**CANCER EXCELLENCE AWARD**

**Implementation**

* HEE Oral Cancer training evening session for the dental team
* Practice Facilitator to visit the dental practice and go through the framework below
* Cancer excellence Award for practice

Accreditation sheet for Healthy Living Dentistry.

|  |  |  |
| --- | --- | --- |
| **Outcome measure- to be completed before facilitator visits** | **Evidence** | **Date achieved** |
| 1. Clinical team members have read guide and know where to find it in the practice | Discussion with facilitator |  |
| 2. At least one dentist and one team member (all team members are welcome) to attend the HEE oral cancer course  | certificate |  |
| 3. All dentists and therapists dentist in practice to complete online training(BDA/CRUK oral cancer toolkit) ‘Carrying out a head and neck exam’<https://www.doctors.net.uk/eClientopen/CRUK/oral_cancer_toolkit_open/index.html>**PLEASE GO TO AND COMPLETE THE ‘EDUCATIONAL QUIZ’ TO RECEIVE YOUR CPD** | Certificate |  |
| 4. All dentists and therapists to familiarise themselves with online referral system. At least one dentist to undertake training on electronic 2 week referral | DiscussionCertificate |  |
| 5. The practice will have evidence of a system to prompt them to ask patients about smoking and alcohol consumption behaviours as part of the regular dental examination visit: *e.g. custom screen on clinical IT system, additional question on medical history form.*The practice will have resources and up to date information available for patients which provide advice and information about local smoking cessation and alcohol services and healthy eating. (e.g. leaflets, screens, campaigns) | Medical history formSight of literature available |  |
| 6. The practice undertakes to see patients with cancer needing an urgent assessment prior to cancer treatment.  | Verbal agreement |  |
| 7. Practice staff will participate in a facilitated team meeting to:* Increase knowledge related to the local oral cancer good practice guide
* Disseminate learning from training
* Implement this team action plan to enable tools from within the good practice guides to become embedded within the daily routine of the practice protocols
 | Notes of meetingAction plan and date whole team informed of introduction of the guide materials. |  |
| **PRACTICE NAME** |  |
| **CONTRACT NUMBER** |  |
| **NAME OF PROVIDER OR PRACTICE MANAGER** |  |
| **SIGNED** |  |
| **DATE COMPLETED** |  |
| **Comments from primary care facilitator** |  |
| **Name of Primary care facilitator** |  |
| **Date & Signature of facilitator** |  |