

Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System

Draft Oral Health & Dental Strategy (All ages)

2024-2027

**May 2024
v0.3**

Executive Summary

Why have we produced this strategy?

Good oral health is an integral component of general health. The World Health Organisation (WHO) defines oral health as “a state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, gum disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual’s capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing”.

Access to routine and urgent dental care is a national issue. It is also one of the number one reasons for MP enquiries, patient complaints, and scrutiny discussions due to increased access issues and political interest.

The Health and Social Care Act 2012 created a new commissioning framework for the provision of health, social care, and public health in England. From April 2013, NHS England became the single commissioner for all dental services, including primary, secondary, and unscheduled dental care. In addition, local authorities became responsible for improving the oral health of their communities and for commissioning oral health improvement services.

The delegation of primary care commissioning functions to some Integrated Care Boards (ICBs) from 1 July 2022 and to all ICBs on 1st April 2023 has led to ICBs exploring opportunities to commission dental services to prevent poor oral health, protect and expand access and deliver high quality care. From a national dental care and treatment perspective, the restoration of mandatory services following the pandemic remains a key delivery priority.

Dental care is commissioned by the integrated care board (ICB) and provided by urgent, community and domiciliary dental care services, general dental practices, hospital-based dental specialties, and university dental schools. In contrast, oral health improvement is commissioned by the local authority Public Health team and provided by a range of providers alongside community dental services, NHS teams and university dental schools. Local authorities are statutorily required to provide or commission oral health improvement programmes appropriate to their areas and oral health surveys. A broad range of other services have a role in oral health, for example homeless service providers, adult social care settings, prison health, early years settings and schools, drugs and alcohol services, and foster carers.

Access to an NHS dentist

The latest national report from August 2023 (up to June 2023) shows that the percentage of the adult population seen by an NHS dentist within the previous 24 months in BNSSG is 40.7% which is an increase from 38.6% in 21/22 but less than 20/21 (44.9%). The percentage of the child population seen by an NHS dentist within the previous 12 months in BNSSG is 53.7% which is an increase from 49.2% in 21/22 and an increase from 36.9% in 2020/21. The local data for children in care shows a significant shortfall of the 100% target for children to be seen by a dentist in the previous 12 months (ICB 75%) this is particularly low in North Somerset at 65% (53% have seen a dentist, 12% did not need to see one).



Although BNSSG are often above the national and regional averages for access, there is significant variability and continued challenges with maintaining NHS service provision. The need to support recruitment and retention of dentists is essential to maintaining services and enabling dentists to meet their contractual obligations.

Dentists have continually raised concerns nationally regarding the current contract introduced in 2006 and contract reform is not expected prior to the next general election. Whilst a focus on mandatory services is critical to restoring access to dental care for the majority of people, NHS England have highlighted some of the flexibilities which exist within the current national dental contractual framework to enable ICBs to tailor services to meet specific population needs, and to take steps to support practices with changes to UDA* values, where this presents clear value for money. The aim of this guidance is to provide ICBs with an outline of the legal requirements of the national dental contractual framework and to highlight the key considerations associated with procuring Additional and Further Services, previously termed 'flexible commissioning'. Further information on this guidance can be found in Appendix 2.

*UDA – Units of Dental Activity are a measure of the amount of work done during dental treatment. More complex dental treatments count for more UDAs than simpler ones. For example, an examination is 1 UDA, fillings are 3 UDAs, and dentures are 12 UDAs.

**UOA – Units of Orthodontic Activity is an indication of the weight of an orthodontic course of treatment. A course of orthodontic activity equates to between 4 and 23 UOA, according to the age of the patient.

Partners across the BNSSG system all agree how important it is to increase targeted oral health interventions, improve access to NHS dental services for the local population and identify plans which seek to reduce health inequalities. People living in deprived communities consistently have poorer levels of oral health than people living in more affluent areas. Given the diverse population across BNSSG there is a need to ensure that oral health interventions are planned on a population-based level to reduce these inequalities. For example, in Bristol there are higher levels of Oral Cancer at 17.28 per 100,000 population, higher than the England and South West rates, in North Somerset it is 12.49 per 100,000 and in South Gloucestershire it is 11.91 both lower than the South West rate and the England rate. Higher incidence is associated with non-healthy behaviours such as alcohol consumption and smoking.

The development of this strategy has included two workshops which involved stakeholders across all areas of dental provision, NHS England, and local authority public health leads. A staff survey was also completed, and the feedback has been integral to the development of this draft strategy. Further engagement with the public and staff is needed to ensure this strategy reflects the feedback received. Delivering this strategy will require a robust governance structure to be in place which continues to bring together all key stakeholders across the ICB.




The draft strategy described within this paper is focused on the priorities for the next two years, but it is expected the work required will span three years given the scale of change required. Consideration of the national contract constraints and the associated procurement regulations relating to the objectives within this strategy should not be understated.

It is important to note that although some areas have been prioritised as commencing within twelve months compared to commencing within two years this is not to suggest that any of the areas identified are of less importance. The prioritisation involved a range of considerations including the direct impact on patient outcomes and reducing health inequalities to determine these timelines.



The draft strategy which has been developed by system partners is summarised as follows:

BNSSG Integrated Care System – Draft Oral Health & Dental Strategy 2024-2027 Summary

Aim	 Promote good oral health across the entire BNSSG population	 Reducing health inequalities by increasing access to NHS dental provision	 Developing the workforce, retaining staff and attracting more applicants
High Level Objectives	<p>Within 12 months*:</p> <ol style="list-style-type: none"> 1. Work together to promote good oral health across all ages of the population 2. Identify and support those who are most likely to struggle to have healthy teeth 	<p>Within 12 months:</p> <ol style="list-style-type: none"> 3. Review of all NHS provision to identify a plan for sustaining NHS Dental provision and increasing population-based access 4. Consider local opportunities to reduce waiting lists through increased use of Tier 2 services and sedation rather than waiting for a general anaesthetic in secondary care <p>Within 2 years:</p> <ol style="list-style-type: none"> 5. Reducing the administrative burden for providers through standardization of referral pathways, access points and shared care records 6. Increasing public awareness of Dental services including access routes and the importance of good oral health 	<p>Within 2 years*:</p> <ol style="list-style-type: none"> 7. Increasing the dental workforce locally by improving staff morale and increasing population-based access across different areas of interest 8. Creating a coordinated and locally focused dental recruitment plan which includes a workforce and skills audit, identifying opportunities to upskill staff and increasing continuing professional development 9. Maintaining NHS dental provision by retaining the existing workforce, identifying retention schemes to prevent trainees moving to other areas and increase career opportunities and support post foundation training

*where regional and national developments allow

Collaborating to form a Bristol, North Somerset and South Gloucestershire Oral Health & Dental Strategy

1. What is driving our strategy?

The main oral diseases are dental caries (decay), gum disease, oral cancers, cleft lip and palate, tooth erosion and orthodontic disorders. Many of the risk factors that can lead to these conditions also contribute to other diseases, emphasising the need to include oral health in initiatives designed to promote health in general.

