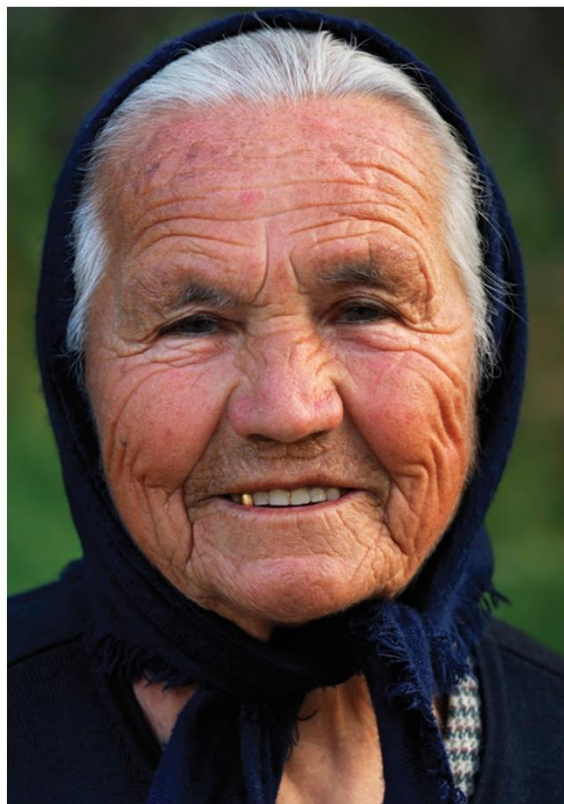


South Eastern Sydney Local Health District Oral Health Service
Integrated Oral Health Promotion Plan
2016-2020



Health
South Eastern Sydney
Local Health District



THE PLAN IN CONTEXT

This plan feeds into the *SESLHD Oral Health Operational Plan 2015-2017*, which describes the overall goals and priorities of our service.

**We acknowledge the traditional owners of the land on which we live and work.
We pay our respects to elders past and present.**



Over tens of thousands of years, message sticks were commonly used as one means of communicating between different Aboriginal tribes/nations. Messages were painted and inscribed on a stick, which was then transported by hand. Typical messages were announcements of ceremonies, warnings, events and happenings. The messenger was ensured safe passage across other nations land.

The oral health message stick helps to spread the word about the messages needed for a healthy mouth and reinforces the NSW Health core values of Collaboration, Openness Respect and Empowerment. The message stick is shaped like a shield to represent the protective effects of good oral hygiene and a fluoridated water supply and to highlight the importance of early intervention and prevention. The circles on the reverse sides are symbolic of the pathways, places and people we encounter when navigating the health system. They also represent coordinating and joining up of health services to provide clients with a seamless journey regardless of where and how they enter the health system.

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EXECUTIVE SUMMARY

[Oral Health 2020: A Strategic Framework for Dental Health in NSW](#)

describes three strategic priorities for action that are reflected in in our *SESLHD Oral Health Service Operational Plan*: improving access to services, reducing inequities in oral health, and investing in prevention. It is essential that prevention be prioritised at this level, for as the costs of and demand for treatment continue to grow, they must be balanced with funding for health promotion that can reduce this burden in the long term. This plan has been developed with that in mind, and in alignment with the following key local strategic influences:

- [The SESLHD Integrated Care Strategy 2015](#), which calls for an agile, joined up system, based on patient centred care, and uses health intelligence to target innovative and proactive action.
- [The SESLHD Equity Strategy](#), which aims to reduce inequities in health and wellbeing by transforming our health services to systematically improve equity, providing more care in the community and more prevention and wellness programs, and refocussing our work to better address the social determinants of health and wellbeing.
- [The SESLHD Community Partnerships Strategy](#), which describes our commitment to building effective and enduring partnerships to improve community health and wellbeing by increasing community participation and engagement, ensuring that community voices are genuinely heard and understood, and improving our responsiveness to community input and shifting towards a co-producing approach to health service design and delivery.

Within this strategic context, our goals and strategies will be as follows:

SESLHD Oral Health Service Integrated Health Promotion Plan 2016-2020

Goal 1: Improve access to oral health services with a focus on equity.

- Strategy 1.1 Undertake equity-focussed investigations to determine who is/is not being adequately reached and who is/is not benefitting fully from our care.
- Strategy 1.2 Develop actions to address gaps and incorporate these into ongoing operational and quality improvement planning.

Goal 2: Deliver targeted early interventions to priority populations.

- Strategy 2.1 Deliver oral health services in settings that provide access to priority populations, with a focus on delivering early interventions.
- Strategy 2.2 Work with services/organisations who routinely access clients from priority populations to encourage oral health risk assessments and referrals into the SESLHD Oral Health Service.

Goal 3: Improve oral health through more proactive and systematic preventive care.

- Strategy 3.1 Deliver proactive and systematic preventive clinical care and brief health promotion interventions in SESLHD dental clinic settings.
- Strategy 3.2 Deliver and/or support delivery of primary prevention strategies to improve oral health.

