Public Health England

Protecting and improving the nation's health

National Dental Epidemiology Programme

Oral health survey of 5-year-old children 2021 to 2022: national protocol

Version 1.0

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

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1. Introduction

Local authorities have been responsible for gathering information on the health needs of their local populations since April 2013 (1). This imperative is described in the Health and Social Care Act 2012 (2), underpinned by Statutory Instrument 2012 number 3094 (3) and Commissioning Better Oral Health (4).

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

The population group for scrutiny for the 2021 to 2022 will be 5-year-olds attending mainstream schools. Biennial surveys of this age group provide an insight into dental health and associated child-rearing practices at a key life stage. The findings will allow local authorities to monitor this age group. The results are a Public Health Outcomes Framework (PHOF) indicator, reported as an item on the Single Data List and classified as Official Statistics.

In response to requests by local authorities this protocol allows for the option of running a parallel survey of 5-year-old children attending special schools in addition to the main survey. The decision about doing this and resourcing the additional fieldwork needs to be taken locally.

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

2. Survey aim

The aim of the survey is to measure the prevalence and severity of dental caries among 5-year-old children within each lower-tier local authority. The resulting reports give details of caries levels and other clinical measures and provide information for local authorities, the NHS and other partners.

This information can be used to:

- enable local authorities to meet their responsibilities with regard to health needs assessments
- inform health needs assessments
- provide comparisons with children of the same age in previous years (2008, 2012, 2015, 2017 and 2019) to permit monitoring of the PHOF measure

- provide standardised information for comparison locally, regionally, between countries of the UK and internationally
- inform local oral health improvement strategies

3. Survey objectives

The objectives of the survey are:

- to examine 5-year-old children using dental caries diagnostic criteria and examination techniques based on those agreed by the British Association for the Study of Community Dentistry (BASCD) for caries prevalence surveys (5)
- to use the sampling procedures described in the BASCD guidance on sampling for surveys of child dental health (6)

4. Sample

The primary sampling unit will be local authority boundaries at unitary, metropolitan borough or lower-tier levels, as has been the case in all recent surveys of this population group.

In a small number of cases it may not be sensible for estimates to be provided for all lower-tier local authorities within a large upper-tier local authority. Where there is no need for small area estimates there should be discussion between the regional dental epidemiology coordinator (DEC), relevant consultants in dental public health and statistical advice may need to be sought to agree a reasonable sampling method to allow for estimates of other geographical areas to be produced.

4.1 Survey population

The main survey population is defined as all those children attending state-funded primary schools of all classifications (excluding special schools) within the local authority who have reached the age of 5 years but have not had their 6th birthday on the date of examination (Appendix I).

4.2 Sampling procedure

Discussion is required between local authority commissioners and consultants in dental public health in PHE centres to establish the size and type of sample that is required to meet local needs. For example, specific areas or population groups may be of interest, so

enhanced samples may be required. Once this has been agreed the fieldwork team can undertake the sampling process.

4.2.1 Sample size

A minimum sample size of 250 examined children is required per lower-tier local authority, from a minimum of 20 mainstream schools. To allow for absenteeism and inaccuracies in the numbers of children, it is advised that a minimum of 360 children are randomly selected, based on a 70% response rate. Refer to each local authority's previous 5-year-old survey response rate when deciding on the number of children to select. All children with agreement to participate should then be examined, even though this may mean a final sample of examined children larger or smaller than the minimum sample size of 250 in some cases. It is recognised that as the proportion of children with agreement to participate reduces, the representativeness of the sample also reduces.

The minimum sample size is unlikely to produce a sufficiently large sample to facilitate local planning for many areas, in which case larger samples will be required. Details of these requirements and the need for local stratification will be determined by local authorities with advice from local consultants in dental public health, in liaison with providers of the survey. Where larger samples are drawn, the children selected may need to be coded as additional sample A or B or C to allow for valid estimates to be calculated for the local authority area. This should be agreed with the national dental public health team. There is further guidance on additional sampling in section 7.5.14.

Local dental epidemiology co-ordinators (DECs) must be informed of proposed sampling methods so that they can confirm their validity before the survey commences.

If a survey of children attending special schools is to be undertaken in parallel with the standard survey, a different sampling method may be required (Appendix N).

4.2.2 Sampling process

Guidance on the required stratified sampling procedures is provided in the step by step sampling guide. This is based on the epidemiology quality standard by Pine and others, 1997a (6). Advice on sampling can also be requested from the local dental epidemiology coordinator.

Lists of all state maintained primary schools within each local authority area, and the numbers of pupils attending each, will be required as the first stage in the sampling process.

Special schools should not be included in the main sampling frame. If a parallel survey of special schools is being planned, guidance is available at Appendix N.

In most local authority areas, a 2-stage sampling procedure will be required for the survey

Using class lists, children who will be age-eligible on the planned day of examination will be identified (Appendix I) and sampling of the appropriate intensity carried out (section 4.2). A list of these sampled children, along with their home postcodes, sex, ethnicity and multiple birth status will be formed into a table (Appendix L).

A stratified sampling method, which takes school size into account, is described in the step by step sampling guide. The school size bandings and sampling intensity described are guidance only. It may be necessary to alter these to produce suitable numbers of children for whom to seek agreement to participate. For example, schools could be divided into those with fewer than 30 children aged 5 and those with 30 or more. All the children in the smaller schools would be sampled, while 1 in 2 or 1 in 3 in the larger schools would be sampled. Regardless of the selected size bandings and intensities, it is still essential to calculate the correct proportions of children to be selected from small and large schools to ensure the sample is representative of the distribution in the overall population. This is the normal process for the sampling techniques used in previous surveys. Four tables need to be constructed showing how the sample will be structured and copies of these, together with details of the sampling methodology, must be sent to the local DEC for agreement before any schools are contacted or children selected.

While sampling, it is advisable to sample 1 or 2 extra schools within each size band. These can then be used as substitutes in case other schools refuse to take part or cannot take part due to unexpected problems. Neither schools nor children should be substituted to compensate for children who do not return an agreement to participate form. It is recognised that as the proportion of children with agreement to participate reduces, the representativeness of the sample also reduces. An increased number of examined children will give greater precision to the data but will not affect the representativeness of the sample as it is unlikely that the response rate for a sample of 170 children will be different from that of a sample of 500 children.

Every effort should be directed towards encouraging and supporting parents and persons with parental responsibility to return agreement to participate forms (section 6.3.1).

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

Contact details of dental epidemiology co-ordinators

Region	Name of DEC	NHS.net email address
East Midlands	Allan Reid	allan.reid@nhs.net
East of England	Feema Francis	feema.francis@nhs.net
London	Charlotte Klass	charlotte.klass1@nhs.net
North East	Kamini Shah	Data to be submitted via encrypted memory stick
North West	Emma Hall-Scullin	To be confirmed
South East	Jeyanthi John	jjohn@nhs.net
South West	Zoë Allen	zoe.allen4@nhs.net
West Midlands	Vicky Massey	vicky.massey@nhs.net
Yorkshire and the Humber	Sandra Whiston	sandra.whiston@nhs.net

4.3 General Data Protection Regulations

A note about the General Data Protection Regulations (GDPR) and school dental surveys is provided (Appendix D).

4.3.1 GDPR and the lawful basis for the primary school health data collections

The GDPR became UK law on 25 May 2018. It updated and strengthened the ways in which personal data is protected.[1]

All processing of personal data, meaning all aspects of the collection, use and sharing of personal data about identifiable individuals,[2] must have a lawful basis under the GDPR. Article 6 of the GDPR sets out the range of purposes for which personal data can be lawfully processed. Article 9 sets out the associated conditions for the lawful processing of 'special categories' of personal data, including data about health.

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

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

1 Further information on the GDPR can be found on the Information Commissioner's Office website: Guide to the UK General Data Protection Regulation (UK GDPR) and;
2 Key definitions

- public interest in the area of public health

4.3.2 GDPR and dental health surveys

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

The official authority for dental health surveys is provided by The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012.[3] This official authority means that the lawful basis for processing children's personal data for this purpose is considered to be provided by:

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

4.3.3 Informing parents and persons with parental responsibility

Dental surveys involve a physical examination, so the written agreement of a parent or person with parental responsibility must be obtained for their children to be included.

