proportion of settings by IMD withdrawing and reasons Number and proportion of children withdrawing and reasons Number and proportion of settings and children maintaining the STB programme
Methods	Quarterly monitoring reports	Questionnaire survey for setting staff to assess knowledge and behaviours	Quarterly monitoring reports	Quarterly monitoring reports, Quality assurance visits and audit data, Interviews/ questionnaire with oral health promotors and wider stakeholders	Quarterly monitoring reports

Logic Model



Frequently Asked Questions

How long does the funding to local authorities last for?

The funding to local authorities is planned for five years. However, it has only been confirmed for this financial year April 2024-2025. An announcement on future funding will be made in June at the spending review.

Resources

Toothbrush and toothpaste packs

How long will local authorities receive supplies of toothbrush and toothpaste packs from Colgate?

The toothbrush and toothpaste packs from Colgate have been secured for the next 5 years.

Will Colgate also supply the toothbrushing racks?

Colgate will not by supplying the toothbrushing racks so these will need to be purchased using the additional funding provided to local authorities.

Will the Colgate toothbrushes brushes fit existing holders?

Colgate toothbrushes do not fit into existing toothbrushing racks. A list of compatible toothbrushing racks can be found in the product section of this document.

Will toothbrushing racks be provided?

No. They will need to be purchased using the additional funding provided to local authorities. Compatible racks with the Colgate toothbrushes are highlighted in this toolkit.

There are a few toothbrushing racks that are compatible with the Colgate toothbrushes as specified in this toolkit.

If using a storage rack system without a lid, storage systems should be stored within a designated toothbrushing trolley or in a clean, dry cupboard, stored at adult height as per the national guidance.

Do we have to accept the Colgate offer?

The distribution of Colgate toothbrushes and toothpaste is planned for the next 5 years at no extra costs to the local authority. The offer is voluntary. If the local authority decides not to take up that offer then they can use the funding allocated to purchase alternative toothpaste and toothbrush packs.

How many toothbrush and toothpaste packs will Colgate supply?

There will be three brushes per year per eligible child for in-setting toothbrushing and 2 toothbrush and toothpaste packs per eligible child per year to take home.

Where is the link to order the toothbrushing?

This was sent out as a letter to Directors of Public Health. Please find attached the link below to allow you to order the toothbrush and toothpaste packs:

https://docs.google.com/forms/d/e/1FAIpQLScqz0pRDpuv4rOQ28-AGj5dZxLHUf0jUy282C2TJSe8e8RRyA/viewform

How will the toothbrushes be labelled?

A permanent marker can be used to mark the toothbrush racks and toothbrushes with the child's name and a number.

Where will the resources be stored and will there be additional resource for re-distribution.

The funding provided can be used for storage and redistribution of the resources. Delivery location and storage will need to be agreed locally.

Can the toothbrushes and toothpaste tubes be recycled?

The toothpaste tubes and lids can be recycled in the normal plastics recycling subject to local rules. The toothpaste tube does not require rinsing prior to recycling. Further information is at www.colgate.com/goodness. Unfortunately, it is difficult to recycle plastic toothbrushes at the moment but information on alternative recycling facilities is at https://www.recyclenow.com.

Parental information

Are there parental information leaflets and consent forms to use?

Each Community Dental Service will have their own approved information leaflets and consent form locally.

Will the Colgate additional educational resources be appraised to ensure messages are evidence-based and will they use inclusive images representative of our local populations?

The Colgate resources have been approved by DHSC. If you prefer to use your own resources, then you would have to organise this at a local level. Please work with your consultant in dental public health to develop the leaflets to quality assure the content of the leaflets in line with current evidence. The packs will be assembled locally so inclusion of the Colgate leaflets is optional.

Commissioning of the STB programme

What procurement route is advised?

For most London Local Authorities, Oral Health Promotion activities (including supervised tooth brushing) are delivered by the Community Dental Services (CDS) providers as part of their clinical services contract with the ICB. The funding for this activity is included within the Personal Dental Services Agreement (PDS contract) and is paid to the provider on behalf of the Local Authority. A small number of Local Authorities have directly commissioned OHP with CDS providers, however, some of these contracts have an end date which falls within the STB programme. While LAs may be following a procurement process to extend or recommission these services, there would be a significant risk if the national STB programme activity was to be varied into these contracts. The Dentistry, Optometry & Pharmacy (DOP) Commissioning Hub recommends that all contractual arrangements for the national STB programme are varied into the existing CDS contracts, which have a current end date of 31/03/207 but will be extended before the current end date.

In collaboration with Dental Public Health, the London Commercial Hub (procurement experts) and CDS providers, the DOP commissioners will produce an MOU, containing the service specification which can be varied into the exists CDS PDS Agreements. The MOU will be shared with LAs for comments before a final version is agreed upon. The commissioning advice provided by the London Commercial Hub with be shared with LAs so local teams have assurance that the appropriate PSR option has been used. There will be no variation in the service specification. Within the MOU there will be a section for LAs to enter the required local information such as value of funding and number of schools which will take part in the programme.

The MOU will be shared one all required advice has been received and implemented, at the beginning of June.

Will additional resources be given for expansion of oral health teams to support this programme?