INTRODUCTION

Our local area

Our vision at South Eastern Sydney Local Health District (SESLHD) is *Working Together to Improve the Health and Wellbeing of our Community*. We have a diverse population of over 840,000 people across a geographic area covering nine local government areas (LGAs). From Sydney's central business district to the Royal National Park, our area includes highly urbanised areas of eastern Sydney, industrialised areas around Port Botany, and suburban areas in southern Sydney.

Our SESLHD communities reflect strong and vibrant diversity.

- More than one-in-three of our residents were born overseas, with almost three-quarters of these coming from non-English speaking countries. More than one-in-three of the babies delivered in our hospitals are born to mothers from non-English speaking countries, many of whom have only recently arrived in Australia. Refugees, international students, young adults from developing Asian countries and ageing European post-World War II migrants are just some of the many cohorts of people who bring a breadth and depth of cultural and linguistic diversity to our District¹.
- Around 6,300 Aboriginal people live in our District, equating to just under 1% of our total population. The largest numbers of Aboriginal residents live in the Botany Bay LGA (around 1,850 people) and Randwick LGA (around 600 people)².

Despite many people in our District experiencing relative advantage and good health, there are many that do not. Our District is home to²:

- 10,000 people who are long-term unemployed
- 20,000 children who live in low income families
- 77,000 people who are carers of older people
- 100,000 people who are pensioners
- 28,000 people who are aged 65 years and over and live alone
- 50,000 adults who run out of food at least once a year and cannot afford to buy more
- 30,000 people with a profound or severe disability
- 37,000 residents who do not speak English well or at all
- 67,000 adults who report high levels of psychological distress
- 44% of people living with HIV in NSW reside in the area served by SESLHD

SESLHD is home to a large number of people who experience socioeconomic disadvantage². For example, Botany Bay, Randwick and Sydney LGAs have a higher proportion of public housing than the NSW average. In Botany Bay LGA, 11% of all dwellings are public housing, with up to 70% in some suburbs³. About 20% of NSW's identified homeless population live in SESLHD, equating to around 5,600 people. The largest proportion of people who are homeless in our District are in Sydney Inner City, representing 60% of our homeless population².

Oral health in NSW and SESLHD

The dental status of children is a key predictor of oral health across the population. The NSW Child Dental Health Survey provides an indicator that factors in *dmft* (deciduous teeth that are decayed, missing or filled because of dental decay, children aged 5-6 years) and *DMFT* (permanent teeth that are decayed, missing or filled because of dental decay, children aged 11-12 years). Figure 1 provides these data by Local Health District (LHD) and across NSW, as described by the NSW Child Dental Health Survey (2007)⁴.

Additional oral health indicators are available through the NSW health population health website [HealthStats NSW](#)⁴. A sample of these is provided in Table 1, with hyperlinks to access the full data and reference notes via the website.

Table 1: Additional oral health indicators

Indicator	SESLHD	NSW
Free of dental caries		
• Children aged 5-6 years	71.9%	61.2%
• Children aged 11-12 years	62.9%	65.4%
Oral health service utilisation		
• Visited a public dental service in the last 12 months, children aged 0-15 years	9.9%	10.7%
• Visited a dental professional in the last 12 months, children aged 5-15 years	85.1%	75.7%

Decayed, missing and filled teeth by Local Health District, children aged 5-6 years and 11-12 years, NSW 2007

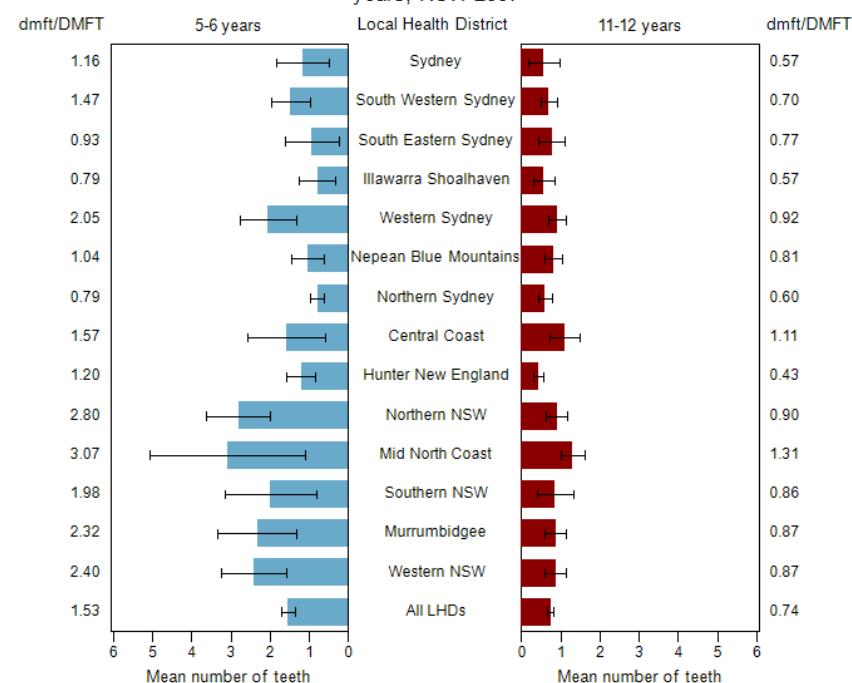


Figure 1: Dental status of children by Local Health District
Source: [HealthStats NSW](#) – click hyperlink for greater detail.

