Public Health England

Dental Public Health Epidemiology Programme

Oral health survey of five and 12-year-old children attending special support schools, 2013-2014

National protocol

Version 2

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[1].

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Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
http://www.gov.uk/phe
@PHE_uk

Prepared by: The Dental Public Health Epidemiology Team (formerly The Dental Observatory)

For queries relating to this document, please contact: Dr Gill Davies, gill.davies@phe.gov.uk

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Contents

1. Introduction

The responsibility of primary care trusts (PCTs) to gather information on the health needs of the local population was transferred to local authorities (LAs) in April 2013, following the White Paper, Equity and Excellence; Liberating the NHS[2]. This imperative is described in the Health and Social Care Act 2012, underpinned by Statutory Instrument 2012 number 3094[3], and Choosing Better Oral Health[4].

Leadership and structures supporting the former NHS Dental Epidemiology Programme transferred into Public Health England (PHE) on 1 April 2013. The programme is undergoing transformation within PHE and by necessity some terms used will change. This protocol has been produced during the transition phase and best descriptive terms available at that time are used.

The former Regional Dental Public Health Leads Network agreed that during the academic year 2013/14 the population groups for scrutiny would be five and 12-year-olds attending special support schools to complement the decennial 2013 Child Dental Health Survey (2013 CDHS). This follows a previous survey in Manchester.

Children from mainstream state-funded schools are included in the National Dental Epidemiology Programme (NDEP) surveys and the decennial National surveys. However, children attending special support schools are excluded from these surveys so their dental health status is not measured in a robust and comparable fashion.

Policies about provision of education for children with physical, learning, communication, behavioural or emotional difficulties vary from one local education authority (LEA) to another. Most authorities will have some special educational provision for children with severe problems. These children may make greater demands on specialist dental treatment services in the short or long term which need to be estimated for planning purposes. In addition, their oral health promotion needs should be measured. For these reasons surveys of children in special support schools are considered to be required and the results can be compared with the 2013 CDHS and with recent NDEP survey results.

2. Aim of the survey

The aim of the survey is to measure the prevalence and severity of dental caries among children attending special support schools within each Local (Education or Upper Tier) Authority to provide a baseline for comparison in subsequent years.

This information can be used to:

2.1 Provide comparisons with children of the same age attending mainstream schools in the same area.

2.2 Inform part of a health needs assessment, particularly Joint Strategic Needs Assessments.

2.3 Inform the local oral health improvement strategy.

2.4 Make comparisons between schools providing education for different prime disabilities.

It is recognised that full examination of some children will not be possible but at the very least the following will be established:

- the number of primary and secondary special support schools in the area
- the number of children attending these schools
- the number and types of disabilities catered for by the age group in question
- the number of children who are fully or partially examinable and those who are not
- the number of examinable children who have extraction or caries experience

3. Objectives

To identify non-residential special support schools which provide education for five-year-olds and/or 12-year-olds. To gain consent and examine these children using caries diagnostic criteria and examination techniques based on those agreed by the British Association for the Study of Community Dentistry (BASCD), Diagnostic criteria for caries prevalence surveys[5] and using BASCD recommended sampling procedures described 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[1].

It is acknowledged that the majority of children with disabilities and other special needs are now educated at mainstream schools. A variety of factors including logistics, ethics, data protection, stigmatising and labelling issues all mean that it is not currently possible to run a survey of all children with special needs. This survey is clearly limited to those children who, for a range of reasons attend special support schools and the arising data will be described clearly as such.

4. Considerations for special support schools

4.1 Personnel

Ideally the survey examiner requires the skills of a dental epidemiologist and those of a clinician who is used to working with special needs children. He/she must be able to undertake a standardised examination of as many children as possible and maximum co-operation is best achieved by an experienced clinician. Experience allows the clinician to cope with unpredictable responses and helps with patience and persistence. A flexible approach is necessary and all efforts should be made to avoid distress.

Two support workers are required and one of these should be familiar with the school or the children. The school nurse can be invaluable in providing advice which may help with children's co-operation.

4.2 Conduct

The survey should, as far as possible, follow the guidelines for mainstream surveys. Any deviations should be documented. Head teachers and school nurses at schools that have not been involved in surveys before may need more explanation, as they are unfamiliar with the purpose, process and practical issues. As disturbance to

classes is likely to be higher than in mainstream it is beneficial if all affected class teachers are fully informed.

It is likely that the process will take longer than in mainstream schools. The children may be brought for examination one by one and examination will take longer. Consideration for reducing disturbance may necessitate specific children being brought in an order decided by the school. The dignity and right to privacy of the children should be respected.

4.3 Sample

Relatively few children have severe special needs so sampling of schools or individuals is not required. In order that comparisons can be made with mainstream educated children the same age groups should be surveyed (see section 6).

Children may not be grouped by age as in mainstream schools so care must be taken when specifying the subset of children to be included. For example, to compare with 12-year-old children the intention should be to examine all special needs children whose date of birth falls within the appropriate range but who may be spread through various ‘classes’ in a special support school.

Funding of education at special support schools is a very complicated affair and in most cases the state provides funds for the majority of children attending independent special support schools. For this reason all types of special support schools, regardless of their funding status will be included.

5. Preparatory communication with relevant work partners

5.1 Identifying schools

Communication with the LEA will assist with identification of special support schools which are non-residential and which exclusively take children because of their physical, mental, social or behavioural special needs. LEA websites are also good sources of lists of special support schools although some checking may be required to ensure an up to date list is being used.

All types of non-residential special support schools should be included, except short term assessment units. The following descriptors of special support schools’ status may be used, and all types should be included in the local survey:

Community Special Schools
Other Independent school
Academy special converter
Academy special sponsor led school
Foundation special school
Non-maintained special school
Free special schools

As there are very low numbers of hospital schools and the numbers of five or 12-year-olds attending them may be very low, they should be excluded from this survey.

5.2 Classifying schools

Each special support school will cater primarily for a specific main type of disability. It is recognised that many children have multiple disabilities so the code of the school

will be used to classify the prime disability (see 12.4). This classification may be found out from LEA lists or from their website.

5.3 Gaining school co-operation

As many special support schools will be unfamiliar with dental surveys and some may have no contact with community dental services this may lead to uncertainty about the sharing of data or co-operating with requests from the NDEP fieldwork teams. It is therefore essential that colleagues within the LA are approached to seek their support for the survey. If Directors of Public Health (DsPH), 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 their colleagues feel confident to take part.

A letter from the Director of Dental Public Health, PHE, which demonstrates the support of PHE will be sent to Regional and LA Directors of Public Health (Appendix B). Local Authority DsPH will be asked to convey their support to colleagues in Departments for Children's Services and to headteachers.

Consultants in Dental Public Health (CsDPH) based in PHE Centres or, in the absence of these, Clinical Directors, leads for dental epidemiology or other suitable personnel may find it helpful to contact the Director of Public Health, or person acting in that capacity, for each LA. The purpose of this contact would be to discuss, ideally face to face, the purpose of the 2013/14 National Dental Epidemiology Programme survey of five and 12-year-olds attending special support schools and why it is important to LAs.

6. Sample

The sampling unit will be LA boundaries at unitary, metropolitan borough or upper tier level. In the majority of cases the geographies contain fewer than ten schools for five-year-olds, 12-year-olds or both and, in the remainder only a very small number may need to consider sampling schools. Most schools have small numbers of children.

Under these circumstances there is no requirement to either sample schools or to sample children.

The survey population is defined as all those children attending special support schools who have reached the age of five, but have not had their sixth birthday and those who have had their twelfth but not their thirteenth on the date of examination. Lists of all classes which may contain a child who is aged five or aged 12 on the day of examination will be used to identify the sample.

Sampling procedure - for only one or two local authorities with large numbers of special support schools:

In the very small number of cases where sampling may be indicated *a sampling procedure which stratifies for size of school will be used. This is similar to the method used for surveys of five-year-old children. 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[5]. Advice can be requested from regional coordinators, staff in the Dental Public Health Team (the*

former Dental Observatory)and further advice may be sought from Girvan Burnside (email: g.burnside@liv.ac.uk).

Lists of all special support schools in the upper tier LA and rough figures for the numbers of children by age group attending each, will be required as the first stage in the sampling process.

In LA areas where there are more than 20 special support schools catering for five-year-olds or more than 20 catering for 12-year-olds a sampling procedure will be required which takes the distribution of these children into account. The aim will be to attend sufficient sampled sites and examine all consented willing children until a sample of at least 200 children has been seen, in the proportions calculated.