The funding from DHSC to local authorities should be used to expand oral health promotion teams to deliver the programme.

Could the funding be transferred directly to the CDS to avoid having to go through the local authority internal contracting process?

The funding has already been received by local authority separate to the existing public health grant.

When does the current funding run until?

The funding should have been received by local authorities in April 2025. It is anticipated that it will take a few months to be able to implement the programme for mobilisation in September 2025. The funding is from April 2025 to April 2026.

STB programme implementation

Is this STB programme aimed at state funded nurseries?

They do not need be state funded. Settings should be prioritised based on IMD 1 and 2 (if already covered by existing STB programme, then please add early years settings in IMD 3,4 and 5).

Funding is based on number the number of children residing in IMD deciles 1 and 2 but we are targeting settings in IMD deciles 1 and 2, so the numbers will not match.

This is a pragmatic approach, recognising that some children will not be attending educational settings and some will travel across wards and borough boundaries for education. The funding numbers can be used to target the same number of children in settings in the most deprived areas of the local authority.

Does the allocated additional funding to LAs have to be used on the STB programmes?

The funding to local authorities can be used to ensure that the manifesto commitment is being wholly met and that all 3 to 5 year olds living in the 20% most deprived areas are brushing daily. There is also flexibility to provide additional provision beyond the priority population. This might include older or younger children, children in IMDs 3, 4, and 5, those with Special Educational Needs and Disabilities or those from “PLUS” groups, aligned with the CORE20PLUS5 framework and oral health needs assessments.

If you are in a class where some of the children are 5 and some are 6 and what do you do when the children are 5 and then they turn 6?

A pragmatic approach should be adopted, which includes the whole class, not just those aged 3-5 years. Children should be included for the entire academic year regardless of changes in age.

Will the Community Dental Service be delivering the training? Or will there be training from the DHSC?

The CDS will be responsible for training locally. There is no national training for the early years settings.

How is training going to work for childminders?

Childminders can be trained through the family hubs as a group. This model has been used in some London boroughs.

Is there a set number of settings that needs to be targeted with this funding?

There is not set number of settings. The funding from DHSC is based on the number of children so this will depend on the size of the settings.

Do the oral health promotion teams have the capacity to deliver this?

The dental commissioners, the Community Dental Service providers and the consultants in dental public health have met and agreed in principle to deliver the programme. The local authority funding can be utilised to expand the capacity of the oral health promotion teams and purchase the toothbrushing racks.

Considering the resources and workforce, what is the best way of delivering the STB programme?

As suggested in the implementation model, it is suggested that local authorities work at an ICB footprint to avoid duplication of efforts and resources and support sharing good practice. We have recently piloted an STB programme across local authorities in one of the London ICB working as a network with local authorities, community dental services, dental commissioners and the consultant in dental public. This has supported shared learning to support STB implementation.

Monitoring and evaluation

What are the monitoring and evaluation requirements?

National reporting will be required; this is likely to be quarterly. The national reporting framework has not been finalised. However, it is recommended that local authorities monitor and evaluate their schemes locally. We have provided the frameworks for monitoring and evaluation of the STB programme.

Will this programme be evaluated at the national/ regional level?

Evaluation is planned nationally; the details of this are being finalised. You may also wish to conduct evaluation at a borough or system level.

Contacts

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RE-AIM – Home – Reach Effectiveness Adoption Implementation Maintenance

Appendix 1: Example Service Specification

Service Specification for Supervised Toothbrushing in nurseries and schools 2025-2026

Many thanks to Katie Ferguson North Central London ICB with input from Huda Yusuf for this example service specification.

1. **Service specification overview**

1.1 This Service Specification sets out the requirements for the commissioned supervised toothbrushing programme in xxxx(local authority)

1.2 This is a new programme which is being commissioned to align-with, but sit separately from, local authority-commissioned supervised toothbrushing programmes which exist already. The funding is from DHSC (March 2025). The programme will expand the reach of supervised toothbrushing programmes within the borough and drive improvements in oral health.

1.3 Aim of the programme: The aim of this integrated programme in the long term is to contribute to improvements in oral health of young children across the borough , and a reduction in oral health inequalities, through delivery and coordination of a supervised toothbrushing programme in early years settings in the most deprived areas of the borough (Index of Multiple Deprivation (IMD) 1 and 2), alongside creating supportive environments aligning with Healthy Early Years London and Healthy Schools London. The programme will support implementation of healthy snack and drinks policies and water only nurseries/schools to maintain child healthier weight and oral health (Recommended but optional).

1.4 Funding: The programme is initially commissioned for 1 year, from xxxx with continuation of the programme subject to further funding from DHSC.

1.5 Provider: The role of the Oral Health Promotion Team at xxxx Community Dental Service (hereafter referred to as the Provider) will be to establish and oversee the delivery of the programme in targeted early years settings, with the programme itself being delivered on a day-to-day basis by staff in the settings themselves.

2. **Programme rationale**

2.1 Tooth decay (dental caries) in early years is a public health problem affecting 1 in 4 children aged 5 years in London. In xxx(local authority), xx% of children aged have experience

of tooth decay. There are significant oral health inequalities in the experience of tooth decay by deprivation and ethnicity.