Whilst these clinical indicators are important, it is equally important to recognise the broader concepts of oral health. As described by NSW Health⁴, oral health is an integral component of lifelong health and is much more than the absence of oral disease. It includes a person's comfort in eating and social interactions, their self-esteem and satisfaction with their appearance. This plan will consider all these issues.

Strategic context

Public oral health services in SESLHD are delivered to people who meet the [NSW Health Policy for Eligibility of Persons for Public Oral Health Care](#)⁵. In order for people under the age of 18 to be eligible for non-admitted oral health care services they must normally reside within the boundaries of SESLHD and be eligible for Medicare. People aged 18 and over must normally reside within the boundaries of SESLHD, be eligible for Medicare, and hold or be listed as a dependent on one of the following valid Australian Government concession cards: Health Care Card, Pensioner Concession Card or Commonwealth Seniors Health Card. Holders of the State Seniors Card are not eligible for care unless they also hold one of the other concession cards listed above.

[Oral Health 2020: A Strategic Framework for Dental Health in NSW](#)⁶ sets the platform for the delivery of these services, with emphasis on improving access to oral health services in NSW, reducing disparities in the oral health status of people in NSW and improving the oral health of the NSW population through primary prevention.

Our local **SESLHD Oral Health Service Operational Plan** flows from the statewide framework, describes our services and identifies a number of priorities for local action. This **Integrated Oral Health Promotion Plan** sits below the Operational Plan and will contribute to a subset of the overall service priorities, with a particular focus on the following excerpts:

- Focus on prevention
- Improving outcomes for priority populations
- Establishing a new integrated model of care, with more flexibility in service provision

- Building stronger community partnerships
- Raising the profile of the oral health service

Implementation of this plan will take place within a broader context of service redesign that is now underway. *The SESLHD Oral Health Service Review: Final Report (November 2013)*⁷ recommended significant changes to our models of service delivery with an overall goal of delivering more efficient and accessible oral health services to priority populations across SESLHD. Three core elements of the service examined in this context were:

- Service and value delivery
- Organisational structure
- Internal and external alliances and partnerships

Issues of notable relevance to health promotion included recommendations to develop a plan to increase access for priority populations, and to develop a more structured and strategic approach that will to improve oral health in priority populations.

Implementation of this plan will also be influenced by external factors: we do not work in isolation. Our plan will be informed by strategic directions determined by the NSW Oral Health Promotion Network, of which all LHDs are members. We link with other LHDs and speciality networks in delivery of projects and work collaboratively with our neighbouring LHDs.

All of the goals, strategies and actions described in this plan have been developed within this strategic context.

Figure 2 (over page) provides a summary of some of the key strategic influences on this plan, both within and beyond our local District.



Underpinned by key strategic partnerships including: Statewide Oral Health Promotion Network, other local services/groups, community partnerships, and partnerships with other LHDs and speciality networks

Figure 2: Key strategic influences

Principles for action

The three SESLHD Strategies shown in Figure 2 are particularly well-aligned with the priorities described in our service's Operational Plan and the recent service review, as they relate to integrating health promotion into services, engaging communities and addressing inequities. The three key principles below will underpin this plan to ensure that SESLHD strategic alignment is reflected across all our actions.

1. Integrate health promotion into all our services

The [SESLHD Integrated Care Strategy](#)⁸ calls for care that “is not limited to medical or clinical treatment but engages and supports lifestyle and behavioural changes required to better self-manage and stay healthier in the community”. Effectively integrating health promotion into a clinical service takes time and investment. We recognise that it may sometimes be difficult to reconcile that with the immediate and urgent demands of clinical service delivery, but we will find a way to achieve that balance for the long-term sake of both our clients and our health system.

2. Work in partnership with our communities

The [SESLHD Community Partnerships Strategy](#)⁹ describes our District's commitment to building effective and enduring community partnerships. Community partnerships are those that we forge/strengthen with patients, their families and carers, volunteers, community members and other organisations that represent or serve them. In practice, we will ask:

- Can we demonstrate that we successfully engaged communities?
- Can we demonstrate that we did hear and understand what was said?
- Can we demonstrate that we acted on this?

3. Focus on priority populations

The [SESLHD Equity Strategy](#)² describes our District's commitment to working together to improve equity in health and wellbeing, with a focus on those who need it the most. This aligns with the focus of the SESLHD Oral Health Service and the eligibility criteria to access those services⁵. Different priority populations can have very different needs (eg¹⁰⁻¹²). This requires our attention when planning and delivering health promotion.

Our priority populations include vulnerable people at higher risk of poor health as a result of barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability². It includes marginalised people and communities who experience discrimination and exclusion because of unequal power relationships across economic, political, social and cultural dimensions². It also includes groups such as children (and their parents) for whom early interventions can deliver life-long benefits².

