

NICE Shared Learning Collection submission template

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Title of submission: The development, implementation and monitoring of a community-based fluoride varnish programme in an inner-city London borough.

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Description:

The NICE Public Health guideline *Oral health: local authority oral health improvement strategies* makes recommendations for the delivery of community-based interventions and activities to improve oral health and reduce oral health inequalities. The guideline recommends that Local Authorities consider fluoride varnish programmes for nurseries and primary schools in areas where children are at high risk of poor oral health.This case study describes a community-based fluoride varnish programme in an inner-city London borough which aims to deliver two fluoride varnish applications per year to children between the ages of 3 to 10 years.

Does the submission specifically refer to the implementation of NICE guidance?

Yes

Does the submission relate to the general implementation of NICE guidance?

 Yes

Specific NICE guidance:

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| The reference number of the NICE guidance: *TBC* |  |
| The full title of the NICE guidance: Oral health: local authority oral health improvement strategies |  |
| Guidance type: Public Health Guideline |  |
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Sponsorship:

This programme is commissioned and funded by the London Borough of Islington (Public Health for Camden and Islington) and the service provider is Whittington Health NHS Trust Community Dental Service.

Your submission

Aim and objectives:

Aims:

* To provide 2 fluoride varnish applications per year to children aged 3-10 years, in children’s centres, selected schools (up to year 5) and other selected early year’s settings in Islington.
* To increase the number of children and their families accessing local NHS dental services.
* To improve oral health and reduce oral health inequalities in children in Islington, by increasing access to fluoride, dental services and oral health promotion.

Objectives:

* Provide a high quality, evidence-based service which represents good value and is responsive to local needs and guidance and policy across Islington and nationally;
* To strengthen relationships with stakeholders in schools and children’s centres in Islington to secure their participation in the programme.
* Work collaboratively with the Islington Oral Health Promotion Team; Heads of Primary Schools, Nurseries and Children’s Centres; Early Years Foundation Stage; Healthy Schools Team; Community Link Workers; Health Visitors; Family Support Workers; Dental Public Health; Dental Commissioners and a wider group of stakeholders.
* To work with home-school liaison staff to find out how to maximise contact with parents/carers, to explain the project and obtain consent for fluoride varnish application.
* To improve access to local NHS dental services by children and their families by signposting all children to local dental services and promoting regular dental check-ups.
* To identify and urgently refer those children who require dental treatment to local dental services.
* To carry out health promotion sessions with parents/carers, explaining the project and gaining consent for the fluoride application, as well as providing important information about how to prevent dental caries through appropriate fluoride use and access to dental care.
* To provide topical application of fluoride varnish twice a year in the school, children’s centre and other selected early years settings, to children aged 3-10 years (year 5) only, where parents/carers have consented.
* To work with school staff to provide ongoing support and advice on prevention and access to families contacted through the programme. It is expected that schools will identify and reach families whom they consider most at risk of dental disease.
* To refer children to other services when needs other than dental care are identified, e.g. child protection cases.
* Ongoing data collection and monitoring of programme.
* To thoroughly evaluate all aspects of the programme on an annual basis including surveys measuring the participant experience.
* To contribute to an increase in regular NHS dental service attendance by all residents including those from BME groups and those for whom English is not their first language.
* To use a preventive focus to address oral health inequalities in Islington.

Context:

In 2011, there were 206,100 residents in Islington.[[1]](#footnote-1) Twenty percent were between 0-19 years old, and this group is expected to increase by 16% in the next 20 years. Islington is the most densely populated local authority in England and one of the five most deprived boroughs in London. According to the Child Poverty report (2011), 43% of children in Islington are living in poverty. Despite overall improvements in the oral health of children in the UK, health inequalities remain between households in the lowest and highest social classes, and these disparities have persisted over time.

Dental decay is one of the most common chronic diseases, despite being entirely preventable. In Islington, tooth decay is a significant problem; epidemiological surveys show disease levels to be higher than both regional and national levels (6). In addition, persistent inequalities exist with trends suggesting that dental disease is increasingly concentrated in population groups suffering social deprivation or exclusion, including young children. Socially excluded and disadvantaged people suffer the effects of poor oral health with the added disadvantage of poor access to dental care and preventive services. Young children with high levels of decay are more likely to require extractions under GA with the associated costs of hospital admission. It is therefore particularly important to ensure that oral health promotion and dental services are targeted at those at highest risk of developing oral diseases in order to reduce financial costs to the NHS, and to reduce costs in terms of morbidity and its social impact on individuals and community .