A table should be constructed that shows the distribution of five-year-old children in all the special support schools. The second stage is to group the schools by numbers attending, and give each a unique number ready for random sampling. It is probably easiest to produce enough random numbers to give one for every school, then record the order in which they were sampled.

Special support schools within each size band should then be sampled by production of random numbers until a sufficiently large sample is produced, along with some substitute schools.

The process should be repeated for schools catering for 12-year-olds but, for purposes of efficiency schools that cater for both five and 12-year-olds who were randomly sampled in the process to select schools for the younger group could be used in the selected sample for 12-year-olds, before making up the rest of the sample using random numbers.

The completed tables and explanations of the methodology should be sent to regional coordinators for agreement and sign-off before any schools are contacted.

7. Consent

Positive consent is required following guidance from the Department of Health (Appendix D). Parental, positive, written consent should be sought for parents of both five and 12-year-old children.

The procedure for obtaining positive consent must involve:

- giving parents an invitation letter which gives clear information explaining the nature and purpose of dental surveys in broad terms and simple language (example given in Appendix M)

- provision of a form which reports parental consent or refusal for the survey, indicates that parents have read and understood the information letter and includes a signature and a date of this (attached form given in Appendix M)

- in view of the special needs of the children the fieldwork team may wish to provide easy access by telephone to someone who can answer questions

- distribution of a second letter with consent form, ideally on differently coloured paper, to those who do not respond to the first

- acceptance of, and respect for, the decision of a child to decline an examination

It may help site staff to encourage returns if lists are provided that show which children have been sent consent letters and a column for them to record which ones have been returned (Appendix N).

Many schools use a home-school diary and school bags system to communicate with parents. Use could also be made of this system to inform parents and seek consent as letters or additional notices about the survey can be inserted into these.

Limited abilities with written English may be higher among parents of this group so additional assistance may be required.

Parent's attention may be drawn more if coloured paper or envelopes are used.

Other strategies may be necessary to maximise the number of consent forms returned, however, coercion to provide positive consent should not be used.

NDEP teams must keep a record of the number of all children approached, the numbers with parental consent, parental refusal and no consent.

8. Personnel

8.1 The four Regional Dental Public Health Consultants have overall responsibility to ensure the co-ordination and the regional planning and delivery of the NDEP working with the Dental Public Health staff in PHE Centres. The commissioning of the surveys will be the responsibility of the LAs in partnership with NHS England dental commissioning teams based in NHS England Area Teams.

8.2 Fieldwork for the survey will be carried out by Salaried/Special Care Dental Service staff. The dental examinations will be carried out by registered dental clinicians who will be trained to national standards by the regional trainers, using the approved BASCD training pack, to ensure that they are familiar with the examination method and criteria. Examiners must also be calibrated annually following the BASCD guidance on the statistical aspects of training and calibration of examiners for surveys of child dental health[6] and examiners who do not conform to the accepted diagnostic standards will need to be retrained and recalibrated, or replaced. In this instance, training and calibration will be provided for 12-year-olds for all examiners and, additionally for five-year-olds for new examiners and those who have not examined this group for some time.

8.3 The survey examiner requires the skills of a dental epidemiologist and those of a clinician who is used to working with special needs children. He/she must be able to undertake a standardised examination of as many children as possible and maximum co-operation is best achieved by an experienced clinician. Experience allows the clinician to cope with unpredictable responses and helps with patience and persistence. A flexible approach is necessary and all efforts should be made to avoid distress.

Whoever carries out the examination must be trained and calibrated. This should be carried out at the time of the regionally organised, annual calibration. If this is not possible the regional coordinator must be contacted and alternative arrangements made.

Two support workers are required and one of these should preferably be familiar with the school or the children. One worker is required to record the codes that the examining dentist provides and the other will help support the process by liaising with staff, fetching the children, assisting with examination and encouraging co-operation. The school nurse can be invaluable in providing advice which may help with children's co-operation.

8.4 The NDEP Regional Coordinator has a duty to ensure, from a regional perspective, that the appropriate BASCD quality standards for dental epidemiological programmes are maintained. This will be undertaken in consultation with the CsDPH or other Dental Public Health Advisers responsible to PHE, who may wish to apply their own additional quality standards in line with local policy.

9. General conduct of the survey

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

9.1 The planning and organisation of the survey will be carried out by Salaried/ Special Care Dental Service NDEP fieldwork teams who will liaise with LAs to obtain lists of special support schools and identify those who cater for five- or 12-year-old children. The type of main disability each school caters for will be established, ready for coding.

9.2 Headteachers of identified special support schools will be contacted by a trained member of the NDEP fieldwork team. The aims and objectives of the survey will be explained and the co-operation of the school sought. Dates for examination will be set at a mutually convenient time and date.

9.3 Lists of all age eligible children to be included in the survey will be obtained prior to the examination. These lists should include the following information: name, date of birth and home postcode.

9.4 Using these lists, children who will be age eligible on the planned day of examination will be identified (see Appendices K and L). A list of these sampled children, along with their home postcodes will be formed and the data entered into a list to record consent status (Appendix N).

9.5 A letter will then be sent to each identified child's parent or guardian outlining the details of the survey and informing them that their child will be included, and seeking their consent. A second letter will be distributed to those who have not returned a form from the first drop.

9.6 The provision or withholding of consent or non-return of valid consent forms will be recorded for each child and entered onto the sheet mentioned at 9.4.

9.7 The dental examinations will take place in the schools in a situation identified as being suitable for that purpose and convenient for the smooth running of both the survey and the school.

9.8 It is good practice to inform parents/guardians if a clinical condition requiring closer investigation is seen during examination, for example sepsis or extensive caries. If a therapist or hygienist is undertaking the examinations, or if there is no intention to provide information about a child's clinical status, then the consent letter (Appendix M) should be modified to reflect this.

10. Fieldwork

Examinations will take place in the schools, after training and calibration of examiners and must be completed by the end of July 2014. 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.

Equipment, instruments and materials

To ensure standardisation, no mobile surgeries or equivalent should be used.

10.1 The children will be examined supine on tables with mats and the examiner seated or standing behind them whenever possible. However, the disabilities of some children will prevent a supine examination with a Daray lamp. It has to be accepted that a variety of examining approaches will be required and in some cases only a partial examination will be possible. This should be documented and coded (see 12.8) and teeth and surfaces that cannot be fully seen coded accordingly (Code 9).

Schools will have a variety of equipment to assist with positioning for eating, learning, standing and relaxation. These may include standing frames, supportive chairs, beanbags, pre-formed foam chairs and tilting wheelchairs. The examining team should use whatever position gives the highest level of co-operation along with the best access. The child's safety and comfort is the overriding consideration.

A directionable head lamp, such as that worn by cavers, can be used instead of the fixed Daray lamp. It is acknowledged that this may not provide the same light levels as the standard examining lamp but some directional light, which leaves both hands free, is the next best option. A pen torch with well charged batteries may be used to provide additional light as another alternative if neither a Daray nor a headlamp are suitable.

All equipment must be robust and reliable. Thorough testing, before taking it into schools, is strongly advised.

It may not be possible with some children to use cotton wool rolls, cotton buds or pledgets to clear the teeth of debris and moisture. This should be recorded as a 'partial' examination (see 12.8).

A toothbrush may be used to encourage initial mouth opening as this is more familiar than a mouth mirror. It may be necessary to leave the brush in place as a prop while the arches are examined with a mouth mirror.

If detailed feedback is provided for parents it should be couched in terms which respect any existing patient-clinician relationships.

10.2 An inspection light (Daray X100 with Halogen bulb with PivotD desk mount or Brandon Medical MT608BASCD are suitable if a replacement is needed) yielding approximately 4000 lux at one metre will be used for illumination. This requires that the Daray Versatile be set to the brighter of the two settings. A spare 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 G).

10.3 The instruments required for the caries examination will include No.4 plane 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.

10.4 Local policies and infection control arrangements will be applied to prevent cross-infection 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 subject.

10.5 Cotton wool rolls, cotton buds, or pledgets of cotton wool will be used to clear teeth of moisture. These will also be used to clear debris where necessary.

10.6 Suitable shaded spectacles will be used to protect the subject's eyes from the light and the possibility of damage.

10.7 Data may be entered either onto paper record sheets (Appendix O and P) or directly onto computer, with safeguards for both methods (see 11.4).

11. Collection of data - general Information

11.1 Training and calibration

Trained and calibrated dental clinicians, assisted by appropriately trained assistants, will undertake the collection and recording of both non-clinical and clinical data. Evidence of intra-examiner reproducibility is desirable – brief guidance is given in Pine et al[6].