Our priority populations	
	• Aboriginal people
	• People who experience: <ul style="list-style-type: none">○ Homelessness○ Mental illness issues○ Drug and alcohol issues
	• People from some culturally and linguistically diverse backgrounds, particularly refugees
	• Children and their parents
	• Young people aged 15-24, particularly young parents
	• Older people
	• People with chronic and complex conditions

Figure 3: Our priority populations

Delivering oral health promotion in this context

Prevention is, of course, better than cure. This form of health promotion – primary prevention – is typically seen in population-wide, community based interventions that aim to prevent health issues before they begin. In the oral health context, this includes the fluoridation of public water supplies, building oral hygiene skills across the whole population and promoting healthy nutrition (such as the avoidance of sweetened drinks). Other factors that increase oral health risk (such as smoking) are also an appropriate focus for oral health promotion action – even if the individual does not realise the link. Whilst primary prevention is important, and is strongly emphasised in the statewide strategies described in *Oral Health 2020*, there are limits to the capacity of our local oral health services to achieve this kind of population reach. Our best potential is to work in partnership with others who do so, such as our local health promotion team, and/or seek additional specific funding.

Other prevention approaches have an equally important place in oral health promotion. Secondary prevention typically targets people who are most at risk, and intervenes early so as to improve health outcomes. Oral health risk assessments and strategies/services that target priority populations are typical secondary approaches. These fit well with the funding structure of our SESLHD Oral Health Service that already places a strong emphasis on children and disadvantaged adults.

Although it is often overlooked in discussions about health promotion, tertiary prevention is also important. Even someone with advanced oral health issues can benefit from proactive, best-practice clinical care to maximise their oral health outcomes and prevent or at least reduce future problems. Ensuring clients complete their care as intended is a key

issue. Proactive preventive care such as chairside oral hygiene instruction is in more recent times being integrated with health promotion interventions addressing broader lifestyle risk factors such as diet, smoking and alcohol use. These interventions can then be linked in to community-based health promotion programs for a truly integrated approach to care^{6, 13-15}.

We know that people who are most disadvantaged experience worse health, have more risk factors and use preventive health services less than those who are most advantaged^{16, 17}. Oral health is no exception: there is evidence of a direct link between disadvantage and poor oral health^{18, 19}. Ensuring that the most vulnerable and disadvantaged in our communities can access and fully benefit from our care is also essential.

Oral health promotion therefore covers a broad scope of action. The potential benefits for our clients and the wider community are significant, as is the potential to reduce future system costs.

“The cost of providing treatment continues to grow, as does the demand for public dental services. This demand for individual treatment will need to be balanced with the need to fund health promotion and disease prevention initiatives.”

– *Oral Health 2020*⁶

In the pages that follow, we have developed a scope of action for our District that considers these different elements of health promotion and that aligns strategically with our oral health goals, priorities and principles.

THE PLAN AT A GLANCE

1

Improve access to oral health services with a focus on equity.

Strategy 1.1 Undertake equity-focussed investigations to determine who is/is not being adequately reached and who is/is not benefitting fully from our care.

Strategy 1.2 Develop actions to address gaps and incorporate these into ongoing operational and quality improvement planning.

2

Deliver targeted early interventions to priority populations.

Strategy 2.1 Deliver oral health services in settings that provide access to priority populations, with a focus on delivering early interventions.

Strategy 2.2 Work with services/organisations who routinely access clients from priority populations to encourage oral health risk assessments and referrals into the SESLHD Oral Health Service.

3

Improve oral health through more proactive and systematic preventive care.

Strategy 3.1 Deliver proactive and systematic preventive clinical care and brief health promotion interventions in SESLHD dental clinic settings.

Strategy 3.2 Deliver and/or support delivery of primary prevention strategies to improve oral health.



GOAL 1: IMPROVE ACCESS TO ORAL HEALTH SERVICES WITH A FOCUS ON EQUITY

What the evidence tells us

Improving access to oral health services is the first goal of *Oral Health 2020*⁶. This is echoed in our own Operational Plan, and also links directly to a major strategic priority for our whole District: the *SESLHD Equity Strategy*, which describes our commitment to ensuring that everyone across our communities has a fair opportunity to live a long, healthy life. We know that people with a low socio-economic status are the least likely to access oral health services^{4,6}. People who need our services most are the least likely to use them. This cycle of disadvantage further compounds their health inequities²⁰. When disadvantage begins in childhood, it has a compounding impact across the entire life course, affecting and shaping their prospects and social situation, and impacting on their lifelong health and wellbeing²¹⁻²³.

Strategic Direction 1 of the *SESLHD Equity Strategy* challenges us to transform our health services to systematically improve equity. It asks:

- Do we reach and meet the needs of those who experience inequities?
- Do we act on the social determinants of health that affect the health and wellbeing of our service users, their families and carers?
- How are service users, families, carers and the community being engaged to be more involved in and in control of their health care?
- What information do services collect to monitor and respond to this?

This challenges us to look at service access issues through an equity lens. Only through better understanding can we begin to bridge the access gap.

