BNSSG ICB Board Meeting

Date: Thursday 6th March 2025

Time: 12:15 – 15:30

Location: Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Agenda Number:	6.2	
Title:	Oral Health & Dental Strategy	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	N/A
Purpose: Discussion		
Key Points for Discussion:		

To review the BNSSG Oral Health & Dental strategy with the objective of agreeing the strategy and plan as final. Please note the development approach to date, previous discussion with the Primary Care Operational Group (12.12.23, 10.12.24, 11.02.25), Primary Care Committee (30.1.24, 17.12.24) and ICB Board February 2024. Overall the feedback was to complete further public engagement, develop a plan and related measures to evidence delivery.

Producing this strategy has required a collaborative approach, working with stakeholder colleagues and organisations across BNSSG dental provision, public health, and oral health promotion across the 3 local authorities.

Further engagement with the public was completed in summer 2024. The feedback has been incorporated where possible into this update. An implementation plan and key metrics are now included which addresses the main points received.

The Board are asked to note the progress to date throughout this development on page 5 which demonstrates the ICB commitment to increasing access for the BNSSG population alongside a longer term plan being agreed.

Recommendations:	To discuss: • the updated strategy, accompanying plan and key metrics • To note the positive progress over the last 2 years since commissioning of dental services was delegated to ICBs • To note the improvements prioritised locally and note the considerations related to the national contract
Previously Considered By and feedback :	Primary Care Operational Group (12.12.23, 10.12.24, 11.02.25), Primary Care Committee (30.1.24, 17.12.24), ICB Board February 2024. Request to complete further public engagement, develop plan and measures. Further public engagement completed and incorporated where possible.
Management of Declared Interest:	None to declare.
Risk and Assurance:	There are 9 risks included on the Primary Care Committee risk register relating to the dental programme in BNSSG. 4 relate to capacity to deliver the change ranging from a score of 6 to 15. 3 relate to access to services and waiting times. The remaining 2 relate to the debt incurred by providers through underperformance and risk of contract handbacks due to low UDA rates.
Financial / Resource Implications:	The Dental budget in BNSSG is circa £59million. Following notification from NHS England on 21 February 2025 that the ICB is required to purchase 19076 additional urgent care appointments the investment from existing funds is being confirmed. Please see plan for some of the existing investments and those planned.
Legal, Policy and Regulatory Requirements:	Please see appendices for an overview of NHS England guidance on Opportunities for flexible commissioning in primary care dentistry: A framework for commissioners.
How does this reduce Health Inequalities:	The strategy seeks to meet the outcomes framework objectives for SER7, 8 and 9 together with STA10 and 12.
How does this impact on Equality & diversity	Equality Impact Assessment/ Equality Impact Screening Assessments to be completed for each change and presented with each decision paper.
Patient and Public Involvement:	Public engagement took place throughout 2024 including a survey to gather feedback, Healthwatch newsletters requesting comments, presentations to different forums and a staff survey. The website included an easy read version.
Communications and Engagement:	Communication and engagement needs identified and detailed in strategy.
Author(s):	Claire Ripley, Programme Consultant Jenny Bowker, Deputy Director of Performance and Delivery – Primary Care and Children's Services Adrienne Day, Primary Care, Service Improvement Project Manager
Sponsoring Director / Clinical Lead / Lay Member:	David Jarrett, Chief Delivery Officer

Agenda item: 6.2

Report title:

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

Oral Health & Dental Strategy (All ages)

2024-2027

February 2025
v0.7

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1. Executive Summary

1.1. Why have we produced this strategy?

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.

Significant progress has been made during the first two years of delegated commissioning in BNSSG including:

