**ORGANISATION AND SERVICE SPECIFICATION**

|  |  |
| --- | --- |
| Care Pathway/Service | **Oral Health Improvement Service** |
| Commissioner Lead |  |
| Provider Lead |  |
| Period |  |
| Applicability of Module E (*Acute Services Requirements*) |  |

|  |
| --- |
| 1.0 Purpose |

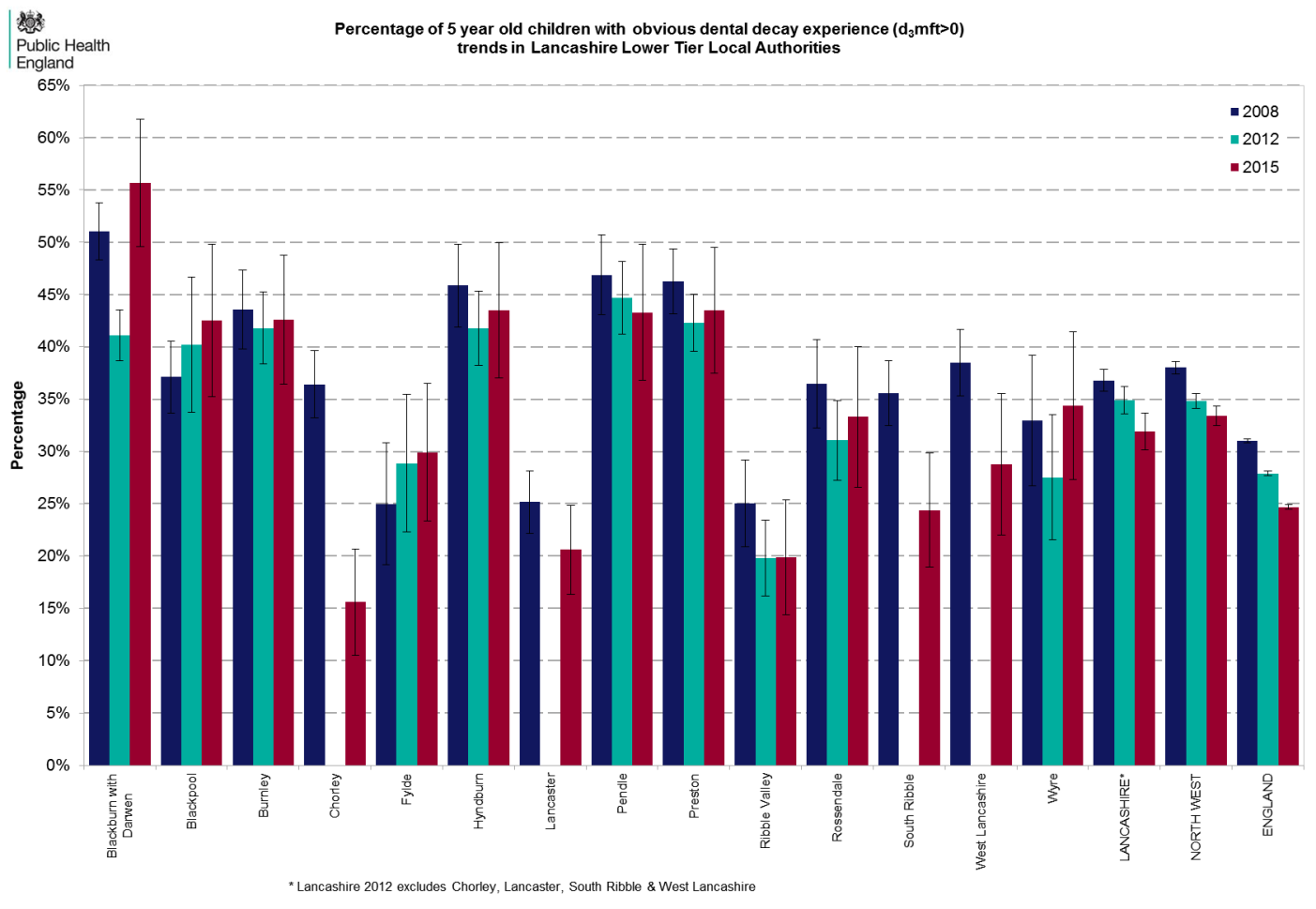
**1.1 Aim**

This service specification was developed to support the delivery of better oral health to populations living in all 12 districts of Lancashire across the 3 localities of North, Central and East, improving their health outcomes and reducing health inequalities. Although it is acknowledged that poor oral health affects all ages, it is recognised that good habits laid down in the early years will provide solid foundations for good oral health throughout life. Therefore the focus of this specification will be on children and young people and increasing their exposure to fluoride to benefit their long term oral health as recommended within *Local authorities improving oral health: commissioning better oral health for children and young people - An evidence-informed toolkit for local authorities (June 2014)[[1]](#footnote-1)*

**1.2 Evidence Base**

* Delivering Better Oral Health – An evidence based toolkit for prevention 3rd edition (PHE, revised March 2017)
* Local authorities improving oral health: commissioning better oral health for children and young people - An evidence-informed toolkit for local authorities (PHE, June 2014)
* NICE guidance: Oral health: approaches for local authorities and their partners to improve the oral health of their communities (October 2014)
* Public Health England Dental Public Health Intelligence Programme Surveys
* The state of children’s oral health in England (Faculty of Dental Surgery, 2015)

Tooth decay is the most common oral disease affecting children and young people (CYP) in England, yet it is largely preventable. The most recent National Dental Epidemiology Programme for England, oral health survey of five-year-old children 2015 was published in May 2016.[[2]](#footnote-2) This reported the third survey of its kind, the previous aforementioned ones having taken place in 2008 and 2012. Using the three surveys, comparisons can be made, and we can describe indicative changes in the oral health status of children across Lancashire. In the main, the severity and prevalence of tooth decay has returned to levels previously recorded and continues to be worse than the national average as shown in the graph below.