Tooth decay impacts on oral health-related quality of life including eating, speaking, socialising, school attendance and ability to sleep. The causes of tooth decay are socially determined, which in turn influence dietary and tooth brushing behaviours. Providing supportive environments in early years to enable healthy behaviours is an important way to improve oral health and reduce health inequalities. This includes implementation of healthy food and snack policies, water only settings (optional)and supervised toothbrushing programmes to reduce sugary intake and increase the availability of fluorides.

2.2 The latest survey showed that xx% of 3 year olds (2019/20) have tooth decay experience. Keeping in mind that the primary dentition would have only been present in the mouth for up to three years these decay levels represent a large early burden of disease.

2.3 The primary reason for hospital admission among children is tooth decay. Some children may require general anaesthetic for the procedure due to them being very young (pre-cooperative) or uncooperative, have multiple teeth requiring extraction or have very broken-down teeth or infection. These procedures represent a failure of prevention, and are also risky for children, as almost all are carried out under general anaesthetic.

2.4 There is a social gradient in the experience of tooth decay – data at London level from the 2018/19 survey of 5 year olds, shows that there is a slope index of inequality of 18.7% in the prevalence of tooth decay in 5 year olds across deprivation deciles, from the most to least deprived .

2.5 There are also inequalities evident by ethnicity: in London, the prevalence of tooth decay among 5 year olds varies by ethnic group, with decay being highest amongst ‘Other ethnic groups’ (40.0%) and Asian/Asian British ethnic groups (36.9%) (2018/19 survey) As such, we plan to collect ethnicity data for children joining the programme and for our feedback to ensure the scheme works to reduce any ethnicity-based inequalities.

2.6 Evidence has demonstrated the effectiveness of the use of fluoride (toothpaste, tablets, drops, rinses, varnishes) in reducing dental caries. Thus, health promotion interventions which incorporate the regular use of fluorides have been shown to be successful in reducing dental caries. Toothpastes are by far the most widespread form of fluoride usage. The decline in the prevalence of dental caries in children in the past thirty years has been attributed to regular home use of fluoride in toothpaste.

2.7 An updated systematic review on the effectiveness of fluoride toothpaste conducted in 2019, based on a review of 96 studies, confirmed the significant benefit of using fluoride

toothpaste compared with non-fluoride toothpaste in the prevention of tooth decay. Children who start brushing with fluoride toothpastes in infancy are less likely to experience tooth decay than those who start bushing later. It also stimulates positive oral health behaviour from a young age. Supervised tooth brushing in a nursery/ school setting has been shown to be associated with significant reductions in the proportion of children having decay experience by age 5. For instance, Scotland's national 'Child Smile' programme has demonstrated strong evidence of the effectiveness of supervised toothbrushing programmes in reducing inequalities, whereby supervised toothbrushing had the greatest impact in children from the 40% most deprived areas.

2.8 This supervised toothbrushing programme supplements existing child oral health improvement programmes in place such as brushing for life, staff training and other fluoride delivery programmes in some settings, as well as wider work to ensure children having healthy weight as part of an approach to tackle common risk factors and improve children's overall health and wellbeing. It integrates oral health into wider public health initiatives such as child healthy weight and promoting health in early years.

3. Policy Drivers

3.1 The supervised toothbrushing programme supports the ambitions of the following national, regional and local policies (please add local policies)

- NHS England (2022) Core20PLUS5 for children and young people – An approach to reducing health inequalities

- Office for Health Improvement and Disparities (OHID) (updated 2022) Child oral health, applying all our health

- OHID (updated 2021, 4th edition) Delivering better oral health – an evidence-based toolkit for prevention

- Public Health England (2014). Local authorities improving oral health: Commissioning better oral health for children and young people

- NICE Guideline (2014) Oral health: approaches for local authorities and their partners to improve the oral health of their communities

- The London Health Inequalities Strategy (2018-28)

- London's Every Child a Healthier Weight Delivery Plan (2022)

- The Mayor of London's Healthy Early Years, Healthy Schools and Water Only Schools Programmes

4. Aims and objectives of the programme

4.1 To implement a supervised toothbrushing programme and promote healthy food and snack policies (optional) to integrate oral health into wider public health initiatives and reduce oral health inequalities in the most deprived populations in the borough.

4.2 Strategic objectives:

- To support consistent, evidence-informed oral health information (e.g. training of front line staff e.g. early years staff on oral health) and promote oral health in early year's giving every child the best start in life

- (optional) To support creating health-promoting environments including healthy food and snack policies (including water only policies) in nurseries and children's centres (e.g. integrating oral health within Healthy Schools and Healthy Early Years programmes)

- To deliver community-based preventive services to increase the availability of fluorides though a supervised toothbrushing programme

- To signpost children and families to local NHS dental services

- Reduction in prevalence of tooth decay and oral health inequalities in children in the long term

- Improved health and wellbeing of children more broadly through integration of oral health into other child and public health initiatives, adopting a common risk factor approach

4.3 Service objectives:

- To develop and deliver an efficient and effective supervised toothbrushing programme to improve oral health in children in the borough, which meets staff, parent and child satisfaction