Dental public health programmes, which are the responsibility of local authorities, should be commissioned following strategic planning. There is good evidence that in addition to place-based generic health improvement activities, which will address some of the common risk factors for dental decay, strategies to increase the exposure to fluoride are effective.

World Class Commissioning (WCC) was a statement of intent issued by the Department of Health in 2007.[[2]](#footnote-2) The aim was to deliver outstanding performance in the way NHS health and care services were commissioned by the former Primary Care Trusts (PCTs). At the heart of the WCC agenda, was an ambition to transform people’s health and well-being outcomes at a local level, while reducing health inequalities and promoting inclusion.

In line with WCC principles, Islington Public Health worked with commissioners and providers of dental services to produce a detailed oral health needs assessment and an Annual Public Health Report[[3]](#footnote-3) which focused on oral health in Islington. This highlighted higher levels of dental caries in Islington 5-year-olds compared to other London boroughs. In addition, much of this disease remained untreated. The data showed a significant association between deprivation and dental caries, and also low dental attendance, in this age group. In response to this, a local oral health commissioning strategy was developed. In addition to the established “Brushing for Life” programme which involved the distribution of fluoride toothpaste and advice to parents of young children, the strategy recommended a community-based fluoride varnish programme to further address oral health inequalities in young children.

It is important that oral health promotion interventions in both clinical and community settings are evidence-based. There is high quality evidence to suggest that sustainable improvements in oral health can be achieved by increasing fluoride use in children.A Cochrane review[[4]](#footnote-4) concluded that the application of fluoride varnishes two to four times a year, either in the permanent or primary dentition, is associated with a substantial reduction in caries increment. This relative effect applies in populations with different levels of caries risk and exposure to other sources of fluoride. A meta-analysis of 13 trials showed evidence of an average reduction of 43% (95% CI 30% to 57%) in decayed, missing and filled tooth surfaces with the use of fluoride varnish on permanent dentition. Evidence from the meta-analysis of 10 trials assessing the effect of fluoride varnish on the primary dentition suggests a 37% (95% CI 24% to 51%) reduction in decayed, missing and filled tooth surfaces.(3)

Multi-faceted oral health improvement programmes with topical fluoride applications targeted at young children have now been piloted in a number of areas. As a result, there is now more literature available to commissioners of such programmes[[5]](#footnote-5) Examples include information around establishing and maintaining such a programme, in particular regarding parent engagement (5) and recommendations on clinical practice for dental staff working with young children.(6) However, when the local Public Health team conducted their options appraisal to identify the most appropriate programme model for their pilot, it became apparent that there was a lack of practical guidance available for commissioning such a programme.

There are a number of community-based fluoride varnish programmes in operation in the UK with the aim of reducing dental caries in children. However, as each geographical area has its own set of unique local factors, there does not appear to be a single programme model that can be replicated in all areas. Local factors should be considered when planning such a programme, to ensure a greater likelihood of success with such initiatives.

This article summarises the main learning points gained from the experience of implementing a community-based fluoride varnish programme. Commissioners and providers may wish to consider these findings when planning similar programmes. Collaborative working, effective communication, a flexible approach and good project management skills, are of paramount importance in ensuring the success of such programmes.

Methods:

ESTABLISHMENT OF THE PROGRAMME

Step 1: Oral health seen as a local commissioning priority

Influencing the commissioning agenda

An “oral health champion” – in the form of the local Director of Public Health - was an essential element in influencing the local commissioning agenda. Public health support for investment in dental public health allowed the commissioning of an extensive oral health needs assessment and the publication of the *Annual Public Health Report in 2009* which was entirely devoted to oral health.2 The piloting of a community-based fluoride varnish programme was an integral part of the subsequent oral health commissioning strategy.

