Office for Health Improvement & Disparities

National Dental Epidemiology Programme

Oral health survey of 5 year old schoolchildren, 2023 to 2024: national protocol

Published August 2023

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 oral health.

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1. Introduction

Local authorities are responsible for gathering information on the health needs of their local populations. This imperative is described in the Health and Social Care Act 2012 (reference 1), underpinned by Statutory Instrument 2012 number 3094 (reference 2).

Leadership and structures supporting the National Dental Epidemiology Programme transferred into Public Health England on 1 April 2013 and then to the Office for Health Improvement and Disparities (OHID) on 1 October 2021. This protocol forms part of the support that OHID provides.

The population group for the 2023 to 2024 survey will be 5 year old children attending mainstream schools. 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.

This protocol allows for the inclusion of 5 year old children attending special schools in addition to the main survey sample. 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 will give details of dental caries levels and other clinical measures and provide information for local authorities, the NHS and other partners.

As this age group is surveyed every two years, the information will measure trends in dental caries in 5 year old children.

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, 2019 and 2022) to permit monitoring of the PHOF measure
- provide standardised information for comparison locally, regionally and between countries of the UK
- inform local oral health improvement strategies

3. Survey objectives

The objectives of the survey are:

- to use the sampling procedures described in the British Association for the Study of Community Dentistry (BASCD) guidance on sampling for surveys of child oral health (reference 3)

- to examine 5 year old children using dental caries diagnostic criteria and examination techniques based on those agreed by BASCD for dental caries prevalence surveys (reference 4)

- to report on the prevalence of dental caries

4. Sample

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

In some areas 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) and local 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 mainstream state-funded primary schools within a local authority area who have reached the age of 5 years but have not had their 6th birthday on the date of examination. Children attending special schools may be included in the survey as an additional survey population.

4.2 Sampling procedure

Discussion is required between local authority commissioners and consultants in dental public health in NHS England 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. All children with parental 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.

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 coding additional samples in section 8.1.13 of this document.

Local DECs must be informed of proposed sampling methods so that they can confirm their validity before the survey commences.

4.2.2 Sampling process

In most local authority areas, a 2-stage sampling procedure will be required for the survey. A random sample of schools will be selected, followed by a random sample of children.

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

Special schools should not be included in the main sampling frame. If an additional sample of special schools is being planned, guidance is available in Appendix I.

A stratified sampling method, which takes school size into account, is described in the Step by step sampling guide - age specific (reference 5). 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 who are 5-years-old and those with 30 or more. All the children in the smaller schools would be sampled, while 1 in 2 or 1 in 3 children 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 methods 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 method, 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.

Using class lists for the second stage, children who will be eligible on the planned day of examination will be identified and sampling of the appropriate intensity carried out. A list of these sampled children will be formed into a table (Appendix L).

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.

Further detail on sampling procedures for the survey is available in the appropriate step by step sampling guide (reference 5). This is based on the epidemiology quality standard by Pine and others (reference 3). Advice on sampling can also be requested from the local dental epidemiology coordinator.

Contact details of dental epidemiology co-ordinators:

- East Midlands, Rizwana Lala, rizwana.lala@nhs.net
- East of England, Feema Francis, feema.francis@nhs.net
- London, Charlotte Klass, charlotte.klass1@nhs.net
- North East, Kamini Shah, kamini.shah4@nhs.net
- North West, Emma Hall-Scullin, emma.hall-scullin2@nhs.net
- South East, Jeyanthi John, jjohn@nhs.net
- South West, Zoë Allen, zoe.allen4@nhs.net
- West Midlands, Vicky Massey, vicky.massey@nhs.net
- Yorkshire and the Humber, Martin Ramsdale, martin.ramsdale@nhs.net

4.3 General Data Protection Regulations

The GDPR became UK law on 25 May 2018. It updated and strengthened the ways in which personal data is protected. More information is available in the Guide to the UK General Data Protection Regulation (UK GDPR) (reference 6). Detail on GDPR and the lawful basis for the collection, processing and sharing of personal data about identifiable individuals is provided in section 6.1.2 of this document.

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

5. Responsibilities

5.1 Overarching responsibilities

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

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

5.2 Commissioning responsibilities

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

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

5.3 Personnel

Fieldwork for the survey will be carried out by services commissioned by local authorities, sometimes in partnership with NHS organisations. The dental examinations will be carried out by registered dental clinicians who will be trained and calibrated to national standards by regional standard examiners to ensure that they are familiar with the examination method and criteria. Examiners must be trained and calibrated annually using the approved BASCD training pack and following BASCD guidance on the statistical aspects of training and calibration of examiners for surveys of child oral health (reference 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, usually dated within the last 3 years.

6. Data sharing responsibilities

6.1 Information sharing and protection

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

6.1.1 Responsibilities of schools

Schools are required to provide for all children on their roll who will have reached the age of 5 years but have not had their 6th birthday on the date of examination:

- first name and surname, which is used to identify the child and check that written parental agreement for them to be examined has been received
- date of birth, which is used to confirm that the child is the right age to take part in the survey and to distinguish between children with the same name

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.