Priorities for action

In-depth analyses of service data allow us to rigorously explore imbalances across our health system, from access issues to service performance. Known as a “deep data dive”, this is recommended by both the *SESLHD Equity* and *Integrated Care Strategies*. Combined with appropriate community consultation and engagement as per the *SESLHD Community Partnerships Strategy*, this will enable us to ask and answer:

- What clients do we see? Are certain groups overrepresented? Are others underrepresented? Why?
- Who doesn't turn up to appointments? Why not?
- Does everyone benefit equitably from our care? How do we know?
- What do our clients and potential clients truly need?

“Are our service models designed to recognise and respond to complex needs? The newly arrived migrant with poor English who cannot get a job... the Aboriginal man that experiences severe mental illness and is homeless.... the pensioner who lives alone and has no one to look out for her.... the woman who has experienced domestic violence, moved into public housing and struggles to support herself and her children. Accessibility of services, transport, access to interpreters and trauma-informed care are just some of the many strategies required.”

– *SESLHD Equity Strategy*²

What we will do

Goal 1. Improve access to oral health services with a focus on equity			
Strategies	Actions <i>See also page 20 for our implementation approach</i>	Responsibility	Monitoring & evaluation <i>See also page 21</i>
1.1. Undertake equity-focussed investigations to determine who is/is not being adequately reached and who is/is not benefitting fully from our care.	1.1.1. Implement the first stage of the <i>Exploratory Oral Health Research Project for SESLHD</i> . This aims to describe the current utilisation of oral health services in SESLHD and examine any potential variations due to recent changes in models of service delivery. The aims of the first stage are to: <ul style="list-style-type: none"> • Develop knowledge about the available datasets and how the data can be used and analysed. • Analyse trends in the data to generate hypotheses to inform a larger project. <p>Methods will include deep data dives and community consultation and engagement.</p>	Lead: Director Partnerships: NSW Centre for Oral Health Strategy, University of NSW, South Eastern and Research Collaboration Hub (SEaRCH), NSW Bureau of Health Information	To be developed with project partners with consideration of (but not limited to) the following data sources: Information System for Oral Health: in-house and Oral Health Fee for Service Scheme data accessed through the NSW Centre for Oral Health Strategy Medicare data Special Needs Dental Service Clinic: additional manual data collection
	1.1.2. Upon completion of the first stage, develop, implement and evaluate a larger project that is focused on both service delivery and quality of care. It is anticipated the cost of this project would be approximately \$200,000. External funding will be sought.	Community partnerships as per the <i>SESLHD Community Partnerships Strategy</i>	
1.2. Develop actions to address gaps and incorporate these into ongoing operational and quality improvement planning.	1.2.1. Apply the outcomes of this goal as they become available to further inform other actions described in this plan.	Lead: Director Partnerships: SESLHD Oral Health Service Executive Team	Evidence of inclusion in relevant planning and service delivery
	1.2.2. Ensure that the outcomes of all actions described under Strategy 1.1 are reflected in all service planning, not just within the scope of health promotion.		

GOAL 2: DELIVER TARGETED EARLY INTERVENTIONS TO PRIORITY POPULATIONS

What the evidence tells us

As already described, those people who need our services most are often the least likely to use them, which further compounds their health issues and inequities^{6, 20}. The intent of this second goal, which has a secondary prevention focus, is to reach out more effectively to priority populations and intervene earlier to produce the best outcomes.

This is also consistent with the *SESLHD Integrated Care Strategy 2015*⁸, which aims to create an agile joined up system, based on patient centred care, and a health intelligence structure to enable targeted action through innovative models that deliver care proactively. The health intelligence gleaned through the deep data dive (Goal 1) will inform this second goal, and we will take two different approaches to achieve it.

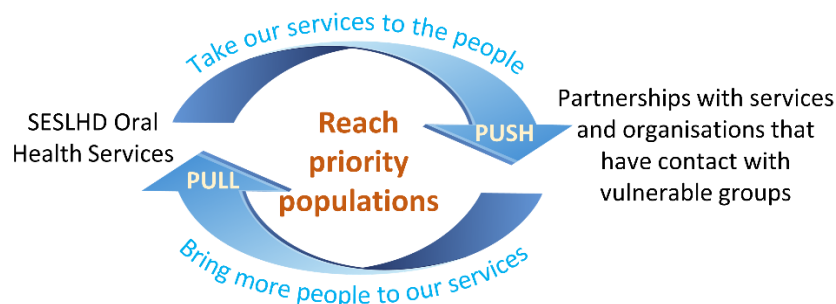


Figure 4: Priorities for Goal 2

Priorities for action

The first approach is to proactively deliver services in settings where we are likely to reach priority populations. In marketing terms, this is a *push* strategy (see Figure 4). Our Special Needs Dental Service is delivered at the Mission Australia Centre in Surry Hills, serving people experiencing homelessness, drug and alcohol and/or mental health issues. Our Aboriginal Dental Clinic at the La Perouse Aboriginal Community Health Centre helps us to meet the needs of Aboriginal people and allows us to build important partnerships with Aboriginal people and organisations. Both reflect the *SESLHD Integrated Care Strategy's* goal to deliver “seamless, effective and efficient care in the right place and at the right time”. We will extend this approach to other settings and priority populations.