1. Increasing the minimum rate paid to providers above the national minimum of £28 to £30 to assist practices with recruiting and retaining staff
2. Offering an enhanced rate to providers for additional activity above 2023/24 with a forecast to deliver in excess of 45,000 more UDAs during 2024/25 (when compared to the previous year)
3. Collaborative working with all underperforming providers to identify the support required and opportunities to release activity for areas most in need
4. Offering a 'golden hello' bonus incentive payment of £20,000 per dentist to help practices that are struggling to attract people through the usual recruitment routes (8 places)
5. Increasing the provision of stabilisation services to ensure patients are able to access care that stabilises their oral health and reduces the likelihood of people going in and out of the urgent care system, or of receiving no treatment at all (8 practices providing in excess of 22 sessions per week, procurement for 25/26 due to be completed imminently)
6. Reopening of the St Pauls dental practice in February 2024 under a new provider following the closure in June 2023. The contract includes mandatory services (routine check-ups for patients on the practice books) and dental public health (treatment courses to get people dentally fit)
7. New practice in Winterbourne, South Gloucestershire (opened August 2024)
8. Additional services for children in care / children looked after (commenced August 2024)
9. Supporting all NHS practice staff to complete continuing professional development during 2024/25 (in accordance with requirements of General Dental Council) through additional funding
10. Additional urgent dental care appointments for those without a regular dentist accessed by calling NHS111*
11. Introducing a Supervised Toothbrushing scheme fully operational in schools for 3–5-year-olds (nursery, and reception children), extending the number of settings to help more children
12. First Dental Steps schemes where Health Visitors give oral health packs to parents of babies and siblings in targeted areas.

* Further work is underway following the NHS England notification of 21 February 2025 that the ICB is required to purchase 19076 additional urgent care appointments over and above the current baseline as part of the governments objective to deliver 700,000 appointments nationally.

Producing this strategy has required a collaborative approach, working with stakeholder colleagues and organisations across BNSSG dental provision, public health, and oral health promotion 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.

1.2. Why is this strategy so important?

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, workplaces, adult social care settings, prison health, early years settings and schools, drugs and alcohol services, and foster carers.

1.3. Access to an NHS dentist

The latest national report which has been published is from August 2023 (up to June 2023), this shows that the percentage of the adult population seen by an NHS dentist within the previous 24 months in BNSSG is 38.40% which is similar to 38.6% in 2021/22 but less than 2020/21 (44.9%). The percentage of the child population seen by an NHS dentist within the previous 12 months in BNSSG is 55.09% which is an increase from 49.2% in 2021/22 and an increase from 36.9% in 2020/21.

The latest Department of Health and Social Care Fingertips profile up to September 24 shows the following but it should be noted that increases in activity have been identified since this time:

Proportion of adults seen by an NHS dentist in last 24 months (18+ yrs) Sep 2024 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	17,392,375	39.1	39.1	39.1
South West NHS Region	↓	1,417,297	31.1	31.1	31.2
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board - QUY	↓	280,436	36.4	36.3	36.5
NHS Dorset Integrated Care Board - QVV	→	219,060	34.6	34.5	34.7
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board - QOX	↑	229,466	31.2	31.1	31.3
NHS Cornwall and the Isles of Scilly Integrated Care Board - QT6	↓	139,626	29.9	29.8	30.1
NHS Devon Integrated Care Board - QJK	↓	285,989	29.1	29.0	29.2
NHS Somerset Integrated Care Board - QSL	↓	126,056	27.9	27.7	28.0
NHS Gloucestershire Integrated Care Board - QR1	→	136,664	26.7	26.6	26.9

Figure 1 Proportion of Adults seen by an NHS dentist in the last 24 months (18+ yrs)- Sept 2024. Available at: https://fingertips.phe.org.uk/profile/dental/data#page/1

Proportion of children seen by an NHS dentist in last 12 months (<18 yrs) Sep 2024 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	6,572,731	54.4	54.3	54.4
South West NHS Region	↑	537,394	48.2	48.1	48.3
NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board - QUY	↑	106,757	53.9	53.7	54.1
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board - QOX	↑	102,709	52.6	52.4	52.8
NHS Dorset Integrated Care Board - QVV	↑	71,151	49.4	49.1	49.7
NHS Gloucestershire Integrated Care Board - QR1	→	63,157	48.7	48.5	49.0
NHS Cornwall and the Isles of Scilly Integrated Care Board - QT6	↑	52,213	47.8	47.5	48.1
NHS Devon Integrated Care Board - QJK	↓	97,355	42.9	42.7	43.1
NHS Somerset Integrated Care Board - QSL	→	44,052	39.6	39.3	39.9

Figure 2 Proportion of children seen by an NHS dentist in the last 24 months (18+ yrs)- Sept 2024. Available at: https://fingertips.phe.org.uk/profile/dental/data#page/1

In 2018/19 the number of Units of Dental Activity* contracted in BNSSG was 1,534,402 and at the end of the year 1,441,942.60 had been delivered (94%). In 23/24, 1,461,307 UDAs were contracted with 971,907 delivered (67%). For Units of Orthodontic Activity** the number contracted, and performance remained the same between 18/19 and 23/24 with an overall performance of 101%. The rates for UOAs are much higher than UDA.