These risk factors include but are not limited to:

- Diets high in sugary foods and drinks, including 'hidden' sugars in foods that may not be expected to contain sugars
- Inappropriate infant feeding practices (e.g. frequent snacking, fizzy drinks) *
- Poor oral hygiene
- Dry mouth (often the side effect of certain medications e.g. psychotropic medications)
- Smoking/use of tobacco and other carcinogenic substances
- Excessive alcohol consumption.

* Current evidence suggests that breastfeeding up to 12 months of age is associated with a decreased risk of tooth decay.



The NHS England South West Oral Health Needs Assessment published in January 2021 identified the following needs for BNSSG and this has been the framework for the development of this strategy:

NHS England and NHS Improvement South West of England Oral Health Needs Assessment January 2021: Key recommendations for BNSSG grouped under relevant headings

Improving Access & Addressing Variation	Workforce Development	Population Level Oral Health Interventions	Integration & Collaboration
<p>The levels of access to NHS dentistry in BNSSG are generally above the regional and national average for both children and adults but there is significant variability between inner city and rural areas.</p>	<p>There is a need to support the recruitment and retention of dentists providing NHS services.</p>	<p>There is a need to support targeted programmes to reflect the diversity of the population in the STP and reduce inequalities.</p> <p>There are higher levels of Oral Cancer in Bristol.</p>	<p>There is evidence that there is difficulty being experienced by Dentists in meeting their contractual targets.</p>

By the end of July 2024, every ICB should have undertaken an oral health needs assessment, in consultation with service users, patient organisations and the profession. NHS England should provide support to ICBs to undertake this, including sharing examples of best practice and learnings from other ICBs. NHS England must also ensure each assessment is sufficient to meet its intended purpose.

Accessing NHS Dental Services in BNSSG

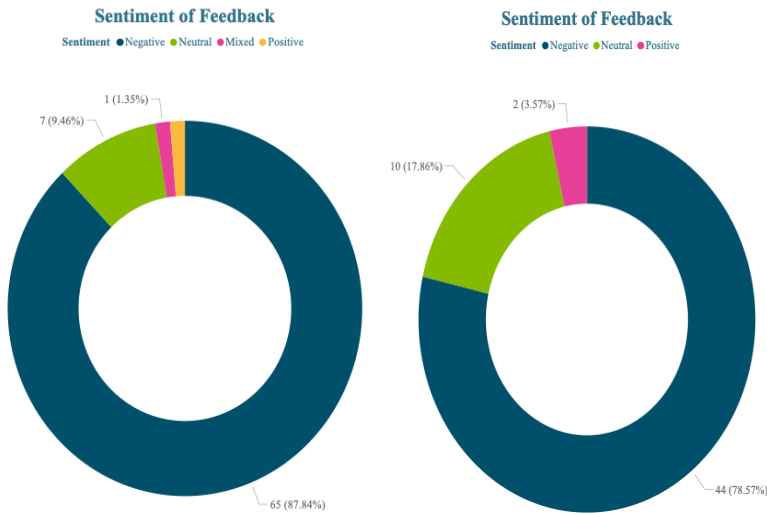
The dental contract data provided by the South West Collaborative Commissioning Hub suggests that the volume of unique contracts failing to achieve at least 30% of contracted activity at mid-year point has continued to increase over recent years. Data at mid-year 2023/24 also showed a significantly higher number of contracts failing to deliver contracted activity than the number of contracts identified in the previous financial year.

The situation for practices in BNSSG ICB is not unique with those achieving above 96% of the agreed contract at the end of the financial year being a challenge both regionally and nationally. The reasons contributing to this are the current Unit of Dental Activity (UDA*) rates, difficulty with recruiting the required workforce to deliver on the contract (sometimes due to higher UDA rates in other areas of the ICB or region) and financial pressures caused by a high amount of clawback as a result of not delivering above 96%. In exceptional circumstances, practices may be allowed to carry a shortfall in UDAs forward to the next year if a practice is confident it can demonstrate how it will make up that shortfall, but this is not common due to the lack of confidence that this will be possible.

The feedback on dental services that Healthwatch received during 22/23 reflected that most concerns were related to access to NHS dentistry, deregistration related to Covid or privatization of normal dental practice. The feedback received throughout 2023/24 was consistent with these key themes. A summary of this feedback is shown in the following diagram and was fundamental to the development of this strategy.



BNSSG Healthwatch Feedback 2022-23



103/109 of the total negative feedback received were related to **access to NHS dentistry, deregistration related to Covid or privatization of normal dental practice.**

Patients complained of lack of provision during **pregnancy, for infants, dementia patients, Ukrainian refugees** and many suffered pain for long periods

A survey completed in 2023 by Kerry McCarthy MP for Bristol East showed that 59.7% of patients said they were not on an NHS dentist’s active patient register with the most common reasons for this being (a) a lack of practices taking on new NHS patients, and (b) NHS dental surgeries switching to only provide private care. Although 40.3% of respondents had needed emergency dental work at some point over the past 3 years, reassuringly, almost two-thirds of this group (65.5%) had been treated quickly for urgent issues. When asked what they think the key problem with NHS dentistry is, most constituents cited the lack of dental practices in Bristol taking on new NHS patients. ‘Too many practices switching to only offer patients private treatment’ came a close second.

When constituents’ spoke about their experiences some had resorted to ‘DIY dentistry’, including by pulling their own teeth, and many others unable to get help until their needs became urgent. Several constituents struggled to find a dentist that accommodates their needs: particularly wheelchair accessibility, children’s dentistry and catering to autistic patients.