11.2 Computer software

Data will be collected and processed using the NDEP Formats [5YR14SS] and [12YR14SS] with the Dental Survey Plus 2 (DSP2) version 2.1 release 3. The formats are available electronically from: www.nwph.net/dentalhealth

These contain several free fields for local use. If these are insufficient for local information requirements it is requested that additional fields are added to the end of the NDEP Format and the revised format labelled to show that it differs from the national one.

Newer computers and upgraded ones using Windows 7 or later are incompatible with DSP2. A machine with Windows 6 or earlier should be kept aside to allow data entry

and analysis of data in DSP2. The alternative is to use a patch, the details of which are given at Appendix I.

11.3 Confidentiality

Fieldwork teams will ensure that all data are handled with full regard to confidentiality and the Data Protection Legislation. Access to all data files will be controlled and protected by passwords. Fieldwork teams will only retain anonymous processed data files for purposes of further analysis. As personal data processed for purposes of research and statistics falls within the scope of the Act (but may be exempt from subject access) each provider team will register their data collection and analysis computer systems.

11.4 Security

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

If data are collected onto paper sheets in the field, transfer onto computer will occur with the minimum of delay. Paper copies will be kept securely and distant from the electronic database when inputting is not occurring. These should be retained and destroyed according to local protocols.

11.5 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 LA is required according to the guidance.

Survey files should be saved into the 'Survey' folder of DSP2.

Data handling guidance instructions on the checking, cleaning and labelling of data files will be available from: www.nwph.net/dentalhealth

11.6 File transfer

Data files will only be transferred on disk or stick by hand delivery from the NDEP fieldwork team to the regional coordinator or by sending as an e-mail attachment from an nhs.net address to the regional coordinator's nhs.net address.

12. Collection of non-clinical data

Non-clinical data may be entered onto paper sheets or DSP2 before going to the school for the clinical examination.

12.1 Organisational boundary coding

Each child will be coded to show the upper tier LA within which the school is sited. This is defined by the geographical position of the child care site within LA boundaries and should be clear as the LA will have provided lists of the sites they control. A table of codes for LAs is provided in Appendix J.

12.2 Examiner

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

12.3 Examination date

The date of the examination will be recorded.

12.4 School name, postcode and type

The school name and postcode will be entered and the 'school type' will be coded according the first listed, **main** type of disability which it caters for :

0	ASD	Autistic spectrum disorder
1	BESD	Behavioural emotional and social difficulty
2	H1	Hearing impairment
3	V1	Visual impairment
4	MLD	Moderate learning difficulty
5	PMLD	Profound and multiple learning difficulty
6	SLD	Severe learning difficulty
7	Sp LD	Specific learning difficulty
8	PD	Physical disability
9	SLCN	Speech language and communication
10	Other	Including Asperger's syndrome, ADHD, Multi-sensory impairment

12.5 Child identity number

A unique identity number will be entered for each child, which consists of a prefix from the school code and a suffix, which numbers participants from class lists. The list of site prefixes should be locally agreed.

The use of identity numbers instead of names improves anonymity of the data, but if longitudinal surveys are intended it is essential that the examination sheet is used (Appendix Q) and kept securely to allow the child participants to be identified and tracked in subsequent years.

12.6 Date of Birth

Use of just the month and year of birth increases anonymity. However this causes difficulty when checking ages of examined children in the complete datasets. It has therefore been agreed that all children will be recorded onto computer as being born on the 15th of the month. DSP2 formats will then 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 five- or 12-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 October 2007 to August 2009 for the five-year-olds and October 2000 to August 2002 for the 12-year-olds (Appendices K and L also help to identify the narrower ranges for examination dates in each month).

12.7 Home address postcode

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

N.B. 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.

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

12.8 Examination status

It is recognised that cooperation levels may be lower in this group of the population because of the effect of disabilities. It is useful information to know how many children could not cooperate with a dental examination so coding has been provided to indicate this. Where children simply refuse to take part, code 4 should be used. If their disability meant that they were unable to cooperate then the appropriate codes should be applied. It is left to the common sense of examiners to select the code that most closely fits individual circumstances.

The type of examination will be recorded as follows:

0 Full examination completed
1 Partial examination only
2 No examination possible
3 Child absent
4 Child refused examination
5 Training examination

13. Collection of clinical data

When possible, subjects will be examined lying down on a mat or a table and the examiner will be seated behind the subject. The examination will be visual, aided by mouth mirrors and the standardised light source only as described above.

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 (13.8). Radiographic or Fibre-optic transillumination examination will not be undertaken.

Only the primary teeth will be recorded for five-year-old children, and only the permanent teeth will be recorded for 12-year-old children.

When only a partial examination is possible the priority for coding should be :

1. Record any missing teeth
2. Record presence or absence of plaque
3. Record sepsis
4. Record condition of teeth

13.1 Oral cleanliness: Assessment of Plaque

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

13.2 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.

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.

13.3 Conventions

The following conventions will apply:

a) 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.

b) The presence of supernumerary teeth will not be recorded. If a tooth and a supernumerary exactly resemble one another then the distal of the two will be regarded as the supernumerary.

c) Among five-year-olds missing primary incisors are assumed exfoliated and assigned tooth Code 8.

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

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

f) Discoloured, non-vital incisors, without caries or fractures should be scored T for trauma on all surfaces.

g) Surfaces which are obscured e.g. banded teeth, should be assumed to be sound and coded '-' or '0'.

13.4 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 are described: mirror only.
b) tooth surface examination: mirror + cotton wool (for drying).

13.5 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.

Tooth Code 7 – Extracted for orthodontic reasons – for 12 year olds
Surfaces are regarded as extracted for orthodontic reasons if the tooth of which they were part has, in the opinion of the examiner, been extracted solely for orthodontic reasons. Unless there is overwhelming evidence to the contrary, after questioning the child, missing first permanent molars will be recorded as extracted due to caries.

Tooth Code 8 - Unerupted or missing other
This code will be used for teeth that are unerupted, congenitally absent or missing due to reasons unknown. It will also be used for missing incisors in the five-year-old children.

13.6 Obscured surfaces

All obscured surfaces are assumed sound (surface Code '0' or '-' 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.

13.7 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 0 - Sound
Criteria - a surface is recorded as 'sound' if it shows no evidence of treated or untreated clinical caries at the 'caries into dentine' threshold. The early stages of caries, as well as other similar conditions are excluded. Surfaces with the following defects, in the absence of other positive criteria, should be coded as present and 'sound':

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

All questionable lesions should be coded as 'sound'.

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 or not there is a filling in the surface. 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 (with the exception of 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. NB: 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.

13.8 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, i.e. 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.

13.9 Abscess/Sepsis

Following examination of the mouth for caries, if, in the opinion of the trained examiner, the presence of an abscess or sinus has been noted – record Code 1 in the appropriate section on the form. If no abscess or sinus present – Code 0.

All sepsis must be recorded regardless of cause. No attempt should be made to identify the cause of the infection.

13.10 Optional variables

Optional variable for ethnic code

It is of particular and increasing importance for the ethnic coding to be recorded and fieldwork teams are encouraged to do this. Best practice is to use the ethnicity data collected by schools from parents.

The coding method should not vary, as there is now a standard method of categorisation and coding for Education Skills and Children's Services (ESCS). These are suitable for alignment into the 2011 Census groupings, which are:

Highest level grouping	To include these groups
A White	A1 English/Welsh/Scottish/Northern Irish/British A2 Irish A3 Gypsy or Irish Traveller A4 Any other white background
B Mixed	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

There are three additional codes which may be used for local use and should be defined to allow for particular additional ethnic groups which may be of interest in each locality:

F Specific ethnic other - 1
G Specific ethnic other - 2
H Specific ethnic other - 3

Further guidance and descriptions of groupings can be found on page 20 of the Ethnicity Data Standard provided by the Information Standards Board for Education ESCS which can be downloaded from:
www.education.gov.uk/escs-isb/standardslibrary/a0077051/ethnicity-data-standard

Optional variable for assessment of treatment need

An optional spare variable may be used in the DSP2 format to collect broad information on treatment need. Criteria will be agreed locally.

Optional data to identify ward, locality or other unit

It should be noted that the low number of special support schools will preclude analysis at most geographic levels below upper tier local authority. However, spare variables have been provided, as usual, to allow collection of further data which may be analysed locally. If these three are insufficient for local needs then 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.