No change is required to the way in which this written agreement is obtained. Fieldwork teams should use the information (Appendix J) and agreement to participate form (Appendix Ji). Only children for whom agreement to participate has been received should be included in the survey.

5. Responsibilities

5.1 Overarching responsibilities

The overarching responsibility for planning this survey and quality assuring the resulting products lies with the national Dental Public Health team, which is responsible for initiating and managing the project, ensuring that the design of the study meets appropriate standards and that arrangements are in place to ensure appropriate conduct and reporting.

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3 Legislation.gov.uk

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

5.2 Commissioning responsibilities

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

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

5.3 Personnel

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

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

Fieldwork personnel should be trained in data protection, safeguarding and other relevant information governance issues. Disclosure and Barring Service certificates may be requested by schools and all fieldwork team members must have valid certificates available.

6. Preparation

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

6.1 Planning and organisation of the survey

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

Fieldwork teams will contact the local authority education department to obtain lists of all state-funded primary schools within the area that educate 5-year-olds, including community schools, academies, foundation schools and free schools.

6.2 Contacting primary schools

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

A letter to headteachers (Appendix C) is provided which should be used to give schools more detail about the purpose and nature of the survey. It also shows that the request for co-operation comes from a formal, legitimate source.

Class 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
- home postcode
- sex
- multiple birth
- ethnicity

It is permissible to sample 5-year-old children from year 1 only, where fieldwork is completed by the last day before the February 2022 half-term holiday. This should result in a sample of children with an average age of 5.5 years. In these circumstances care should be applied when proposing the sampling method for approval by the DEC.

6.3 Seeking agreement to participate

Agreement to participate for undertaking dental examination of children in an epidemiological survey is required.

The procedure for obtaining agreement to participate is:

1. Give parents and persons with parental responsibility of sampled children information about the survey (Appendix J) and agreement to participate form (Appendix Ji).
2. Record on a form (Appendix K) which children have returned the signed agreement form and which have not.
3. Distribute a second agreement to participate form, ideally on differently coloured paper, to those who do not respond to the first.
4. Accept and respect the decision of a parent, person with parental responsibility or child to decline an examination.

In a few instances, arrangements exist whereby core agreement to participate in all health surveillance is provided for the whole of school life. Where this includes dental examination or checks, it can be regarded as sufficient. In such cases parents and persons with parental responsibility for children randomly selected should be sent the information on the nature and purpose of the survey (Appendix J). They should also be sent the letter for parents or persons with parental responsibility where core agreement to whole of school life health surveillance is adopted (Appendix Jii).

Electronic methods of gaining agreement to participate are being increasingly used in public health programmes. The decision to use an electronic method should be made locally following consultation with the DEC. It is likely to depend on whether this is used in other local public health programmes, such as childhood immunisations.

6.3.1 Maximising agreement to participate

It is important that every effort is made to maximise the proportion of agreement to participate forms returned from parents and persons with parental responsibility. Coercion to provide agreement to participate should not be used and would make the process illegal. However, there are a range of approaches which local authorities and fieldwork teams can adopt.

It is important to send the letter from the national lead for dental public health (Appendix B) to local authorities and to encourage directors of public health to contact schools directly using the letter to headteachers (Appendix C). Local authorities can also support in publicising the survey and oral health promotion teams with existing links to local schools may be able to support this.

Fieldwork teams can maximise agreement to participate through building their relationship with schools. Visiting schools in person early in the survey process, particularly those schools where agreement to participate was low in previous surveys, is a recognised approach. Requesting each school designates a member of staff to liaise with the fieldwork team is helpful. Identifying the link between educational attainment and health,[4] as recognised by Ofsted, and the forthcoming inclusion of oral health within the safeguarding and welfare requirements of the Early Years Foundation Stage Framework may also be of use.

The distribution, completion and return of agreement to participate forms may be managed in a variety of ways. Traditionally these have been sent to parents and persons with parental responsibility to complete at home, although completion at school events, at drop-off or pick-up time or via post with a stamped addressed envelope included are alternatives. Providing schools with customised lists by class of the children for whom a form is required along with an envelope in which to collect returned forms can support the process (Appendix K).

6.3.2 Recording agreement to participate

Fieldwork teams must keep a record of the number of children for whom agreement to participate was sought and the number of children with agreement to participate. Appendices M and O must be completed electronically with this information and submitted securely with the data files to DECs. This information is critical to enable calculation of national and local response rates for the survey.

It is good practice to double check the examination sheet to identify clearly those children for whom agreement to participate has been provided. All children with agreement to participate should be examined where the child is willing to co-operate. Children whose parents and persons with parental responsibility have not returned an agreement to participate form must not be examined.

6.4 Feedback to parents and persons with parental responsibility

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

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4 Guidance: The link between pupil health and wellbeing and attainment

Feedback letters should be placed in individual envelopes directed to a child's parent or person with parental responsibility and posted to the child's home or distributed by the school.

6.5 Safeguarding

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

7. Data collection

7.1 Information sharing and protection

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

7.1.1 Responsibilities of schools

For all 5-year-old children on their roll, schools are required to provide:

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

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

7.1.2 Legal basis for schools to share children's personal information with fieldwork teams

All local authorities in England have a statutory duty to undertake dental surveys as part of a programme to help improve the dental health of people in their area. The official authority for these surveys is provided by The NHS Bodies and Local Authorities

(Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012.[5] Local authorities will usually commission a fieldwork team, which may include one or more qualified dentist, dental therapist and/or dental hygienist, from a local NHS Trust to carry out the survey on their behalf.

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

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

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

However, as dental surveys involve a physical examination, schools and fieldwork teams must ensure that:

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

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

Schools are responsible for ensuring that the parents of all children eligible to take part in the dental survey are provided with the parental agreement form and the 'Information for Parents' leaflet, although the dental health team may undertake this on their behalf.

The school is also responsible for:

- receiving the signed agreement forms from parents

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5 legislation.gov.uk

- informing the fieldwork team of which children have parental agreement to receive a dental examination
- providing the signed agreement forms to the fieldwork team

The fieldwork team is responsible for:

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

7.1.4 Responsibilities of fieldwork teams

Fieldwork teams are responsible for sending to the DEC the complete dental survey record for each child taking part. This record will include the personal information of each child provided by the school together with the results of the dental examination.

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

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

Fieldwork teams must:

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

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

7.1.5 Responsibilities of Public Health England

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

PHE is responsible for:

- ensuring that only staff from the PHE Dental Public Health team have access to the personal data of the children taking part in the survey

- ensuring this information is securely protected
- retaining the personal data of the children taking part in the survey for 3 years and securely deleting this information at the end of this period

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

PHE is responsible for:

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

7.2 Non-clinical and clinical survey data

Non-clinical and clinical survey data should be collected using the Access data collection tool, with the specific format for this survey. The format contains several free fields for local use at the end. If these are insufficient for local information requirements, bespoke requirements can be arranged by contacting DentalPHIntelligence@phe.gov.uk

7.3 File management

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

Guidance on the checking, cleaning and labelling of data files is available in the Guidance for handling data 5yr 2022 document.

7.4 File transfer

Data files must only be transferred by hand on a password-protected memory stick from the fieldwork teams to their DECs or via e-mail from an nhs.net address to the DECs' nhs.net address.

7.5 Collection of non-clinical data

Non-clinical and clinical data will be collected using the data collection sheet at Appendix M. The information below (sections 7.5.2 to 7.5.15) is relevant to the fields in the data collection sheet. Where agreement to participate has not been received, no

further data on the child is required and this should be recorded within the summary information worksheet as shown at Appendix O.

7.5.1 Recording of information to allow data linkage

The data from this year's survey where possible will be used to investigate the differences in dental caries prevalence and severity between 3-year-olds and 5-year-olds. To link information at an individual level with the previous 3-year-old dataset 2019 to 2020, it is essential that a list is formed of all children examined, with their survey unique ID number (section 7.5.8), their first and family names, date of birth (dd/mm/yyyy) and postcode. This information will be kept separate from the clinical data.

All fieldwork teams should complete an electronic copy of Appendix P to provide these details for all examined children only unless the local authority did not undertake a previous 3-year-old survey.