Once parental agreement to participate is obtained, schools are required to provide the following information for these children only:

- home postcode, which is used to enable national and local analyses of socio-economic and geographic differences in oral health
- sex, which is used to help confirm the identity of the child and to enable national and local analyses of sex differences in oral health
- ethnic group, which is used to enable national and local analyses of ethnic group differences in oral health
- multiple birth status, which is used to help identify if any children are for example a set of twins when checking for duplication errors

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

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

Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 (reference 2). Local authorities will usually commission a fieldwork team, which may include one or more qualified dentist, dental therapist and/or dental hygienist, from a local NHS trust to carry out the survey on their behalf.

The official authority for oral health surveys means that the lawful basis under the 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 oral health surveys means that schools do not need to obtain the consent of parents or guardians to share their children's personal information with fieldwork teams. In addition, partners to the survey should be assured that the principles of the GDPR have been adhered to in the designing of this protocol.

However, as oral health 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 'Office for Health Improvement and Disparities 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

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

6.1.3 Responsibilities for obtaining parental agreement for children to take part in oral health surveys

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

The school is also responsible for:

- receiving the signed agreement forms from parents
- 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 as appropriate and in line with local protocols

6.1.4 Responsibilities of fieldwork teams

Fieldwork teams are responsible for sending to the local dental epidemiology coordinator the complete dental survey record for each child taking part. This record will include the personal information of each child 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 an encrypted password-protected memory stick, sent to the DEC by secure email or uploaded to a secure folder accessible only by the fieldwork team and DEC.

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 in line with local protocols

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

6.1.5 Responsibilities of dental epidemiology co-ordinators

Dental epidemiology co-ordinators are responsible for sending the survey data and documentation securely to OHID. These files will be uploaded to a region-specific secure Microsoft Teams channel accessible only to the relevant DEC and named OHID staff.

6.1.6 Responsibilities of the Office for Health Improvement and Disparities (OHID)

The role of OHID is to analyse the data collected by the fieldwork teams and publish the results of the survey in a national report on children's oral health.

OHID is responsible for:

- ensuring that only staff from the OHID national 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

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

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

7. 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.

7.1 Planning and organisation of the fieldwork

The planning and organisation of the fieldwork will be carried out by commissioned fieldwork teams who will liaise with local authorities, 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 the survey (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 mainstream state-funded primary schools within the area that educate children aged 5-years-old, including community schools, academies, foundation schools and free schools.

7.2 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 and 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.

Information from selected schools will be requested in 2 stages. The first stage will be to obtain class lists of all children aged 5-years-old at the date of examination to enable random sampling of children. These lists should include the following information:

- name
- date of birth

Home postcode, sex, ethnicity and multiple birth should not be collected at this stage. This will avoid the collection of special category data for all children, which may be considered excessive and not in line with data protection principles.

Fieldwork teams should agree with schools that the additional child information will be provided once parental agreement to participate has been received. Where this information is not available from a school, fieldwork teams will need to request this information via an amended parental agreement to participate form. This should be requested from the national dental public health team via the local dental epidemiology coordinator.

7.3 Seeking agreement to participate

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

Only children for whom agreement to participate has been received from a parent or person with parental responsibility should be included in the survey.

The procedure for obtaining agreement to participate is:

1. Record name and date of birth of the children who have been sampled on Appendix K.

2. Give parents and persons with parental responsibility of sampled children information about the survey (Appendix J part 1) and an agreement to participate form (Appendix J part 2).

3. Update Appendix L as to which children have returned the signed agreement form.

4. Distribute a second agreement to participate form, ideally on differently coloured paper, to those who do not respond to the first.

In some areas, 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 part 1). 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 J part 3).

7.3.1 Electronic agreement

Electronic methods of gaining agreement to participate are increasingly being used in public health programmes. The decision to use an electronic method should be locally agreed 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. Any electronic agreement method must be carried out in line with data protection regulations. To ensure no children are excluded from the survey, consideration must be given to families who may be unable to

access electronic agreement methods and an alternative agreement method offered. For further advice please contact the local DEC.

7.3.1 Maximising agreement to participate

Every effort should be directed towards encouraging and supporting parents and persons with parental responsibility to return agreement to participate forms. Coercion to provide agreement to participate should not be used and would make the process illegal. However, there are several approaches that local authorities and fieldwork teams can adopt.

It is important to send the letter from the senior responsible officer for the NDEP (Appendix 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, who has parent contact, to liaise with the fieldwork team is helpful to follow-up non responders. Fieldwork teams should work closely with the named school contact to optimise consent rates. Identifying the link between pupil health and wellbeing and attainment (reference 8), as recognised by Ofsted is another approach worth considering.

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 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).

7.3.2 Recording agreement to participate

Fieldwork teams must keep a record of the children for whom agreement to participate was sought and whether agreement to participate was received or no form was returned in Appendix L.

7.4 Agreement to participate received

Once agreement to participate has been received, for those children only, the second information request stage will be to obtain the following information from the school (section 6.1.1 of this document):

- home postcode
- sex
- ethnicity
- multiple birth

This information should be recorded in Appendix L.

Appendix L will be used to complete the data collection sheet (Appendix M) and to calculate numbers to complete the summary sheet (Appendix N), which must be completed electronically and submitted securely with the data files to DECs. This summary information is critical to enable calculation of national and local response rates for the survey.

8. Data collection

Non-clinical and clinical data may be entered either onto paper record sheets (Appendix M) or directly onto computer, with safeguards for both methods (see sections 9.1 and 9.2 of this document). 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 N.

8.1 Collection of non-clinical data

The information in this section is relevant to the fields in the data collection sheet (Appendix M).

8.1.1 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 G).