Due to the severity and age of children experiencing tooth decay, often the only treatment option available is extraction under general anaesthesia. Dental extractions were a leading cause for hospital admissions in children in England aged five to nine years old in 2015/16[[3]](#footnote-3). Dental treatment under general anaesthesia (GA) presents a small but real risk of life-threatening complications for children. The table below highlights the number of admissions in Lancashire for extractions under anaesthesia in 2015/16.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Admissions for extractions under general anaesthesia in 2015/16** | | | | | |
| **LA Name** | **Age 0-4yrs** | **Age 5-9yrs** | **Age 10-14yrs** | **Age 15-19yrs** | **Total 0-19yrs** |
| Burnley | 36 | 109 | 20 | \* | \* |
| Chorley | 31 | 96 | 30 | 8 | 165 |
| Fylde | 19 | 30 | 6 | \* | \* |
| Hyndburn | 35 | 96 | 28 | 7 | 166 |
| Lancaster | 6 | 13 | \* | \* | 28 |
| Pendle | 57 | 95 | 15 | 6 | 173 |
| Preston | 66 | 206 | 41 | 10 | 323 |
| Ribble Valley | 8 | 21 | 9 | \* | \* |
| Rossendale | 20 | 71 | 21 | 8 | 120 |
| South Ribble | 24 | 123 | 30 | 10 | 187 |
| West Lancashire | 32 | 122 | 26 | 16 | 196 |
| Wyre | 36 | 110 | 19 | 8 | 173 |

Tooth extractions under GA are not only potentially avoidable for most children but also costly. The cost of extracting multiple teeth in children in hospitals in 2011-2012 was £673 per child with a total NHS cost of nearly £23 million1.

Dental treatment is a significant cost, with the NHS in England spending £3.4 billion per year on dental care (with an estimated additional £2.3 billion on private dental care[[4]](#footnote-4)).

The provision of free fluoride toothpaste offers an effective way to reduce levels of tooth decay in populations. Evidence (Marinho, 2008[[5]](#footnote-5)) suggests that fluoride toothpaste, which is commonly linked to the decline in the prevalence of tooth decay in many developed countries, can protect children and adolescents against this condition by an average of 24% (95% CI, 21% - 28%). In addition, reviews of clinical effectiveness by NICE (PH55)[[6]](#footnote-6)and PHE (Commissioning Better Oral Health for Children and Young People, 20141) have found that the targeted provision of toothbrushes and paste by post and by health visitors effectively reduced tooth decay in 5 year olds with a return of investment after 5 years of £4.89 for every £1 spent and, after 10 years, £7.34 for every £1 spent. In addition, an assessment of the cost effectiveness of a postal toothpaste programme to prevent tooth decay among five-year-old children in the North West of England (Davies, G. M. et al., 2003[[7]](#footnote-7)) suggests that in 2003 the estimated cost per tooth saved from decay was £80.83, the cost per child of preventing tooth decay experience was £424.38 and avoiding extractions was £679.01.

**1.3 General Overview**

**1.3.1 Context**

The 2012 Health and Social Care Act conferred responsibility for oral and general health improvement to local authorities enshrined in law by The NHS Bodies and Local Authorities (Partnership arrangements, Care Trusts, Public Health and Local Healthwatch Regulations 2012 (SI 2012/3094) Regulation 17[[8]](#footnote-8). Oral health has some of the most wide-reaching and long lasting effects on health and development throughout the life course. Lancashire County Council is commissioning a range of evidence-based Oral Health Improvement (OHI) interventions from 1st April 2018 to 31st March 2019. Implementation of these OHI interventions will be informed by need as identified by both national and local data and will incorporate best practice to improve oral hygiene and reduce inequalities in oral health for children and young people in Lancashire

Oral health is an integral part of overall health. A significant proportion of the population in England experiences very good levels of oral health1. Successive oral surveys2 have shown that child and adult oral health has been improving over the past 40 years. However, vulnerable, disadvantaged and socially excluded groups are at greater risk of oral diseases affecting their teeth, gums, supporting bone, and soft tissues of their mouth, tongue and lips. People in the North West in particular are at higher risk of oral disease than those in other parts of the country.

In Lancashire, due to the diverse nature of the county and its associated health inequalities, the impact of poor oral health is felt across all twelve districts with significant variation.

**1.3.2 The impact of poor oral health**

Tooth decay (dental caries) is the most common oral disease affecting children and young people in England, yet it is largely preventable. The frequency of intake of sugars is particularly relevant for dental caries. Demineralisation of tooth surfaces occurs after a sugar intake and a subsequent drop in pH takes place in the mouth as oral bacteria convert sugar to acid. Extrinsic acid from the diet, both food and drink, can also wear away the tooth enamel and cause tooth surface loss, making them more prone to decay and sensitivity[[9]](#footnote-9)

Children’s primary (baby) teeth are more susceptible to decay than permanent (adult) teeth owing to differences in their chemical composition and physical properties. In particular, primary teeth have thinner and often less resilient enamel that does not provide as much protection from bacteria. Infants’ and toddlers’ primary teeth can also be affected by an aggressive form of decay called early childhood caries. The disease is associated with the frequent consumption of sugary drinks in baby bottles or sipping cups as it occurs in the upper front teeth and spreads rapidly to other teeth (Royal College of Surgeons Faculty of Dental Surgery, 2015[[10]](#footnote-10)).