Appendix P is a password-protected workbook. When it is opened, a password will be needed. This password will be sent to fieldwork teams by the DECs. The password will start with a capital E and have no punctuation or spaces.

7.5.2 Lower-tier local authority name

The clinical data collection sheet for each child examined requires entry of the name of the lower-tier or unitary local authority within which the school is sited. This is defined by the geographical position of the school within local authority boundaries. This should be clear, as the local authority will have provided lists of the schools they cover. A table of local authority codes and names is provided (Appendix H).

7.5.3 Examiner

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

7.5.4 School name

Care must be taken to record each school with a single method of spelling and punctuation to avoid erroneously creating schools that the computer programme recognises as distinct. For example, a single school recorded as St Mary's in 5 records and St. Marys in 10 others will appear to be 2 schools when the data entry checks are undertaken.

7.5.5 Type of school

The type of school will be recorded as follows:

0 Mainstream
1 Special school

7.5.6 School postcode

The school postcode will be recorded. If a postcode is not provided, it may be found on the Royal Mail website.

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

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

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

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

7.5.7 Date of examination

The date of the examination will be recorded.

7.5.8 Child identity number

A unique identity number must be entered for each child, which consists of a prefix from the lower-tier local authority code and a suffix, which is the participant's identification number generated from the class list. The list of lower-tier local authority codes is given the fourth column in Appendix H.

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

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

The 250th child to be sampled in Aylesbury Vale would have the following ID number:

Lower-tier local authority code									Number of sampled child			
E	0	7	0	0	0	0	0	4	0	2	5	0

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

7.5.9 Date of birth

The full date of birth should be entered dd/mm/yyyy.

7.5.10 Home postcode

Home postcodes will be recorded for all children for whom agreement to participate is provided and should be sought from the school or found from the Royal Mail website. In the rare instances of refusal, lists from child health databases can be requested. Guidance on the format of postcodes is provided above (section 7.6.6).

7.5.11 Sex

The sex of each child examined will be recorded as follows:

0 Male
1 Female
2 Other

7.5.12 Multiple birth

Multiple birth children, such as twins and triplets, may appear as duplicates because of the same date of birth and home postcode. Identifying multiple birth children will reduce the number of queries raised during data cleaning.

Multiple birth children will be recorded as follows:

0 No
1 Yes

7.5.13 Ethnicity

Examined children will be coded for ethnic origin to meet the requirements of the Health and Social Care Act, 2012. The act:

> "…introduced the first specific legal duties on health inequalities, including duties on the Secretary of State for Health. All staff undertaking NHS and public health functions on behalf of the Secretary of State are responsible for ensuring compliance with these duties and this guidance is designed to help you do so."

This includes a requirement to collect ethnicity data to enable reporting of inequalities in oral health by ethnic group. Further information is available in Reducing Health Inequalities and the Equality Act 2010.

The best method is to use the ethnicity data schools collect from parents and persons with parental responsibility for the purposes of completing the school census. This data is suitable for alignment into the 18 ethnic groups recommended for use by the government:

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

Children can only be classified at a lower ethnicity descriptor from the list given for their higher-level descriptor. For example, A White must have a lower code A1 to A4 only or lower code X if the lower ethnicity is not provided. If you use lower code B3, then the higher code must be B Mixed.

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

7.5.14 Sample group codes

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

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

All 'additional' samples, if used, should be defined locally and descriptions communicated to DECs who will then advise the national dental public health team.

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

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

(See Appendix N for guidance if a parallel survey of special schools is being planned).

7.5.15 Examination status

The type of examination will be recorded as follows:

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

7.6 Collection of clinical data

Examinations in schools should commence immediately after the training and calibration of examiners and must be completed by the end of June 2022. This allows sufficient time for checking and cleaning the data.

Only trained and calibrated dental clinicians, along with appropriately trained assistants, will undertake the collection and recording of non-clinical and clinical data. Intra-examiner monitoring of diagnostic consistency requires an examiner re-examining about 10% of children. If new examiners, or those who needed additional training after their initial calibration, subsequently fail to maintain diagnostic consistency it would be advisable to exclude them from the team the following year (7).

7.6.1 Location of examinations

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

7.6.2 Examination position

A table with a mat or suitable fully reclining chair will be used for examination, with the examiner seated behind the child, not the side. If a reclining chair is used, an assessment should be made of the safety of it for both the examiner and the volunteer. Some chairs can tip backwards as smaller children move upwards in them if there is no support underneath.

7.6.3 Examination light

A purpose built light yielding approximately 4,000 lux at one metre will be used for illumination. Further details are included in Appendix G.

7.6.4 Instruments and materials

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

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

Personal protective equipment should be worn by the examiner and assistant as detailed in the relevant national guidance. National and local policies and arrangements will be applied to maintain infection prevention and control and avoidance of allergic reactions to latex and glove powder. A fresh set of autoclaved instruments will be used for each volunteer.

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

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

Data may be entered either onto paper record sheets (Appendix M) or directly onto computer, with safeguards for both methods (sections 7.3 and 7.4).

7.6.5 Examination process

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.

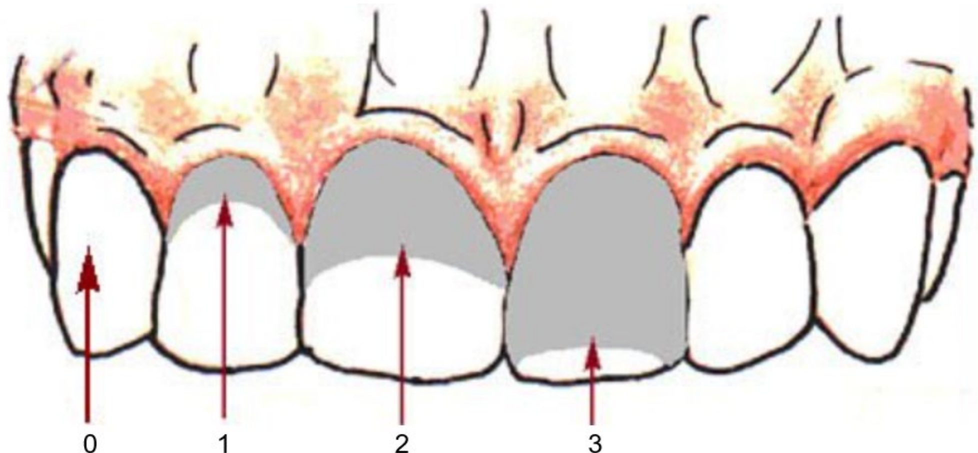
Probes must only be used for cleaning debris from the tooth surfaces to enable satisfactory visual examination and for defining fissure sealants as indicated below (section 7.6.8). Radiographic or fibre-optic transillumination examination will not be undertaken.

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

7.6.6 Oral cleanliness

Oral cleanliness serves as a proxy measure for tooth brushing and fluoride exposure. A simple measure based on the oral hygiene index of the Malmö University Oral Health Country/Area Project (8) will be used. A probe is not used for this part of the examination, which involves visual examination only of the labial surfaces of the upper anterior sextant. The teeth should not be disclosed. Only easily visible plaque should be recorded; food debris should be ignored.

The coding to be used is:



Source: Malmö University Oral Health Country/Area Project[8]

0 Teeth appear clean
1 Plaque covering not more than one third of the exposed labial tooth surfaces of the upper anterior sextant
2 Plaque covering more than one third but not more than two-thirds of the exposed labial tooth surfaces of the upper anterior sextant
3 Plaque covering more than two-thirds of the exposed labial tooth surfaces of the upper anterior sextant
9 Assessment of the upper anterior sextant cannot be made

Coding should be based on plaque coverage, irrespective of its location on the labial surfaces of the upper anterior sextant.

7.6.7 Dentition status

Teeth and surfaces will be examined in a standard order. Either the letters and numbers system 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.

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:

1. The teeth present or absent are described as such: mirror only
2. Tooth surface examination: mirror and cotton wool (for drying)

The condition of each tooth surface will be recorded using the BASCD Diagnostic Criteria for Caries Prevalence Surveys (5). The application of the criteria is included in the BASCD training 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.

Only the primary teeth will be recorded for this survey of 5-year-old children.

7.6.8 Diagnostic criteria and tooth and surface 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.

A 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. 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.