The second approach is to develop proactive mechanisms whereby other services and organisations will identify at-risk people and refer them into our services. In marketing terms, this is a *pull* strategy (see Figure 4). An example is the Early Childhood Oral Health (ECOH) Program, which encourages child health professionals to routinely check for signs of early childhood caries by *lifting the lip*. It is a community-based, early intervention program, built on the principles of integrated service delivery⁶ and has been shown to increase the referral rate to public oral health services for children under five years of age by community health professionals²⁴. This health promotion program has now become mandatory NSW Health policy²⁵ and is a model that we can expand upon.

What we will do¹

Goal 2. Deliver targeted early interventions to priority populations			
Strategies	Actions <i>See also page 20 for our implementation approach</i>	Responsibility	Monitoring & evaluation <i>See also page 21</i>
<p>2.1. Deliver oral health services in settings that provide access to priority populations, with a focus on delivering early interventions.</p> <p>PUSH STRATEGY:</p> <p>Services</p> <p>↓</p> <p>Priority populations</p>	<p>2.1.1. Define our future approaches to delivering oral health services in these settings. Reflect on evidence and best practice, our own local experiences, and input from local communities. Document our agreed approach in a Communications Plan to ensure clarity and consistency.</p>	<p>Lead: Lead Dental Officer/Oral Health Executive</p> <p>Partnerships: with the services and organisations that serve and represent our priority populations, and community partnerships as per the <i>SESLHD Community Partnerships Strategy</i></p>	<p>Service data should ideally describe:</p> <ul style="list-style-type: none"> • People reached, including relevant demographic data to track reach into priority populations • Issues identified • Services delivered • Relevant service delivery outcomes <p>See page 21 for a discussion of service delivery data issues</p>
	<p>2.1.2. Ensure that the services we already deliver are consistent with the approach determined in 2.1.1 – ie based on evidence of best practice. This may include reviewing and strengthening services provided in settings such as:</p> <ul style="list-style-type: none"> • Special Needs Dental Services at Mission Australia Centre in Surry Hills • Aboriginal Dental Clinic at the La Perouse Aboriginal Community Health Centre 		
	<p>2.1.3. Expand our agreed approaches to better meet the needs of priority populations. Early priorities will include:</p> <ul style="list-style-type: none"> • Providing a mobile dental service (van) for priority populations such as residential aged care clients and youth at risk • Providing outreach services utilising portable dental equipment for priority populations such as refugees (eg at Intensive English Centres) 		
	<p>2.1.4. Explore opportunities to attract additional funding (such as grants) to support implementation of Strategy 2.1.</p>		

¹ **Implementation note:** This important work can begin immediately, without waiting for Goal 1 to be complete. We know much already. Goal 1 will further inform our work over time.

Goal 2. Deliver targeted early interventions to priority populations			
Strategies	Actions <i>See also page 20 for our implementation approach</i>	Responsibility	Monitoring & evaluation <i>See also page 21</i>
	2.1.5. Promote these services more effectively, including more proactive marketing and communication strategies.		
<p>2.2. Work with services/organisations who routinely access clients from priority populations to encourage oral health risk assessments and referrals into the SESLHD Oral Health Service.</p> <p>PULL STRATEGY:</p> <p>Services</p> <p>↑</p> <p>Priority populations</p>	<p>2.2.1. Define our future approaches to working with these services/organisations. Reflect on evidence and best practice, our own local experiences, and input from local communities. Document our agreed approach in a Communications Plan to ensure clarity and consistency across all our actions.</p> <p>2.2.2. Ensure that the actions we already deliver are consistent with the approach determined in 2.2.1 – ie based on evidence of best practice. This may include reviewing and strengthening services and programs such as:</p> <ul style="list-style-type: none"> • The <i>ECOH</i> program • The <i>Smile for Your Baby</i> antenatal program • OOHC (Out of Home Care) Children Program <p>2.2.3. Expand our agreed approaches into new partnerships, exploring the best potential to effectively reach priority populations (see Figure 3 page 9). Early priorities to explore will include services/organisations who work with:</p> <ul style="list-style-type: none"> • People who experience mental illness • Disadvantaged people from culturally and linguistically diverse backgrounds • Young people and young parents in particular • People with complex and chronic conditions <p>2.2.4. Explore opportunities to attract additional funding (such as grants) to support implementation Strategy 2.2.</p>	<p>Lead: Oral Health Programs Coordinator/Oral Health Executive</p> <p>Partnerships: with the services and organisations that serve and represent our priority populations, and community partnerships as per the <i>SESLHD Community Partnerships Strategy</i></p> <p>NSW Oral Health Promotion Network</p>	<p>At a minimum, the SESLHD Oral Health Service will collect data to identify clients who have been referred to us through these processes and the sources of those referrals.</p> <p>Ideally, data would also be collected by the partner services/organisations undertaking the oral health risk assessments, to inform future service planning. However the capacity for this depends on what is reasonable within each service/organisation. This will be discussed on an individual basis.</p>

GOAL 3: IMPROVE ORAL HEALTH THROUGH MORE PROACTIVE AND SYSTEMATIC PREVENTIVE CARE

What the evidence tells us

There are two pathways to providing preventive care: delivering secondary and tertiary health promotion in our clinics, and going out into communities to deliver primary prevention. Collectively, this provides a strong foundation for oral health promotion.