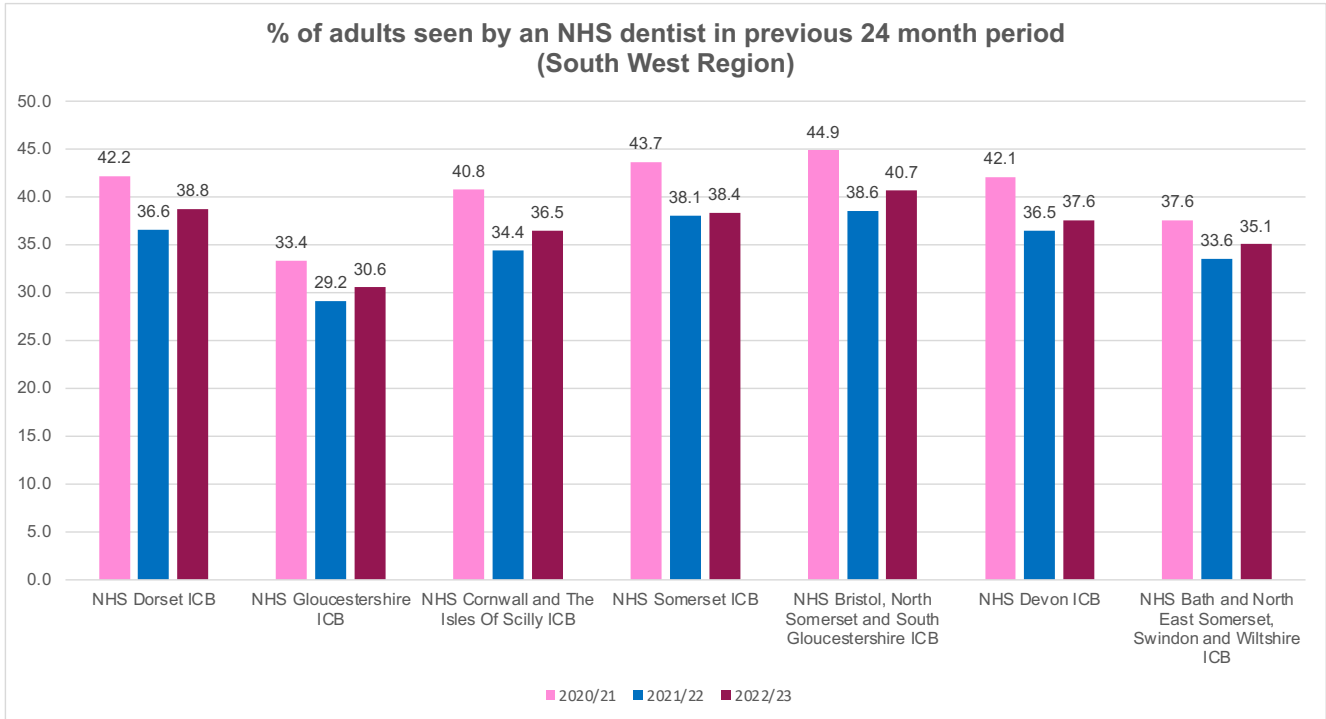
Many of the constituents shared concerns about the worsening state of NHS dental care, and the way in which the Government has not adequately funded the dentistry sector more generally. While most participants said their experiences of emergency dentistry were positive, several were shocked at how much they had to pay – particularly when further treatment (e.g. fitting of crowns, root canal work) was needed.

Some seen urgently for more complex problems did not realise this was private treatment, with what was felt to be an extortionate price tag. Others were shocked that there was not more financial help available for pensioners, and those on low incomes who don’t receive means-tested benefits.

BNSSG Dental Access Data

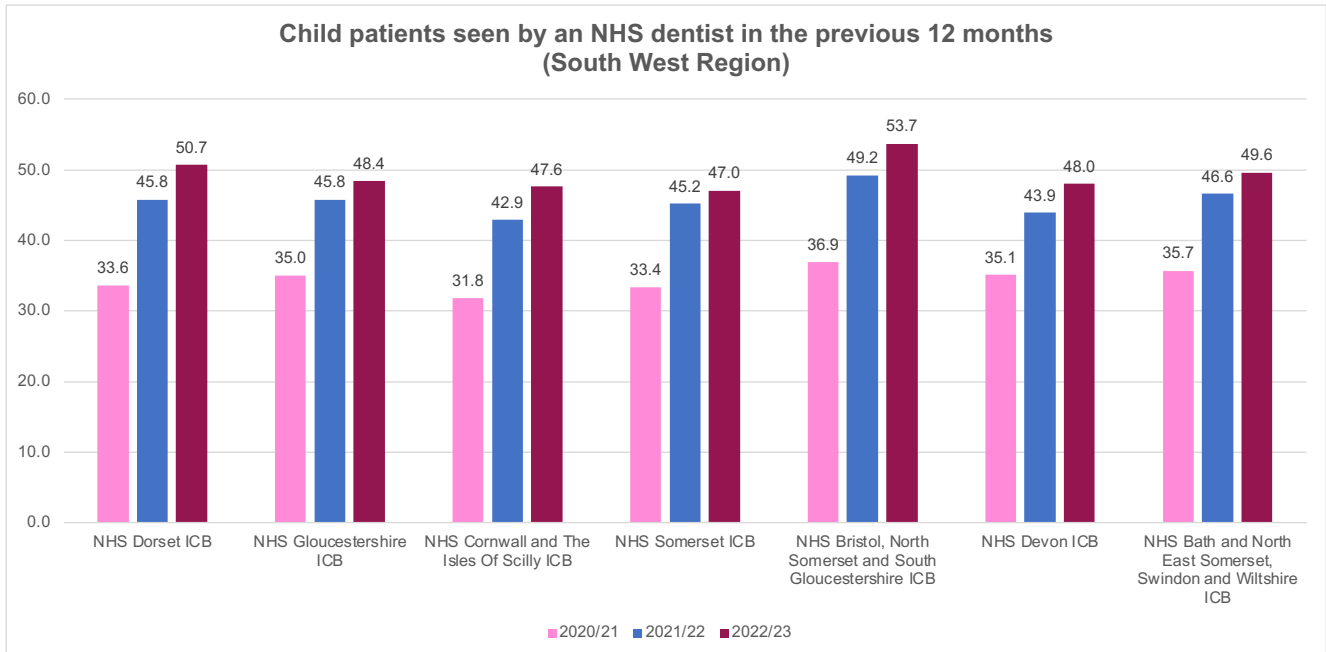
The latest national report from August 2023 (up to June 2023) shows that the percentage of the adult population seen by an NHS dentist within the previous 24 months in BNSSG is 40.7% which is an increase from 38.6% in 21/22 but less than 20/21 (44.9%).





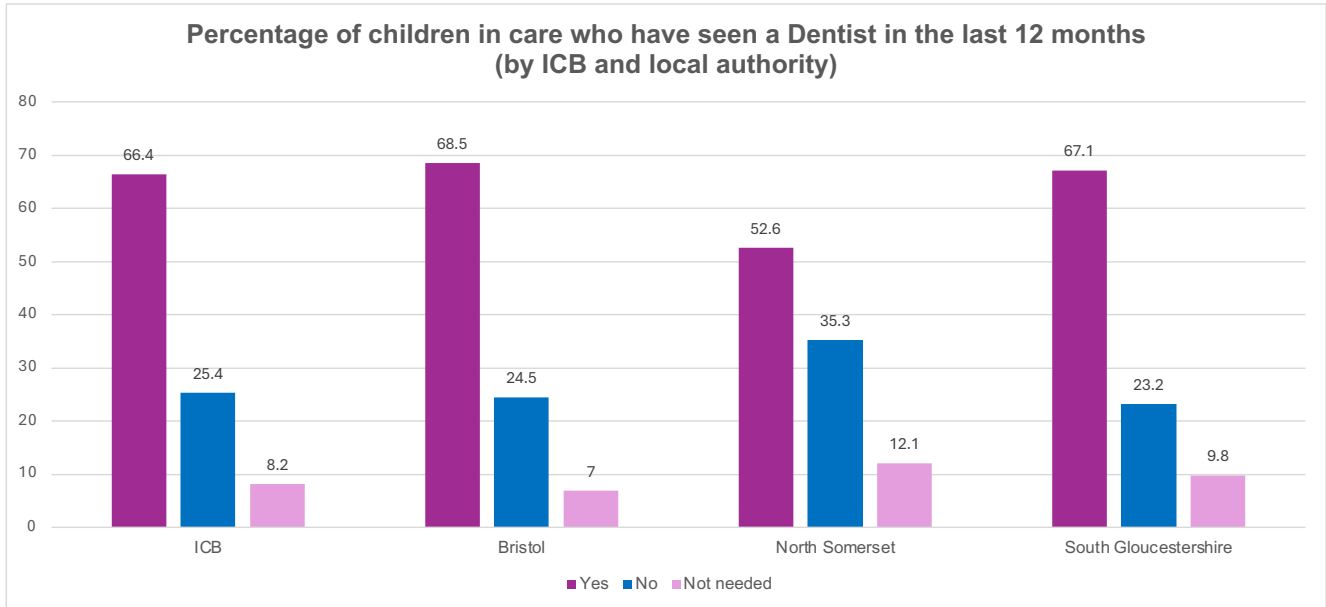
Source: NHS Digital Dental Statistics for England, 2022-23, Annual Report published August 2023

The percentage of the child population seen by an NHS dentist within the previous 12 months in BNSSG is 53.7% which is an increase from 49.2% in 21/22 and an increase from 36.9% in 2020/21.