The tooth and surface codes, which are mutually exclusive, are as follows:

Diagnosis	Tooth code	Diagnostic criteria
Extracted due to caries	6	Code 6 should be used where a tooth has been extracted due to caries. Missing primary canines and molars are considered extracted and assigned code 6, unless there is unquestionable evidence that they have been lost for other reasons.
Unerupted or missing (other)	8	A missing primary incisor is assumed exfoliated and assigned code 8.

Diagnosis	Surface code	Diagnostic criteria
Sound	–	A surface is recorded as sound using a dashed mark (–) if it shows no evidence of treated or untreated clinical caries at the 'caries into dentine' threshold. The early stages of caries, as well as other similar conditions, are excluded. A surface with any of the following defects, in the absence of other criteria, is coded as sound: • white or chalky spots • discoloured or rough spots • stained pits or fissures in the enamel that are not associated with caries into dentine • dark, shiny, hard, pitted areas of enamel showing signs of moderate-to-severe fluorosis A surface with a questionable lesion is coded as sound.
Arrested caries into dentine	1	This code is only for arrested dentinal caries.
Caries into dentine	2	A surface is assigned code 2 where, after visual inspection, there is caries into dentine. On incisors where the lesion starts mesially or distally, buccal or lingual surfaces are normally involved.
Caries with pulpal involvement	3	A surface is assigned code 3 where a carious lesion involves the pulp, irrespective of whether it has been restored. Retained roots following extraction or gross breakdown are assigned code 3.
Filled and carious	4	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]) is assigned code 4 unless the lesion is so extensive as to be classified as 'caries with pulpal involvement', in which case the filling would be ignored and the surface assigned code 3.
Filled with no caries	5	A surface which contains a satisfactory permanent restoration of any material is assigned code 5 (except for obvious sealant restorations which are assigned code N).
Unrecordable	9	Excluded from examination as the examiner is unable to form a judgement on the state of a surface, for example because more than half of it is obscured by orthodontic bands.

Diagnosis	Surface code	Diagnostic criteria
Filled, needs replacing (not carious)	R	A filled surface is assigned code R 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 ‘carious’ category.
Crown	C	All surfaces which have been crowned are assigned code C. This is irrespective of the materials employed or of the reasons leading to the placement of the crown. Code C is assigned to pre-formed and stainless steel crowns.
Trauma	T	A surface is recorded as traumatised if, in the opinion of the examiner, it has been subjected to trauma. It may be fractured with exposed dentine, discoloured, or have a temporary or permanent restoration (excluding a crown). Minor trauma, affecting enamel only, is not recorded. Where a tooth is missing through trauma, all surfaces should be coded T. Discoloured, non-vital incisors, without caries or fractures, are assigned code T on all surfaces. Any surface exhibiting caries experience, as defined by the caries criteria, is assigned the appropriate caries experience code (code 1-5), irrespective of the presence of traumatic damage.
Sealed surface, type unknown	$	An occlusal, buccal or lingual surface with some type of fissure sealant where no evidence of a defined cavity margin can be seen is assigned code $. Where a clear sealant is in place and there appears to be a lesion showing through the material, the surface is assigned code $.
Obvious sealant restoration	N	An occlusal, buccal or lingual surface with 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 defined cavity margin is present, the surface is assigned code $.

Diagnosis	Surface code	Diagnostic criteria
Unseen because cooperation withdrawn (used in special schools only)	#	Where a surface has not been examined because cooperation was withdrawn during an examination.

7.6.9 Coding conventions

The following coding conventions will apply:

- a tooth is deemed to have erupted when any part of it is visible in the mouth. Unerupted surfaces of an erupted tooth are assumed sound
- supernumerary teeth are not recorded. If a tooth and a supernumerary resemble one another, the distal of the 2 is regarded the supernumerary
- surfaces are recorded as missing (due to caries) where a tooth has been extracted due to caries. Surfaces which are absent for any other reason are not included in this category
- caries takes precedence over trauma and non-carious defects such as hypoplasia
- where doubt exists about the classification of any condition, the lower category should always be recorded

7.6.10 Enamel caries

The presence or absence of enamel caries should be recorded. White or brown carious opacities or discolouration in an area of plaque stagnation constitute enamel caries. Typical sites include pits, fissures, approximal surfaces and gingival margins. The enamel surface may be intact or may demonstrate localised breakdown without dentine exposure. There should be no obvious shadowing from underlying dentine caries.

Extrinsic staining and dental anomalies presenting as white or brown spots do not constitute enamel caries. In instances of doubt, enamel caries should be considered absent.

The coding to be used is:

0 No enamel caries
1 Enamel caries present

7.6.11 pufa

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

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

The coding to be used is:

0 No pufa signs
1 pufa sign
2 Two or more pufa signs

7.6.12 Optional spare variable

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

8. Data submission

Data should be entered into a secure computer with the Access format for the 2021 to 2022 survey as soon as possible after visiting the school. Data should not be left to be entered as a batch when all fieldwork is completed.

Prior to sending on completed data files, each fieldwork team is responsible for checking their data for inaccuracies. Common errors include incorrect dates of birth, duplicate entries for children or schools and clinical data for children coded as being absent. Step-by-step guidance on the process is provided in the Step-by-step sampling guide.

Once the data has been checked and any identified errors corrected, files should be correctly labelled according to the guidance and sent to the relevant DEC to upload. Extracted Excel files should be labelled to indicate the age group and local authority to which they refer. Data files must only be transferred by hand on a password-protected memory stick from the fieldwork team to a DEC, or via email from an nhs.net address to a

DEC's nhs.net address. The following will be reported for each lower-tier local authority using the template in Appendix O:

- start and finish dates of the period of examinations (dd/mm/yyyy to dd/mm/yyyy)
- total number of mainstream schools providing education to 5-year olds
- total number of 5-year-old children attending listed schools
- number of schools visited providing education for 5-year olds
- number of 5-year-old children for whom agreement to participate was initially sought
- number of 5-year-old children with agreement to participate and without a response
- number of 5-year-old children with agreement to participate examined, absent and refused examination.

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

Data will be submitted as cleaned Excel survey files, exported from the Access data collection database. The summary and data linkage worksheets will be submitted as completed Excel documents.

All returns should be made to DECs as soon as possible after completion of the survey and no later than 31 July 2022. Returns should include:

- the completed Appendix O summary worksheet for each upper-tier and lower-tier local authorities within it
- the Excel survey file for each local authority, labelled to indicate which local authority it refers to
- the completed Appendix P data linkage worksheet for each local authority

DECs will upload the data files, received from fieldwork teams, to the shared DEC network folder for the appropriate region.

9. Data publication

A national report and local authority tailored reports will be produced by the national dental public health team. Responsibility for governance of the data lies with this team.

Cleaned and verified copies of the raw, anonymised data will be available to DECs as soon as practicable following publication of the main report. This will enable DECs and PHE colleagues to make maximum use of their data if further analysis is required locally.

Local authority personnel can apply to become super users, to access the raw, anonymised data for specific purposes. Becoming a super user requires a local authority to contact DentalPHIntelligence@phe.gov.uk with the following information:

- name and contact details of staff member to become a super user
- name of relevant upper-tier local authority

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

9.1 Data requests

Other data requests should be emailed to DentalPHIntelligence@phe.gov.uk

10. References

1. Department of Health (2010). Equity and excellence: Liberating the NHS. London, The Stationery Office. Accessed in June 2016

2. Department of Health (2012). Health and Social Care Act 2012. London, The Stationery Office. Accessed in June 2016 from: Health and Social Care Act 2012 (legislation.gov.uk)

3. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 (SI No. 2012/3094). Regulation 17 Statutory Instrument 2012 No 3094

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

5. Pitts NB, Evans DJ and Pine CM (1997): British Association for the Study of Community Dentistry (BASCD) diagnostic criteria for caries prevalence surveys – 1996/97. Community Dental Health 14: (Supplement 1), 6-9

6. Pine CM, Pitts NB and Nugent ZJ (1997a): British Association for the Study of Community Dentistry (BASCD) guidance on sampling for surveys of child dental health. A BASCD coordinated dental epidemiology programme quality standard. Community Dental Health 14: (Supplement 1), 10-17