*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.

The local data for children in care reviewed in 2023/24 showed a significant shortfall of the 100% target for children to be seen by a dentist in the previous 12 months (ICB 75%) this was particularly low in North Somerset at 65% (53% have seen a dentist, 12% did not need to see one). This is expected to improve significantly as new services commenced during summer 2024 (updated data awaited).

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 aim of the strategic plan is to demonstrate how we are prioritising identifying the areas of the population that need access to NHS dentistry and supportive services the most. Underpinned by completing equality impact assessments for each key decision we will continually apply a framework of proportionate universalism which seeks to improve health for everyone (where national financial allocations allow), but with a greater focus on those who need it. The need to support recruitment and retention of dentists is just as essential to maintaining services and enabling dentists to meet their contractual obligations.

Returning to prepandemic levels will be challenging for the ICB because the current financial allocation is based on under delivery of contracts and does not cover the entire population. In addition, Dentists have continually raised concerns nationally regarding the current contract introduced in 2006 and contract reform is still awaited. 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 3.

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. The South West Oral Health Needs Assessment completed in 2021 reported that in Bristol there are higher levels of Oral Cancer at 17.28 per 100,000 population, higher than the England average of 14.6. The incidence of oral cancer in Bristol, Plymouth, Bournemouth, Christchurch and Poole, Torbay, Cornwall and Dorset is higher than the national average. There is, however, significant variation within the region from 19.9/100,000 in Plymouth to 11.9/100,000 in South Gloucestershire (12.4 in North Somerset). 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 local dental staff survey was also completed (all dental staff in BNSSG), and the feedback has been integral to the development of this draft strategy. Further engagement with the public and staff was completed in summer 2024 and the feedback included as part of this has been incorporated where possible into this update.

The 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. Delivering this strategy will require a robust governance structure to be in place which continues to bring together all key stakeholders across the ICB.