Poor oral health can affect children’s and young people’s ability to sleep, eat, speak, play and socialise with other children. Other impacts include pain, infections, poor diet, and impaired nutrition and growth[[11]](#footnote-11). According to the Global Burden of Disease Study in 2010[[12]](#footnote-12), five to nine-year-old children in the UK experienced the most disability caused by poor oral health.

Oral health is an integral part of overall health and when children are not healthy, this affects their ability to learn, thrive and develop1.

Poor oral health may also be indicative of dental neglect and wider safeguarding issues[[13]](#footnote-13).

**1.3.3 The prevalence of children’s tooth decay in England**

Oral health has improved significantly since the 1970s owing to greater awareness of its importance and the widespread availability of fluoride. However, the Dental Public Health Epidemiology Programme found that while children’s oral health has improved, almost a quarter (24.7%) of five-year-olds still had tooth decay in 2014. This equates to approximately 166,467 five-year-olds in England who had some experience of tooth decay with 144,901 of five-year-olds having one or more untreated decayed tooth2.

Moreover, in 2015/16, 60,361children under 19 years of age were admitted to hospital for tooth extractions with just under 60% of cases for children nine years or under3.

Evidence shows that people living in deprived communities consistently have poorer oral health than people living in more affluent communities. Stark regional differences also exist. For example in 2015, 20% of five-year-olds had tooth decay in South East England compared to 34.4% in the North West of England, with even greater inequalities within local authority areas3.

**1.3.4 Oral health in Lancashire**

Over recent years, the dental health of children in Lancashire has been generally worse than many other parts of England. In addition there was marked variation across the county, with young children in Burnley, Preston and Hyndburn having comparatively worse oral health than Fylde, Ribble Valley and Lancaster. To tackle this, a number of oral health improvement programmes were delivered across Lancashire by the then discrete Primary Care Trust- provided Oral Health Improvement Teams.

The interventions focussed, in the main, on reducing sugar intake between meals, reducing smoking and alcohol misuse, increasing access to dental services via the training of setting based staff and education of parents and carers, and increasing exposure to fluoride, primarily via toothpaste distribution. However, implementation in terms of programme content and level of services was variable and unevenly distributed across Lancashire.

It was, however, recognised at this time that a large element of oral health improvement could and should be undertaken in the settings where children and their families most frequently access and by a wider health and social care workforce. The Smile4Life Programme was, therefore, developed by a robust Local Authority and NHS partnership and launched in 2010 for implementation across Lancashire. Smile4Life supports co-ordinated activity with the aim of reducing tooth decay in children and laying solid foundations for good oral health throughout life. Central to the programme are evidence-based messages on tooth brushing, diet and lifestyle that can be embedded into the daily activities of Children Centres and Early Years Foundation Stage settings.

However, significant reduction in dental caries was seen to be most associated with increased exposure to fluoride via toothpaste distribution and fluoride varnish application. In Blackburn with Darwen in particular, where in previous years children had amongst the highest levels of prevalence and severity of tooth decay, a large statistically significant [10%] reduction in tooth decay prevalence was reported in The National Dental Epidemiology Programme for England, oral health survey of five-year-old children published in 2012[[14]](#footnote-14). It is likely that a substantial provision of free fluoride toothpaste and facilitated access to dental services contributed to this.

**1.3.5 National drivers**

The NHS Outcomes Framework (2015-16[[15]](#footnote-15)) also includes the following indicators on improving dental health:

3.7 i Decaying teeth, ii Tooth extractions in secondary care for children under 10

4.4 ii Access to NHS dental services

The Public Health Outcomes Framework, ‘Healthy Lives, Healthy People: improving outcomes and supporting transparency’ sets a decrease in the decayed, missing and filled teeth (dmft) rate of dental caries in children aged five as an indicator of local and national health improvement.

A national Children’s Oral Health Improvement Programme Board (COHIPB) was launched on 26 September 2016. The Board’s ambition is that “every child grows up free from tooth decay as part of every child having the best start in life”. The Board’s objectives are to ensure:

* child oral health is on everyone’s agenda
* the early years and dental workforce have access to evidence based oral health improvement training
* oral health data and information is used to the best effect by all key stakeholders
* all stakeholders use the best evidence for oral health improvement
* child oral health improvement information is communicated effectively

**1.4 Objectives**

* Enabling oral health improvement across the life course by giving every child the best start in life and laying solid foundations for good oral health throughout life
* Using policy and practice to help create environments that improve oral health by adopting an integrated approach with partners for oral health improvement
* Working in partnership to address the underlying causes of health inequalities and the causes of poor general and oral health through upstream evidence informed actions
* In collaboration with partnership bodies using, sharing and developing information and intelligence for promoting good oral health
* Accessing oral health training for the wider health and social care workforce
* Supporting children and young people (CYP) through their families, early years, schools and community settings to maintain good oral health including adoption of a place based approach such as Smile4Life and implementation of supervised toothbrushing in childhood settings
* Development of a pathway that increases access to NHS dentistry and prevention, in particular for vulnerable children and adults
* Review current oral health improvement initiatives to ensure that they:
  + Meet local needs
  + Involve upstream, midstream and downstream interventions that involve both targeted and universal approaches
  + Consider the totality of evidence of what works
  + Engage with partners and integrate across organisations and across bigger footprints as required
* Consider using pooled budgets across organisations and geographies and using cost benefit analysis tools