Source: NHS Digital Dental Statistics for England, 2022-23, Annual Report published August 2023

The local data for children in care shows a significant shortfall of the 100% target for children to be seen by a dentist in the previous 12 months (ICB 75%) this is particularly low in North Somerset at 65% (53% have seen a dentist, 12% did not need to see one).



Source: Sirona Health & Care Contractual Reporting Dashboard up to November 2023

Regionally BNSSG performs quite well but given the South West region has the lowest access rates of the seven regions, together with the level of patient feedback received, it is essential that plans seek to improve this position.

Core20plus5* – Children & Young People

In developing Core20plus5 for Children & Young People NHS England have identified that there are clear and persistent inequalities in prevalence of dental caries in 5-year-old children based on deprivation and inequalities are worsening. There are also clear inequalities in prevalence of dental caries (decay) in 5-year-old children based on ethnicity. The Children and Young People’s version of Core20plus5 has a specific ‘asks’ around dentistry for young people because:

- Removal of decayed teeth is the most common reason for a 5–9-year-old child to be admitted to hospital in England
- Decay can cause pain leading to problems with eating, sleeping, communication and socialising, as well as resulting in time away from education and work for parent/carers
- Good oral health a key indicator of school readiness
- Dental disease is almost always preventable.

*Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.

The table overleaf shows in the last Fingertips Public Health Data report of 2021/22 Bristol had the highest proportion of 5-year-olds with experience of visually obvious tooth dentinal decay in the South West region.

Fingertips Public Health Data Report 2021/22

Area	Value	95% Lower Ci	95% Upper Ci
England	23.7	23.3	24.0
South West region	19.1	18.0	20.2
Bristol	27.2	21.2	34.1
Plymouth	24.6	19.7	30.3
North Somerset	22.1	15.9	29.8
Torbay	21.3	16.9	26.5
Somerset Cty	20.9	18.5	23.5
Cornwall	19.4	15.0	24.6
Devon	18.1	15.7	20.7
Swindon	17.8	13.3	23.3
South Gloucestershire	17.4	12.6	23.6
Gloucestershire	16.8	14.9	18.8
Wiltshire	15.5	10.7	21.9
Bath and North East Somerset	10.3	7.1	14.7

Source: Fingertips Public Health Data, Office for Health Improvement & Disparities, Regional Positions 2021/22

2. Collaborating to form an Oral Health & Dental Strategy in Bristol, North Somerset and South Gloucestershire

The aim of developing a dental strategy for the next 3 years is to provide a roadmap for the integrated care system describing the action needed to increase oral health interventions, sustain NHS dental provision and to deliver these improvements focused on the population needs. The Joint Forward Plan describes our commitment to developing this for the population. The progress report which accompanies this describes the work completed during the first year of delegated commissioning and should be read in conjunction with this document.

Producing this strategy has required a collaborative approach, working with stakeholder colleagues and organisations across BNSSG dental provision, public health, and oral health improvement across the 3 local authorities, to create a joined-up integrated whole system oral health & dental strategy that delivers on better oral health and care for communities across BNSSG.

2.1 Local Context

Dental care is commissioned by the integrated care board (ICB) and provided by urgent, community and domiciliary dental care services, general dental practices, hospital-based dental specialties, and university dental schools. In contrast, oral health improvement is commissioned by the local authority Public Health team and provided by a range of providers alongside community dental services, NHS teams and university dental schools. Local authorities are statutorily required to provide or commission oral health improvement programmes appropriate to their areas and oral health surveys. A broad range of other services have a role in oral health, for example homeless service providers, adult social care settings, prison health, early years settings and schools, drugs and alcohol services, and foster carers.

What is currently happening in oral health promotion?