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

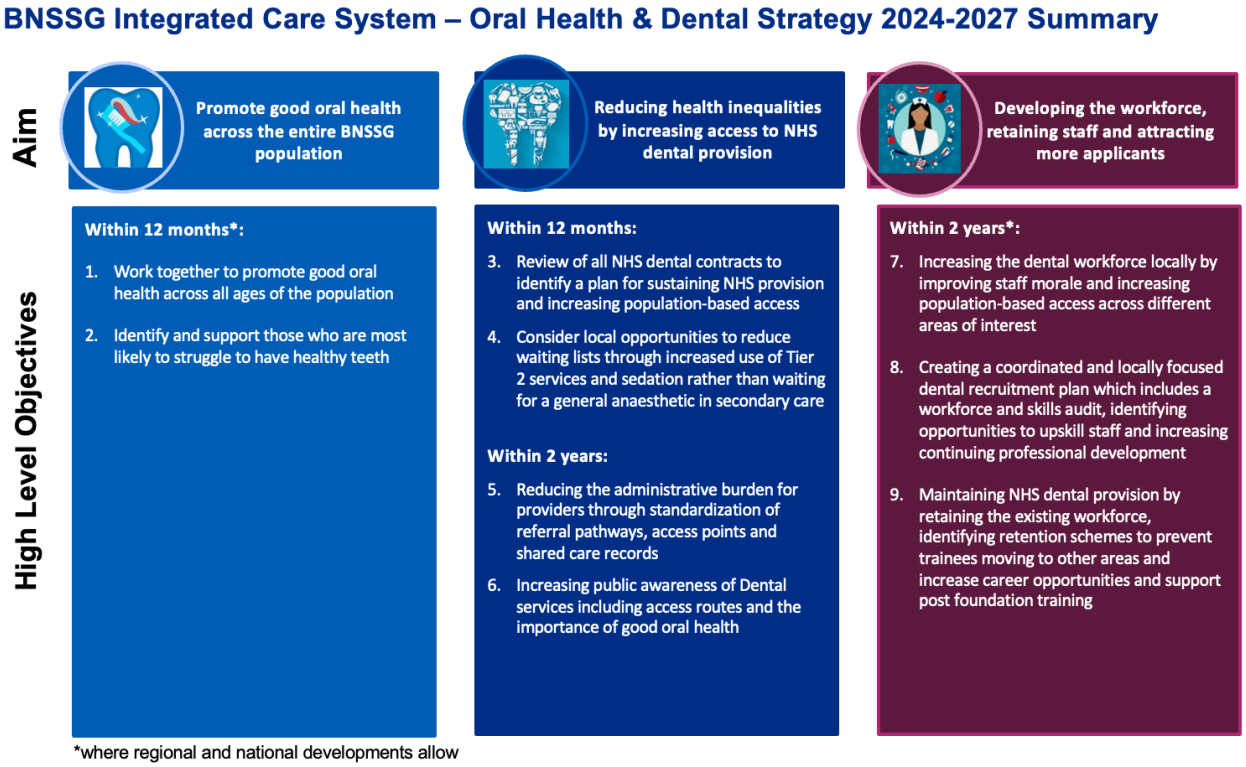


Figure 3 BNSSG ICS Strategy summary

1.4. How will we monitor improvement?

The following metrics have been identified but will require further analysis and developments across the years of implementation (it is also intended to revisit the previous staff survey to assess changes as part of the workforce programme):

Table 1 Strategy aims and indicators across the years of implementation

Strategic Aim	Indicator	Source	19/20	24/25	25/26	26/27
 **Promote good oral health across the entire BNSSG population**	Number of 3-5 year olds taking part in the supervised toothbrushing programme	Local contract monitoring data	N/A	12860	16340	To be confirmed
	Hospital admissions for dental caries (0 to 5 years) registered per 100,000 head of population	Public Health Profiles, Department of Health and Social Care	414.2	To be confirmed as recent years data not published		
	Prevalence of experience of dentinal decay in 5 year old schoolchildren in the South West	Office for Health Improvement & Disparities: National Dental Epidemiology Programme (NDEP) for England: oral health survey of 5 year old schoolchildren.	Bristol 15.5	17.8	To be confirmed jointly with local authority oral health leads as part of BNSSG Oral Health Network	
			NS 13.9	25.9		
			SG 14.3	12.8		
	Oral cancer registrations per 100,000 (directly standardised rate)	Public Health Profiles, Department of Health and Social Care	Bristol 17.7	No data available since 2019, updates awaited.		
			NS 12.3			
			SG 12.7			
 **Reducing health inequalities by increasing access to NHS dental provision**	Percentage of the adult population seen by an NHS dentist within the previous 24 months	Public Health Profiles, Department of Health and Social Care.	36.40%	38%	40%	43%
	Percentage of the child population seen by an NHS dentist within the previous 12 months	Business Services Authority official year end statistics (reported directly but also monitored through the NHS South, Central and West National Dental Commissioning geospatial tool).	53.90%	55%	58%	60%
	Number of Units of Dental Activity commissioned		1,534,402	1,451,791	1,451,791	1,451,791
	Number of Units of Dental Activity delivered		1,441,942	987217	1045290	1074325
	Overall performance on UDA contract		94%	68%	72%	74%
	Number of urgent care appointments commissioned		To be confirmed following notification from NHS England on 21 February 2025 that the ICB is required to purchase 19076 additional urgent care appointments over and above the current baseline (awaiting confirmation of current baseline from Business Services Authority)			
	Number of urgent care appointments delivered	Business Services Authority data and local data returns.				
 **Developing the workforce, retaining staff and attracting more applicants**	Number of dentists who joined the NHS	Business Services Authority official year end statistics. Based on joiners and leavers across each year since 2020/21 (at end of 2023/24 38 dentists joined the NHS and 46 left). Further metrics to be agreed.	35*	38	40	40
	Number of dentists who left the NHS		37*	35	32	28