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

8. Malmö University. Oral Health Country/Area Profile Project. Accessed July 2020

11. Appendices

Table of appendices

Appendix	Title
A[#]	Statutory Instrument 2012, No. 3094
B[#]	Letter of support from programme lead for dental public health to directors of public health
C*	Letter to headteachers
D[#]	The lawful basis for processing dental survey data under the GDPR and DPA 2018
E	Stages in the National Dental Epidemiology Programme
F	Operational timetable
G	Examination light
H	Local authority names and codes
I	Date-of-birth bands for survey of 5-year-olds 2021 to 2022
J*	Information for parents and persons with parental responsibility
Ji*	Agreement to participate for parents and persons with parental responsibility
Jii*	Letter for parents or persons with parental responsibility where core agreement to whole of school life health surveillance is adopted
K*	Tracking list for schools to record which children have returned agreement to participate forms
L~	Examination day sheet, illustration example of Excel worksheet
M*	Data collection sheet survey of 5-year-olds 2021 to 2022
N	Selected sections from the national protocol for the 2013 to 2014 oral health survey of 5 and 12-year-old children attending special schools
O~	Data summary, illustration example of Excel worksheet for mainstream primary school information
Oi~	Data summary, Excel worksheet for special school information
P ~	Data linkage sheet, illustration example of Excel worksheet

[#] Documents will be available in pdf format
* Documents will be available in Word format
~ Document will be available in Excel format

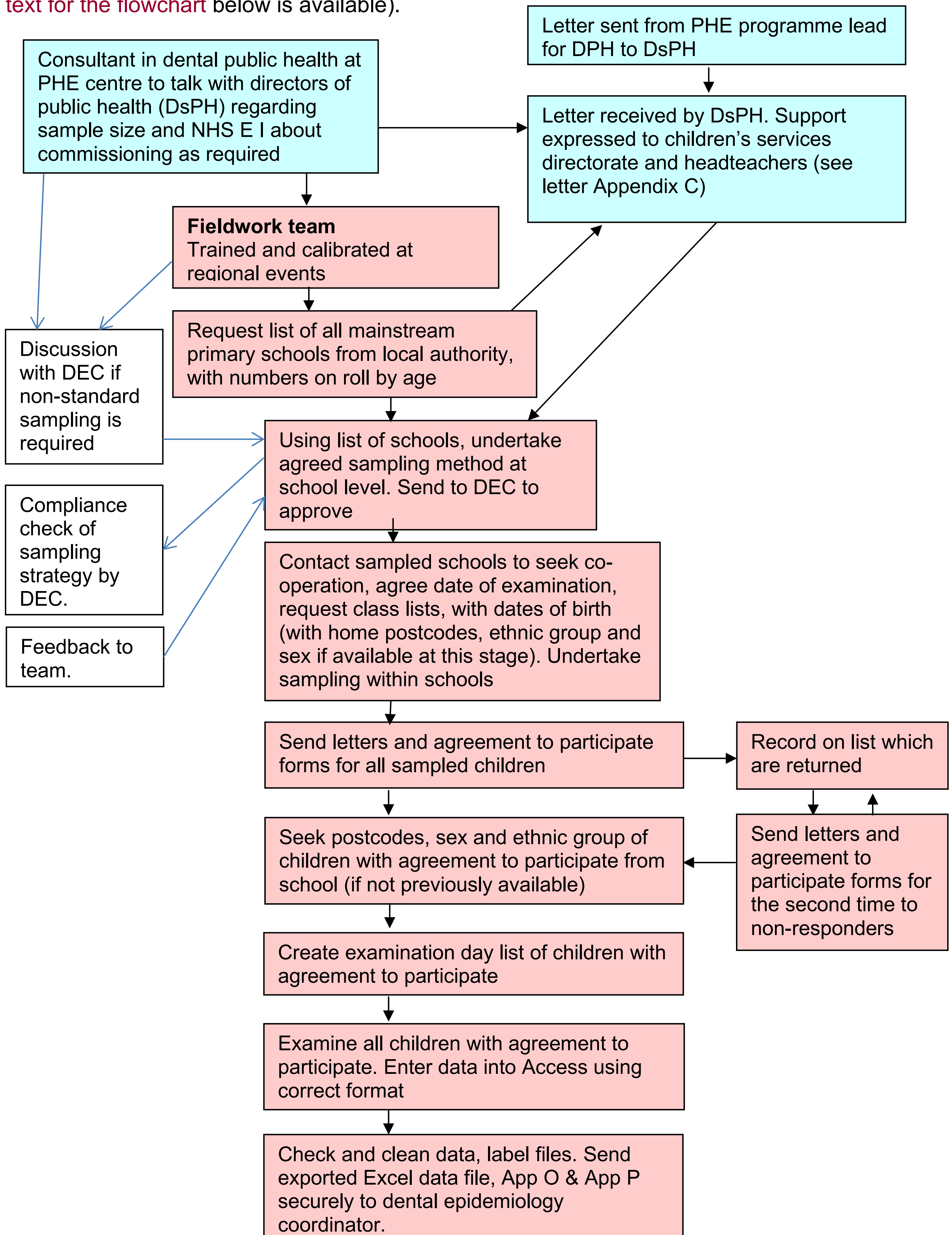
Appendix A. Statutory Instrument 2012, No. 3094 – extract: Available via the Oral Health Collections page

Appendix B. Letter of support from programme lead for dental public health to directors of public health: Available via the Oral Health Collections page

Appendix C. Letter to headteachers: Available via the Oral Health Collections page

Appendix D. The lawful basis for processing dental survey data under the GDPR and DPA 2018: Available via the Oral Health Collections page

Appendix E. Stages in the National Dental Epidemiology Programme (Accessible alternative text for the flowchart below is available).



Appendix F. Operational timetable

Event	Date for completion
National clinical training and calibration for standard examiners	Online training 5 July 2021 Calibration 8 July 2021
Regional training and calibration for fieldwork teams	September – October 2021
Results from regional calibration to be sent to DECs	September – October 2021
Data collection and ongoing data entry	To start immediately after regional training and calibration; completed by 30 June 2022
Completion of data checking and labelling of local authority data files. Secure forwarding of cleaned data files to DECs as soon as possible before deadline.	31 July 2022
DECs to upload summaries and copies of local authority data files to the national dental public health team	To be uploaded as and when they have been checked, completed by 31 August 2022
National DPH team – checking of data, returning errors for clarification by fieldwork teams via DECs, and collation of clean, verified data	As and when data files arrive.
National DPH team – compute estimates for local authorities and report findings	Once all national data has been submitted, cleaned and verified
Publication of results online	Four months after receipt of last data set dependent upon PHE gateway.
Feedback of cleaned anonymised data	Four months after receipt of last data set.

Appendix G. This appendix sets out further detail on the examination lighting requirements for the survey.

Proposal:

Supply of a new light model (custom made X100E) specifically for use in BASCD Epidemiology surveys, to replace the X100H currently in use within the programme.

Problem:

We had officially discontinued supply of the X100H (the current light used in the surveys) back in 2016, however to this day we have had to continue manufacture of this model as it remains listed as the required light in the official protocol, so it is only available on request for BASCD customers only and we do not market this product or make it available to any of our other customers. Unfortunately now we are making such low volumes of this light each year for your staff and as a result, our production costs have risen greatly and we are unable to continue supply for much longer. We proposed switching the protocol over to an LED light from our range but we were informed of the many consistency issues that would be caused in your survey data in doing so. We had the following points made by Nigel Monaghan, *Consultant in Public Health/Dental Public Health, Public Health Wales*:

- We wish to maintain consistency of the standards in terms of light colour and brightness – to ensure that data collected across surveys remains comparable over time.
- We note that over time the Halogen bulb performance deteriorates (faster than an LED light would.
- That you can produce a light without controls to alter brightness etc.
- The stated standard is "A purpose built light yielding 4000 lux at 1 metre…"

Solution:

We made a new version of the X100 with a custom LED bulb specifically designed to mimic all the visual qualities of the existing Halogen bulb, whilst providing you the benefits of LED technology. This new model has a fixed brightness as per the requirement, and matches the colour temperature and light output of the old Halogen lamp exactly. The main benefits of our new light are as follows;

- Lower total cost of ownership, greatly reduced usage costs, longer-lasting equipment, no more bulb changes.
- No heat in the beam, more comfortable for user and patient.
- Safety – cool bulb to the touch, no risk of burns or bulbs falling out.
- Design – sturdy, aluminium head.
- BioProtect antimicrobial coating to assist in infection control – lasts for the lifetime of the product.
- Fully sealed head – ensures much easier and more efficient cleaning of the light. With no heat to disperse, LED lamps do not require venting like a typical lamp.
- 360 degree rotation of the head, for easier positioning.
- Lightweight and available with an optional carry case for safe storage and transport.