**1.4.1 Expected Outcomes:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Measurable Outcome** | **Lancashire Average** | **North West Average** | **National Average** |
| Work towards attaining a reduction in the incidence of decayed, missing (due to decay) and filled teeth (d3mft) in 5 year old children towards the national average | 1.2 | 1.3 | 0.8 |
| To secure year on year improvement on the reduction in the prevalence of dental caries (d3mft>0) in 5 year olds towards the national average | 31.9% | 33.4% | 24.7% |

|  |  |  |  |
| --- | --- | --- | --- |
| **Measurable Outcome** | **Lancashire (Admissions % popn)** | **North West (Admissions % popn)** | **National (Admissions % popn)** |
| Reduction in the % children and young people admitted to hospital for tooth extraction towards the national %: |  |  |  |
| 0 – 4 year olds | 0.6% | 0.3% | 0.3% |
| 5 – 9 year olds | 1.5% | 1.1% | 0.8% |
| 10 – 14 year olds | 0.6% | 0.6% | 0.5% |
| 15 – 19 year olds | 0.4% | 0.4% | 0.3% |
| Total 0 – 19 year olds | 0.8% | 0.6% | 0.5% |

* Increased demonstration of evidence-based oral health improvement activity being undertaken by the wider workforce
* All children looked after have access to evidence based oral health improvement information and activities and are sign-posted to relevant services including NHS dentistry.
* Smile4Life Programme is recognised and utilised as the oral health improvement tool of choice by both allied professionals and the public

|  |
| --- |
| 2.0 Scope |

**2.1 Service Description**

A number of co-ordinated evidence based oral health interventions will be delivered across Lancashire, driven by local need and incorporating best practice to support the population to make improved lifestyle choices that will benefit their long term oral health.

Activity undertaken will support six key areas:

* Workforce development, in particular, the accessing of e-learning tools that provide and support the cascading of oral health training for the wider health and social care workforce
* Provision of toothbrushes and toothpaste (via children centres and reception classes and utilising the wider social health and social care workforce)
* Supervised toothbrushing for all reception aged children across Lancashire
* Implementation of an integrated programme of oral health improvement support such as the Smile4Lifeprogramme
* Development of a pathway that increases access to NHS dentistry and prevention, in particular for vulnerable children and adults

The above OHI activity will be underpinned by/embedded with the following detail:

The key areas described above will be delivered to the standards and methods recommended in ‘Delivering Better Oral Health – An evidence-based toolkit for prevention, 3rd edition’. This will include ensuring that the service providers and their staff are aware of:

* The ‘advice for patients’ in Delivering Better Oral Health (3rd edition)
* The fact that oral disease is, in most cases, preventable
* How fluoride can help prevent tooth decay
* Links between dietary habits and oral health
* Links between health inequalities and oral health
* The needs of groups at higher risk of poor oral heath
* Where to get advice about local dental services, including advice about cost and transport links
* How oral health in childhood affects oral health in adulthood
* Links between poor oral health and alcohol and tobacco use

The service providers will engage with relevant early years settings and professionals to support their work with families to increase understanding of how good oral health contributes to children’s general health and wellbeing. This includes:

* Promoting breastfeeding and healthy weaning and food, snacks and drinks that are part of a healthier diet
* Advising on alternatives to foods and drinks that contain sugar and pacifiers
* Explaining that tooth decay is a preventable disease and how fluoride can help to prevent it
* Encourage regular toothbrushing at least twice a day including last thing at night and promoting the use of family fluoride toothpaste as soon as teeth come through. Spitting not rinsing after toothbrushing.
* Encouraging people to regularly visit the dentist from when a child gets their first tooth and explaining who is entitled to free dental treatment
* Provide details on how to access routine and emergency dental services
* Encourage the promotion of a healthier lifestyle including preventing the uptake of excessive alcohol consumption and tobacco use
* Using sugar-free medicine
* Demonstrating how to achieve and maintain good oral hygiene and encourage toothbrushing from an early age
* Asking the dentist about fluoride varnish

Setting based staff and relevant wider workforce will have the skills and resources to promote oral health by for example:

* Receiving oral health improvement training
* Receiving all relevant resources, including fluoride toothpaste, to enable implementation of the interventions
* Ensuring they understand how to access local dental services and how to support people to use them

A programme of integrated oral health improvement support, such as Smile4Life, will be delivered across Lancashire, utilising the quality assured resources to:

* Encourage Healthy Eating and Drinking
* Encourage Regular Toothbrushing
* Encourage the Promotion of a Healthier Lifestyle
* Visit a Dentist Regularly

**2.2 Oral Health Improvement Training**

Oral health improvement e-learning opportunities will be promoted to appropriate health and social care workforce e.g.