8.1.2 Examiner

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

8.1.3 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.

8.1.4 School type

The type of school will be recorded as follows:

0 Mainstream

1 Special school

8.1.5 School postcode

The school postcode will be recorded. If a postcode is not provided, it may be found on the school's website or 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 in the Access data collection programme with the first part (outward code) in the first box and the second part (inward code) in the second box, without spaces. Care should be taken to ensure the correct postcode is entered, as an incorrect postcode means that 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.

8.1.6 Date of examination

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

8.1.7 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 a participant's identification number generated from the class list. The list of lower tier local authority codes is given in the fourth column in Appendix G.

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.

8.1.8 Date of birth

The full date of birth should be entered dd/mm/yyyy. This should be between 01/09/2017 and 31/08/2019.

8.1.9 Home postcode

Home postcode will be recorded for each child in the required format. Guidance on the format of postcodes is provided above in section 8.1.5 of this document.

8.1.10 Sex

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

0 Male

1 Female

2 Other

8.1.11 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

8.1.12 Ethnicity

Examined children will be coded for ethnic origin to meet the requirements of the Health and Social Care Act, 2012. 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 (reference 9).

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 19 ethnic groups recommended for use by the government (reference 10).

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

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

Table 1. Ethnic groups

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

8.1.13 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 so they can be identified and included or excluded from analyses accordingly.

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

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

0 Main sample

1 Additional sample A

2 Additional sample B

3 Additional sample C

4 Additional sample D

5 Special school

See Appendix I for guidance if an additional sample of special schools is being planned.

8.1.14 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

8.2 Collection of clinical data

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.

Examinations in schools should commence immediately after the training and calibration of examiners and must be completed by the end of June 2024. 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 (reference 7).

8.2.1 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.

8.2.2 Examination position

Children will be examined in a supine position lying on mats on tables and the examiner seated or standing behind them whenever possible. A suitable fully reclining chair may be used for examinations if a table is unavailable, 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.

8.2.3 Examination light

A purpose-built light yielding approximately 4,000 lux at one metre will be used for illumination. The standard lamp for the survey is the Daray model X100E, which replaced the Daray X100H. Further information on lighting is available from the national dental public health team.

8.2.4 Instruments and materials

The instruments required for the caries examination will include No.4 plain mouth mirrors, ball ended community periodontal index of treatment needs (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.

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

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

8.2.5 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 cotton wool rolls, cotton buds or pledgets of cotton wool. Compressed air should not be used, in the interests of comparability and cross-infection.

Probes must only be used for cleaning debris from tooth surfaces to enable satisfactory visual examination and for defining fissure sealants as indicated in section 8.2.8 of this document. Radiographic or fibre-optic transillumination examination will not be undertaken.

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

The following is the sequence of examination:

1. Plaque assessment

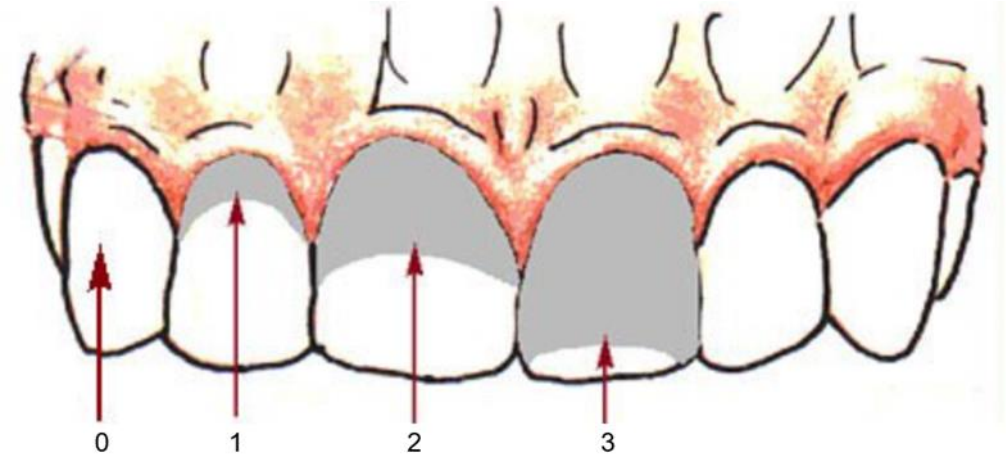
2. Caries

3. pufa

8.2.6 Plaque assessment

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 (reference 11) 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 shown in Figure 1 below.

Figure 1. Plaque assessment



Source: Malmö University Oral Health Country/Area Project (reference 11).

Figure 1 shows:

0 All exposed labial tooth surfaces of the upper anterior sextant appear clean

1 Plaque covering not more than one third of the total area 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 total area of the exposed labial tooth surfaces of the upper anterior sextant

3 Plaque covering more than two-thirds of the total area 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 of the total area of the exposed labial tooth surfaces, irrespective of its location on the labial surfaces of the upper anterior sextant. Scoring is not based on the individual tooth in the sextant with the most plaque coverage.

8.2.7 Dentition status

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

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 using a mirror only

2. Tooth surface examination using a mirror and cotton wool for drying

The condition of each tooth surface will be recorded using the BASCD diagnostic criteria for caries prevalence surveys (reference 4).

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

8.2.8 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.

Table 2: tooth codes

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.

The tooth and surface codes, which are mutually exclusive, are in Table 3.

Table 3: surface codes

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).