- To promote the uptake of the supervised toothbrushing programme across a high number of target settings and children in the most deprived wards (IMD 1 and 2 and if programmes exist already in IMD 1 and 2 expand to IMD 3,4 and 5)

- For settings to maintain a supervised toothbrushing programmes on an on-going basis (during the period of this service specification)

- To enhance the knowledge, skills and confidence to maintain good oral health among early years staff and families

- Work collaboratively with partners to integrate oral health promotion with wider health promotion across early years settings and support settings to be health promoting (such as the implementation of healthy food, snack and drink policies)

- To monitor and evaluate the programme

- Deliver the programme for 12 months (xx to xx)

4.4 The Provider will work within the aims, objectives and scope of the Service detailed in this Specification, for the period of the programme. The contract for this service specification sits within a wider Contract Variation for the whole programme of work xx CDS are completing.

5. Service description

5.1 The programme being commissioned from the Provider is delivery of a supervised toothbrushing programme targeted at 3 to 5 year olds within early years settings (including pre-schools, day nurseries, children's centres, maintained nurseries and independent nurseries) in the most deprived wards (IMD 1 and 2). The local authority will be responsible for identification of settings and sharing data with the Provider.

5.2 The programme will be delivered in line with the current national protocol for supervised toothbrushing programmes: Public Health England (2025) Improving oral health: A toolkit to support commissioning of supervised toothbrushing programmes in early years and school settings and reviewed in accordance with any future updated protocol.

5.3 The Provider will work with local authority Oral Health Leads, Dental Public Health, the ICB and dental commissioners. To allow the programme to have maximum impact within given capacity, it is anticipated that within this first year, the focus will be on larger settings first with a view that other settings within the most deprived wards in each borough will be approached when the list of larger settings has been exhausted, in consultation with the local authority and the Consultant in Dental Public Health.

5.4 The programme will operate during normal working hours on weekdays (Monday-Friday), with any exceptions to this only with prior agreement from the settings and with the intention of maximising participation in the programme (e.g. evening training sessions for staff/parents). As many of the settings will be open for up to 52 weeks a year, it is envisaged that the programme will not be restricted to term-time delivery. The Provider will manage their approach to setting up the programmes in different settings in an efficient way so as to maximise participation across the borough, in consultation with the local authority Oral Health Leads.

5.5 The local authority will be initially responsible for introducing the programme to the setting and promoting the STB programme among different stakeholders. The Provider will be responsible for engaging settings in the programme, assessing the suitability of settings to deliver the programme, conducting staff training, providing the settings with the resources needed to start and maintain the programme and quality assuring the programme in each setting on an ongoing basis, as well as collecting monitoring data to assess the performance of the programme. Staff in the settings themselves will be responsible for delivering a daily supervised toothbrushing programme within their own settings.

5.6 The programme shall involve the following elements:

- A communication plan to ensure good uptake of the programme across the target settings

- Assessment of the suitability of settings to deliver the programme

- Identification of a designated programme lead responsible for overall delivery of the programme in each setting

- Development of a protocol in accordance with national guidance for each setting to deliver the programme

- Staff training to ensure all staff in each setting are trained in key messages around oral health promotion, healthy weight and dental access and how to deliver a supervised toothbrushing programme in a safe and effective way - including supervision of children while brushing, using an appropriate and effective toothpaste and toothbrush, and correct brushing technique; as well as protocols for infection control/prevention management including maintaining a storage system for brushes

- Supply of age-appropriate toothbrushes and toothpaste packs to settings and other resources to enable settings to deliver the programme and ensure a high uptake, such as promotional material – with supplies to settings renewed at regular intervals to enable them to maintain the programme on an on-going basis

- Support to early years staff to obtain consent from parents (such as clear and standardised consent form; guidance on responses to frequently asked questions; other support on a case-by-base basis, based on needs articulated by the settings)

- On-site oral health promotion support to settings as they initiate their programmes to support with early challenges in programme implementation

- Promoting oral health messages to parents to enable regular tooth-brushing to continue at home as well as importance of healthy eating and regular dental visits

- Reinforce promotion of healthy eating, as well as policies on healthy snacks and 'water only' within target settings to support wider Local Authority work, and signpost interested setting to Health Early Years London (optional)

- Response to ad hoc queries from settings in a timely manner to support delivery of the programme

- Quarterly quality assurance visits to each setting to ensure standards of health and safety and programme effectiveness are being maintained; and support to settings on a case-by-case basis to put improvements in place, visiting more frequently as needed

- Establishment of a monitoring framework to collect data from each setting on programme consent and uptake, submitting data as required to the Commissioner

- A baseline and follow up survey with staff at each setting to monitor changes in knowledge and behaviour around oral health improvement, using validated tools

- A baseline and follow up survey with parents at each setting - to monitor changes in knowledge and behaviour around oral health improvement, using validated tools.

5.7 Resources produced by the provider should be fully accessible, clear, concise and culturally appropriate. Information should be easy to read, understand and adapt into children's daily lives by their parents and staff within the settings.

6. Funding

6.1 The contract value of £xx is an inclusive cost and the local authority will not be charged for any additional costs or charges unless previously agreed by the local authority.