Proposed new product: X100E (X100 LED custom Epidemiology light)	**Existing product:** X100H (X100 Halogen) (supplied since 2012)

Technical Specifications comparison:

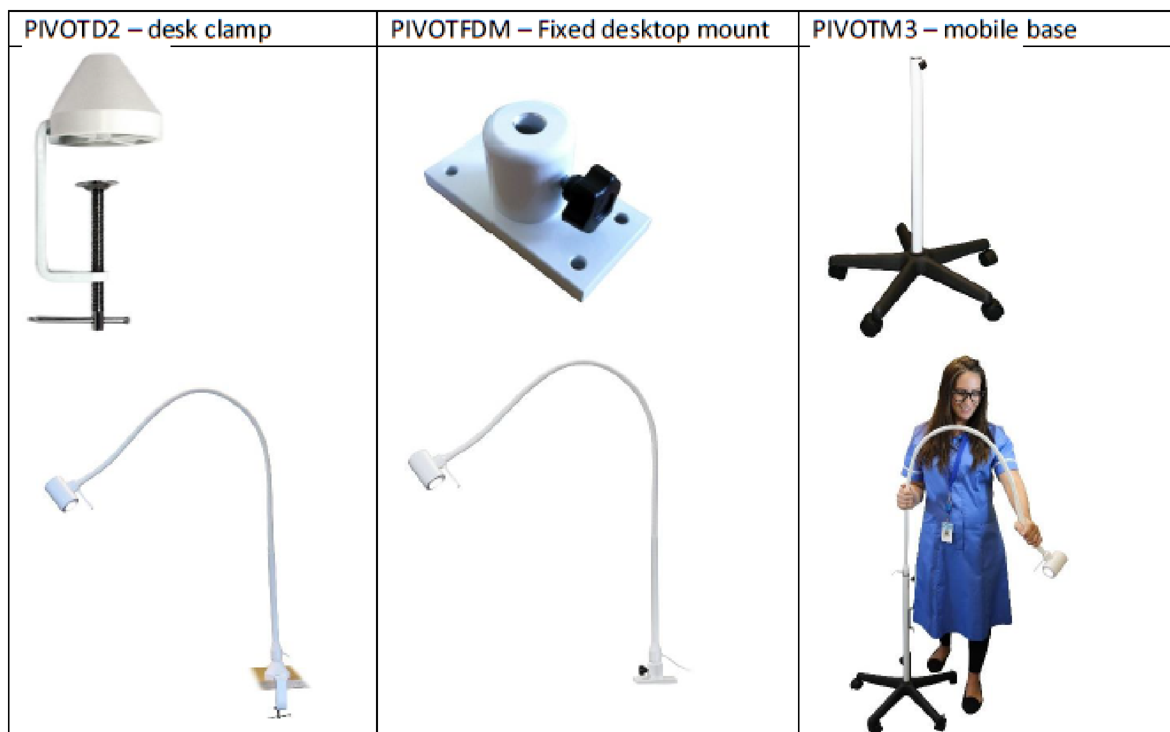
	Proposed:	**Existing**
Model	**X100E (X100 LED custom Epidemiology light)**	**X100H (X100 Halogen light)**
Life of bulb	40,000 hours (8hr day)	1,000 hours (8hr day)
Colour temperature	3000K	3000K
Light source	LED	Halogen
CRI	97	Unpublished
Beam angle	10°	10°
Heat produced	≤2°C	Unpublished – hot to touch
Power consumption	6W	20W

Compatibility with existing parts:

Our new light X100E has the same mounting spigot, so it will fit directly to any existing DARAY mounts that you currently use in conjunction with the X100H. Including the desk clamp, the mobile freestanding 5-castor base, the fixed desktop mount, and the wall bracket.

New/replacement mounts are still available to purchase from us.

Mounting options:



We have had some discussion with Paddy Evans, *Assistant Clinical Director (Acting), Paediatric and Adult Special Care Dental Services* regarding our proposal, and she has asked us to lay out costs for various supply options:

- A whole light for total replacement of X100H or new requirement.
- An 'upgrade kit' for any old working X100H lights to convert them to an LED light source.
- Spare/replacement parts to cover loss/damage.

See the below table;

Order code	Description	Your price (ex.VAT)
X100E	X100E light fixture only (includes power supply)	£230.00
	Choose mounting type (if needed):	
PIVOTD2	Desk clamp	£28.00
PIVOTFDM	Fixed desktop mount	£28.00
PIVOTM3	Mobile 5-castor base	£82.50
	Spare/replacement parts	
DRK4148	Replacement 12V power supply (for desk version)	£14.00
DRK4176	Replacement 12V power supply (for mobile versions)	£21.00
(TBC)	Replacement X100E bulb only	£24.00
(TBC)	Upgrade kit – for conversion of X100H to LED. Includes bulb and power supply.	£38.00

If you have any questions, please feel free to call or email:
zane.richardson@daray.co.uk 01283 228518 07784 663455

Appendix H. Local authority names and codes

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Barking and Dagenham	E09000002	Barking and Dagenham	E09000002
Barnet	E09000003	Barnet	E09000003
Barnsley	E08000016	Barnsley	E08000016
Bath and North East Somerset	E06000022	Bath and North East Somerset	E06000022
Bedford	E06000055	Bedford	E06000055
Bexley	E09000004	Bexley	E09000004
Birmingham	E08000025	Birmingham	E08000025
Blackburn with Darwen	E06000008	Blackburn with Darwen	E06000008
Blackpool	E06000009	Blackpool	E06000009
Bolton	E08000001	Bolton	E08000001
Bournemouth, Christchurch and Poole	E06000058	Bournemouth, Christchurch and Poole	E06000058
Bracknell Forest	E06000036	Bracknell Forest	E06000036
Bradford	E08000032	Bradford	E08000032
Brent	E09000005	Brent	E09000005
Brighton and Hove	E06000043	Brighton and Hove	E06000043
Bristol, City of	E06000023	Bristol, City of	E06000023
Bromley	E09000006	Bromley	E09000006
Buckinghamshire	E06000060	Buckinghamshire	E06000060
Bury	E08000002	Bury	E08000002
Calderdale	E08000033	Calderdale	E08000033
Cambridgeshire	E10000003	Cambridge	E07000008
		East Cambridgeshire	E07000009
		Fenland	E07000010
		Huntingdonshire	E07000011
		South Cambridgeshire	E07000012
Camden	E09000007	Camden	E09000007
Central Bedfordshire	E06000056	Central Bedfordshire	E06000056
Cheshire East	E06000049	Cheshire East	E06000049
Cheshire West and Chester	E06000050	Cheshire West and Chester	E06000050
City of London	E09000001	City of London	E09000001
Cornwall	E06000052	Cornwall	E06000052
County Durham	E06000047	County Durham	E06000047
Coventry	E08000026	Coventry	E08000026
Croydon	E09000008	Croydon	E09000008
Cumbria	E10000006	Allerdale	E07000026
		Barrow-in-Furness	E07000027
		Carlisle	E07000028
		Copeland	E07000029
		Eden	E07000030
		South Lakeland	E07000031
Darlington	E06000005	Darlington	E06000005
Derby	E06000015	Derby	E06000015