Diagnosis	Surface code	Diagnostic criteria
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 or a Maryland bridge abutment.
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)	#	Unseen because cooperation withdrawn (used in special schools only)

8.2.9 Coding conventions

The following coding conventions will apply:

- a tooth is deemed to have erupted when any part of it is visible in the mouth. Unerupted 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 two 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
- where doubt exists about the classification of any condition, the lower category should always be recorded, that is, if in doubt, score low

8.2.10 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

8.2.11 pufa

All children should be examined for the presence or absence of the pufa signs listed below in the primary dentition. The mouth should be examined in the same order as before (upper right, upper left, lower left, lower right), ensuring that the lips or cheeks are gently retracted to allow the soft tissues to be examined. Only score 1 pufa score per tooth. Lesions to be looked for are:

(p) open pulp

(u) traumatic ulceration

(f) fistula

(a) abscess

The following codes will be used:

0 - No teeth with pufa signs

1 - One tooth with one or more pufa signs

2 - Two or more teeth with pufa signs

8.2.12 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@dhsc.gov.uk

8.3 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 part 1) should be modified to reflect this. The DEC can provide advice and support.

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.

8.4 Safeguarding

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

9. Data submission

9.1 Data collection tool

The Access data collection tool with the specific format for this survey should be used to input the non-clinical and clinical survey data as soon as possible after visiting the school, this is available from the survey toolkit (reference 13). Data should not be left to be entered as a batch when all fieldwork is completed. The data collection tool contains several free fields for local use at the end. If these are insufficient for local information requirements, bespoke requirements can be arranged by contacting dentalphintelligence@dhsc.gov.uk.

Prior to sending on completed data files, each fieldwork team is responsible for checking their data for inaccuracies. Common errors include 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 checking, cleaning and labelling of data files is available in the Guidance for handling data, available from the survey toolkit (reference 14).

9.2 File transfer

Once the data has been checked and any identified errors corrected, files should be correctly labelled according to the guidance and sent securely to the relevant DEC to upload. Extracted Excel files should be labelled to indicate the survey group, year and local authority to which they refer. Data files must only be transferred 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 N:

- 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 old children
- total number of 5 year old children attending listed schools
- number of schools visited
- number of 5 year old children for whom agreement to participate was initially sought
- number of 5 year old children with agreement to participate

- number of 5 year old children for whom agreement to participate was sought and who did not respond or for whom a negative response was received
- number of 5 year old children with agreement to participate who were examined
- number of 5 year old children with agreement to participate who were absent on the day of the survey
- number of 5 year old children with agreement to participate who refused to be examined on the day of the survey

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

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

All returns should be made to DECs as soon as possible after completion of the survey and no later than 31 July 2024. Returns should include:

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

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

10. Data publication

A national report will be produced by the national dental public health team and published on the Oral Health Collections page (GOV.UK) (reference 12).

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

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

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

10.1 Data requests

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

11. References

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

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

3. 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

4. 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

5. Office for Health Improvement and Disparities (2023): Step by step sampling guide - age specific. Available from: https://www.gov.uk/government/publications/oral-health-survey-guidance

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

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. Public Health England (2014): The link between pupil health and wellbeing and attainment. Available from: https://www.gov.uk/government/publications/the-link-between-pupil-health-and-wellbeing-and-attainment

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

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

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

12. GOV.UK Oral Health Collections page: www.gov.uk/government/collections/oral-health

13. Oral health survey of 5 year old children,2023 to2024: toolkit: https://www.gov.uk/government/publications/oral-health-survey-of-5-year-old-children-2023-to-2024-toolkit

12. Appendices

Appendix	Title
A	Statutory Instrument 2012, No. 3094
B	Letter of support from programme lead to directors of public health (PDF)
C	Letter to headteachers (editable Word document)
D	The lawful basis for processing dental survey data under the GDPR and DPA 2018 (PDF)
E	Stages in the National Dental Epidemiology Programme
F	Operational timetable
G	Local authority names and codes
H	Date-of-birth bands for survey of 5 year old children, 2023 to 2024
I	Selected sections from the national protocol for the 2013 to 2014 oral health survey of 5 and 12-year-old children attending special schools
J part 1	Information for parents and persons with parental responsibility (editable Word document)
J part 2	Agreement to participate form for parents and persons with parental responsibility (editable Word document)
J part 3	Letter for parents or persons with parental responsibility where core agreement to whole of school life health surveillance is adopted (editable Word document)
K	Tracking list for schools to record which children have returned agreement to participate forms (PDF)
L	Examination day sheet, illustration example of Excel worksheet
M	Data collection sheet survey of 5 year old children, 2023 to 2024 (editable Word document)
N	Data summary, illustration example of Excel worksheet for primary school information

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

If needed this is available to print from 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 (reference 3).

Appendix B: letter of support, survey of 5 year old children, 2023 to 2024

This appendix is a letter of support from the senior responsible officer for NDEP to directors of public health and is available to download from the Oral health survey of 5 year old children, 2023 to2024: toolkit (reference 13).