Options appraisal including feasibility study

As part of an options appraisal to determine the most appropriate service model for local implementation, organisations from across the UK were asked about their experiences of running fluoride varnish (FV) programmes. It became apparent that there was not a single programme model that could be replicated in all areas. A small feasibility study was therefore conducted to gain a clearer understanding of the practical requirements of a programme in Islington. Issues for investigation included: the most appropriate settings and target groups (including participant age); methods for maximising uptake; data collection and monitoring. The feasibility study was carried out in two children’s centres and two primary schools in the borough, using King’s College Hospital Dental Nurse Education & Training Centre (DNETC) trained staff from both general and community dental service providers.

A service specification and protocol, informed by the options appraisal, were then developed for a pilot community-based programme to deliver two fluoride varnish applications a year to children aged 3-8 years. Skill mix was encouraged, with the majority of the workforce comprising of DNETC nurses. The programme would not include a screening element, but would include signposting to local NHS dental services, to ensure the programme was focused on the main aim of increasing fluoride availability and to make it as cost-effective as possible.

DEVELOPMENT OF THE PROGRAMME

Step 2: Pilot programme implementation

The local community dental service was commissioned to deliver the pilot programme for a period of 10 months from September 2010.

Stakeholder engagement was key to successful implementation. Relevant parties that the team worked in partnership with included: primary schools and children’s centres, local GDPs, local authority departments of education, early years and children’s services. Participating settings included 44 primary schools (in 19 of these over half of the pupils were eligible for free school meals), 16 children’s centres and one special needs school. Shortly after commencement of the pilot, parental demand led to the age range being extended to include children aged up to 10 years.

In addition to consent forms being sent to parents from the settings, the oral health promotion team held 108 promotional sessions with parents to maximise consent rates. The more informal approach of speaking to parents at school gates proved to be more effective than the more formal parent information sessions and parent evenings.

Parents of 6,997 children (approximately 59% of the eligible population) gave consent for their child to participate. Of these children, 96% received one FV and 68% received 2 FV applications during the 10 month pilot. Reasons for not applying fluoride varnish included: absence, adverse medical history and child refusal on application day. Although a formal screening element was not included in the programme, dental nurses identified over a quarter of the participating children would benefit from a dental examination; these parents were sent a letter recommending they take their child to the dentist for a check-up. In addition all children enrolled in the programme were signposted to local NHS dental services. Refer to Table 1 for a summary of learning from the pilot which informed the substantive programme service specification.

Step 3: Procurement and implementation of a substantive programme

The tender process

Taking into account the learning from the pilot phase, a tender process commenced to appoint a provider to deliver a three year contract. The main aims of the programme were:

1. Provide two FV applications per year to children aged 3-10 years, in children’s centres, the most deprived schools (up to year 5) and other selected early year’s settings in Islington (target of 12,000 FV applications per year by the end of the contract term).
2. Increase the number of children and their families accessing local NHS dental services.
3. Improve oral health and reduce oral health inequalities in children in Islington, by increasing access to fluoride, dental services and oral health promotion.

Prospective providers were asked to submit evidence demonstrating that they could meet the requirements outlined in the service specification. This included appropriate clinical and management capacity to deliver a high quality, evidence-based programme which represented good value and was responsive to local needs, as well as local and national guidance and policy.

Service specification development

Taking into account lessons learnt during the pilot, a detailed service specification, including key performance indicators covering activity targets and quality standards, was developed. Clinical and infection control protocols were also included. During the options appraisal phase, a number of costing scenarios were put forward, which were used to inform the service model. This included making decisions around: the most appropriate number and type of settings; number of FV applications and frequency; age range of eligible children; whether a screening element should be included; and skill mix and staffing levels.

The local oral health needs assessment had highlighted a correlation between dental caries rates and schools in the most deprived areas of the borough. A decision was therefore made to take a more targeted approach than was taken during the pilot to ensure that the children most in need would be able to benefit from the service. Out of a total of 44 primary schools in the borough, 34 (77%) of the most deprived schools (based on proportion of pupils eligible for free school meals) would continue to participate in the substantive programme, as well as all 16 children’s centres. The provider would also be expected to identify other appropriate settings such as community nurseries. As the age range of 3-10 years old was well accepted during the pilot, it was decided to continue with this age range post-pilot.