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Derbyshire	E10000007	Amber Valley	E07000032
		Bolsover	E07000033
		Chesterfield	E07000034
		Derbyshire Dales	E07000035
		Erewash	E07000036
		High Peak	E07000037
		North East Derbyshire	E07000038
		South Derbyshire	E07000039
Devon	E10000008	East Devon	E07000040
		Exeter	E07000041
		Mid Devon	E07000042
		North Devon	E07000043
		South Hams	E07000044
		Teignbridge	E07000045
		Torridge	E07000046
		West Devon	E07000047
Doncaster	E08000017	Doncaster	E08000017
Dorset	E06000059	Dorset	E06000059
Dudley	E08000027	Dudley	E08000027
Ealing	E09000009	Ealing	E09000009
East Riding of Yorkshire	E06000011	East Riding of Yorkshire	E06000011
East Sussex	E10000011	Eastbourne	E07000061
		Hastings	E07000062
		Lewes	E07000063
		Rother	E07000064
		Wealden	E07000065
Enfield	E09000010	Enfield	E09000010
Essex	E10000012	Basildon	E07000066
		Braintree	E07000067
		Brentwood	E07000068
		Castle Point	E07000069
		Chelmsford	E07000070
		Colchester	E07000071
		Epping Forest	E07000072
		Harlow	E07000073
		Maldon	E07000074
		Rochford	E07000075
		Tendring	E07000076
		Uttlesford	E07000077
Gateshead	E08000037	Gateshead	E08000037

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
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	E07000242
		Hertsmere	E07000098
		North Hertfordshire	E07000099
		St Albans	E07000240
		Stevenage	E07000243
		Three Rivers	E07000102
		Watford	E07000103
		Welwyn Hatfield	E07000241
Hillingdon	E09000017	Hillingdon	E09000017
Hounslow	E09000018	Hounslow	E09000018
Isle of Wight	E06000046	Isle of Wight	E06000046
Isles of Scilly	E06000053	Isles of Scilly	E06000053
Islington	E09000019	Islington	E09000019
Kensington and Chelsea	E09000020	Kensington and Chelsea	E09000020

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
		Folkestone and Hythe (was Shepway)	E07000112
		Swale	E07000113
		Thanet	E07000114
		Tonbridge and Malling	E07000115
		Tunbridge Wells	E07000116
Kingston upon Hull, City of	E06000010	Kingston upon Hull, City of	E06000010
Kingston upon Thames	E09000021	Kingston upon Thames	E09000021
Kirklees	E08000034	Kirklees	E08000034
Knowsley	E08000011	Knowsley	E08000011
Lambeth	E09000022	Lambeth	E09000022
Lancashire	E10000017	Burnley	E07000117
		Chorley	E07000118
		Fylde	E07000119
		Hyndburn	E07000120
		Lancaster	E07000121
		Pendle	E07000122
		Preston	E07000123
		Ribble Valley	E07000124
		Rossendale	E07000125
		South Ribble	E07000126
		West Lancashire	E07000127
		Wyre	E07000128
Leeds	E08000035	Leeds	E08000035
Leicester	E06000016	Leicester	E06000016
Leicestershire	E10000018	Blaby	E07000129
		Charnwood	E07000130
		Harborough	E07000131
		Hinckley and Bosworth	E07000132
		Melton	E07000133
		North West Leicestershire	E07000134
		Oadby and Wigston	E07000135
Lewisham	E09000023	Lewisham	E09000023

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Lincolnshire	E10000019	Boston	E07000136
		East Lindsey	E07000137
		Lincoln	E07000138
		North Kesteven	E07000139
		South Holland	E07000140
		South Kesteven	E07000141
		West Lindsey	E07000142
Liverpool	E08000012	Liverpool	E08000012
Luton	E06000032	Luton	E06000032
Manchester	E08000003	Manchester	E08000003
Medway	E06000035	Medway	E06000035
Merton	E09000024	Merton	E09000024
Middlesbrough	E06000002	Middlesbrough	E06000002
Milton Keynes	E06000042	Milton Keynes	E06000042
Newcastle upon Tyne	E08000021	Newcastle upon Tyne	E08000021
Newham	E09000025	Newham	E09000025
Norfolk	E10000020	Breckland	E07000143
		Broadland	E07000144
		Great Yarmouth	E07000145
		King's Lynn and West Norfolk	E07000146
		North Norfolk	E07000147
		Norwich	E07000148
		South Norfolk	E07000149
North East Lincolnshire	E06000012	North East Lincolnshire	E06000012
North Lincolnshire	E06000013	North Lincolnshire	E06000013
North Northamptonshire	E06000061	North Northamptonshire	E06000061
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
Northumberland	E06000057	Northumberland	E06000057
Nottingham	E06000018	Nottingham	E06000018
Nottinghamshire	E10000024	Ashfield	E07000170
		Bassetlaw	E07000171
		Broxtowe	E07000172
		Gedling	E07000173
		Mansfield	E07000174
		Newark and Sherwood	E07000175
		Rushcliffe	E07000176

Upper-tier local authority	Upper code	Lower-tier local authority	Lower code
Oldham	E08000004	Oldham	E08000004
Oxfordshire	E10000025	Cherwell	E07000177
		Oxford	E07000178
		South Oxfordshire	E07000179
		Vale of White Horse	E07000180
		West Oxfordshire	E07000181
Peterborough	E06000031	Peterborough	E06000031
Plymouth	E06000026	Plymouth	E06000026
Portsmouth	E06000044	Portsmouth	E06000044
Reading	E06000038	Reading	E06000038
Redbridge	E09000026	Redbridge	E09000026
Redcar and Cleveland	E06000003	Redcar and Cleveland	E06000003
Richmond upon Thames	E09000027	Richmond upon Thames	E09000027
Rochdale	E08000005	Rochdale	E08000005
Rotherham	E08000018	Rotherham	E08000018
Rutland	E06000017	Rutland	E06000017
Salford	E08000006	Salford	E08000006
Sandwell	E08000028	Sandwell	E08000028
Sefton	E08000014	Sefton	E08000014
Sheffield	E08000019	Sheffield	E08000019
Shropshire	E06000051	Shropshire	E06000051
Slough	E06000039	Slough	E06000039
Solihull	E08000029	Solihull	E08000029
Somerset	E10000027	Mendip	E07000187
		Sedgemoor	E07000188
		South Somerset	E07000189
		Somerset West and Taunton	E07000246
South Gloucestershire	E06000025	South Gloucestershire	E06000025
South Tyneside	E08000023	South Tyneside	E08000023
Southampton	E06000045	Southampton	E06000045
Southend-on-Sea	E06000033	Southend-on-Sea	E06000033
Southwark	E09000028	Southwark	E09000028
St. Helens	E08000013	St. Helens	E08000013
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
		West Suffolk	E07000245
		Ipswich	E07000202
		Mid Suffolk	E07000203
		East Suffolk	E07000244
Sunderland	E08000024	Sunderland	E08000024
Surrey	E10000030	Elmbridge	E07000207
		Epsom and Ewell	E07000208
		Guildford	E07000209
		Mole Valley	E07000210
		Reigate and Banstead	E07000211
		Runnymede	E07000212
		Spelthorne	E07000213
		Surrey Heath	E07000214
		Tandridge	E07000215
		Waverley	E07000216
		Woking	E07000217
Sutton	E09000029	Sutton	E09000029
Swindon	E06000030	Swindon	E06000030
Tameside	E08000008	Tameside	E08000008
Telford and Wrekin	E06000020	Telford and Wrekin	E06000020
Thurrock	E06000034	Thurrock	E06000034
Torbay	E06000027	Torbay	E06000027
Tower Hamlets	E09000030	Tower Hamlets	E09000030
Trafford	E08000009	Trafford	E08000009
Wakefield	E08000036	Wakefield	E08000036
Walsall	E08000030	Walsall	E08000030
Waltham Forest	E09000031	Waltham Forest	E09000031
Wandsworth	E09000032	Wandsworth	E09000032
Warrington	E06000007	Warrington	E06000007
Warwickshire	E10000031	North Warwickshire	E07000218
		Nuneaton and Bedworth	E07000219
		Rugby	E07000220
		Stratford-on-Avon	E07000221
		Warwick	E07000222
West Berkshire	E06000037	West Berkshire	E06000037
West Northamptonshire	E06000062	West Northamptonshire	E06000062
West Sussex	E10000032	Adur	E07000223
		Arun	E07000224
		Chichester	E07000225
		Crawley	E07000226
		Horsham	E07000227
		Mid Sussex	E07000228
		Worthing	E07000229

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: ONS Geographical Lookups.