Appendix C: letter to headteachers, survey of 5 year old children, 2023 to 2024

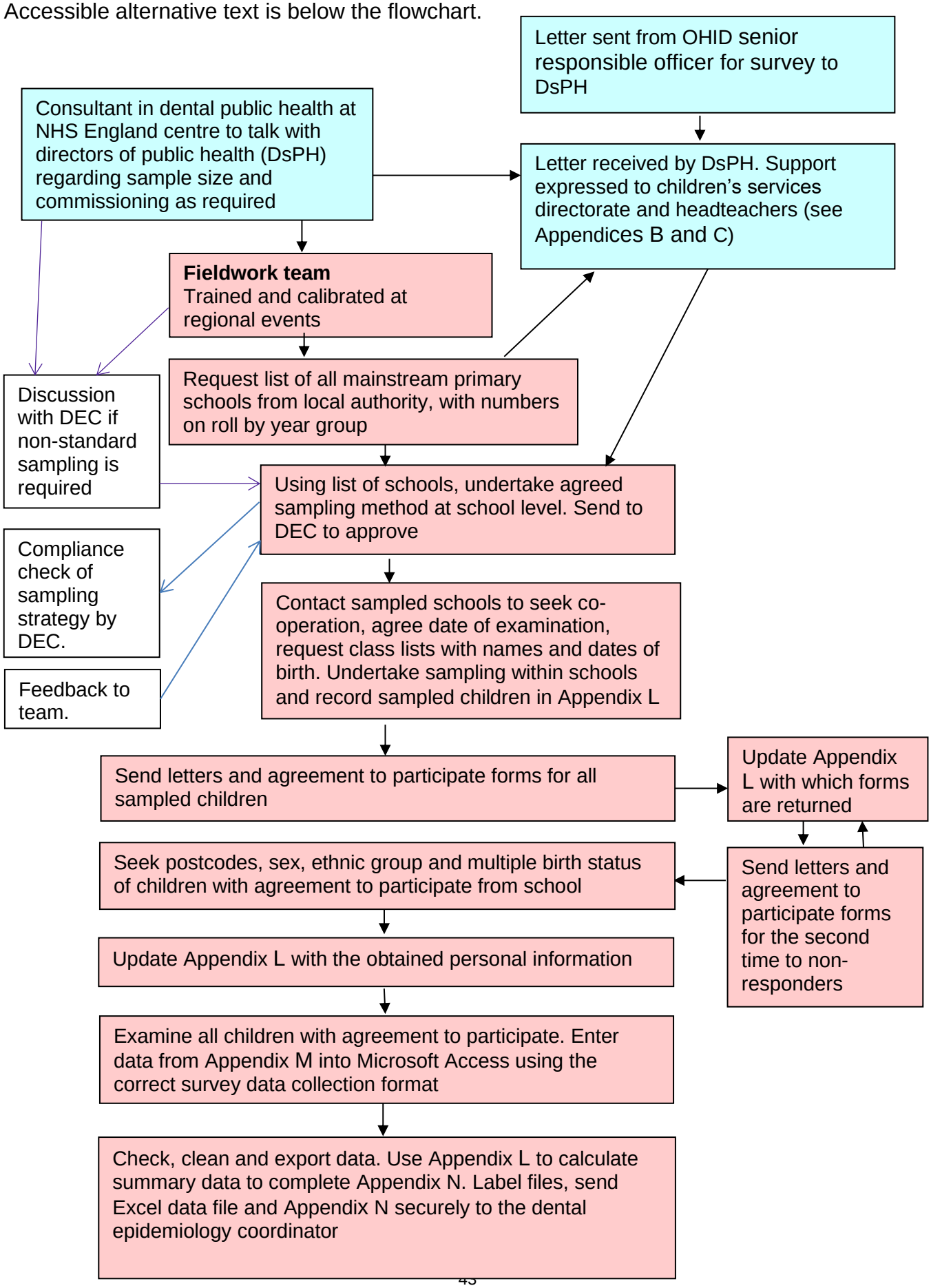
This appendix is available to download from the Oral health survey of 5 year old children, 2023 to 2024:toolkit (reference 13).

Appendix D: lawful basis for data under GDPR DPA 2018

This appendix contains information on the lawful basis for processing dental survey data under the GDPR and DPA 2018 and is available to download from the Oral health survey of 5 year old children, 2023 to 2024:toolkit (reference 13).

Appendix E: stages in the National Dental Epidemiology Programme

Accessible alternative text is below the flowchart.



This flowchart gives an overview of the steps in the dental survey. Steps are colour coded blue if undertaken by national and regional dental public health teams, pink if undertaken by fieldwork teams and white if undertaken by dental epidemiology coordinators.

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

2. The directors of public health cascade this information to directors of children services in local authorities and head teachers to gain support for the survey.

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

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

5. Fieldwork teams are trained and calibrated for the survey at regional events.

6. The fieldwork teams get lists of the numbers of children by year group attending mainstream schools from local authorities.

7. Using these lists, the fieldwork teams sample the schools to take part in the survey and the sampling is checked and confirmed by the local dental epidemiology coordinator.

8. Sampled schools are contacted by the fieldwork teams to take part in the survey. Class lists including names and dates of birth are requested from those schools and the children are then sampled.

9. Information letters requesting agreement to participate in the survey are sent to the parents and people with parental responsibility of the sampled children.

10. Information about the children with agreement to participate is sought from the school or parents including home postcode, sex, ethnic group and multiple birth status.

11. Lists of children to be examined are drawn up and all children who are present in the school on the day of examination for whom agreement to participate has been received are examined.

12. All the data collected are entered into a computer and checked for errors. They are then sent securely to the local dental epidemiology coordinator.