In the clinical setting, proven proactive clinical strategies include pit and fissure sealants²⁶ and fluoride varnishing²⁷, both of which are recommended as best practice for preventive oral health care^{13, 14, 28}. Oral hygiene instruction may also be delivered at the chairside, but it is important to ensure a consistent focus on evidence-based messages²⁹ and evidence-based methods of delivery^{13, 14}. Attention to lifestyle factors such as nutrition, weight and smoking is also growing in significance in clinical health settings^{6, 13-15}. Even relatively brief interventions can be beneficial, particularly if they follow evidence-based protocols that include systematic risk assessments, strategies such as motivational interviewing³⁰ and active referral into suitable follow-up health promotion programs and services³¹⁻³³. Importantly, patients are reported to agree that it is appropriate for this form of proactive health promoting care to be delivered by health services^{34, 35}.

At the community level, these same lifestyle factors contribute to the leading causes of mortality and morbidity across Australia¹⁶. Although our own funding and capacity for community-level primary prevention is limited, we need not work in isolation: there are opportunities for us to achieve common goals through building effective partnerships.

Priorities for action

In the clinic setting, some action is already occurring but not yet at an optimal level. We will aim to be more **proactive** in terms of identifying the best opportunities to take preventive action (in addition to addressing immediate clinical needs) and **systematic** in terms of building this into our policies and practices, to ensure that we provide consistent and equitable care for all (ie not just opportunistically). We will include:

- Evidence-based preventive clinical care designed to reduce future oral health issues, such as pit and fissure sealants and fluoride varnishing.
- Evidence-based chairside oral hygiene instruction, with particular attention to delivering care that is more appropriate to our priority populations, utilising the whole team more effectively and using evidence-based messages and models of care.
- Proactive and routine lifestyle risk assessments of all clients (eg smoking, nutrition), providing evidence-based brief interventions and referring at-risk people into evidence-based preventive care programs.

We will implement monitoring and reporting systems that will describe service delivery to clients from priority populations, the issues identified, the proactive preventive care provided and evidence of impact.

At the community level, we will invest the limited resources that we have available for primary prevention in evidence-based actions most likely to reach priority populations. We can extend our capacity by building stronger partnerships and seeking external funding for these actions.

What we will do²

Goal 3. Improve oral health through more proactive and systematic preventive care			
Strategies	Actions <i>See also page 20 for our implementation approach</i>	Responsibility	Monitoring & evaluation <i>See also page 21</i>
3.1. Deliver proactive and systematic preventive clinical care and brief health promotion interventions in SESLHD dental clinic settings.	3.1.1. Take a more proactive and systematic approach to the delivery of evidence-based preventive clinical care ^{13, 14, 28} including (but not limited to) pit and fissure sealants ²⁶ and fluoride varnishing ²⁷ .	Lead: Oral Health Executive Partnerships: NSW Oral Health Promotion Network SESLHD Health Promotion Service and relevant health promotion programs Community partnerships as per the <i>SESLHD Community Partnerships Strategy</i>	Ensure that service data collection systems are in place (see page 21) Develop clear target indicators (eg % of clients to receive this care)
	3.1.2. Make greater investments in proactive and systematic chairside oral hygiene instruction, with a focus on: <ul style="list-style-type: none"> Utilising the whole team more effectively Ensuring that the messages are evidence-based^{13, 14, 29} Ensuring that care models are evidence-based^{13, 14, 29} Maximising attention, comprehension, persuasion and capacity to adopt the recommended behaviours³⁶ Tailoring messages and care provided to the needs of priority populations 		Ensure that service data collection systems are in place (see page 21) Develop clear target indicators (eg % of clients to receive this care)
	3.1.3. Build on the work already underway ^{eg 37} to be more proactive and systematic in undertaking brief health promotion interventions such as: <ul style="list-style-type: none"> Assessing smoking status, and providing at-risk clients with brief advice³⁰ and referral to the Quitline. Assessing risk related to poor nutrition, and providing at-risk clients with brief advice and referral to the Get Healthy Information and Coaching Service. Assessing risk related to poor nutrition, and providing at-risk children aged 7-13 and their parent/carer with brief advice and referral to Go4Fun. 		Ensure that service data collection systems are in place (see page 21) Develop clear target indicators (eg % of clients with a completed risk assessment, % of at-risk clients offered referral)

² **Implementation note:** As with Goal 2, this important work can begin immediately, and will be further informed by the outcomes of Goal 1 over time.