* Smile4Life e-learning module <http://www.lancashirechildrenstrust.org.uk/resources/?siteid=6274&pageid=40899>
* Improving Mouth Care <http://www.e-lfh.org.uk/programmes/improving-mouth-care/how-to-access/>
* Health Visitor HCP oral health module 10 Health promotion subsection Dental Health Promotion <http://www.e-lfh.org.uk/programmes/healthy-child-programme/> <http://www.rcpch.ac.uk/system/files/protected/education/HCP-0-5-curriculum.pdf>

Oral health improvement training will be provided to ensure all associated staff and volunteers, including the early years workforce and staff supporting Children Looked After, can deliver evidence based oral health improvement interventions relevant to their roles and responsibilities. Training will be prioritised in settings who work with the following priority groups:

* Children (with a focus on those in the most deprived areas and early year’s settings)
* Children in care
* Children with a physical or learning disability

**2.3 D****istribution of oral health packs**

Toothpaste, toothbrushes and an evidence based information leaflet will be procured and made up into oral health packs for distribution via Neighbourhood Centres to all parents/carers of new born children and by setting based staff to all reception aged children. These packs should contain mint flavoured 1450ppm fluoride toothpaste as recommended in “Delivering Better Oral Health”.

**2.4 Targeted Supervised Toothbrushing Programme**

An effective supervised toothbrushing programme will be delivered in all reception classes across Lancashire. The purpose of the programme is to improve children’s oral health by increasing exposure to fluoride and improving behavioural and self-care skills at home. The programme shall be run in each establishment to a standardised protocol in line with published evidence[[16]](#footnote-16).

Evidence based information will be provided including parent/child information leaflets to promote the Programme. All literature must be approved by the Council and/or Service Delivery Lead.

Supervision and on-going support in terms of training, cross infection control and consent for participation will be provided to participating settings. All settings shall have a designated lead person who is responsible for the toothbrushing programme in their setting. The programme will be quality assured in each setting at least 2 times a year.

An additional oral health pack will be given to children at the end of the summer and winter term to support the integration of home tooth brushing at night and at least one other occasion into the daily routine and will also include signposting information to NHS dental services**.**

Free toothpaste at concentrations (1450ppmF) recommended in “Delivering Better Oral Health”, and toothbrushes will be provided to participating settings for the duration of the contract.

**2.5 Smile4life Programme**

Early years settings that have already completed or part completed the Smile4Life Programme will be identified and continued support given

A scoping exercise will be conducted to review geographic coverage of current Smile4Life accreditation and target future work to recruit early years settings in the less represented areas of highest deprivation and dental need.

Support will be given to identified Practice Based Prevention Practitioners supporting the implementation of Smile4Life, within their local communities, on behalf of the NHS.

**2.6 Promotion and Marketing**

Where oral health improvement materials and resource packs are provided, these must be evidence based and targeted to support the overarching aims of this specification. Localised materials shall only be produced if this is based on a needs analysis and a social marketing approach is taken to their development and be consistent with and reinforce national evidence-based messages around good oral health improvement, practice and healthy eating, where appropriate.

Oral health improvement materials must be available in a range of accessible formats and mediums to meet the language and literacy needs of Service Users and their clients.

Innovative ways of engaging with the wider health and social care workforce and public should be identified and provided, maximising opportunities for marketing and promoting evidence-based oral health improvement.

**2.7 Accessibility/acceptability**

The delivery of the service will be done in a non-stigmatising and non-discriminatory way, providing fair and equitable access, in compliance with the Equality Act 2010.

Individuals will not be discriminated against on the grounds of gender, race, disability, sexual orientation, sexual practices, gender reassignment, age, pregnancy or maternity, marriage/civil partnership or belief system. All applicable legislation must be adhered to.

The oral health improvement service will be accessible to people who have difficulties accessing support to become well, including people with mental health problems, from black and minority ethnic communities, people with sensory impairments, and people with learning disabilities or learning difficulties and people from the Gypsy/Romany/travelling communities.

|  |
| --- |
| 3.0 Service Delivery |

**3.1 Service Model**

The oral health improvement interventions will be delivered in accordance with the guidelines contained in Delivering Better Oral Health (3rd edition), Commissioning Better Oral Health for Children and Young People, Smokefree and Smiling (2nd edition) & relevant NICE Oral Health Promotion guidance.

An agreed method of demonstrating intervention implementation will be provided to ensure evidence can be given to commissioners in relation to efficiency and value for money.

A demonstration of how innovative, locally relevant oral health improvement activity whilst working efficiently is undertaken will be required.

**3.2 Competencies and Training**

All relevant staff need to be appropriately qualified, or working towards an appropriate public health qualification, such as a Certificate, Diploma or Degree in Public Health. Staff will be supported in their work so as to realise their potential, work positively with service users and positively promote the oral health improvement.

All relevant staff need to continuously update the skills and techniques relevant to their public health work and align evidence of this to the Public Health Skills and Knowledge Framework.

All relevant staff should have up to date oral health improvement/public health training that can be evidenced.

All staff should be aware of all local dental services in their area, and pathways for referral into them.

All relevant staff will have clear areas of responsibility and remits.

Health and Safety, CAF and safeguarding training is required as part of this contract.

All staff will receive annual training on confidentiality and information governance.

The provider shall have effective performance management measures in place for staff performance, to include those related to staff competency and capability, professional development and appraisal procedures. This shall also include evidence of professional updates (where appropriate) and regular supervision.

Relevant staff employed by the provider shall be able to use technology, input into information management systems and record interventions effectively to ensure that the monitoring reports required for the management of the specification are accurate.

All training costs will be met by the provider.