*2020/21 figure
**2018/19-2020/21

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

2.1. What else 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:

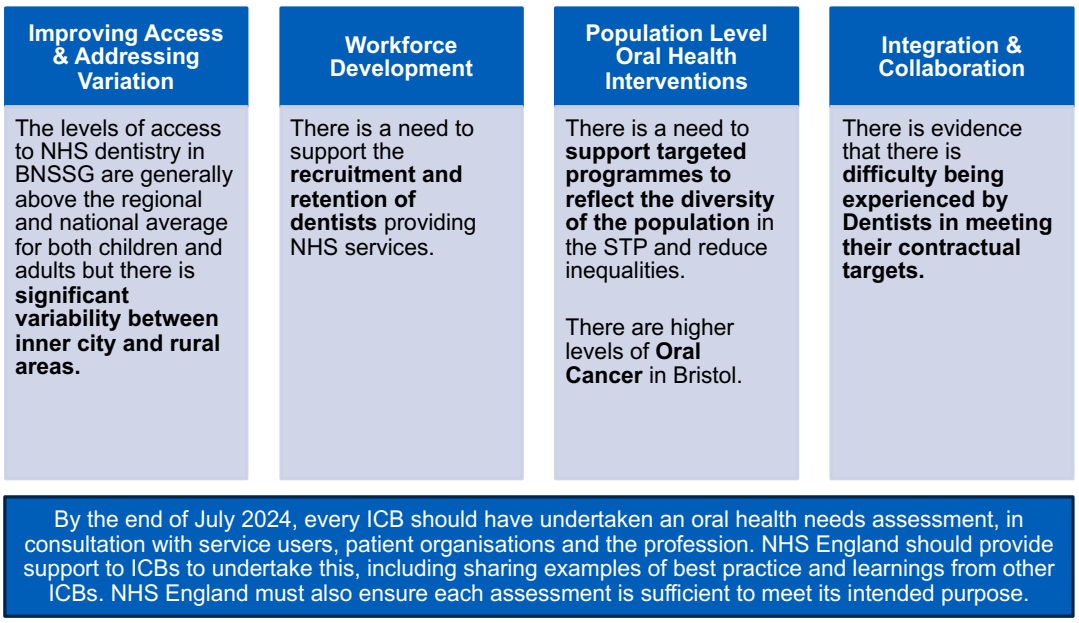


Figure 4 NHS England and NHS Improvement South West of England Oral Health Needs Assessment January 2021: Key recommendations for BNSSG grouped under relevant headings

2.2. 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. The 2023/24 year-end data from the Business Services Authority shows that 10/98 UDA contracts in BNSSG delivered under 50% of the contract with 21 contracts providing between 50-75%. Positively, 32 contracts have delivered above the 96% target with 18 of the 32 exceeding 100% and 35 achieving between 75 and 96%.

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 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 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 felt 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.