14. Reporting of data

Prior to sending on data files, each fieldwork team is responsible for checking their data for inaccuracies. The main areas for error occur with incorrect dates of birth and/or ages, duplicate entries for children or sites and entry of clinical data for children coded absent.

Guidance will be provided which will give a step-by-step guide to the whole data handling process. This will be available from: www.nwph.net/dentalhealth

Once data have been checked and errors corrected, files should be correctly labelled according to the guidance and sent on to NDEP Regional Coordinators to upload. Files can be passed by hand on password protected memory sticks or disks directly to the regional coordinator or they can be sent as e-mail attachments from an nhs.net address to an nhs.net address. Separate files should be formed for each LA, labelled to indicate the age group and LA to which they refer.

The following will be reported using Appendix T:

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

2) Total number of schools providing education for five-year-olds.

3) Total number of schools providing education for 12-year-olds.

4) Number of schools visited providing education for five-year-olds.

5) Number of schools visited providing education for 12-year-olds.

6) Total number of five-year-old children attending listed schools.

7) Total number of 12-year-old children attending listed schools.

8) Number of five-year-old children with parental consent, parental consent refused and consent form not returned.

9) Number of 12-year-old children with parental consent, parental consent refused and consent form not returned.

10) Number of five-year-old consented children examined, absent and refused examination.

11) Number of 12-year-old consented children examined, absent and refused examination

Results will be submitted as cleaned SurveyPlus data files and completed Word documents.

All returns should be made to regional coordinators as soon as possible after completion of the survey and no later than 31st July 2014. These must only be made by direct handing over of a password protected memory stick or disc or by e-mail attachments from an nhs.net address to an nhs.net address and should include:

i) the completed summary reporting sheet – Appendix T;

ii) the DSP2 survey files for both age groups labelled to indicate which age group and LA they refer.

Regional coordinators will re-check and clean the data files received from fieldwork teams before sending them to the DPH Team, via the secure web portal.

Cleaned and verified copies of the data will be sent to DPH staff working in PHE Centres, via the four Regional Dental Public Health Consultants. The national report and LA tailored reports will be provided by the DPH Team and the NW KIT. DPH staff in PHE Centres will work with their named LAs and their public health analysts to make maximum use of their data if further analysis is required.

15. References

1. Department of Health (2010). Equity and excellence: Liberating the NHS. London, The Stationery Office.

2. Statutory Instrument 2012 No 3094. National Health Service, England Social Care Fund, England Public Health, England. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Health watch) Regulations 2012. Available at : http://www.legislation.gov.uk/uksi/2012/3094/regulation/35/made

3. Department of Health (2005). Choosing Better Oral Health. London, The Stationery Office.

4. 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.

5. 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.

6. 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.

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

16. Table of Appendices

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

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

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

2012 No. 3094

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

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

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

Extract from pages 8, 9, 26 and 27

PART 4

DENTAL PUBLIC HEALTH FUNCTIONS OF LOCAL AUTHORITIES

Interpretation

16. In this Part—

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

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

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

Exercise of functions of local authorities

17.—

(1) Each local authority (**h**)[2] shall have the following functions in relation to dental public health in England.

1 (**g**) 1991 c.56. Section 87(1) is substituted by section 58(1) and (2) of the Water Act 2003 (c.37).
2 (**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)**[3] 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)**[4] ("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.

3 (**a**) Paragraph 13 of Schedule 1 to the 2006 Act is substituted by section 17(2) and (13) of the 2012 Act.
4 (**b**) S.I. 2006/185.

Appendix B – Letter of support from Director of Dental Public Health, Public Health England to Directors of Public Health

Dental Public Health
Wellington House
133 to 155 Waterloo Road
London SE1 8UD

T +44 (0)20 7654 8179

www.gov.uk/phe

To : Directors of Public Health
for forwarding to Directors of Education

September 2013

Dear Director of Public Health and Director of Education,

Re: Surveys of the oral health of children in mainstream and special needs schools

I am writing to make you aware of a national Child Dental Health Survey which is taking place in England during the academic year 2013/14. As you will know, the oral health of five year olds is an indicator in the public health outcomes framework.

The survey is taking place in England, Wales and Northern Ireland of children attending mainstream schools in randomly sampled local authorities and will be run by a consortium led by the Office for National Statistics. In England this will be complemented by a survey of 5 and 12-year old children who attend special support schools. The information generated will be used to make comparisons of the oral health of these children with their same-age peers attending mainstream schools.

Currently the only way the clinical needs can be measured is by fieldwork surveys and this method of measurement produces robust information.

Surveys conducted previously have suggested that there may be significant inequalities in oral health between these two groups. It is important that we understand more about the oral health status of children with special needs in order to target prevention and treatment delivery. This is particularly relevant as serious medical conditions can be de-stabilised by dental pain and infection and provision of treatment can be challenging.

Public Health England is asking for directors of public health to give support for local involvement. Dental Epidemiology Regional Coordinators will be working with Directors of Community Dental Services to ensure fieldwork teams are allocated to local areas. It would be very helpful if directors of public health could voice their support to Directors of Children's services and for them to pass on their endorsement to headteachers of special support schools. Consultants in Dental Public Health in your local Public Health England centre are available to advise during the whole process, including commissioning of these surveys.

The findings will be made widely available and shared with you and colleagues.

Yours sincerely

Dr Sue Gregory OBE
Director of Dental Public Health
E sue.gregory@PHE.gov.uk

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

National Dental Epidemiology Programme for England
Survey of five and 12-year old children attending special support schools 2013/2014

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 the Community Dental Service usually carry out these surveys. As with all NHS employees the teams are covered by the Data Protection Act and take confidentiality very seriously. 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 special support schools within a local authority area. They will ask for cooperation from the school and for access to lists of all children that may be included, showing dates of birth and home postcodes. From these lists they will identify children who will be the correct age on the day of examination. Positive, written consent will then be sought via letters home to parents, which the team will provide.

On the day of examination the team will set up their mobile equipment at an agreed location at the school and undertake brief examinations of the consented 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 is recorded anonymously; no names, gender or complete dates of birth are recorded. All data are kept securely and only staff with the dedicated computer programme can view the information. Datasets are securely sent to regional centres for uploading via a secure web portal to the national coordinating centre. This centre collates data from all over England and produces reports on levels of dental health for England as a whole and at a variety of local government and health organisation levels. At no point is any individual identifiable, as the data are anonymised from the examination stage and only 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 positive consent

Consent for School Dental Inspections and Dental Epidemiological Surveys

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

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

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

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

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

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

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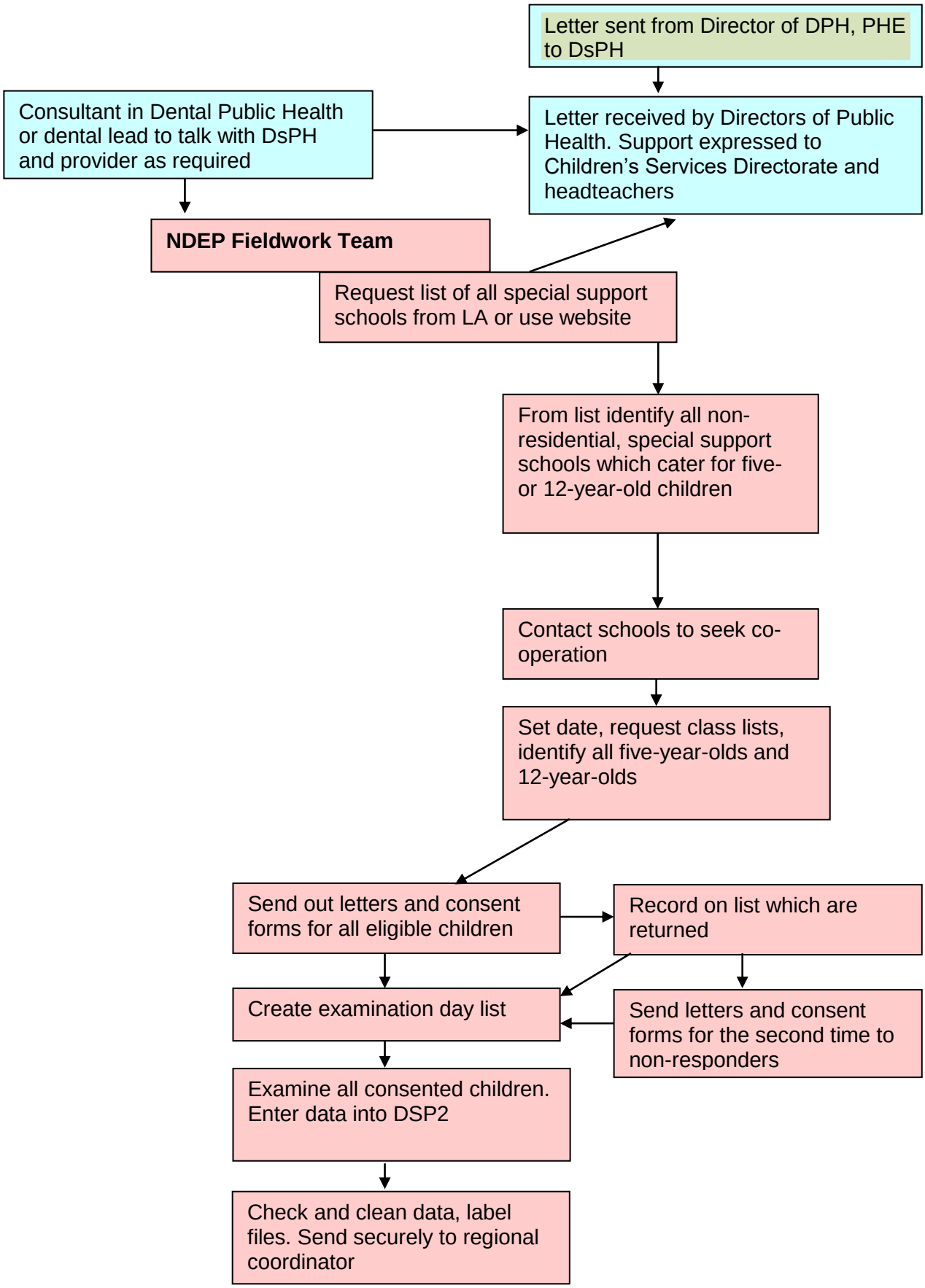
[1] *Good practice in Consent* (HSC 2001/023)
http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/HealthServiceCircularsArticle/fs/en?CONTENT_ID=4003736&chk=OigZnc