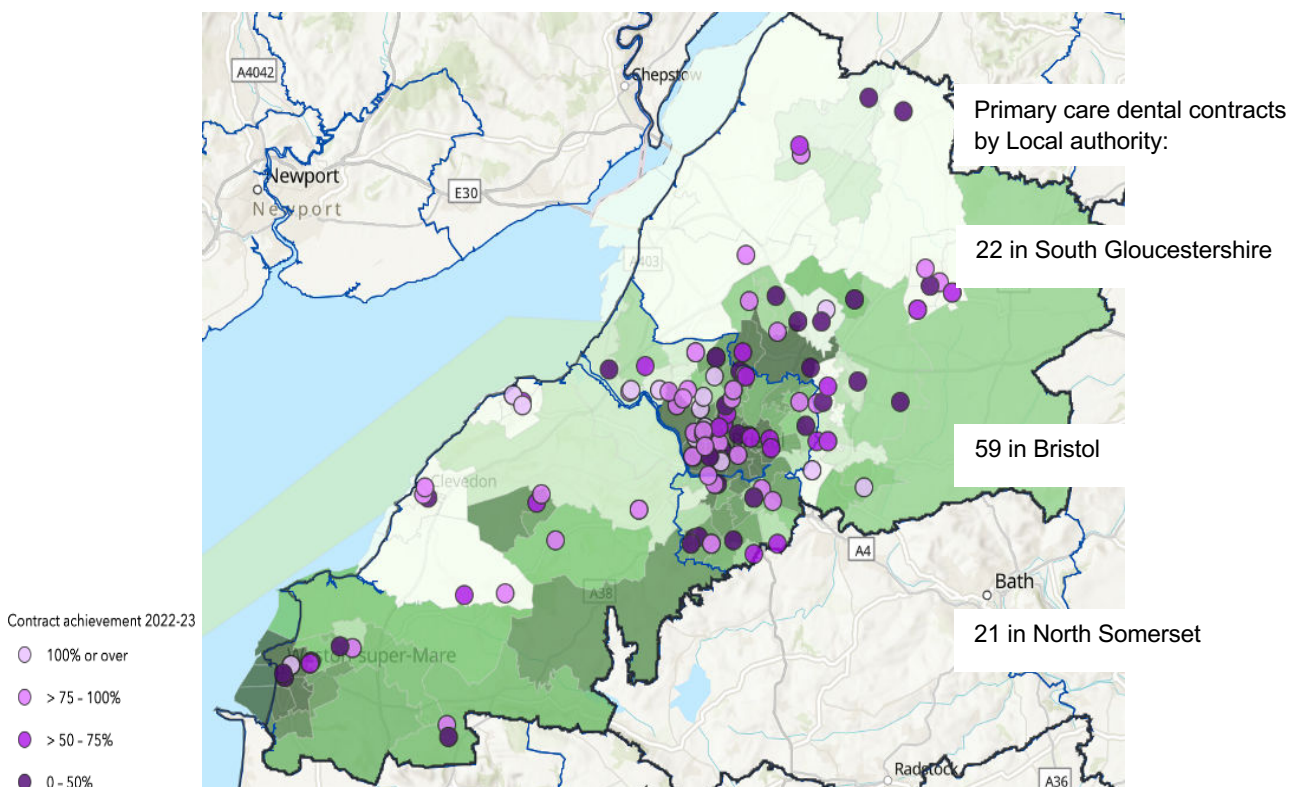


Oral Health Promotion and (separately) Oral Health Surveillance are both embedded in a broad NHS contract with the community dental service provided by the Bristol Dental School. This contract was previously managed by the NHS England primary care commissioning directorate and responsibility was delegated to the ICB in 2023. Further discussions are taking place regarding this and how we can redesign the health promotion that is delivered to ensure this continues to meet the needs of the population.

Oral health promotion across the integrated care system has been very varied and based on historic need. Whilst oral health surveys have been successfully delivered by community dental services, commissioned oral health promotion services have experienced staffing and capacity challenges. As a result, some authorities have taken a hands-on approach including employing specific oral health promotion staff. The intention going forward is to form an Oral Health Improvement Working Group that will work together across the local authorities and related services to embed oral health promotion into existing programmes and services. The aim of this group is to identify general and targeted opportunities to improve oral health using evidence-based methods.

Dental Provision in BNSSG

There are currently 102 primary care dental contracts across BNSSG together with the University Hospitals Bristol and Weston NHS Foundation Trust Dental Hospital which includes the Primary Care Dental Service and Bristol Dental School.



The above map is taken from the South Central West geospatial dental mapping tool which uses national reporting data from the latest national report to the end of March 2023. Not all practices shown have continued to provide NHS services in 2023/24, two contracts ended at the end of March and the Bupa St Pauls contract was handed back in June 2023 (please see the accompanying progress report regarding this). The reports to November 2023 suggested that those providers not

achieving 50% of their annual contract is 45% in Bristol, 38% in North Somerset and 50% in South Gloucestershire.

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) Primary Care Dental Service provides the following Services, many of which are co-located:

The Community Dental Service (CDS) provides dental care for people who are unable to access treatment from a General Dental Practitioner (GDP) because of special needs, or disabilities. This includes, for example, those individuals with mobility problems, learning difficulties or complex medical histories, children in care, those with dental anxiety and those who are housebound. The Service is provided across Bristol, Bath, Weston and Yate, and referrals are welcome from GDPs, General Medical Professionals, other health care professionals such as health visitors, carers and relatives. Home visits are available where patients are housebound, or where the disability is such that the individual would find it too difficult to visit a clinic, but this is at the discretion of the service.

The Dental Access Centre (DAC) provides treatment for patients who have experienced difficulty in being accepted by an NHS GDP. The Service gives priority to the relief of pain, but a partial or full course of treatment may be available where clinic capacity permits. Where possible, patients will then be referred to local GDPs for continuing care. The Service is available from the Dental Department, Riverside Health Centre in Bath.

The **Dental Out of Hours Emergency Service (OOH)** operates from clinics at Easton in Bristol (Charlotte Keel), Bath City Centre (Riverside) and Weston General Hospital. The Service provides emergency treatment to all patients whether you are NHS, private, do not have access to regular dental care, or are just visiting the area.

To access the DAC or OOH Service patients need to telephone 111.

UHBW also provide Oral Health Promotion and support the epidemiological survey.

Bristol Dental School

The Bristol Dental School offers both undergraduate and postgraduate training and is ranked 4th in the UK for dentistry (Complete University Guide Subject Rankings 2024).

Bristol Dental School moved to a £36million purpose-designed Dental School in Bristol City Centre. The aim is to help students to put theory into practice in state-of-the-art facilities and working with the local community to offer treatment to those in need. They have completely refurbished an existing building in the heart of the city. Students have fed into decisions on the project board and represented the student voice to make this space one of a kind. This includes:

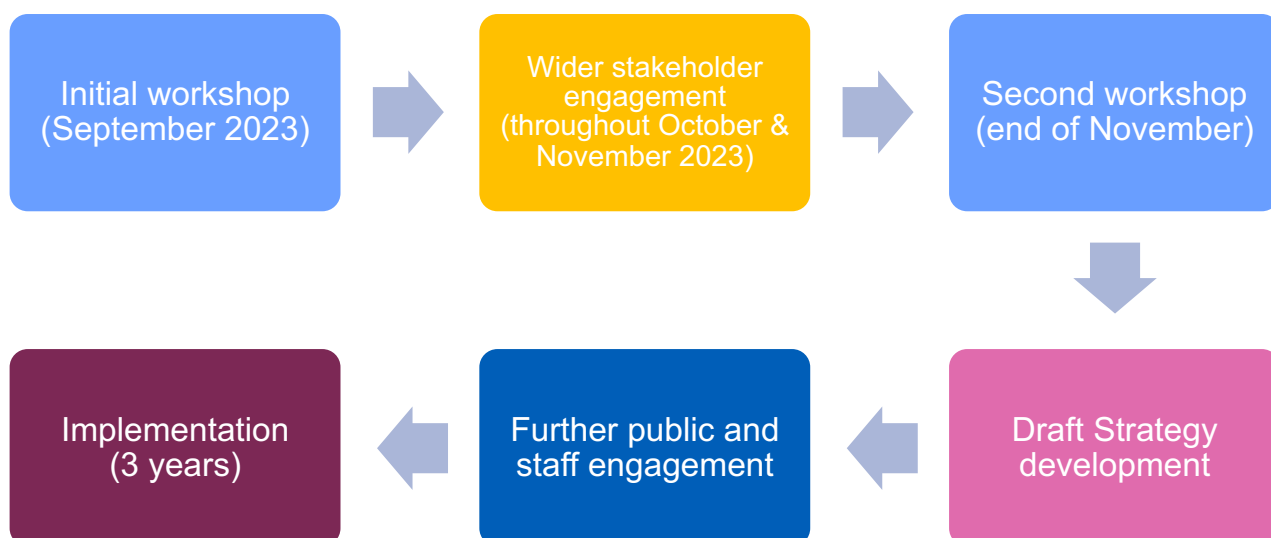
- Dental clinics with 119 dental chairs
- Clinical skills suite
- Prosthetics teaching and dental production laboratories
- Computer suites
- Teaching spaces
- Informal study spaces
- Social areas



- Large changing facilities and locker spaces
- Large bike storage and maintenance

The focus is high-quality training for dental professionals to prepare them for work in primary care dentistry. The new model ensures they have an exclusive space specifically designed to support clinical education and training but retaining a strong partnership with Bristol Dental Hospital. The newfound flexibility to manage this space and patient lists, means they can expand intakes and introduce new programmes as well as engage with underrepresented communities, delivering patient care and oral health education through their students, and by promoting access to training through established widening participation routes. There will continue to be a strong link between Bristol Dental School and the Dental Hospital on Lower Maudlin Street, through specialist placements for undergraduate students and for postgraduate students who work alongside NHS Consultant clinics. The Dental Hospital will continue to treat NHS patients requiring specialist care.