Appendix F: operational timetable

Event	Date for completion
National clinical training and calibration for standard examiners	Online training 21 June 2023 Calibration 30 June 2023
Regional training and calibration for fieldwork teams	September to October 2023
Results from regional calibration to be sent to DECs	September to October 2023
Data collection and ongoing data entry	To start immediately after regional training and calibration; completed by 30 June 2024
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 2024
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 2024
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: Analyse data and publish results tables for local authorities and report national headline findings	Two months after receipt of last data set dependent upon publication processes
Publication of report on the oral health collections webpage (reference 13)	Four months after receipt of last data set dependent upon publication processes
Release of cleaned anonymised data	Four months after receipt of last data set dependent upon publication processes

Appendix G: local authority names and codes

Upper tier local authority	Upper code	Lower tier local authority	Lower code
Barking and Dagenham	E09000002	Barking and Dagenham	E09000002
Barnet	E09000003	Barnet	E09000003
Barnsley	E08000016	Barnsley	E08000016
Bath and North East Somerset	E06000022	Bath and North East Somerset	E06000022
Bedford	E06000055	Bedford	E06000055
Bexley	E09000004	Bexley	E09000004
Birmingham	E08000025	Birmingham	E08000025
Blackburn with Darwen	E06000008	Blackburn with Darwen	E06000008
Blackpool	E06000009	Blackpool	E06000009
Bolton	E08000001	Bolton	E08000001
Bournemouth, Christchurch and Poole	E06000058	Bournemouth, Christchurch and Poole	E06000058
Bracknell Forest	E06000036	Bracknell Forest	E06000036
Bradford	E08000032	Bradford	E08000032
Brent	E09000005	Brent	E09000005
Brighton and Hove	E06000043	Brighton and Hove	E06000043
Bristol, City of	E06000023	Bristol, City of	E06000023
Bromley	E09000006	Bromley	E09000006
Buckinghamshire	E06000060	Buckinghamshire	E06000060
Bury	E08000002	Bury	E08000002
Calderdale	E08000033	Calderdale	E08000033
Cambridgeshire	E10000003	Cambridge	E07000008
		East Cambridgeshire	E07000009
		Fenland	E07000010
		Huntingdonshire	E07000011
		South Cambridgeshire	E07000012
Camden	E09000007	Camden	E09000007
Central Bedfordshire	E06000056	Central Bedfordshire	E06000056
Cheshire East	E06000049	Cheshire East	E06000049
Cheshire West and Chester	E06000050	Cheshire West and Chester	E06000050
City of London	E09000001	City of London	E09000001
Cornwall	E06000052	Cornwall	E06000052
County Durham	E06000047	County Durham	E06000047
Coventry	E08000026	Coventry	E08000026
Croydon	E09000008	Croydon	E09000008
Cumberland	E06000063	Cumberland	E06000063
Darlington	E06000005	Darlington	E06000005
Derby	E06000015	Derby	E06000015
Derbyshire	E10000007	Amber Valley	E07000032
		Bolsover	E07000033
		Chesterfield	E07000034

Upper tier local authority	Upper code	Lower tier local authority	Lower code
		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
Gloucestershire	E10000013	Cheltenham	E07000078
		Cotswold	E07000079
		Forest of Dean	E07000080
		Gloucester	E07000081
		Stroud	E07000082
		Tewkesbury	E07000083
Greenwich	E09000011	Greenwich	E09000011

Upper tier local authority	Upper code	Lower tier local authority	Lower code
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
Kent	E10000016	Ashford	E07000105
		Canterbury	E07000106
		Dartford	E07000107
		Dover	E07000108
		Folkestone and Hythe	E07000112
		Gravesham	E07000109
		Maidstone	E07000110
		Sevenoaks	E07000111
		Swale	E07000113

Upper tier local authority	Upper code	Lower tier local authority	Lower code
		Thanet	E07000114
		Tonbridge and Malling	E07000115
		Tunbridge Wells	E07000116
Kingston upon Hull, City of	E06000010	Kingston upon Hull, City of	E06000010
Kingston upon Thames	E09000021	Kingston upon Thames	E09000021
Kirklees	E08000034	Kirklees	E08000034
Knowsley	E08000011	Knowsley	E08000011
Lambeth	E09000022	Lambeth	E09000022
Lancashire	E10000017	Burnley	E07000117
		Chorley	E07000118
		Fylde	E07000119
		Hyndburn	E07000120
		Lancaster	E07000121
		Pendle	E07000122
		Preston	E07000123
		Ribble Valley	E07000124
		Rossendale	E07000125
		South Ribble	E07000126
		West Lancashire	E07000127
		Wyre	E07000128
Leeds	E08000035	Leeds	E08000035
Leicester	E06000016	Leicester	E06000016
Leicestershire	E10000018	Blaby	E07000129
		Charnwood	E07000130
		Harborough	E07000131
		Hinckley and Bosworth	E07000132
		Melton	E07000133
		North West Leicestershire	E07000134
		Oadby and Wigston	E07000135
Lewisham	E09000023	Lewisham	E09000023
Lincolnshire	E10000019	Boston	E07000136
		East Lindsey	E07000137
		Lincoln	E07000138
		North Kesteven	E07000139
		South Holland	E07000140
		South Kesteven	E07000141
		West Lindsey	E07000142
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