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

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

Appendix E - Stages for National Dental Epidemiology Programme teams to undertake the survey.



Appendix F - Operational timetable

Training for regional coordinators – National Protocol	October 2013
National clinical training and calibration	
Regional training and calibration	As soon as can be arranged following national training.
Data collection and ongoing data entry	To start as soon as possible and completed by 20 July 2014. CDHS examining to be completed first.
Completion of data checking and labelling of LA data files. Secure forwarding of cleaned data files to regional coordinators as soon as possible before deadline.	By 31 July 2014.
Regional coordinators to upload summaries and copies of LA data files to the Dental Public Health Team (formerly The Dental Observatory) via the web portal www.nwph.net/dentalhealthupload/login.aspx	To be uploaded as and when they have been checked, completed by 31 August 2014.
Dental Public Health (DPH) Team - Checking of data and collation	As and when data files arrive.
North West Knowledge and Information Team (NW KIT) / DPH Team – compute estimates for LAs	From end of August 2014.
Publication of results on website www.nwph.net/dentalhealth	December 2014 or four months after receipt of last data set dependent upon PHE gateway process and to be agreed in conjunction with CDHS.
Feedback of cleaned data to regional coordinators, KITs, CsDPH, PHE.	February 2015 or five months after receipt of last data set
Publication of results in Community Dental Health	June 2015 dependent upon receipt of last set of data

Appendix G - 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 PAT tested, as with any electrical equipment, and signs of damage noted and acted upon.

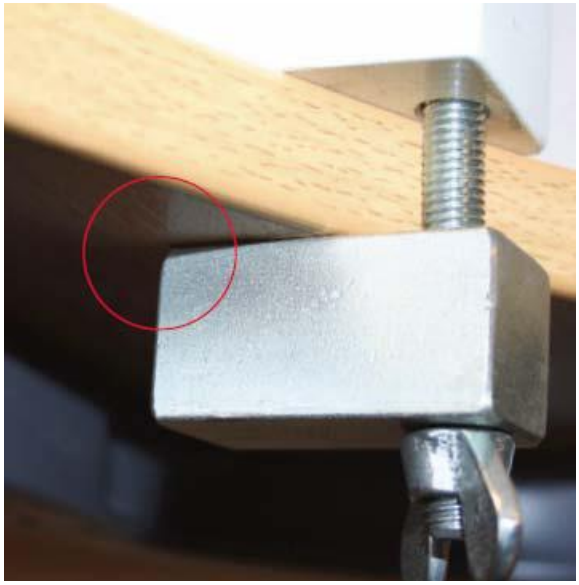
The clamps should be fitted and used correctly and checked to ensure they are firmly fixed to a work surface. For this reason it is best practice to establish a set examination site at a venue and avoid moving around from one room to another.

The Pivot D2 clamp has replaced the Pivot D clamp and can be sourced from Daray Ltd
Tel: 0870 777 2664 Sales.team@daray.co.uk www.Daray.com

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).

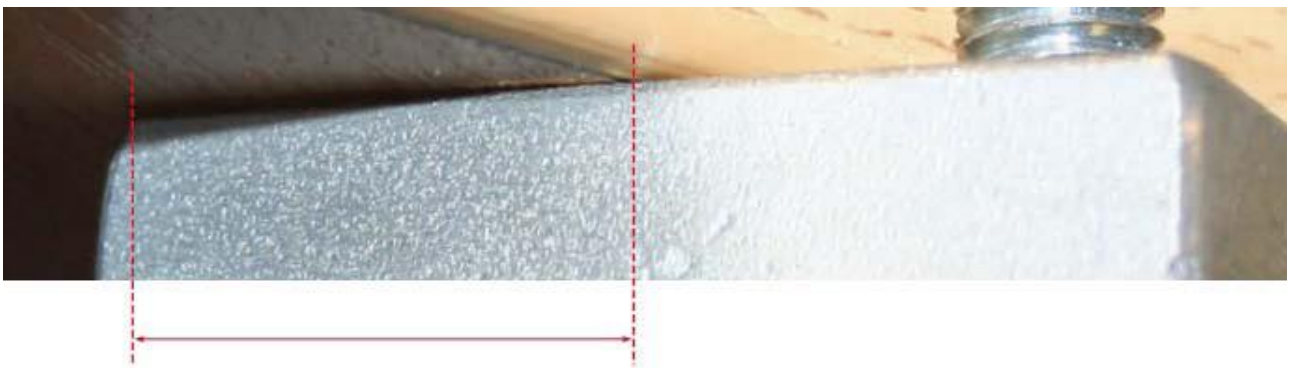
Examiners should check that the lamp is stable before undertaking examinations.

Pic 1: Correct fitting and use of the clamp



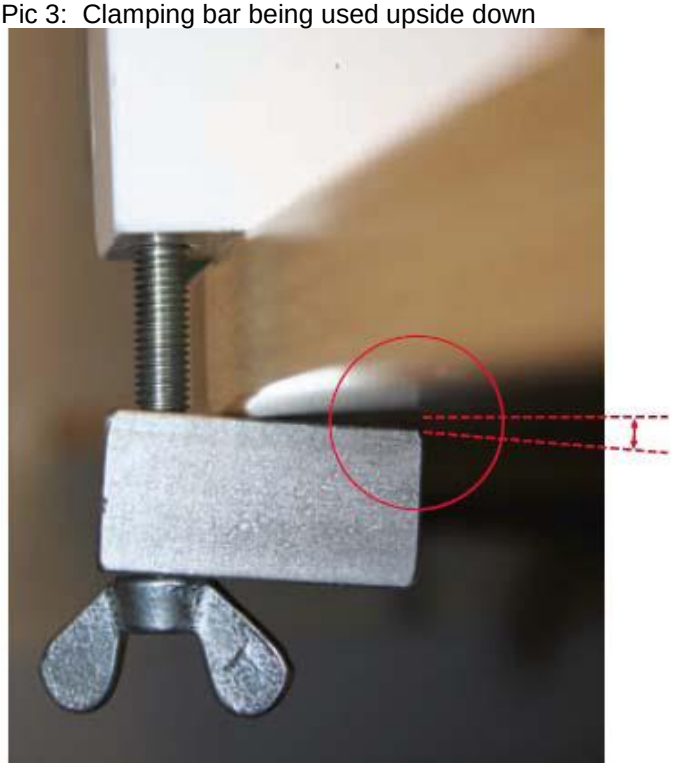
Pic 2: Correct fitting and use of the clamp

Note the surface contact along the length of the clamp

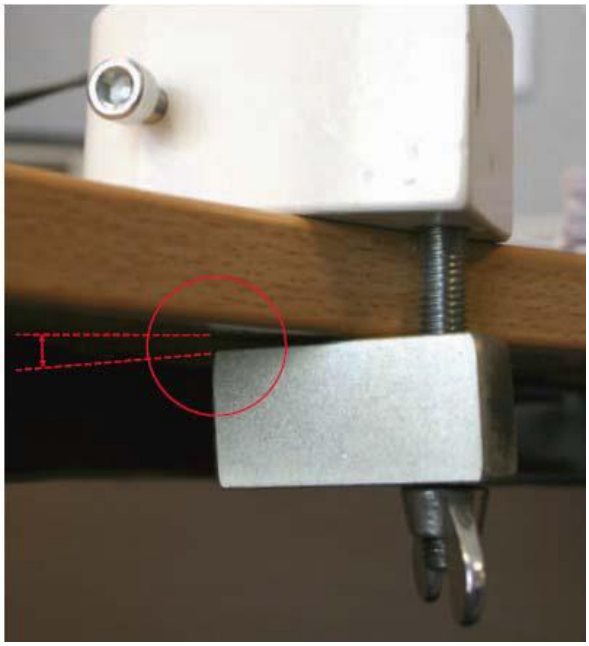


Incorrect use of clamp:

Pic 3: Clamping bar 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.