Reducing inequalities and barriers to accessing the programme were key performance indicators. The provider was expected to give parents/carers and children high quality, clear information about the programme, taking into account language and cultural barriers. As well as translating materials and offering interpreter services, the provider was expected to build relationships with relevant staff including family support and outreach workers, and voluntary sector groups, in order to reach the most vulnerable families and marginalised communities. The provider was expected to use a variety of formal and informal methods to increase child participation and retention.

To ensure the safety of participants, the service specification outlines minimum standards for a number of areas including: infection control; risk assessments; staff qualifications and experience (including CRB checks and child protection training); prescribing; checking of consent and medical history; strict adherence to exclusion criteria and contraindications.

To ensure high quality record keeping, monitoring and reporting, the provider was required to invest in appropriate information technology including developing a database especially for the programme. The use of mobile technology such as tablets and encrypted memory sticks was encouraged – all following the relevant organisational information governance and data protection policies.

Expected outcomes for monitoring and evaluation were also outlined in the service specification. Refer to Table 2 for a summary of the lessons learned during programme implementation and delivery.

The programme is commissioned by the London Borough of Islington Public Health department, with an annual budget of less than £200,000.

Results and evaluation:

Step 4: Monitoring and evaluation

The provider sends the commissioner data on activity indicators such as: number of FV applications; proportion of total target group giving positive consent; proportion of total consents resulting in FV applications; proportion of total children (with consent) with no dentist; total promotional events attended; and proportion of children receiving 2 FV applications per year.

These results are discussed at quarterly steering group meetings. The steering group membership is made up of the provider clinical lead and project manager for the FV programme, the public health commissioner, and a dental public health consultant. At the steering group, the team discusses progress against the activity and quality performance standards outlined in the service specification. Any incidents or complaints are discussed. The group also discusses any issues arising and ideas for improving the service including ensuring that the service is targeting the most relevant groups. At the end of the financial year, a more detailed end of year evaluation report is submitted by the provider and implications for service development are discussed. In addition to regular membership, this meeting is attended by a honorary Consultant in Dental Public Health and the Head of the Provider service. This includes findings from a participant experience survey where a representative sample of child participants, parents and staff (at settings) are surveyed. Refer to Table 3 for interim results following 33 months of programme implementation.

Table 3: Interim results following 33 months of programme implementation (July 2011 – March 2014)

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| Number of fluoride varnish applications completed (Up to March 2014) | 33,490 |
| Number of eligible children in participating settings ( as of March 2014) | 11,571 |
| Number of children with positive consent | 8,273 |
| Average proportion of total target group with positive consent | 72% |
| Proportion of total consents resulting in fluoride varnish applications (%)  | 90% |
| % of settings receiving 2 fluoride varnish programme visits every year  | 100% |
| Proportion of total children (at time of giving consent) with no dentist (%) | 27% |
| Number of promotional sessions held | 422 |

The consent rate ranges from 59% in some settings to 88% in others. Deprivation does not seem to have an effect on the consent rate - 18 out of the 20 most deprived schools have a consent rate of 61% or more and the average consent rate across the top 20 most deprived schools (based on FSM data) is 71.5%. Some of the less deprived schools have lower consent rates than the most deprived schools in the borough.

The number of children identified by the FV team dental nurses as having a potential dental treatment need during a visit are recorded. The parents of these children are sent a letter with details of local NHS dentists and encouraged to take their child to a dentist for a check-up. These data can be matched against follow up visits to see whether the same children still have an obvious treatment need at the next visit. This indicates whether the child received treatment from a dentist between FV team visits. This treatment need is identified by dental nurses identifying and recording problems visible to the naked eye (e.g. gross caries, broken teeth, exposed pulp etc.). It is not a formal calibrated dental screening measure as dental nurses are not formally trained to identify dental problems. However, it does give an indication of the levels of obvious treatment need in this population.

After the first year of the programme, the team assessed whether those children identified by dental nurses as benefiting from a dental check-up/treatment at their first FV application, still had this need at the next FV application visit. It was found that 58% of the children whose parents had been sent a letter recommending they take their child to the dentist after the FV team’s first visit, did not require a further letter at the next visit, suggesting that the child had been taken to a dentist. A similar assessment was done at the end of the second academic year which showed 55% of children may have received dental treatment following the referral letter by the nurses.