Upper tier local authority	Upper code	Lower tier local authority	Lower code
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	E06000065	North Yorkshire	E06000065
Northumberland	E06000057	Northumberland	E06000057
Nottingham	E06000018	Nottingham	E06000018
Nottinghamshire	E10000024	Ashfield	E07000170
		Bassetlaw	E07000171
		Broxtowe	E07000172
		Gedling	E07000173
		Mansfield	E07000174
		Newark and Sherwood	E07000175
		Rushcliffe	E07000176
Oldham	E08000004	Oldham	E08000004
Oxfordshire	E10000025	Cherwell	E07000177
		Oxford	E07000178
		South Oxfordshire	E07000179
		Vale of White Horse	E07000180
		West Oxfordshire	E07000181
Peterborough	E06000031	Peterborough	E06000031
Plymouth	E06000026	Plymouth	E06000026
Portsmouth	E06000044	Portsmouth	E06000044
Reading	E06000038	Reading	E06000038
Redbridge	E09000026	Redbridge	E09000026
Redcar and Cleveland	E06000003	Redcar and Cleveland	E06000003
Richmond upon Thames	E09000027	Richmond upon Thames	E09000027
Rochdale	E08000005	Rochdale	E08000005
Rotherham	E08000018	Rotherham	E08000018
Rutland	E06000017	Rutland	E06000017
Salford	E08000006	Salford	E08000006
Sandwell	E08000028	Sandwell	E08000028
Sefton	E08000014	Sefton	E08000014
Sheffield	E08000019	Sheffield	E08000019

Upper tier local authority	Upper code	Lower tier local authority	Lower code
Shropshire	E06000051	Shropshire	E06000051
Slough	E06000039	Slough	E06000039
Solihull	E08000029	Solihull	E08000029
Somerset	E06000066	Somerset	E06000066
South Gloucestershire	E06000025	South Gloucestershire	E06000025
South Tyneside	E08000023	South Tyneside	E08000023
Southampton	E06000045	Southampton	E06000045
Southend-on-Sea	E06000033	Southend-on-Sea	E06000033
Southwark	E09000028	Southwark	E09000028
St. Helens	E08000013	St. Helens	E08000013
Staffordshire	E10000028	Cannock Chase	E07000192
		East Staffordshire	E07000193
		Lichfield	E07000194
		Newcastle-under-Lyme	E07000195
		South Staffordshire	E07000196
		Stafford	E07000197
		Staffordshire Moorlands	E07000198
		Tamworth	E07000199
Stockport	E08000007	Stockport	E08000007
Stockton-on-Tees	E06000004	Stockton-on-Tees	E06000004
Stoke-on-Trent	E06000021	Stoke-on-Trent	E06000021
Suffolk	E10000029	Babergh	E07000200
		East Suffolk	E07000244
		Ipswich	E07000202
		Mid Suffolk	E07000203
		West Suffolk	E07000245
Sunderland	E08000024	Sunderland	E08000024
Surrey	E10000030	Elmbridge	E07000207
		Epsom and Ewell	E07000208
		Guildford	E07000209
		Mole Valley	E07000210
		Reigate and Banstead	E07000211
		Runnymede	E07000212
		Spelthorne	E07000213
		Surrey Heath	E07000214
		Tandridge	E07000215
		Waverley	E07000216
		Woking	E07000217
Sutton	E09000029	Sutton	E09000029
Swindon	E06000030	Swindon	E06000030
Tameside	E08000008	Tameside	E08000008
Telford and Wrekin	E06000020	Telford and Wrekin	E06000020
Thurrock	E06000034	Thurrock	E06000034
Torbay	E06000027	Torbay	E06000027

Upper tier local authority	Upper code	Lower tier local authority	Lower code
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
Westminster	E09000033	Westminster	E09000033
Westmorland and Furness	E06000064	Westmorland and Furness	E06000064
Wigan	E08000010	Wigan	E08000010
Wiltshire	E06000054	Wiltshire	E06000054
Windsor and Maidenhead	E06000040	Windsor and Maidenhead	E06000040
Wirral	E08000015	Wirral	E08000015
Wokingham	E06000041	Wokingham	E06000041
Wolverhampton	E08000031	Wolverhampton	E08000031
Worcestershire	E10000034	Bromsgrove	E07000234
		Malvern Hills	E07000235
		Redditch	E07000236
		Worcester	E07000237
		Wychavon	E07000238
		Wyre Forest	E07000239
York	E06000014	York	E06000014

Source: ONS Geographical Lookups

Appendix H: date of birth bands, survey of 5 year old children, 2023 to 2024

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 2023	October 2017	August 2018	September 2017 and 2018*
October 2023	November 2017	September 2018	October 2017 and 2018*
November 2023	December 2017	October 2018	November 2017 and 2018*
December 2023	January 2018	November 2018	December 2017 and 2018*
January 2024	February 2018	December 2018	January 2018 and 2019**
February 2024	March 2018	January 2019	February 2018 and 2019**
March 2024	April 2018	February 2019	March 2018 and 2019**
April 2024	May 2018	March 2019	April 2018 and 2019**
May 2024	June 2018	April 2019	May 2018 and 2019**
June 2024	July 2018	May 2019	June 2018 and 2019**
July 2024	August 2018	June 2019	July 2018 and 2019**

* If born 2017, birthday should be later than the day of examination. If born in 2018, birthday should be on or before the day of examination

** If born 2018, birthday should be later than the day of examination. If born in 2019, birthday should be on or before the day of examination

Appendix I: amended sections taken 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 5 year old children attending special schools within each local (education or upper tier) authority.