Appendix H - Sources of information

- This national protocol, DSP2 format, guidance to data input and handling and feedback forms are all available from the NDEP website www.nwph.net/dentalhealth

- Site to buy DSP2: http://usd.swreg.org/com/storefront/47803/product/478031

- List of special support schools and contact details from Schools Information within LEA or Children's Services Department, or use LA Education website.

- If home postcodes cannot be obtained from schools, school nurses, school 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 new unit required, to replace a Daray Versatile (this is no longer produced):

  Either The Daray X100 Halogen (£179 + VAT) with Pivotd2 to allow desk-mounting (£37 + VAT)
  Contact Daray Tel: 0333 321 0971
  www.daray.co.uk
  www.daray.co.uk/docs/X100.html

Or The MT608BASCD (£310.32 + VAT incl clamp and bulb)
Contact Brandon Medical Co. Ltd
Tel: 01132 777393
www.brandon-medical.com/products/medical-lighting/examination-lights/mt6008-examination-lamps

Appendix I - Guidance and adaptation to allow DSP2 to run on new versions of Microsoft Windows. With thanks to colleagues at Cardiff University.

32-bit and 64-bit Windows

The terms 32-bit and 64-bit refer to the way a computer's processor (also called a CPU), handles information. The 64-bit version of Windows handles large amounts of random access memory (RAM) more effectively than a 32-bit system.

Most programs designed for the 32-bit version of Windows will work on the 64-bit version of Windows. However this is **not** true for 16-bit applications like DSP2 as the table below shows.

Table 1. Tests of installation of both versions of DSP2 on Windows 7 and 8 operating systems

	Windows 7	Windows 8
32-bit	Yes	Yes
64-bit	No	No

To find out if your computer is running 32-bit or 64-bit Windows, do the following:

1. Open System by clicking the **Start** button, clicking **Control Panel**, clicking **System and Security**, and then clicking **System**.
2. Under **System**, you can view the system type.

DSP2 Deployment

As a short-term interim, and somewhat cumbersome measure, DSP2 may be deployed on 64-bit Windows 7 by using Windows XP Mode. This comes as a separate download and works only with Windows 7 Professional, Ultimate, and Enterprise.

Machines purchased from retail outlets will be running the consumer versions of Windows 7. A Windows Enterprise licence will be required and the Windows operating system will need to be re-installed. It is recommended that professional IT support is provided for this process.

Windows XP mode is not present in Windows 8 though it may be possible to deploy this using Microsoft's virtualisation technology Hyper-V.

64-bit Windows machines are becoming very common and it is likely that the next version of Windows will be 64-bit only. Because of this, and the extra support required to deploy DSP2 on Windows 7 there is a clear need to update or replace DSP2.

Summary

- Existing installations will continue to work. However Microsoft are withdrawing support for Windows XP. Corporate type environments will be replacing Windows XP with Windows 7, and in many cases this will be 64-bit Windows 7 (e.g. Cardiff University)
- Both versions (1.1 and 2.1) of DSP2 install on 32-bit Windows 7 and 8.
- DSP2 will install on 64-bit Windows 7 but will require IT support to install, and an enterprise licence of Windows will need to be acquired.

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	E06000028	Bournemouth	E06000028
Bracknell Forest	E06000036	Bracknell Forest	E06000036
Bradford	E08000032	Bradford	E08000032
Brent	E09000005	Brent	E09000005
Brighton and Hove	E06000043	Brighton and Hove	E06000043
Bristol, City of	E06000023	Bristol, City of	E06000023
Bromley	E09000006	Bromley	E09000006
Buckinghamshire	E10000002	Aylesbury Vale	E07000004
		Chiltern	E07000005
		South Bucks	E07000006
		Wycombe	E07000007
Bury	E08000002	Bury	E08000002
Calderdale	E08000033	Calderdale	E08000033
Cambridgeshire	E10000003	Cambridge	E07000008
		East Cambridgeshire	E07000009
		Fenland	E07000010
		Huntingdonshire	E07000011
		South Cambridgeshire	E07000012
Camden	E09000007	Camden	E09000007
Central Bedfordshire	E06000056	Central Bedfordshire	E06000056
Cheshire East	E06000049	Cheshire East	E06000049
Cheshire West and Chester	E06000050	Cheshire West and Chester	E06000050
City of London	E09000001	City of London	E09000001
Cornwall	E06000052	Cornwall	E06000052
County Durham	E06000047	County Durham	E06000047
Coventry	E08000026	Coventry	E08000026
Croydon	E09000008	Croydon	E09000008
Cumbria	E10000006	Allerdale	E07000026
		Barrow-in-Furness	E07000027
		Carlisle	E07000028
		Copeland	E07000029
		Eden	E07000030
		South Lakeland	E07000031
Darlington	E06000005	Darlington	E06000005

Upper Tier Local Authority	Upper Code	Lower Tier Local Authority	Lower Code
Derby	E06000015	Derby	E06000015
Derbyshire	E10000007	Amber Valley	E07000032
		Bolsover	E07000033
		Chesterfield	E07000034
		Derbyshire Dales	E07000035
		Erewash	E07000036
		High Peak	E07000037
		North East Derbyshire	E07000038
		South Derbyshire	E07000039
Devon	E10000008	East Devon	E07000040
		Exeter	E07000041
		Mid Devon	E07000042
		North Devon	E07000043
		South Hams	E07000044
		Teignbridge	E07000045
		Torridge	E07000046
		West Devon	E07000047
Doncaster	E08000017	Doncaster	E08000017
Dorset	E10000009	Christchurch	E07000048
		East Dorset	E07000049
		North Dorset	E07000050
		Purbeck	E07000051
		West Dorset	E07000052
		Weymouth and Portland	E07000053
Dudley	E08000027	Dudley	E08000027
Ealing	E09000009	Ealing	E09000009
East Riding of Yorkshire	E06000011	East Riding of Yorkshire	E06000011
East Sussex	E10000011	Eastbourne	E07000061
		Hastings	E07000062
		Lewes	E07000063
		Rother	E07000064
		Wealden	E07000065
Enfield	E09000010	Enfield	E09000010
Essex	E10000012	Basildon	E07000066
		Braintree	E07000067
		Brentwood	E07000068
		Castle Point	E07000069
		Chelmsford	E07000070
		Colchester	E07000071
		Epping Forest	E07000072
		Harlow	E07000073
		Maldon	E07000074
		Rochford	E07000075
		Tendring	E07000076
		Uttlesford	E07000077

Upper Tier Local Authority	Upper Code	Lower Tier Local Authority	Lower Code
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
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