2.2 High Level Plan for the Development of an Oral Health & Dental Strategy in BNSSG



The two workshops and staff survey have now been completed. Further engagement with patients and staff as part of the developing strategy is now required but it should be noted that incorporating any feedback will need to be within the national contractual regulations which are outside of the ICBs control.

The workshops and survey provided useful insights into the areas stakeholders felt we need to focus our strategy and the timelines for doing so. The framework for the workshops and survey were consistent with the findings of the South West Oral Health Needs Assessment and focused on:

- Improving access and addressing variation
- Workforce
- Population level oral health interventions
- Integration and collaboration

The second workshop prioritised each area under the headings of:

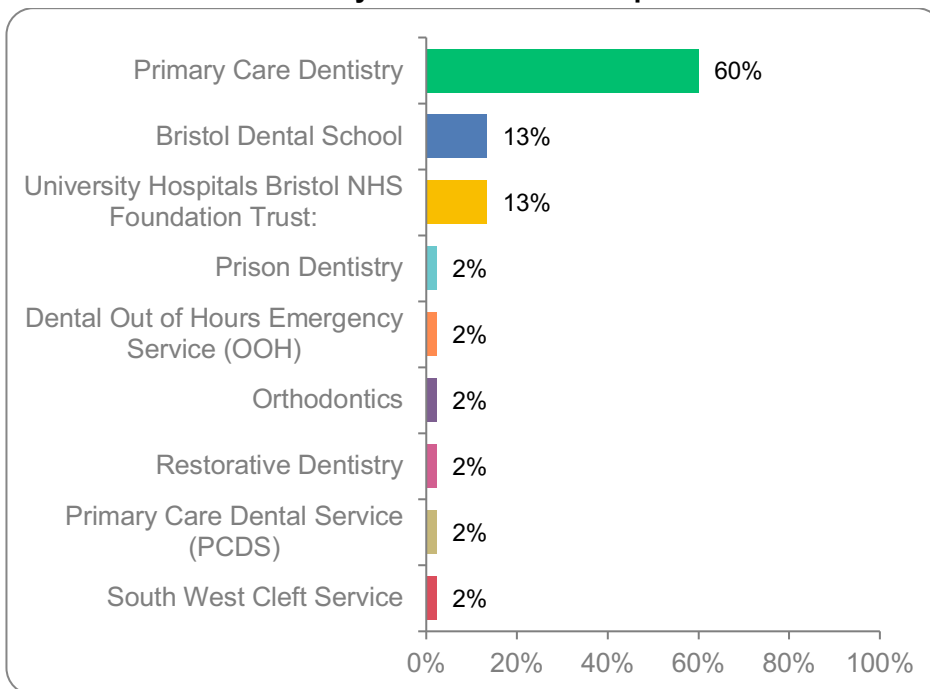


1. Reducing health inequalities by increasing access to NHS dental provision
2. Developing the workforce, retaining staff, and attracting more applicants
3. Reducing the burden of dental disease through oral health promotion and integration with other services

BNSSG Dental Staff Survey Headlines

The staff survey undertaken in November led to 50 responses, 45 of the respondents answered where they worked as follows:

BNSSG Dental Staff Survey October 2023 Workplace:



44 of the respondents felt that the top 5 priorities were:

- Development of a revised stabilisation offer for primary care
- Standardisation of referral pathways and access points
- Review of urgent care access routes
- Career progression pathways, opportunities to upskill
- Increased use of Tier 2 to reduce secondary care waiting lists

Only 10% of the 50 respondents believed their service was funded appropriately and 63% said they did not enjoy working for the NHS. 28% said they routinely feel depressed about their work and 26% insecure.

67% of 45 respondents said they do not anticipate working for the NHS in 2 year's, 44% (34 respondents) said that this was due to funding, 35% said this was due to pay.

55% have an interest in working with vulnerable people but 41% feel there are not the opportunities to do so with 75% saying this was due to funding. When asked which groups they would like to work with (but are not currently) respondents said those with dental phobia, migrants and asylum seekers and



Children in care closely followed by those in care homes, people with learning disabilities, medically compromised individuals and people experiencing homelessness.

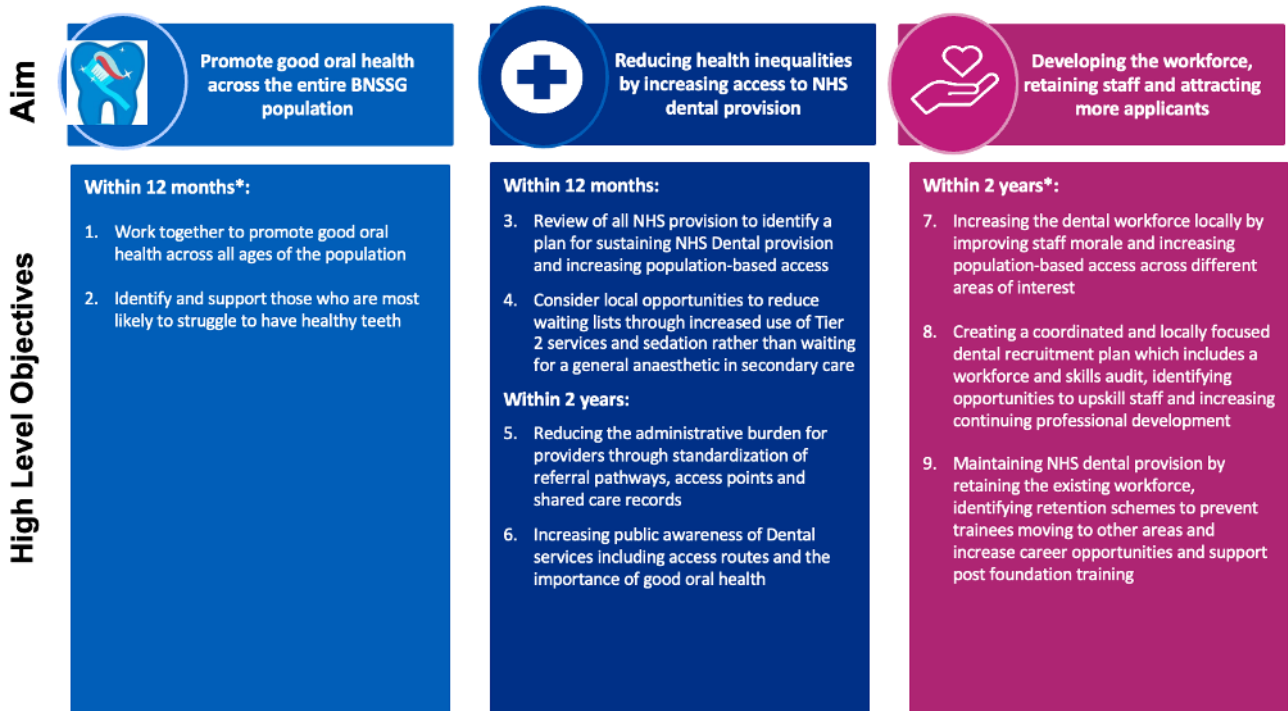
55% stated they were not aware of the primary care networks in their area, 60% stated they did not understand the role of primary care networks but 84% said they would welcome the opportunities to work with GPs and other NHS services.