**3.3 Business Continuity**

The provider shall make provision to employ an adequate number of staff with the sole purpose of fulfilling the requirements stated in this specification, including contingency planning for time of sickness, absences or any other occurrence that may jeopardise the delivery of the interventions at levels sufficient to meet the performance objectives and standards in this contract. These staff will not be delegated duties beyond the scope of this specification.

**3.4 Clinical Governance**

The provider is required to demonstrate the principle of ‘best value’ through continuous service improvement taking into account a combination of effectiveness (successful outcomes), efficiency (high productivity) and economy (costs).

The provider shall ensure that robust Clinical Governance systems are in place to include, but not limited to:

* Service User safety (incident, risk management, alerting system, infection control, safe environment, safeguarding).
* Clinical effectiveness considerations (cost effectiveness, evidence-based practice, compliance with NICE guidance, participation in audit and policy development).
* Staff management (continuing professional development (CPD), supervision, equality and diversity).
* Patient/public experience (complaints management, consent, patient/public information, patient/public involvement).
* Information governance (client records, data protection, confidentiality)
* The provider shall have clear policies aimed at managing risk/safe working practices and procedures to remedy poor performance.
* The provider shall report Serious Incidents occurring within the Service in line with process agreed with the Commissioner and in line with the Council Procedures. All serious untoward incidents must be reported to the Council normally within 3 working days of the incident. The service must then provide an outlined report of the incident and its outcome within 45 days of notification of the incident.

**3.5 Buildings and Accommodation**

The service will be delivered from premises that support the provision of effective and efficient delivery and meet the needs of the service users. This may include:

* Neighbourhood Centres
* Integrated care community hubs such as general practices and/or community clinics
* Third sector organisational settings
* Schools
* Early years settings
* Educational institutions that include childcare
* NHS dental practices
* Special care dental service
* Residential care homes

**3.6 Intervention Delivery Equipment**

The provider is responsible for purchasing, within the contract price, toothbrushes and toothpaste and other resources to support the delivery of the oral health improvement interventions.

Equipment used in the implementation of the oral health improvement interventions remains the responsibility of the provider. Therefore, the provider is responsible for purchasing, maintaining and replacing equipment.

The provider shall ensure that robust infection control systems are in place through the implementation of clear policies and procedures.

**3.7 Integrated Working**

The provider shall arrange for staff to work in a manner that increasingly embeds integrated working within the Council and with partners. Provision of the service will require a flexible, innovative and collaborative approach and the provider shall ensure that Staff establish excellent working relationships with an appropriate range of individuals and agencies including but not limited to:

* 0-12 Early Years Providers
* Children’s Services
* Public health team including Public Health Project Support Managers, and the Consultant in Dental Public Health for Lancashire
* Health Visiting & Public Health Nursing teams
* Special Care Dental Service
* Drug & alcohol services
* Early Years Settings including: Childminders; Private Voluntary and Independent settings and Primary Schools
* Integrated Care Community hubs such as General Practices and/or Community Clinics
* Local Dental Network
* NHS England
* Primary Care, including Pharmacy, Dental, Optometry and General Practice contractors
* Providers of homeless services
* Public Health England
* Schools including Special Schools
* Stop smoking service

**3.8 Communication and Marketing**

All costs in relation to communication and marketing will be met by the provider.

**3.9 Health and Wellbeing**

Foresight (2008) Mental Capital and Wellbeing Project Report

The Government’s Foresight project on Mental Capital and Wellbeing, report recommends five ways to wellbeing. It presents the evidence and rationale between each of the five ways, drawing on a wealth of psychological literature. In line with similar messages for healthy eating, these are Connect, Be Active, Take Notice, Keep Learning and Give.

The service will be highly encouraged to promote wellbeing in the workplace.

**3.10 National Standards, Evidence and Guidance**

The provider shall comply with all current and future relevant legislation, regulation, guidelines and statutory circulars which are applicable, incorporating relevant best-practice including but not limited to:

* Local Authorities Improving Oral Health: Commissioning Better Oral Health for Children and Young People, Public Health England, 20141
* Choosing Better Oral Health, Department of Health, 2005[[17]](#footnote-17).
* Oral health: approaches for local authorities and their partners to improve the oral health of their communities, NICE Guideline 55, 2014[[18]](#footnote-18).
* Standards for the Dental Team, General Dental Council, 2013[[19]](#footnote-19)
* Clinical Guidelines and Integrated Care Pathways for the Oral Health Care of People with Learning Disabilities British Society for Disability and Oral Health (BSDH), 2012
* Delivering Better Oral Health – An evidence based toolkit for prevention, Public Health England, revised 20178
* Valuing People’s Oral Health: A good practice guide for improving the oral health of disabled children and adults, Department of Health, 2007
* Oral Health Approaches for Dental Team, NICE guideline NG30,2015[[20]](#footnote-20)
* Oral Health Promotion In The Community, NICE QS139 [[21]](#footnote-21)
* Improving oral health: supervised tooth brushing programme toolkit (2016)16

**3.11 Feedback and Engagement**

The views of service users in receipt of oral health improvement activity are very important as they will help to identify those aspects of the interventions which are working well and those which require improvement. The Provider shall have processes in place for routinely seeking and recording client feedback and shall be able to demonstrate how this informs practice and service development.

The provider shall have in place a well-publicised feedback and complaints procedure which includes quality standards related to how complaints are dealt with and responded to.

**3.12 Information Collection and Sharing**

It is required that service users consent that the provider may collect, store and share all data related to the provision of the oral health improvement interventions with the Council and other relevant partners.