6.2 The funding is intended to cover the costs of the programme for 1 year (from 1 xx to xx), with continuation of the programme subject to further funding agreements as part of the wider xxCDS Contract Variation, of which this forms a part.

6.3 The funding is intended to cover the following programme elements:

- Specialist oral health promotion workforce to deliver the programme
- Promotional material to support engagement of settings and children with the programme
- Toothbrushing supplies from Colgate for children and settings to deliver a supervised toothbrushing programme.

This is on the understanding that the programme as a whole will be managed within the Provider's programme management capacity, funded separately through the local authority and administrative support to the programme will similarly be provided at no additional cost, to enable efficient use of specialist staff to deliver the programme.

6.4 This programme is being commissioned to align-with, but sit separately from, local authority-commissioned supervised toothbrushing programmes. Whilst benefiting from the assets within a wider oral health promotion team, the service capacity required to deliver this programme is discreet and should not encroach on the existing capacity commissioned by other organisations to deliver oral health promotion initiatives within the borough.

7. Service mobilisation

7.1 The Provider will be expected to develop a detailed project plan with key milestones and target dates for the mobilisation and delivery of the programme, to ensure they can demonstrate the service is on track to meet the requirements of this service specification.

7.2 It is anticipated that the Provider will seek expressions of interest from settings and work with a sample of settings to initiate the programme by xxx. The provider will work with local authority public health teams, and children's, education and early years teams in each borough and the Consultant on Dental Public to support a formal launch of the programme.

7.3 The Provider will stagger the initiation of programmes across 2025/26, for example concentrating the programme in areas (IMD 1 and 2) without existing toothbrushing programmes initially, while the programme gets up and running, but aim to have a programme up and running in at least xx and up to xx settings across the 5 borough by end of xx.

8. Service monitoring, reporting, evaluation and performance management

8.1 The Provider will ensure high quality monitoring data is captured and provided as part of routine monitoring requirements to ensure effective monitoring and evaluation of the programme. Contracts will be monitored according to quality indicators as well as activity indicators.

8.2 The Provider will be required to regularly attend meetings to report on progress in delivery of this programme. This will consist of monthly /quarterly verbal reports on progress in programme implementation and quarterly written reports on progress against the key performance indicators (see section 9 below). The Provider will in addition give verbal updates about the progress of the programme within individual boroughs at their local authority oral health promotion contract monitoring meetings, for information.

8.3 The Provider will be required to produce an annual service report for the Commissioner summarising activity during the full year (in xx). The annual service report is expected to include both qualitative and quantitative data and outline the service performance, participant outcomes, feedback from service users (staff and parents), and reflect on achievements and challenges. It will include data on the reach of the programme by ethnicity and deprivation (optional).

8.4 The Provider will conduct a baseline survey with parents/carers and staff involved in the project as well as follow up surveys at a suitable interval (sometime between around 6 months to 12 months). The Provider will keep track of the number of settings approached in each ward, progress in getting the programme established and reasons for any settings not taking part. The Provider will work with settings to monitor the number of children consenting to take part in the programme and the number of children taking part on a regular basis. It is the responsibility of the Provider to collect and report this data and evidence, which will form part of the quarterly highlight reports and annual service report.

8.5 The Provider will work with the local authority, Commissioners and consultant in Dental Public Health to enable an evaluation on all or part of the supervised toothbrushing programme when/if required, using an evidence-based framework that will be agreed with the Commissioner and the Consultant in Dental Public Health, supporting the programme. The Commissioner working alongside the Consultant in Dental Public Health will oversee the programme's full evaluation with the local authority but the Provider is expected to contribute to this process.

The full proposed evaluation protocol for the programme can be found here (for information):

8.6 The Provider will alert the local authority as soon as possible, if there are any issues which the Provider feels will impact on the likelihood of the programme not being able to deliver according to this service specification.

8.7 The Provider shall have in place a system for collecting data on adverse incidents in a systematic and detailed manner to ascertain any lessons learnt about the quality of care and to indicate changes that might lead to future improvements.

8.8 The Provider will respond to any reasonable requests for information from the local authority and allow commissioning staff access to the programme with a view to Quality Assurance.

9. Key performance indicators

9.1 Key performance indicators (KPIs) will be reviewed by the local authority with the Provider on a quarterly basis. These will be based upon the service performance data and other relevant evidence.

9.2 KPIs for the supervised toothbrushing programme are outlined below. The data will be expected to be reported at borough level:

Key Performance Indicators:

Domain	**Target**
Training	
Number and proportion of staff delivering the programme who have been trained in each setting	80%-90%
Recruitment	
Number and proportion of targeted settings approached (defined as programme offered to setting)	40%-Q 70%-Q 80%-Q 90%-Q (2025/26)
Number and proportion of settings which have signed up by Index of Multiple Deprivation	10%-Q 20%-Q 45%-Q 50%- Q1(2025/26)
Number and proportion of settings who have declined	Less than 70%
Number and proportion of eligible children within settings approached	Recorded number of children per setting
Proportion of children who have been consented to take part in the programme in each setting	>75%
Programme Fidelity	
Number and proportion of settings which have implemented the STB programme	10%-Q 20%-Q 45%-Q 50%-Q(2025/26)