Goal 3. Improve oral health through more proactive and systematic preventive care			
Strategies	Actions <i>See also page 20 for our implementation approach</i>	Responsibility	Monitoring & evaluation <i>See also page 21</i>
3.2. Deliver and/or support delivery of primary prevention strategies to improve oral health.	3.2.1. Build a strong and mutually beneficial partnership with the SESLHD Health Promotion Service to: <ul style="list-style-type: none"> • Improve alignment of actions and messages • Identify opportunities to support each other's work • Explore opportunities to apply for external funding 	Lead: Oral Health Executive Partnerships: NSW Oral Health Promotion Network SESLHD Health Promotion Service and relevant health promotion programs Community partnerships as per the <i>SESLHD Community Partnerships Strategy</i>	Evidence of partnership in terms of program and service outputs (eg collaborations, influence of the partnership on program/service design and delivery, etc).
	3.2.2. Develop actions with a primary prevention focus, such as replacing sweetened drinks with tap water, nutrition/healthy weight, and smoking cessation/reducing smoking uptake. Ensure that these actions: <ul style="list-style-type: none"> • Are developed in partnership with communities • Are evidence-based • Target priority populations • Can be evaluated to demonstrate impact • Are sustainable Early priorities to explore will include: <ul style="list-style-type: none"> • The Dalang project currently in development at the La Perouse Dental clinic in partnership with the Poche Centre and NSW Centre for Oral Health Strategy • Working with Supported Playgroups • Refugee health/Intensive English Centres Proactively seek funding to support these actions.		Develop appropriate indicators depending on the nature of the project, always with a focus on determining reach into priority populations and evidence of impact.
	3.2.3. Disinvest in actions that do not meet the criteria described in 3.2.2. to ensure that the limited funding available for primary prevention is only invested in actions that have the potential to deliver meaningful outcomes for our local communities.		Evidence that this has occurred in future planning

DELIVERING THE PLAN

Our approach to implementing this plan

Readiness to change and motivation to act require a well-planned approach to achieve long-term outcomes. To achieve this, we will draw upon evidence-based best practice models such as *A Framework for Building Capacity to Improve Health*³⁸ and ask ourselves key questions such as those outlined below.

CONTEXT – who is delivering what action?

WHO: This is mostly our own team but in some cases we will build the capacity of others (such as those delivering oral health risk assessments in other settings).

WHAT: As described in this plan, what specifically are we doing and trying to achieve? Well-defined goals and actions make it easier to answer the following...

Within the relevant who/what context, we will ask ourselves:

ORGANISATIONAL DEVELOPMENT

What kinds of organisational approaches and clinical governance support this action? A written policy? Best practice guidelines or procedures? Workplace systems to support that practice? If we want action to be integrated and sustainable, what is the best way to achieve that?

WORKFORCE DEVELOPMENT

What support do staff need to implement this action? Training? Mentoring? Other forms of professional development?

RESOURCES

Funding is always a consideration when implementing any action, but this extends beyond budgets. What about equipment? Or access to information? Relief from frontline clinical duties? Tools and materials such as oral hygiene/promotional products?

LEADERSHIP

Who will be responsible for seeing that this action is implemented?

This may be more than one person, and often includes local champions and natural leaders within teams.

PARTNERSHIPS

How can partnerships help us to deliver the action more appropriately and effectively? This might include partnerships with patients, their families and carers, volunteers, community members and other organisations that represent or serve them.

**BUILD
CAPACITY TO
IMPLEMENT
THIS PLAN**

Infrastructure

**Problem
solving**

Sustainability

Figure 5: Our approach to implementing this plan

Our approach to monitoring and evaluation

The action tables in the preceding pages include specific notes on monitoring and evaluation of the actions described. This page discusses broader concepts.

Quantitative service delivery data. Key quantitative indicators will describe the services we deliver. This will include:

- How effectively we are reaching priority populations
- The services delivered
- The issues identified whilst delivering services, from oral health indicators to broader socioeconomic and lifestyle factors
- Relevant service delivery outcomes where possible

Monitoring and evaluation of this plan will occur in the broader context of our SESLHD Oral Health Service delivery, and this will determine what data are appropriate and feasible to collect. We will work within our responsibilities related to clinical governance as well as local and statewide reporting requirements. We will also work with our IT partners to determine the most appropriate and feasible mechanisms to do so.

Qualitative feedback from staff. Feedback from our staff will provide valuable insights over the life of this plan. Regular two-way communication will be facilitated, and it will be enabled by regular feedback and reporting on the plan's progress.

Qualitative feedback from clients. Direct feedback from our clients regarding their service experience is different from the feedback regarding our community partnerships discussed elsewhere. Direct

feedback from clients will be encouraged, particularly ensuring that a range of voices are heard across all our different priority populations.

Monitoring the impact of our community partnerships. The *SESLHD Community Partnerships Strategy* emphasises the importance of evaluating the impact of the partnerships that we forge/strengthen with patients, their families and carers, volunteers, community members and other organisations that represent or serve them. It is not enough to just “consult” people. We will demonstrate what impact this had. In the terms of the *SESLHD Community Partnerships Strategy*, this will include:

- Evidence that people are engaged and do participate, and in the context of this plan, evidence that we are effectively reaching the different priority populations described in Figure 3 (page 9)
- Evidence of our increased understanding and attention to their input
- Evidence of real influence and change as a result.

We will also seek to describe the investments we have made in community partnerships in terms of the three strategic directions outlined in the *SESLHD Community Partnerships Strategy*, which in the context of this plan are:

- Building our capacity as a service to foster better community engagement
- Reshaping our services to enable more meaningful community involvement
- Making specific and significant investments in community partnership initiatives.

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