Appendix I. Date-of-birth bands for survey of 5-year-olds 2021 to 2022

Month and year of examination	Children born within these ranges will be 5 years old		Children born in these months may be 5 years old, depending on the date they were born
	Earliest month and year of birth	Latest month and year of birth	
September 2021	October 2015	August 2016	September 2015 and 2016*
October 2021	November 2015	September 2016	October 2015 and 2016*
November 2021	December 2015	October 2016	November 2015 and 2016*
December 2021	January 2016	November 2016	December 2015 and 2016*
January 2022	February 2016	December 2016	January 2016 and 2017**
February 2022	March 2016	January 2017	February 2016 and 2017**
March 2022	April 2016	February 2017	March 2016 and 2017**
April 2022	May 2016	March 2017	April 2016 and 2017**
May 2022	June 2016	April 2017	May 2016 and 2017**
June 2022	July 2016	May 2017	June 2016 and 2017**
July 2022	August 2016	June 2017	July 2016 and 2017**

* If born 2015, birthday should be later than the day of examination. If born in 2016, birthday should be on or before the day of examination

** If born 2016, birthday should be later than the day of examination. If born in 2017, birthday should be on or before the day of examination

Appendix J. Information for parents and persons with parental responsibility: Available via the Oral Health Collections page

Appendix Ji. Agreement to participate for parents and persons with parental responsibility: Available via the Oral Health Collections page

Appendix Jii. Letter for parents or persons with parental responsibility where core agreement to whole of school life health surveillance is adopted: Available via the Oral Health Collections page

Appendix K. Tracking list for schools to record which children have returned agreement to participate forms: Available via the Oral Health Collections page

Appendix L. Examination day sheet, illustration example of Excel worksheet: Available via the Oral Health Collections page – This can later be used to create Appendix P and summary totals for Appendix O.

Name of school: St Peter's R.C

School postcode: FY4 3VG

Date of examination: 11/12/2021

Name of school contact: Mrs Bond

Telephone number: 01253 422653

		Child ID Number														Home postcode				Ethnic Codes		Parental agreement		Examination staus		
Child's first name	Child's surname (family name)	LA Code									Number of sampled child				Date of Birth dd/mm/yyyy	Part 1	Part 2	Sex (M/F/O)	Multiple birth (Y/N)	Higher	Lower	Form returned (Y)	Form NOT returned (N)	Examined	Child absent	Child refused
Melissa	Jones	E	0	6	0	0	0	0	0	9	0	0	0	7	23/03/2017	FY5	6RT	F	N	A	A1		N			
Harry	Smith	E	0	6	0	0	0	0	0	9	0	0	1	2	16/04/2017	FY4	3DF	M	Y	D	D2	Y			Y	
Harvey	Smith	E	0	6	0	0	0	0	0	9	0	0	3	4	16.04.2017	FY4	3DF	M	Y	D	D2	Y		Y		

correct format & valid date

incorrect format or invalid date

Appendix M. Data collection sheet survey of 5-year-olds 2021 to 2022: Available via the Oral Health Collections page

Appendix N. Selected sections from the national protocol for the 2013 to 2014 oral health survey of 5 and 12-year-old children attending special schools

Aim of the survey

The aim of the survey is to measure the prevalence and severity of dental caries among children attending special schools within each local (education or upper tier) authority to provide a baseline for comparison in subsequent years.

This information can be used to:

- provide comparisons with children of the same age attending mainstream schools in the same area
- inform oral and general health needs assessments
- inform local oral health improvement strategies

Considerations for special schools

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. They 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.

Conduct

The survey should, as far as possible, follow the guidelines for mainstream surveys. 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 schools, 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.

Preparatory communication with relevant work partners

Identifying schools

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

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

- community special school
- other independent school
- academy special converter
- academy special sponsor led school
- foundation special school
- non-maintained special school
- free special school

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

As there are very low numbers of hospital schools and the numbers of 5-year-olds attending them may be very low, they should be excluded from the survey.

Gaining school co-operation

As many special 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 local authority are approached to seek their support for the survey. If directors of public health, directors of education and directors of

children's services are aware of the purpose and nature of the surveys, and can see the benefit of them, they can be supportive and ensure their colleagues feel confident to take part.

Sampling

The sampling unit will be local authority boundaries. In the majority of cases the geographies will contain fewer than 10 schools for 5-year olds, 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 schools who have reached the age of 5 but have not had their sixth birthday on the date of examination. 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. Lists of all classes which may contain a child who is aged 5 on the day of examination will be used to identify the sample.

Sampling procedure for local authorities with large numbers of special 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 5-year-old children.
- lists of all special schools in the local authority and rough figures for the numbers of children by age group attending each will be required as the first stage in the sampling process.
- a table should be constructed that shows the distribution of 5-year-old children in all the special 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 schools within each size band should then be sampled by production of random numbers until a sufficiently large sample is produced to meet the needs of the commissioning authority, along with some substitute schools.

Agreement to participate

Positive agreement to participate is required and a similar method should be used as in the mainstream school survey.

Extra efforts to obtain returned agreement to participate forms may be required 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, use the home-school diary and school bags system to communicate with parents and persons with parental responsibility and seek agreement to participate as letters or additional notices about the survey can be inserted into these.

Personnel

Whoever carries out the examination must be trained and calibrated at the regional events.

General conduct of the survey

It is good practice to inform parents and persons with parental responsibility if a clinical condition requiring closer investigation is seen during examination, for example sepsis or extensive caries. If there is no intention to provide information about a child's clinical status, then the agreement to participate letter should be modified to reflect this.

If detailed feedback is provided for parents and persons with parental responsibility should be phrased in terms which respect any existing patient-clinician relationships.

Fieldwork

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.

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 are the overriding considerations.

A directional 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 is suitable.

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

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.

Recording non-clinical information

The data collection sheet (Appendix M) has the option to indicate that the site is a special school:

- mainstream schools should be coded 0
- special schools should be coded 1

Variable 11 sample group has been modified to allow for coding for special schools. Use code 5.

Variable 12 examination status has been modified to allow for partial examinations of children in special schools for the rare instances when an examination cannot be completed. Use code 5.

Where teeth cannot be examined because co-operation ceases the additional tooth code '#' has been provided for charting. This should only be used for children attending special schools.

Appendix O. Data summary, illustration example of Excel worksheet for mainstream primary school information: Available via the Oral Health Collections page

MAINSTREAM PRIMARY SCHOOL SURVEY

							State mainstream primary schools listed by local authority				Number of children with:		Number of children WITH parental agreement to participate:		
Upper-tier LA Code	Upper-tier LA Name	Lower-tier LA Code	Lower-tie LA Name	Name(s) of examiner(s)	Start date of examinations dd/mm/yyyy	End date of examinations dd/mm/yyyy	Total number of schools	Total number of 5-year-olds attending	Number of schools visited	Number of children for whom agreement to participate was sought (sample size)	Agreement to participate provided	Form not returned	Examined	Child absent	Child refused
E10000007	Derbyshire	E07000032	Amber Valley	A.N.Other	12/10/2016	03/04/2017	54	2784	20	354	287	67	267	16	4
E10000007	Derbyshire	E07000033	Bolsover	A.N.Other X Y Other	06/11/2016	02/03/2017	18	1500	18	308	260	48	240	17	3
E10000007	Derbyshire	E07000034	Chesterfield	A.N.Other	25/10/2016	03/05/2017	25	2023	22	327	300	27	264	36	0
E10000007	Derbyshire	E07000035	Derbyshire Dales	X Y Other Y Z Other	15/11/2016	19/12/2016	40	2542	21	350	285	65	258	23	4

Appendix Oi. Data summary, Excel worksheet for special school information: Available via the Oral Health Collections page

Appendix P. Data linkage sheet, illustration example of Excel worksheet: Available via the Oral Health Collections page. Not required if no 3-year-old survey was undertaken.

Name of local authority: Blackpool

Examined children ONLY		**Child ID Number**													**Home postcode**	
Child's first name	**Child's surname (family name)**	**LA Code**									**Number of sampled child**				**Date of Birth dd/mm/yyyy**	**Part 1**	**Part 2**
Harry	Smith	E	0	6	0	0	0	0	0	9	0	0	1	2	16/04/2017	FY4	3DF
Harvey	Smith	E	0	6	0	0	0	0	0	9	0	0	3	4	16.04.2017	FY4	3DF

correct format & valid date

incorrect format or invalid date

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Version 1.0

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Published September 2021
PHE gateway number: GOV-9463

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