Number and proportion of children who are actively taking take part in the programme in each setting	Record number of children
Maintenance	
No and proportion of settings maintaining the programme	65-70%
No and proportion of children taking part in the programme	65-70%
Quality Assurance	
Number of quality audits undertaken	Twice annually
Number of suspended settings and reasons	Record
Parental satisfaction surveys	Results
Early staff satisfaction surveys	Results

* To note that the programme runs from xx to xx

10. Service quality, safeguarding and information governance

10.1 The Provider should ensure that staff delivering training and providing advice to parents and settings are appropriately trained and qualified. The Provider should ensure that staff are up to date with the relevant national guidance and the recent research in the topic area that they cover, ensuring that the messages they deliver are based on the latest available evidence.

10.2 The Provider should ensure that policies and procedures relating to safeguarding are adhered to, that staff have undertaken training appropriate for their professional role. All staff working with children and young people will have undertaken Disclosure Barring Service (DBS) Checks.

10.3 The Provider should ensure that policies and procedures in relation to Information Governance and Data Protection are adhered to. Mandatory staff training must be kept up to date and all staff must be aware of their responsibilities with regards to handling patient data. Staff also need be aware of their responsibilities under the Data Protection Act 2018, the United Kingdom General Data Protection Regulations (UK GDPR) and Computer Misuse Act 1990.

Appendix 2: Letter to head teacher

Re: Supervised toothbrushing programmes in schools and early years settings

Dear Headteacher

We are approaching you to promote and ask for your involvement in the national supervised toothbrushing programme to improve child oral health in the borough.

As you may be aware, child oral health is an important public health problem locally and nationally. Recent data from the national dental epidemiology programme has shown that 1 in 4 children aged 5 have experienced tooth decay in London. Children in deprived areas are significantly affected, with 1 in 3 children aged 5 years having tooth decay experience. Furthermore, the most common reason for children aged 5 to 9 being admitted to hospital is to have treatment for decayed teeth. We also know that having decay experience can impact on children's ability to eat, speak, socialise and sleep and could result in increased school absenteeism affecting children's education and development.

The role of prevention in improving oral health outcomes for children

We want to do the best for children by giving every child the best start in life. Supervised toothbrushing is an evidence-based health intervention, and is expected to deliver improvements to children's oral health and reductions in oral health inequalities.

The government has funded a supervised toothbrushing programme nationally to be rolled out in early year settings and schools, targeting 3 to 5 year olds in the most *deprived* areas. We are fortunate to have received funding for our borough to implement this programme for next 12 months to help support healthy behaviours from a young age and prevent.

The government has worked with the Department of Education to make government-funded childcare more affordable and accessible to the most disadvantaged families.

We will work with you and the Community Dental Service (xxxx) in your area to support the delivery of the supervised toothbrushing programme. I am attaching a clip to a video showing how supervised toothbrushing works: Toothbrushing Club (source: Barnsley)

Healthy school environment

It would also be helpful if your establishment could review your healthy snack policies and implement water only school, if you have not done so already. This will support Healthy Early Years London and Healthy Schools.

https://www.london.gov.uk/programmes-strategies/health-and-wellbeing/healthy-schools-london/water-only-school-toolkit

Access to NHS dental services

There is a well-established urgent dental care service in London. Any child or adult requiring urgent dental care, can access NHS 111 who will then be triaged for their dental needs, provided with advice and if dental treatment is necessary, they will be signposted to the nearest dental practice from a network across London. NHS dental care is free for children.

Next steps

You will soon be contacted by the Community Dental Service (xxx) to ask for your participation in the supervised toothbrushing programme. Brief training will be provided to staff alongside all the necessary resources.

We recognise how busy schools are and we will do our best to minimise disruptions to your daily routines.

Thank you for your consideration and for championing child oral health in your school/nursery.

xxxxx

Appendix 3: DHSC Colgate product letter and allocations to London local authorities

Supervised toothbrushing programme: Protocol to access Colgate-Palmolive product donations

Introduction

Further to our letter of 14 March on the allocation of Public Health Grant funding for supervised toothbrushing, this note sets out information on how eligible local authorities in England can access toothbrushes and toothpastes following announcement of a national supervised toothbrushing programme and a five year collaboration with Colgate-Palmolive.

Product donation and volumes

In total, Colgate-Palmolive is making available goods for use in school or early years setting toothbrushing, take home packs and education resources on oral hygiene for up to 600,000 3- to 5-year-old children as identified in the national programme. Further details on the products available are set out below.

The deadline for accepting donated products in 2025/26 is 26 May 2025.

It is a local decision whether to accept the donated product. The Marmot Institute of Health Equity (The Business of Health Equity: The Marmot Review for Industry - IHE) and NHS England (NHS England » The role of businesses in reducing health inequalities) both support the use of industry partnerships to address health inequalities. Further information on Colgate-Palmolive's governance is also available.