Please see appendix 1 for the full results.

2.3 Draft Strategy Summary

The diagram below summarises the draft BNSSG Oral Health & Dental Strategy on one page and the associated timescales:

BNSSG Integrated Care System – Draft Oral Health & Dental Strategy 2024-2027 Summary



*where regional and national developments allow

How will we deliver on these aims and objectives across the integrated care system?



High Level Objective 1: Work together to promote good oral health across all ages in our population

Poor oral health can affect anyone. Children may be particularly highly impacted as poor oral health in early life may create lifelong problems. Certain lifestyles carry increased risk of poor oral health for example high alcohol intake, use of tobacco and high sugar diets.



This objective aims to support all members of the population across the life course to access the key messages to improve oral health: brush your teeth, reduce your sugar, and see your dentist. This objective takes a life course approach from pregnancy through to breastfeeding and weaning to childhood, adulthood, and old age.

We will achieve this by:

- 1. KNOWING OUR POPULATION'S NEEDS:** Maintaining an accurate, up-to-date assessment of local need.
For example: completing local needs assessments and oral health surveys.
- 2. WORKING TOGETHER RECOGNISING LOCAL PRIORITIES:** Developing evidence-based local action plans that maximise opportunities for collaboration across BNSSG.
For example: Using local data and insights to develop targeted public health programmes as well as working with other areas to identify where it makes sense to develop joint programmes together.
- 3. MAKING USE OF EXISTING RESOURCES:** Embedding oral health in existing services through commissioning training, joining up messaging and incorporating oral health into wider service specifications.
*Child examples: family hubs, midwives, health visitors, public health nurses, those engaged in safeguarding (highlighting poor oral health as an issue of neglect).
Adult examples: healthy weight and diabetic services, stop smoking services, leisure centres, and MECC (make every contact count) in pharmacies and primary care.*
- 4. WORKING WITH POLICY-MAKERS:** Promoting oral health in the development of emerging national, regional and local policies.
For example: To address the commercial determinants of health and create a healthy food and drink environment including alcohol and fast-food licensing, environmental planning such as allotments and water fountain placement, and sweetened food and drink policies.
- 5. FOCUSING ON YOUNG CHILDREN:** Focusing on early-years and Key Stage 1 children in providing sustainable delivery of cost-effective, evidence-based oral health promotion programmes.
For example: a whole school / setting-based approach to oral health including creating a supportive environment, essential school awards, supervised toothbrushing, fluoride varnish programmes.
- 6. REDUCING CANCER RISK:** Supporting reduction in oral cancer risk.
For example: optimising Human Papilloma Virus vaccine uptake and work closely with services such as alcohol and substance misuse services.
- 7. BUILDING EVIDENCE:** Contributing to building the evidence base for oral health promotion in our population.
For example: embedding monitoring and evaluation into our oral health programmes, including measures of inequality.



High Level Objective 2: Identify and support those at greatest risk of poor oral health

There is evidence of a clear link between experiencing deprivation and poor oral health. Specific groups at increased risk include looked after children, those with sensory impairment or learning disabilities,

the frail elderly, those in the Gypsy, Roma and Traveller communities, asylum seekers and refugees, and people experiencing homelessness or drug and alcohol users, those dependent on tobacco. The overarching aim of this objective is to provide targeted support to those most at risk of poor oral health.

We will achieve this by:

1. **FINDING OUT WHO'S AT RISK:** Improving data collection in underserved communities to understand who at-risk groups are in each local authority and to understand their specific oral health needs.
For example: care leavers, Gypsy, Roma, and Traveller communities and those affected by drugs, alcohol or tobacco dependence.
2. **MAKING BEST USE OF RESOURCES IN UNDERSERVED COMMUNITIES:** Ensuring oral health is incorporated into the specifications for existing services.
For example: the substance misuse service, care home policies and asylum seeker services.
3. **FINDING OUT WHAT WORKS:** Identifying cost-effective, evidence-based, targeted oral health promotion initiatives and programmes for those most in need.
For example: using NICE guidance and systematic reviews and identifying examples of best practice implemented in other areas that may benefit our population. Current examples include targeted fluoride varnish programmes, provision of toothbrushes and toothpaste.
4. **DELIVERING LONG-TERM:** Providing sustainable delivery of such oral health promotion programmes.
For example: developing existing voluntary sector links, training staff and carers, and developing of environments supportive to good oral health.



High Level Objective 3: Review of all NHS provision in order to identify approach to sustaining NHS Dental provision and increasing population-based access

To deliver on the aims and objectives we need to review all existing contracts across the system, identify the demand associated with the service and identify the required capacity to deliver this to meet patient needs.

We need to consider the associated funding including UDA rates, building on the shorter-term solutions and principles identified during 2023/24. This should include consideration of complex service delivery and growing costs such as consumables, laboratory and continuing professional development. It is vital to further understand and build plans for sustaining practice provision.

We need to consider targeted access starting with children in care through additional services as defined by the flexible commissioning guidance and consider other population groups such as those experiencing homelessness, asylum seekers and those with Learning Disabilities given the long waiting times for the community service.

We need to build on previous work with care homes, the support provided by outreach services and working with schools and early years services.

Development of a revised stabilisation offer will be a priority to build on the work so far and reduce demand for urgent care.

We need to further understand the reasons patients do not attend for their appointments and increase attendance to reduce wasted appointments.



We need to identify further opportunities for digital innovation being mindful of the digital poverty that exists.



High Level Objective 4: Consider local opportunities to reduce waiting lists through increased use of Tier 2 services and sedation rather than waiting for a general anaesthetic in secondary care

We need to build on the work undertaken regionally and further understand the main reasons BNSSG patients are waiting for treatment in secondary care.

We need to identify local solutions to address this. This may include further utilising the Tier 2 services available and introducing a local sedation pathway as an alternative to general anaesthesia.



High Level Objective 5: Reducing the administrative burden for providers through standardisation of referral pathways, access points and shared care records

The staff survey identified that this needed to be an immediate priority due to consistent frustration with administrative burden caused by the current process.

This needs to include a review of existing referral pathways and access points to identify a more streamlined approach.

We need to explore opportunities to share records to improve patient care through increased availability of information and reduce duplicate administration.



High Level Objective 6: Increasing public awareness of dental services including access routes and the importance of good oral health

There is a need to develop a patient communication and awareness plan including a roadmap on how to access services and the importance of good oral health.

We need to increase understanding of primary care dentistry, what UDAs are and how they were set for contracts through public and professional awareness campaigns.