Upper Tier Local Authority	Upper Code	Lower Tier Local Authority	Lower Code
Kent	E10000016	Ashford	E07000105
		Canterbury	E07000106
		Dartford	E07000107
		Dover	E07000108
		Gravesham	E07000109
		Maidstone	E07000110
		Sevenoaks	E07000111
		Shepway	E07000112
		Swale	E07000113
		Thanet	E07000114
		Tonbridge and Malling	E07000115
		Tunbridge Wells	E07000116
Kingston upon Hull, City of	E06000010	Kingston upon Hull, City of	E06000010
Kingston upon Thames	E09000021	Kingston upon Thames	E09000021
Kirklees	E08000034	Kirklees	E08000034
Knowsley	E08000011	Knowsley	E08000011
Lambeth	E09000022	Lambeth	E09000022
Lancashire	E10000017	Burnley	E07000117
		Chorley	E07000118
		Fylde	E07000119
		Hyndburn	E07000120
		Lancaster	E07000121
		Pendle	E07000122
		Preston	E07000123
		Ribble Valley	E07000124
		Rossendale	E07000125
		South Ribble	E07000126
		West Lancashire	E07000127
		Wyre	E07000128
Leeds	E08000035	Leeds	E08000035
Leicester	E06000016	Leicester	E06000016
Leicestershire	E10000018	Blaby	E07000129
		Charnwood	E07000130
		Harborough	E07000131
		Hinckley and Bosworth	E07000132
		Melton	E07000133
		North West Leicestershire	E07000134
		Oadby and Wigston	E07000135
Lewisham	E09000023	Lewisham	E09000023
Lincolnshire	E10000019	Boston	E07000136
		East Lindsey	E07000137
		Lincoln	E07000138
		North Kesteven	E07000139
		South Holland	E07000140
		South Kesteven	E07000141
		West Lindsey	E07000142

Upper Tier Local Authority	Upper Code	Lower Tier Local Authority	Lower Code
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
Nottinghamshire	E10000024	Ashfield	E07000170
		Bassetlaw	E07000171
		Broxtowe	E07000172
		Gedling	E07000173
		Mansfield	E07000174
		Newark and Sherwood	E07000175
		Rushcliffe	E07000176
Oldham	E08000004	Oldham	E08000004

Upper Tier Local Authority	Upper Code	Lower Tier Local Authority	Lower Code
Oxfordshire	E10000025	Cherwell	E07000177
		Oxford	E07000178
		South Oxfordshire	E07000179
		Vale of White Horse	E07000180
		West Oxfordshire	E07000181
Peterborough	E06000031	Peterborough	E06000031
Plymouth	E06000026	Plymouth	E06000026
Poole	E06000029	Poole	E06000029
Portsmouth	E06000044	Portsmouth	E06000044
Reading	E06000038	Reading	E06000038
Redbridge	E09000026	Redbridge	E09000026
Redcar and Cleveland	E06000003	Redcar and Cleveland	E06000003
Richmond upon Thames	E09000027	Richmond upon Thames	E09000027
Rochdale	E08000005	Rochdale	E08000005
Rotherham	E08000018	Rotherham	E08000018
Rutland	E06000017	Rutland	E06000017
Salford	E08000006	Salford	E08000006
Sandwell	E08000028	Sandwell	E08000028
Sefton	E08000014	Sefton	E08000014
Sheffield	E08000019	Sheffield	E08000019
Shropshire	E06000051	Shropshire	E06000051
Slough	E06000039	Slough	E06000039
Solihull	E08000029	Solihull	E08000029
Somerset	E10000027	Mendip	E07000187
		Sedgemoor	E07000188
		South Somerset	E07000189
		Taunton Deane	E07000190
		West Somerset	E07000191
South Gloucestershire	E06000025	South Gloucestershire	E06000025
South Tyneside	E08000023	South Tyneside	E08000023
Southampton	E06000045	Southampton	E06000045
Southend-on-Sea	E06000033	Southend-on-Sea	E06000033
Southwark	E09000028	Southwark	E09000028
St. Helens	E08000013	St. Helens	E08000013
Staffordshire	E10000028	Cannock Chase	E07000192
		East Staffordshire	E07000193
		Lichfield	E07000194
		Newcastle-under-Lyme	E07000195
		South Staffordshire	E07000196
		Stafford	E07000197
		Staffordshire Moorlands	E07000198
		Tamworth	E07000199
Stockport	E08000007	Stockport	E08000007
Stockton-on-Tees	E06000004	Stockton-on-Tees	E06000004
Stoke-on-Trent	E06000021	Stoke-on-Trent	E06000021

Upper Tier Local Authority	Upper Code	Lower Tier Local Authority	Lower Code
Suffolk	E10000029	Babergh	E07000200
		Forest Heath	E07000201
		Ipswich	E07000202
		Mid Suffolk	E07000203
		St Edmundsbury	E07000204
		Suffolk Coastal	E07000205
		Waveney	E07000206
Sunderland	E08000024	Sunderland	E08000024
Surrey	E10000030	Elmbridge	E07000207
		Epsom and Ewell	E07000208
		Guildford	E07000209
		Mole Valley	E07000210
		Reigate and Banstead	E07000211
		Runnymede	E07000212
		Spelthorne	E07000213
		Surrey Heath	E07000214
		Tandridge	E07000215
		Waverley	E07000216
		Woking	E07000217
Sutton	E09000029	Sutton	E09000029
Swindon	E06000030	Swindon	E06000030
Tameside	E08000008	Tameside	E08000008
Telford and Wrekin	E06000020	Telford and Wrekin	E06000020
Thurrock	E06000034	Thurrock	E06000034
Torbay	E06000027	Torbay	E06000027
Tower Hamlets	E09000030	Tower Hamlets	E09000030
Trafford	E08000009	Trafford	E08000009
Wakefield	E08000036	Wakefield	E08000036
Walsall	E08000030	Walsall	E08000030
Waltham Forest	E09000031	Waltham Forest	E09000031
Wandsworth	E09000032	Wandsworth	E09000032
Warrington	E06000007	Warrington	E06000007
Warwickshire	E10000031	North Warwickshire	E07000218
		Nuneaton and Bedworth	E07000219
		Rugby	E07000220
		Stratford-on-Avon	E07000221
		Warwick	E07000222
West Berkshire	E06000037	West Berkshire	E06000037
West Sussex	E10000032	Adur	E07000223
		Arun	E07000224
		Chichester	E07000225
		Crawley	E07000226
		Horsham	E07000227
		Mid Sussex	E07000228
		Worthing	E07000229

Upper Tier Local Authority	Upper Code	Lower Tier Local Authority	Lower Code
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 five-year-olds 2013/14

For this month of exam ↓	Children born within these ranges will definitely be five 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 2013	October 2007	August 2008	September 2007 and 2008*
October 2013	November 2007	September 2008	October 2007 and 2008*
November 2013	December 2007	October 2008	November 2007 and 2008*
December 2013	January 2008	November 2008	December 2007 and 2008*
January 2014	February 2008	December 2008	January 2008 and 2009**
February 2014	March 2008	January 2009	February 2008 and 2009**
March 2014	April 2008	February 2009	March 2008 and 2009**
April 2014	May 2008	March 2009	April 2008 and 2009**
May 2014	June 2008	April 2009	May 2008 and 2009**
June 2014	July 2008	May 2009	June 2008 and 2009**
July 2014	August 2008	June 2009	July 2008 and 2009**
August 2014	September 2008	July 2009	August 2008 and 2009**
September 2014	October 2008	August 2009	September 2008 and 2009**

* If born 2007 birth day should be later than day of exam, if born 2008 birth day should be same day or before day of exam.

** If born 2008 birth day should be later than day of exam, if born 2009 birth day should be same day or before day of exam.

Appendix L - Guide for date of birth bands for survey of 12-year-olds 2013/14

For this month of exam ↓	Children born within these ranges will definitely be 12 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 2013	October 2000	August 2001	September 2000 and 2001*
October 2013	November 2000	September 2001	October 2000 and 2001*
November 2013	December 2000	October 2001	November 2000 and 2001*
December 2013	January 2001	November 2001	December 2000 and 2001*
January 2014	February 2001	December 2001	January 2001 and 2002**
February 2014	March 2001	January 2002	February 2001 and 2002**
March 2014	April 2001	February 2002	March 2001 and 2002**
April 2014	May 2001	March 2002	April 2001 and 2002**
May 2014	June 2001	April 2002	May 2001 and 2002**
June 2014	July 2001	May 2002	June 2001 and 2002**
July 2014	August 2001	June 2002	July 2001 and 2002**
August 2014	September 2001	July 2002	August 2001 and 2002**
September 2014	October 2001	August 2002	September 2001 and 2002**

* If born 2000 birth day should be later than day of exam, if born 2001 birth day should be same day or before day of exam.

** If born 2001 birth day should be later than day of exam, if born 2002 birth day should be same day or before day of exam.

Appendix M – Consent letter and form. To be added to headed notepaper - minor modifications are acceptable, local details to be added.

Dear Parent,

National Dental Epidemiology Programme for England, oral health survey of five-year-old and 12-year-old children attending special support schools, 2013/14.