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 may not be familiar 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 survey process will take longer than in mainstream schools. The children may be brought to see the dental team one by one and the examination may 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 few hospital schools and the numbers of 5 year old children attending them is likely to be very small, 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, 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 with 5 year old children, 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 who have reached the age of 5 years but have not had their 6th birthday on the date of examination attending special schools. This will involve 5 year old children born between 1 September 2017 and 31 August 2019. Children may not be grouped 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 5 year old children child on the day of examination will be used to identify the sample.

Sampling procedure for local authorities with large numbers of special schools:

1. 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.

2. lists of all special schools in the local authority and rough figures for the numbers of children by year group attending each will be required as the first stage in the sampling process.

3. 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.

4. 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.

Fieldwork

The children will be examined supine lying on mats on tables 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 'Sample group code' allows for coding of special schools, use code 5.

Variable ‘Examination status’ allows 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 J part 1: information for parents of 5 year old children, 2023 to 2024 (to print)

This appendix is survey information for parents or persons with parental responsibility and is available to download and print from the Oral health survey of 5 year old children, 2023 to2024: toolkit (reference 13).

Appendix J part 2: agreement to participate, survey of 5 year old children, 2023 to 2024 (to print)

This appendix is an agreement to participate letter for parents or persons with parental responsibility and is available to download and print from the Oral health survey of 5 year old children, 2023 to2024: toolkit (reference 13). If additional data needs to be collected, please contact the national dental public health team.

Appendix J part 3: core agreement letter, survey of 5 year old children, 2023 to 2024 (to print)

This appendix is a letter for parents or persons with parental responsibility where core agreement to whole of school life health surveillance is adopted and is available to download and print from the Oral health survey of 5 year old children, 2023 to 2024: toolkit (reference 13).

Appendix K: school tracking list, survey of 5 year old children, 2023 to 2024 (to print)

This appendix is a tracking list for schools to record which children have returned agreement to participate forms and is available to download and print from the Oral health survey of 5 year old children, 2023 to 2024: toolkit (reference 13).

Appendix L: examination day sheet, survey of 5 year old children, 2023 to 2024

Below is an illustration example of the examination day spreadsheet. If completed electronically this can later be used to help calculate the summary information for Appendix N data summary sheet. In the example screenshot below, an invalid date of birth format is demonstrated (using full stops as a separator) compared to the correct date of birth format (using forward slashes as a separator). This appendix is available to download from the Oral health survey of 5 year old children, 2023 to 2024: toolkit (reference 13).

Name of school: St Peter's R.C

School postcode: FY4 3VG

Date of examination: 11/12/2023

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	E06000009	0007	23/03/2018								N			
Henry	Smith	E06000010	0012	16/04/2018	FY4	3DF	M	Y	D	D2	Y			Y	
Harvey	Smith	E06000011	0034	16.04.2018	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 old children, 2023 to 2024 (to print)

This appendix is available to download and print from the Oral health survey of 5 year old children, 2023 to 2024: toolkit (reference 13).

Appendix N: data summary, survey of 5 year old children, 2023 to 2024

Below is an illustration example of the data summary spreadsheet for mainstream schools which needs to be completed accurately to enable the calculation of response rates. This file is available to download from the Oral health survey of 5 year old children, 2023 to 2024: toolkit (reference 13). It also includes separate spreadsheets to report on additional surveys and special schools if required, illustration shown below.

MAINSTREAM SCHOOL SURVEY							State mainstream schools (with 5 year old children) 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-tier LA Name	Name(s) of examiner(s)	Start date of examinations dd/mm/yyyy	End date of examinations dd/mm/yyyy	Total number of schools	Total number of 5 year old children 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	12/10/2023	03/04/2024	54	2784	20	354	287	67	267	16	4
E10000007	Derbyshire	E07000033	Bolsover	A N Other X Y Other	06/11/2023	02/03/2024	18	1500	18	308	260	48	240	17	3
E10000007	Derbyshire	E07000034	Chesterfield	A N Other	25/10/2023	03/05/2024	25	2023	22	327	300	27	264	36	0
E10000007	Derbyshire	E07000035	Derbyshire Dales	X Y Other Y Z Other	15/11/2023	19/12/2023	40	2542	21	350	285	65	258	23	4

ADDITIONAL SCHOOL SURVEY						Number of additional children with :		Number of additional children WITH parental agreement to participate :		
Upper-tier LA Code	Upper-tier LA Name	Lower-tier LA Code	Lower-tier LA Name	Number of extra schools visited	Number of children for whom agreement to participate was sought (additional sample size)	Agreement to participate provided	Form not returned	Examined	Child absent	Child refused
E10000007	Derbyshire	E07000032	Amber Valley	2	50	45	5	44	1	0
E10000007	Derbyshire	E07000033	Bolsover	1	15	12	3	12	0	0
E10000007	Derbyshire	E07000034	Chesterfield	3	70	66	4	65	0	1
E10000007	Derbyshire	E07000035	Derbyshire Dales	1	25	19	6	16	1	2

SPECIAL SCHOOL SURVEY							Special Schools (with 5 year old children)				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-tier LA Name	Name(s) of examiner(s)	Start date of examinations dd/mm/yyyy	End date of examinations dd/mm/yyyy	Total number of schools	Total number of 5 year old children 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

Office for Health Improvement and Disparities