The provider is responsible for ensuring that service users records generated during intervention implementation are collated, stored and retrieved in accordance with Data Protection legislation.

The provider and the Council shall ensure that all the necessary permissions and agreed data sharing protocols are in place for sharing information and data with all relevant parties including service users.

When confidential data, is transferred to the Council, it shall be submitted through an agreed secure portal or via another pre-agreed method which meets the Data Protection guidance.

All ICT hardware including, but not limited to: servers, memory storage devices, routers, computers and mobile devices that are used for the communication and/or recording of data related to the administration, provision and monitoring of the service are to be protected with adequate encryption, antispyware and antivirus software as defined by the Council.

Access to all ICT hardware is to be controlled by physical and remote log-in security measures that prevent unrestricted access to the device and/or its operating system.

When personal data is lost, destroyed and/or damaged by unauthorised and/or unlawful processing of such data, the provider is required to implement a breach management plan that is to include immediately notifying the Council of the breach.

**3.13 Council Quality Reviews**

The Council shall, in an on-going manner, review the interventions delivered by the provider and may include:

* Discussions with service users
* Observing intervention delivery
* Ensuring the provider has adequately addressed complaints received from either: service users; Council staff; stakeholder bodies; other interested parties and/or partner agencies

When the Council determines that the intervention delivery is not fit for purpose and/or putting service users at risk, the Council may, alongside other remedial action, increase the frequency and/or number of its quality reviews.

The quality reviews carried out will, as appropriate, be recorded in the Contract Monitoring Report and as appropriate will be reflected in actions included in the Action Plan.

**3.1 Contract Monitoring Report and Meetings**

The provider shall submit complete and accurate Quarterly Contract Monitoring Reports 14 days after each whole 3 month period in a format agreed by the Council.

The Council and the provider shall determine if a contract management meeting is required. The decision will be based on:

* the stage of the Contract
* the amount of risk the Contract is exposed to
* the probability of the Contract under achieving its KPIs
* the degree of concern about the quality of intervention delivery

When a contract management meeting is regarded as necessary it shall be held as soon as possible but within 20 working days from the end of each 3 month intervention delivery period.

|  |
| --- |
| 4.0 Continual Service Improvement/Innovation Plan |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Description of Scheme* | *Milestones* | *Expected Benefit* | *Timescales* | *Frequency of Monitoring* |
| Service review and improvement plan | First plan and action plan produced against the specification | Alignment of the service to the new requirements of service delivery. | May 2018 | Project plan to be produced with a time line. |

|  |
| --- |
| 5.0 Baseline Performance Targets – Quality, Performance & Productivity |

**5.1 Key Performance Indicators (KPIs)**

During the delivery of the service, the provider is to record its achievement of the following outputs and KPIs. The interventions are to be implemented in a manner as to achieve the targets for each of the stated KPIs.

The provider shall provide a quarterly report detailing performance against key performance indicators below. The provider will include details of, and reasons for, any failure to meet any of the key performance indicators.

|  |  |  |
| --- | --- | --- |
| *Performance Indicator* | *Target KPI* | *Tolerance Target KPI* |
| Number of neighbourhood centre and reception class staff trained in OHI (to include detail on who, where and how) – at least one per setting (576 in total) | 100% | 100% |
| Number of free Smile4Life toothbrush and paste packs distributed to parents of new born children via neighbourhood centres (to include detail on where, how and evaluation) (*based on a live birth rate of 13242)* | 100% | 90% |
| Number of free Smile4Life toothbrush and paste packs distributed via reception classes (to include detail on where, how and evaluation) (*based on 13964 reception aged children)* | 100% | 95% |
| Number of reception classes undertaking supervised toothbrushing (498 in total) | 100% | 90% |
| Number of children receiving supervised toothbrushing as part of a programme (to include detail on where, how and evaluation) (*based on 13964 reception aged children)* | 100% | 90% |
| Number of neighbourhood centres and reception classes who are being supported to maintain Smile4Life full accreditation (576 in total) | 100% | 95% |

**5.2 Outputs**

|  |
| --- |
| *Output* |
| Number of staff supporting implementation of oral health interventions |
| Staff feel confident and competent in their OHI support roles and working alongside partner agencies |
| Number and percentage of frontline staff (CYP services) trained who say they have gained knowledge and confidence in delivering OHI messages/practice to clients. |
| Number of service users making formal complaints about the service (verbal or written) and evidence of improvements made to service as a result of feedback |
| Number of service users complimenting the service |
| Number of interventions cancelled due to staff issues |
| Number of supervised toothbrushing sessions cancelled due to school staffing issues |
| Number and percentage of early years practitioners who report feeling more confident to independently lead a supervised tooth brushing scheme |