In the first two years of the FV programme, the crude cost per FV application (calculated by dividing the contract value by the number of FV applications provided) was £18.17. In year three of the programme, the average cost per application reduced to £16.36 per application as the target of 12,000 applications was reached (and exceeded). If the provider continues to exceed their target in subsequent years of the programme, this amount should decrease further.

The costs compare favourably to the cost of treatment in Islington NHS general dental services (GDS). A band 1 treatment course (regular check-up where preventive advice should be offered) costs on average £27.50.

Long-term savings: Similar projects suggest a cost benefit ratio of 1:2 over five years, with savings being made due to a reduction in future restorative treatment. A band 3 course of treatment in an Islington GDS practice costs approximately £330. However, if more complex treatment in secondary care is required, e.g. tooth extraction under general anaesthetic, the costs are substantially greater.

The 2009 Islington Oral Health Needs Assessment identified a year-on-year increase in the number of referrals to the community dental service and secondary care for more complex paediatric dental treatment under sedation or general anaesthetic.

Preventive programmes such as the FV programme and other community-based oral health promotion programmes should help to reduce the number of children requiring more costly and complex dental treatment, by intervening before more complex problems develop. This in turn could indirectly have an effect on other indicators such as school absence, educational attainment and general child health and wellbeing as a result of poor oral health.

The Provider works closely with the Commissioner to review services on a regular basis and to develop innovative strategies for reaching those most at need in the local population. In August 2013, an evaluation of the fluoride varnish programme was conducted. This evaluation found that the Islington community-based fluoride varnish programme had been successful in achieving its main aims and objectives and that is has over-performed against the target number of FV applications it was expected to deliver. Participant experience surveys also showed that the programme was well-regarded by children, parents and teachers.

The evaluation highlighted a number of suggestions for further development to build on the progress already made and to ensure that the service can provide even better value in the future. Recommendations fell under the following themes: review list of participating settings; review the data monitoring and reporting requirements; strengthen partnership working. The FV programme contract was extended for a further 2 years (from April 2014 to March 2016) and changes have been made to performance indicators and targets (as recommended by the service evaluation) to ensure that the programme is doing everything it can to reach those children at highest risk of developing dental caries.

Conclusion

The Islington community-based fluoride varnish programme commenced in September 2010 and the current provider is commissioned to provide the programme until March 2016. Participating settings include: Thirty-eight primary schools (selected settings are based in areas of highest deprivation in the borough), fifteen children’s centres, ten community nurseries and one pupil referral unit. As at March 2014, a total of 33,490 FV applications had been delivered to children through the community-based programme. This is in addition to FV applications delivered in NHS general dental practices to which children in the programme are signposted and encouraged to attend for regular-check ups.

8,273 (72%) of children in the target group had received positive parental consent to participate in the programme. The consent rate ranges from 59% in some settings to 88% in others. No correlation was detected when comparing percentage free school meals to consent given. This is a promising finding as it suggests that higher deprivation is not impacting on the programme achieving high levels of parental consent as was originally hypothesised. It also indicates that there does not appear to be any major barriers to the most vulnerable children participating in the programme.

Severity of dental decay is well correlated with deprivation and data from the latest oral health survey for five-year-old children (2012)[[6]](#footnote-6) suggests that the oral health inequalities gap is gradually reducing in Islington. There was a decrease in prevalence of tooth decay in 5-year-olds from 33.1% in 2008 to 30.4% in 2012. The average number of decayed teeth in those children with decay decreased from 4.51 in 2008 to 4.2 in 2012.

Experience of delivering the programme has highlighted the importance of careful planning at each stage in the process. Effective partnership working and continuous dialogue with all those involved, including parents, children and staff (both in the settings and those delivering the programme) is essential to the success of the programme. In particular, the support and commitment of the staff in the settings where the programme is delivered, is extremely important in ensuring high consent rates, especially in those children at the highest risk of developing dental disease. Local factors should be considered when planning such a programme, to ensure a greater likelihood of success with such initiatives.