There is a need to further consider different levels of understanding and language needs, exploring community champions for translation.



High Level Objective 7: Increasing the dental workforce locally by improving staff morale and increasing population-based access across different areas of interest

We need to improve staff morale by increasing opportunities for additional services which focus on population-based access across different areas of interest. This needs to include opportunities to work with different population groups, increase integration with other primary care services and specialties such as Diabetes.



High Level Objective 8: Creating a coordinated and locally focused dental recruitment plan which includes a workforce and skills audit, identifying opportunities to upskill staff and increasing continuing professional development



To deliver on this we need to agree a dental recruitment and retention plan identifying a coordinated approach at local level which includes a workforce and skills audit, identifying opportunities to upskill staff and increase the opportunity to complete continuing professional development building on the findings of the Health Education England Advancing Dental Care report published in 2021.

We need to increase awareness and availability of career opportunities including apprenticeships for school age children, overcome barriers to international recruitment and explore opportunities for dental students going out to schools, care homes and other areas.



High Level Objective 9: Maintaining NHS dental provision by retaining the existing workforce

In addition to creation of a recruitment and retention plan we need to identify a patient communications and engagement plan which seeks to increase appreciation and understanding of NHS dentistry.

We need to identify retention schemes to prevent trainees from London moving back including guaranteed employment and managing expectations.

We need to explore opportunities for salaried staff, increases in pay and access to the NHS Pension through national lobbying and appeals for contract reform.

There needs to be consideration of a combined training offer for dental staff on the areas recommended by the General Dental Council and for clinical staff in business management.

We need to look at opportunities to increase career support post foundation training focused on population needs.

Further consideration is required on flexible working opportunities to increase work/life balance for staff.

Further Considerations

The workshops and survey have enabled the production of this strategy and provided useful insights into the areas stakeholders felt we need to focus our strategy on and the timelines for doing so. Further engagement with staff, service users and their families is required but it should be noted that incorporating any feedback will need to be within the national contractual regulations which are outside of the ICBs control.

Integration of dental services and oral health, firmly embedded as part of the 'four pillars of primary care', with GP, Pharmacy and Optometry, as well as integrating oral health in a range of wider care pathways, is intended to be a key feature of this developing strategy.

The ICB continues to work closely with colleagues across the integrated care system and colleagues from the Local Dental Committee (LDC) on the actions needed to improve population oral health within 2024-2027.

Appendix 1:

Please see attached presentation describing the outputs from both workshops and the staff survey results.



Appendix 2:

NHS England

Opportunities for flexible commissioning in primary care dentistry: A framework for commissioners

Date published: 9 October, 2023

The following abbreviations and acronyms are used in this document:

- GDS – General Dental Service Contract
- PDS – Personal Dental Service Agreement
- PDS Plus – Personal Dental Service Plus Agreement
- SFE – Statement of Financial Entitlement
- UDAs – Units of Dental Activity
- UOAs – Units of Orthodontic Activity
- COT – Courses of Treatment
- NACV – Negotiated Annual Contract Value
- NAAV – Negotiated Annual Agreement Value
- AACV – Actual Annual Contract Value

The aim of this guidance is to provide ICBs with an outline of the legal requirements of the national dental contractual framework and to highlight the key considerations associated with procuring additional and further services, previously termed ‘flexible commissioning’. Since this concept was introduced in 2020/21, we have refined our national position regarding the legal framework and the boundaries of flexibility open to ICBs. As such, this guidance supersedes any previous guidance provided to commissioners.

This guidance is intended to support commissioners with the following opportunities:

- Additional investment into new or existing contracts to address areas of need including;
 - Increased contracting of mandatory services,
 - commissioning additional capacity for advanced mandatory services, sedation and domiciliary services and orthodontics,
 - commissioning additional capacity for dental public health services and/or further services.
- Reallocation of existing contractual funding away from mandatory Services into new priorities (commissioned as additional or further services);
- Local negotiation of indicative rates for units of dental activity (UDAs) or units of orthodontic activity (UOAs).

The contents of this guidance should be considered alongside the [Policy Book for Primary Dental Services](#) and the national dental contractual framework. Commissioners should continue to give due regard to national procurement guidance and organisational standing orders and standing financial instructions should also be observed when implementing any aspects of this guidance.

Services that can be commissioned under the GDS contract and PDS agreement

Three types of services are described in both the GDS and PDS Regulations: mandatory, additional and further services. Both mandatory and additional services are defined within the regulations. There is greater scope for commissioners to define the target population, required activity and associated

remuneration of further services, including dental public health services, to meet the specific needs of their local populations which go beyond mandatory services.

Mandatory services

Mandatory services may be thought of as the core services which high street and community dental services should be able to provide. These are usually accessed by potential patients requesting care from an individual high street practice. The full list of mandatory services are defined in Regulation 14 of the GDS and PDS regulations and include:

- examination,
- diagnosis,
- advice and planning of treatment,
- preventative care and treatment,
- periodontal treatment,
- conservative treatment,
- surgical treatment,
- supply, and repair of dental appliances,
- the taking of radiographs,
- the supply of listed drugs and listed appliances,
- and the issue of prescriptions.

These activities are then grouped into banded courses of treatment which must be monitored and remunerated as units of dental activity (UDAs) in order to be compliant with the GDS/PDS Regulations and the GDS/PDS SFE.

Additional services

Additional services are defined in Schedule 1 of the GDS/PDS regulations. Additional services include advanced mandatory services, domiciliary services, sedation services and orthodontic services. Requirements for each of these services are provided in the regulations, although orthodontic services are usually commissioned separately. The primary scope for flexibility here is in determining the optimal level of commissioning and subsequent delivery of these services to meet local population needs. Additional services, like mandatory services, must be monitored and remunerated as set out in regulations, either through UDAs or orthodontic activity or as courses of treatment.

Dental public health services and further services

Dental Public Health Services and Further Services are the areas where commissioners have the greatest flexibility to define the target population, associated activities, and associated remuneration as these are not defined with the GDS/ PDS Regulations. The service specification needs to go beyond reasonable expectations for the provision of mandatory services and should not replicate regulatory definitions of either Mandatory or Additional Services. There are a number of ways this could be achieved, for example, through a focus on provision of care to a defined target population, specific access requirements e.g. holding of appointment slots for direct booking of patients seeking urgent care or through a requirement to provide care and treatment not otherwise defined in the GDS/ PDS Regulations such as the provision of additional reports for looked after children.

Commissioners are able to determine their own remuneration approaches for Further Services which could be entirely non-UDA based or take a hybrid approach where there is an overlap with Mandatory Services. For example, a Further Service could describe an outreach activity which would then lead to a Mandatory Service being provided. In these circumstances, there could be a discrete payment for the outreach activity with any associated care delivered because of that outreach being remunerated using UDAs and measured as Courses of Treatment.



Further details regarding the specific regulations can be found here together with examples of how this guidance can be applied:

<https://www.england.nhs.uk/long-read/opportunities-for-flexible-commissioning-in-primary-care-dentistry-a-framework-for-commissioners/>