**Appendix 1**

**Evidence to support identified interventions**

**(taken from Local authorities improving oral health: commissioning better oral health for children and young people - An evidence-informed toolkit for local authorities (PHE, June 2014)**

|  |  |  |  |
| --- | --- | --- | --- |
| * **Supporting Consistent Evidence Informed Oral Health Information** | | | |
| **Nature of intervention** | **Evidence** | **Definition** | **Local implementation** |
| Oral health CPD training for the wider professional workforce (health, education, CYP Provision and others across the service area. | Rogers, 2011  Sprod et al. 1996 | Oral health training for the wider health, social care and education workforce - based on capacity building (ie. increasing knowledge and skills of others) to support oral health improvement in their daily role, as part of every contact counts.. More strategic means of health education - ensuring oral health messages are appropriate and consistent across the board | * Support the delivery of the Smile4Life Programme locally, focussing initially on early years * Ensure the wider workforce are trained to understand the importance of oral health and cascade this training within their teams * Provide consistent, evidence-based oral health information, advice and support through early years services * Enable health and social care practitioners to demonstrate and provide culturally appropriate advice, information and support |
| Integration of oral health into targeted home visits by health/social care workers across the service area. | Rogers, 2011 | Integration of oral health into targeted home visits by health/social care workers based on building the capacity of health /social care workers to provide oral health support during their visits | * Integrate key oral health messages into the family nurse partnership programme which supports new mothers * Provide regular update training required for health and social care workers carrying out home visits |
| * **Community-Based Preventive Services** | | | |
| **Nature of intervention** | **Evidence** | **Definition** | **Local implementation** |
| Targeted provision of toothbrushes and toothpaste (i.e. postal or through Health Visitors) | Rogers, 2011 | Targeted and timely provision of free toothbrushes and toothpaste (ie. postal delivery or via health visitors) and through children centres | * Management of free toothbrush and toothpaste distribution schemes including the development check(s) as outlined by the Healthy Child Programme and to reception aged children |
| Facilitating access to dental services | Rogers, 2011 | Coordinated efforts to identify population groups with low attendance rates, contacting them and arranging dental appointments with appropriate dental services, moves beyond simple signposting to services | * Support Children Centre and EYFS settings to contact and encourage parents to attend a dental appointment and appointments arranged at local dental practices for themselves and their children |
| * **Supportive Environments** | | | |
| **Nature of intervention** | **Evidence** | **Definition** | **Local implementation** |
| Supervised toothbrushing in targeted childhood settings | Marinho et al., 2003  NHMRC, 2007  Rogers, 2011  Sprod et al., 1996 | Supervised tooth brushing programmes established in targeted childhood settings | * Management of supervised toothbrushing programmes in targeted early years settings |
| Contribute to the development of healthy food and drink policies in a number of settings including early years, workplace and residential care. | Rogers, 2011 | Introduction of healthier food and drink policies in early years, workplace and residential care. And other NHS provision to create a health promoting environment | * Ensure nutritional standards are adhered to in all childhood settings * Support the development of policies on snack, celebration and reward foods, including the provision of drinking water, in schools and early years’ settings |

1. Public Health England (2014) Local Authorities Improving Oral Health: Commissioning Better Oral Health for Children and Young People [↑](#footnote-ref-1)
2. Public Health England (2016) National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2015: A report on the prevalence and severity of dental decay. [↑](#footnote-ref-2)
3. Public Health England (2016)Dental Public Health Intelligence Programme: Hospital Episode Statistics: Extractions Data, 0 – 19 year olds, 2011/12 to 2015/16 [↑](#footnote-ref-3)
4. Public Health England (2015) Child Oral Health: applying All Our Health [↑](#footnote-ref-4)
5. Marinho, V.C.C. (2008) Evidence-based Effectiveness of Topical Fluoride. Advances in Dental Research 20; 3 [↑](#footnote-ref-5)
6. NICE (2014) Oral Health: local authorities and partners, Public Health Guideline [PH55] [↑](#footnote-ref-6)
7. Davies, G. M. Worthington, H. V. Ellwood, R. P. Blinkhorn, A.S. Taylor, G. O. Davies, R. M. and Considine, J. (2003) An assessment of the cost effectiveness of a postal toothpaste programme to prevent caries among five-year-old children in the North West of England, Community Dental Health 2003 Dec; 20(4):207-10 [↑](#footnote-ref-7)
8. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, Statutory Instrument No.3094, Part 4; page 8 <http://www.legislation.gov.uk/uksi/2012/3094/regulation/17>/ [↑](#footnote-ref-8)
9. Public Health England (revised 2017) Delivering Better Oral Health: An evidence based toolkit for prevention 3rd edition [↑](#footnote-ref-9)
10. Royal College of Surgeons (2015) Report on the State of Children’s Oral Health [↑](#footnote-ref-10)
11. Nuttall and Harker, 2004 Impact of oral health Childrens Dental Health in the United Kingdom [↑](#footnote-ref-11)
12. Institute for Health Metrics and Evaluation (2015) Global burden of Disease [↑](#footnote-ref-12)
13. Harris et. al,( 2009) British Society of Paediatric Dentistry: a policy document on dental neglect in children [↑](#footnote-ref-13)
14. Public Health England (2012) National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2012: A report on the prevalence and severity of dental decay. [↑](#footnote-ref-14)
15. Department of Health (2015) NHS Outcomes Framework [↑](#footnote-ref-15)
16. Public Health England (2016) Improving oral health: supervised tooth brushing programme toolkit [↑](#footnote-ref-16)
17. Department of Health (2005) Choosing Better Oral Health: An oral health plan for England [↑](#footnote-ref-17)
18. NICE (2014) Oral health: local authorities and partners: Public health guideline [PH55] [↑](#footnote-ref-18)
19. https://www.gdc-uk.org/api/files/Standards%20for%20the%20Dental%20Team.pdf [↑](#footnote-ref-19)
20. NICE (2015) Oral health promotion: general dental practice [NG30] [↑](#footnote-ref-20)
21. NICE (2016) Oral health promotion in the community: Quality standard [QS139] [↑](#footnote-ref-21)