Collaborative working, effective communication, a flexible approach and good project management skills, are of paramount importance in ensuring the success of such programmes.The ability to be flexible and responsive to local needs is fundamental to the success and sustainability of such a programme. Commitment and continuing support from the commissioning body is also fundamental to the success of such a programme.

Over the last few years, a variety of projects related to oral health, including the community-based fluoride varnish programme described in this case study, have been commissioned and delivered in the London Borough of Islington. None of these projects alone is likely to be the reason for improved oral health in the borough, but the cumulative effect and the increased awareness of oral health within the borough may have contributed to the improvement. Commissioners and providers may wish to consider these findings when planning similar programmes.

Key learning points:

There are several community fluoride varnish programmes in operation in the UK. Although valuable lessons can be learned from these regarding good practice, no single programme model is appropriate in all areas. Each geographical area has its own unique local factors which need to be fully considered and explored in order to ensure the acceptance, and hence success, of such an initiative.

High quality record keeping is of paramount importance for risk management, reporting and monitoring purposes. This may require investment in bespoke information technology solutions.

Table 1: Learning from pilot which informed substantive programme service specification

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| Theme | Learning points |
| Target population | Focus on community settings in areas of highest deprivation. |
| Publicity | Use more informal ways of engaging with parents to maximise consent rates |
| Links to GDS | Use opportunities for maximising regular dental attendance |
| Team working | Team to include a “front of house” support role to free up the time that clinicians spend on administrative tasks.Regular team meetings to encourage good communication and shared learning |
| IT solutions | Develop a dedicated live database for the programme to ensure accurate and up to date records are kept for each child. This ensures high quality monitoring and reporting and minimises the risk of out of-date medical history records.  |
| Consent protocol | Parental consent gained for the duration of the programme. Parents given opportunity to update medical history or withdraw child from programme before each application.  |
| Infection control | Infection Control policy must be suitable for non-clinical community settings |
| Incidents and complaints | Procedures must be in place to address these as quickly as possible. |

Table 2: Learning points during programme implementation and delivery

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| Theme | Learning points |
| Planning and scheduling | Scheduling of visits to be done well in advance to take account of the daily routine of the setting and holiday periods. An appropriate amount of time should be left between the FV application and lunch/break time to minimise potential loss in efficacy as a result of food or drink being consumed soon after.Encourage settings with smaller eligible populations to attend FV application days at larger settings that they are in close geographical proximity to. |
| Cultural barriers | Information leaflets should be translated into the main local languages with messages to reflect specific cultural concerns, e.g. statement of support from Islamic Council despite FV containing alcohol. The provider must build relationships with staff in settings and outreach workers to identify and encourage participation from the most vulnerable families, including those where language and/or low literacy levels are barriers. |
| IT support | The functionality of a dedicated and flexible database requires ongoing IT support. |
| Publicity | Substantial resource is required to publicise the programme, to recruit new participants and keep settings and enrolled participants motivated and engaged with the programme.Many residents are not aware that the local water supply is not fluoridated and it is therefore important to keep publicising the importance of obtaining fluoride from other sources. |
| Collaborative working | Ensure the programme integrates with other health promotion initiatives, e.g. Healthy Schools/Children’s Centre/OHP programmes.Identify a link person in each setting and build relationships to ensure good communication between the FV team, settings and parents so that any concerns can be addressed quickly.Provide support to the settings where necessary, e.g. administrative support, so that staff experience minimum disruption to their day.Commissioners and providers must work in close partnership to drive innovation and improvement.  |
| GDP engagement | Engage with local GDPs to: * ensure they are aware of the community programme, to ask patients if their child is enrolled and when they received their last FV application.
* encourage them to offer FV routinely to children from the age of 3 years.
* to determine the proportion of children who were signposted by the programme go on to visit the dentist.
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| Prescribing | A group prescription protocol is used: a dentist signs off prescriptions each week for the number of FV applications expected in each setting. It is not practical to sign off individual prescriptions for each child. |
| Risk assessment | The following risk assessments were undertaken and the programme adapted accordingly: cross-infection and health and safety risks for each site; exclusion due to allergy (colophony); secure transport of data and staff between sites (using public transport); waste management. |

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6. The *National Dental Epidemiology Programme for England: oral health survey of five-year-old children (2012)* [↑](#footnote-ref-6)