The national programme is targeted to support 3- to 5-year-old children living in Lower Super Output Areas in England with an Indices of Multiple Deprivation ranking of 1 and 2. This has provided a defined child population for investment in the Public Health Grant. Beyond the priority population of 3 to 5 year olds there is also flexibility to support older or younger children, children in other deprived areas, those with Special Educational Needs and Disabilities or those from "PLUS" groups, aligned with the CORE20PLUS5 framework and oral health needs assessments.

Logistics

Colgate-Palmolive will distribute products to a nominated delivery location, for each local authority that wishes to accept the offer. Your delivery details will be shared with the email address provided through completion of the google form below.

There will be one or two deliveries in the year depending on the size of the population. One delivery is on offer where the defined child population is under 2,600 children and two deliveries where this is above 2,600 children.

The first deliveries will begin in June 2025 and continue until mid-July to allow for onwards distribution prior to the school holidays where earlier provision of information should also enable earlier delivery to a local authority. The second deliveries are planned to take place in the first two weeks of December 2025.

These timings are intended to support efforts to make goods available to children in line with term times, though we recognise that different programmes will operate in line with local needs and there is flexibility in the offer to respond as appropriate.

We request that a lead contact (name, phone, email) confirms details needed to facilitate delivery (address and site access requirements) via online exchange direct to Colgate-Palmolive at this form.

We also ask for confirmation via the same form if an authority does not wish to access goods in this first year.

DHSC has completed a Data Protection assessment of the proposed collection requirements, and this form is compatible with that assessment.

Upon receipt of goods, local authorities will be responsible for subsequent storage and onward distribution as determined locally. We are aware some local partners have formed small working groups to include these logistics as part of their work plans to facilitate prompt onwards distribution to minimise storage costs.

Review and further information

The arrangements for 2025/26 have been developed with input from DHSC's expert supervised toothbrushing advisory group with commissioner, provider and clinical input from Consultants in Dental Public Health. We recognise that this scheme is being introduced at pace and in some areas, arrangements are in place following procurement or contracts with existing providers. We will review implementation of 2025/26 to inform subsequent years of the collaboration. We welcome feedback as part of this and participation in data collection to inform evaluation and governance and future allocations.

In the event of further questions, we ask that these are directed in first instance to your local Consultant in Dental Public Health.

DHSC, Dental Public Health Team

London local authority Colgate product allocations

Local authority	Population 3 to 5 year olds most deprived 20% LSOA	In setting toothbrush	In setting toothpaste	Take home toothbrush and toothpaste	Pallets
Barking and Dagenham	6,515	19,545	4,126	13,030	14
Hackney	5,154	15,462	3,264	10,308	11
Enfield	5,137	15,411	3,253	10,274	11
Tower Hamlets	4,296	12,888	2,721	8,592	9
Newham	4,140	12,420	2,622	8,280	9
Haringey	3,765	11,295	2,385	7,530	8
Croydon	3,427	10,281	2,170	6,854	8
Brent	3,148	9,444	1,994	6,296	7
Lewisham	2,985	8,955	1,891	5,970	7
Greenwich	2,947	8,841	1,866	5,894	7
Ealing	2,759	8,277	1,747	5,518	7
Southwark	2,608	7,824	1,652	5,216	6
Islington	2,206	6,618	1,397	4,412	6
Lambeth	2,095	6,285	1,327	4,190	5
Waltham Forest	2,061	6,183	1,305	4,122	5
Camden	1,776	5,328	1,125	3,552	5

Westminster	1,319	3,957	835	2,638	4
Hammersmith and Fulham	1,243	3,729	787	2,486	4
Bromley	1,237	3,711	783	2,474	4
Havering	1,058	3,174	670	2,116	3
Hounslow	988	2,964	626	1,976	3
Kensington and Chelsea	938	2,814	594	1,876	3
Wandsworth	699	2,097	443	1,398	3
Bexley	668	2,004	423	1,336	3
Hillingdon	640	1,920	405	1,280	3
Redbridge	560	1,680	355	1,120	3
Sutton	509	1,527	322	1,018	2
Barnet	495	1,485	314	990	2
Merton	236	708	149	472	2
Harrow	115	345	73	230	2
Kingston upon Thames	104	312	66	208	2
Richmond upon Thames	62	186	39	124	2

There will be one or two deliveries in the year depending on the size of the population. One delivery is on offer where the defined child population is under 2,600 children and two deliveries where this is above 2,600 children.

Appendix 4: Staff questionnaire

Supervised Toothbrushing Staff Survey

Instructions

This survey is aimed at staff responsible for delivery of supervised toothbrushing schemes in early years settings, schools and other settings.

We would like to understand your oral health knowledge and views of the supervised toothbrushing scheme. Your feedback will help us understand how the programme is working in practice and how it might be improved to support delivery of schemes in the future.

Taking part in the survey is voluntary. You do not have to complete all the questions if you do not want to. Your answers will remain anonymised and confidential.

The survey should take around 10 minutes to complete.

Thank you for taking the time to share your insights. Your contribution is highly valued and will help strengthen the delivery of supervised toothbrushing programmes.

I confirm that I have read the explanation for this survey, and I consent to take part ☐

About you

Please tick one answer

1) What type of setting do you work in?

☐ Nursery

☐ School

☐ Other: please state……

2) What is your job role?