Please will you help us to plan better dental services? To do this we are preparing to look at the teeth of groups of five-year-old and 12-year-old children attending special support schools in parallel with a national survey of children attending mainstream schools. We can then compare dental health between the two types of schools locally and with other areas of the country.

Please give your consent to your child taking part in this year's survey by signing the attached form and returning it to your child's school. The survey is planned to take place on …….. The children taking part will have a simple examination at their school when a dentist and assistant who are trained to do this work will visit. The dentist will use fresh disposable gloves and sterilised mirrors for each child. The check takes only a few minutes and we will let you know if we find anything wrong. We would be pleased to see you at the school if you would like to be present.

No treatment will be provided, just a quick examination. All children still need to visit their own dentist for regular check-ups.

As part of the survey we will be asking the school to share some information they already have, for example home postcode or ethnic group. The information about your child will be anonymised and stored in a computer file which will be password protected and only dental staff and Public Health England staff will have access to it. The anonymised results will be sent to the national PHE centre so that they can be compared with all other local authorities in England. The findings may be published in a scientific journal but no individual will be identifiable and the analysis and reporting will be carried out on groups.

Thank you for reading this information sheet. If you have any questions please contact ……

Yours sincerely

Clinical Director

CONSENT FORM

I have read and understood the information in the invitation letter about the dental survey.

My child's name is (insert name)…….. Class ……

Please tick appropriate box below:

Yes, I agree to my child taking part in the dental survey ☐

No, I do not want my child to be included ☐

Signed……(parent or guardian) Date ……

Name (block capitals) ……

Optional statements for consent letter:

Please give your home postcode ……..

Please write the name of your child's doctor or medical practice ……

Appendix N – Tracking list for schools to record which children have returned consent forms

National Dental Epidemiology Programme Survey of five and 12-year-olds

Return of consent forms - Class ……

Child's name	Tick when form returned	Notes

Appendix O – Data collection sheet – Five-year-old children

1. Upper Tier LA code |__|__|__|__|__|__|__|__|__| 2. Examiner _____

3. School name _____ 4. School Postcode |__|__|__|__| |__|__|__|

5. Date of examination |_d_|_d_|_m_|_m_|_y_|_y_|_y_|_y_|

6. School type code |__|
0 – ASD (Autistic spectrum disorder)
1 – BESD (Behavioural emotional & social difficulty)
2 – H1 (Hearing impairment)
3 – V1 (Visual impairment)
4 – MLD (Moderate learning difficulty)
5 – PMLD (Profound & multiple learning difficulty)
6 – SLD (Severe learning difficulty)
7 – Sp LD (Specific learning difficulty)
8 – PD (Physical disability)
9 – SLCN (Speech language & communication)
10 – Other

7. Child identity number |__|__|__|__|__|__|__|__|__| 8. Date of birth |1|5|_m_|_m_|_y_|_y_|_y_|_y_|

9. Home postcode |__|__|__|__| |__|__|__|

10. Examination status |__|
0 - Full examination completed
1 - Partial examination only
2 - No examination possible
3 - Child absent
4 - Child refused
5 - Training

11. Plaque measurement |__|
0 - Teeth appear clean
1 - Little plaque visible
2 - Substantial plaque visible
9 - No assessment could be made

Right **UPPER** **Left**

	E	D	C	B	A	A	B	C	D	E	
D											D
O											O
M											M
B											B
L											L

Right **LOWER** **Left**

	E	D	C	B	A	A	B	C	D	E	
D											D
O											O
M											M
B											B
L											L

Tooth Codes

Extracted caries.....	6
Unerupted or missing other.....	8

Surface Codes

Sound..... Blank, '-' , Or	0
Hard, arrested caries.....	1
Decayed.....	2
Decay + pulpal involvement.....	3
Roots only remaining…….	3
Filled and decayed.....	4
Filled.....	5
Filled, needs replacement.....	R
Obvious sealant rest'n.....	N
Sealed surface	$
Crown	C
Trauma.....	T
Unrecordable……..	9

13. Abscess / Sepsis present |__| 0 - Absent 1 – Present

Optional measures

14. Higher Ethnicity |__| See 13.10 15. Lower Ethnicity |__| See 13.10

16. Spare variable |__| 0 - 1 - 2 - 3 -

17. Spare variable |__| 0 - 1 - 2 - 3 -

18. Spare variable |__| 0 - 1 - 2 - 3 -

Appendix P – Data collection sheet – 12-year-old children

1. Upper Tier LA code |__|__|__|__|__|__|__|__|__| 2. Examiner _____

3. School name _____ 4. School Postcode |__|__|__|__| |__|__|__|

5. Date of examination |_d_|_d_|_m_|_m_|_y_|_y_|_y_|_y_|

6. School type code |__|
0 – ASD (Autistic spectrum disorder)
1 – BESD (Behavioural emotional & social difficulty)
2 – H1 (Hearing impairment)
3 – V1 (Visual impairment)
4 – MLD (Moderate learning difficulty)
5 – PMLD (Profound & multiple learning difficulty)
6 – SLD (Severe learning difficulty)
7 – Sp LD (Specific learning difficulty)
8 – PD (Physical disability)
9 – SLCN (Speech language & communication)
10 – Other

7. Child identity number |__|__|__|__|__|__|__|__|__| 8. Date of birth |1|5|_m_|_m_|_y_|_y_|_y_|_y_|

9. Home postcode |__|__|__|__| |__|__|__|

10. Examination status |__|
0 - Full examination completed
1 - Partial examination only
2 - No examination possible
3 - Child absent
4 - Child refused
5 - Training

11. Plaque measurement |__|
0 - Teeth appear clean
1 - Little plaque visible
2 - Substantial plaque visible
9 - No assessment could be made

Right **UPPER** **Left**

	7	6	5	4	3	2	1	1	2	3	4	5	6	7	
D															**D**
O															**O**
M															**M**
B															**B**
L															**L**

Right **LOWER** **Left**

	7	6	5	4	3	2	1	1	2	3	4	5	6	7	
D															**D**
O															**O**
M															**M**
B															**B**
L															**L**

13. Abscess / Sepsis present |__| 0 - Absent 1 - Present

Optional measures

14. Higher Ethnicity |__| See 13.10 15. Lower Ethnicity |__| See 13.10

16. Spare variable |__| 0 - 1 - 2 - 3 –

17. Spare variable |__| 0 - 1 - 2 - 3 –

18. Spare variable |__| 0 - 1 - 2 - 3 -

Tooth Codes

Extracted caries	6
Extracted ortho	7
Unerupted or missing other	8

Surface Codes

Sound	Blank, '-' , Or 0
Hard, arrested caries	1
Decayed	2
Decay + pulpal involvement	3
Roots only remaining	3
Filled and decayed	4
Filled	5
Filled, needs replacement	R
Obvious sealant rest'n	N
Sealed surface	$
Crown	C
Trauma	T
Unrecordable	9

Appendix Q – Examination day sheet

National Dental Epidemiology Programme for England.
Oral health survey of five and 12-year-old children in special support schools, 2013/2014.

Name of School ……..…….. School postcode ……..…… ….

Date of examination _ _ / _ _ / _ _ _ _ Name of school contact……..……Telephone number……..…..

This column to be deleted as soon as possible				Examination status		
Child's name	ID Number	Date of birth	Postcode	Examination (full, partial, not possible)	Child absent	Child refused

Appendix R and S - Dental SurveyPlus 2 Programme Format print outs.

These will be provided in the data handling guidance notes, which will be produced shortly.

Appendix T - Summary information sheet – one form to be completed per LA.

National Dental Epidemiology Programme for England.
Oral health survey of five and 12-year-old children
in special support schools, 2013/2014

Local Authority .....

Name of examiner(s) .....

Start - finish date of examinations (dd/mm/yyyy – dd/mm/yyyy) ..... - .....

Five-year-old children

Total number of special support schools listed by LA: [ ] Number of schools visited: [ ]

Total number of five-year-old children attending listed special support schools: [ ]

Number of children from whom consent sought: [ ]

Number of children with parental consent supplied: [ ] parental consent refused: [ ] consent form not returned: [ ]

Number of children with parental consent : examination: (full, partial & no examination possible) [ ] Child absent: [ ] Child refused: [ ]

12-year-old children

Total number of special support schools listed by LA: [ ] Number of schools visited: [ ]

Total number of 12-year-old children attending listed special support schools: [ ]

Number of children from whom consent sought: [ ]

Number of children with parental consent supplied: [ ] parental consent refused: [ ] consent form not returned: [ ]

Number of children with parental consent : examination: (full, partial & no examination possible) [ ] child absent: [ ] child refused: [ ]