☐ Nursery nurse/ practitioner

☐ Nursery assistant

☐ Teacher

☐ Teaching Assistant

☐ Other: please state……

3) Which local authority borough do you work in? ……..

Oral Heath Knowledge

Please tick one answer

4) What amount of toothpaste is recommended for children aged over 3 years old?

☐ Smear

☐ Pea sized

☐ A line the size of the toothbrush head

5) After toothbrushing it is advised to rinse out with water?

☐ True

☐ False

6) What is the maximum recommended daily sugar intake for a child aged 4-6 years?

☐ 7 cubes of sugar (30g)

☐ 6 cubes of sugar (24g)

☐ 5 cubes of sugar (19g)

☐ Don’t know

Your Views

7) How strongly do you agree or disagree with the following?

Please tick for each statement

	Strongly Disagree **1**	**2**	**3**	**4**	**Strongly Agree** **5**
Supervised toothbrushing is an effective way to improve children's oral health					
I know how to supervise toothbrushing of children					
I am confident that I can supervise children's toothbrushing					
Supervising toothbrushing is part of my role					
Supervised toothbrushing is important					
Supervising toothbrushing is something I want to do					
Supervising children to brush their teeth is easy to do					
Children want to take part in supervised toothbrushing					
Parents think it is important that I supervise children's toothbrushing					
There is enough time for me to support supervised toothbrushing in my setting					

8) **Do you have any suggestions about how you could be further supported to deliver the supervised toothbrushing scheme in your setting?**

9) **What has supported you in running the scheme?**

10) **What were the challenges if any in implementing the supervised toothbrushing scheme?**

11) **Do you have any further comments?**

Thank you for completing this survey

Appendix 5: Parental Questionnaire

Parent, Carer and Guardian Supervised Toothbrushing Questionnaire

Dear Parent, Carer, Guardian,

We are inviting you to fill out our questionnaire so that we can understand the impact of toothbrushing at schools and early years settings.

We would be grateful if you could answer the questions open and honestly. Please answer the following questions thinking about the child who is taking part in the programme not any other children you may have.

Thank you for your help in completing this questionnaire. Please be assured that your information will be treated in the strictest confidence and your answers will remain anonymous. Your name will not be identified in any way.

Please answer the questions by selecting an answer or writing in text as requested.

1) How old is your child (attends nursery/school) now? Please tick one box

☐ Under 2
☐ 2
☐ 3
☐ 4
☐ 5
☐ Over 5

2) What is **your child's** ethnicity? Please tick one box

White	☐ English, Welsh, Scottish, Northern Irish or British ☐ Irish ☐ Roma ☐ Gypsy or Irish Traveller ☐ Any other white background, please specify:
	☐ White and Black Caribbean

Mixed/Multiple Ethnic Groups	☐ White and Black African ☐ White and Asian ☐ Any other mixed or multiple ethnic background
Asian/Asian British	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Any other Asian background, please specify:
Black/ Black British	☐ African ☐ Caribbean ☐ Any other Black background, please specify:
Other ethnic groups	☐ Afghanistan ☐ Algerian ☐ Egyptian ☐ Moroccan ☐ Tunisian ☐ Arab ☐ Turkish ☐ Any other, please specify:

3) What is your child's main postcode? Please do not write your full address.

4) What is the name of the school or Early Years setting your child attends?

The following questions will ask you about cleaning your child's teeth and what they eat and drink

5) What is the recommended age for children to start brushing their teeth or having them brushed for them? Please tick one box

a. Under 6 months of age or when first tooth comes through ☐
b. Between 6 months and 1 year of age ☐
c. Between 1 year and 2 years of age ☐
d. Between 2 years and 3 years of age ☐
e. Between 3 years of age and 4 years of age ☐
f. There is no recommended age ☐

6) How often is it recommended for your child to brush their teeth (or have them brushed for them?) Please tick one box

a. More than three times a day ☐
b. Three times a day ☐
c. Twice a day ☐
d. Once a day
e. Less than once a day ☐
f. Never ☐

7) How often does your child usually brush their teeth (or have them brushed for them?) Please tick one box

a. More than three times a day ☐
b. Three times a day ☐
c. Twice a day ☐
d. Once a day ☐
e. Less than once a day ☐
f. Never ☐

8) At the moment, how often, on average does your child eat biscuits, pastries, cakes, chocolates or sweets? Please tick one box

a. Four or more times a day ☐
b. 3 times a day ☐
c. 2 times a day ☐
d. Once a day ☐
e. Less than once a day ☐
f. Rarely or never ☐

9) At the moment, how often, on average does your child have fizzy drinks, fruit juice or soft drinks like squash, excluding diet or sugar-free drinks? Please tick one box

a. Four or more times a day ☐
b. Three times a day ☐
c. Two times a day ☐
d. Once a day ☐
e. Less than once a day ☐
f. Rarely or never ☐

10) When was the last time your child went to a dentist? Please tick one box

a. In the last six months ☐
b. In the last year ☐
c. In the last two years ☐
d. Longer than two years ago ☐

11) Is there anything else you would like to mention about your child's dental health or planned Supervised toothbrushing programme in your early year setting? Please write below:

Thank you for completing this survey