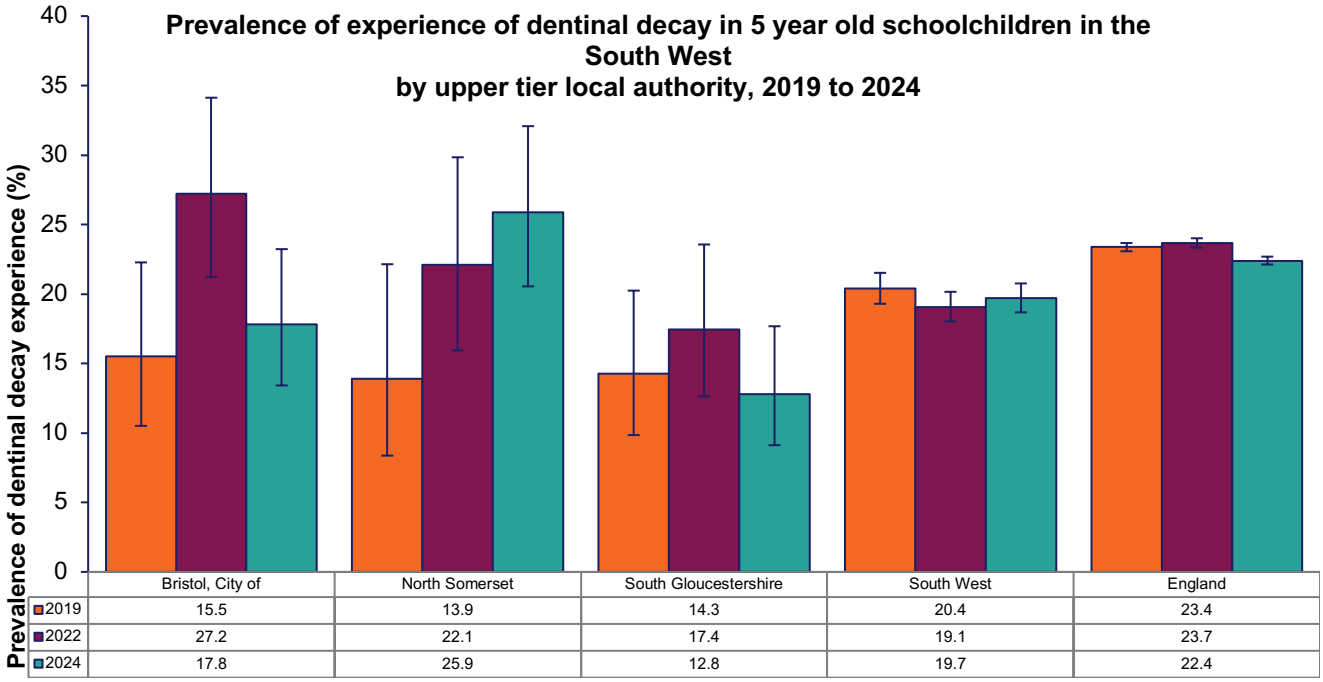
2.3. Core20plus5* – Children & Young People

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 'ask' 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 is 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.

Results of the National Dental Epidemiology Programme (NDEP) survey which took place in the academic year ending 2024 published by the Office for Health Improvement and Disparities Dental Public Health team found the following which further evidences the need for BNSSG to increase access and targeted interventions:



	Bristol, City of	North Somerset	South Gloucestershire	South West	England
2019	15.5	13.9	14.3	20.4	23.4
2022	27.2	22.1	17.4	19.1	23.7
2024	17.8	25.9	12.8	19.7	22.4

Figure 5 Prevalence of experience of dentinal decay in 5-year-old schoolchildren in the South West

3. Collaborative development of 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.

Producing this strategy has required a collaborative approach, working with stakeholder colleagues and organisations across BNSSG dental provision, public health, and oral health promotion 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.

Further engagement on the previous draft strategy was undertaken in Summer 2024 and has been incorporated into this version. This included an online survey and presenting at forums such as the Bristol Community Forum which includes all voluntary sector partners. Overall the feedback included:

- Reducing the size of the original strategy and being more specific
- To focus more on the objectives, timelines, outcomes and metrics to evaluate progress
- Need for a stronger focus on children and reducing health inequalities including asylum seekers, people with learning disabilities, mental health, care leavers*

*Further work is underway with public health leads across the local authorities and region to ensure that additional services or interventions are prioritised in the areas of high need and are tailored to meet the needs of the relevant populations.

3.1. What is currently happening in oral health promotion?

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, 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. There is now an Oral Health Improvement Working Group in place that has started to work together (the local authorities and related services) to identify opportunities 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. Oral Health Promotion and (separately) Oral Health Surveillance are both included with the community dental service provided by the University Hospitals Bristol and Weston NHS Foundation Trust Dental Hospital. Recognising challenges with recruiting staff, the ICB and local authority leads are working closely with the service lead to redesign the health promotion that is delivered to ensure this continues to meet the needs of the population.

3.2. Dental Provision in BNSSG

There are currently 96 NHS primary care dental contracts across BNSSG together with 3 urgent care plus contracts, 8 stabilisation providers and 13 orthodontic contracts. University Hospitals Bristol and Weston NHS Foundation Trust Dental Hospital provides secondary care services and includes the Primary Care Dental Service.

The following map is taken from the South Central West geospatial dental mapping tool which uses national reporting data from the latest national reports, the period currently shown is January to June 2024 and the key relates to contract delivery. Not all practices shown have continued to provide NHS services in 2024/25, two contracts were handed back, with one merging.
University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) Primary Care Dental Service provides the following Services, many of which are co-located:

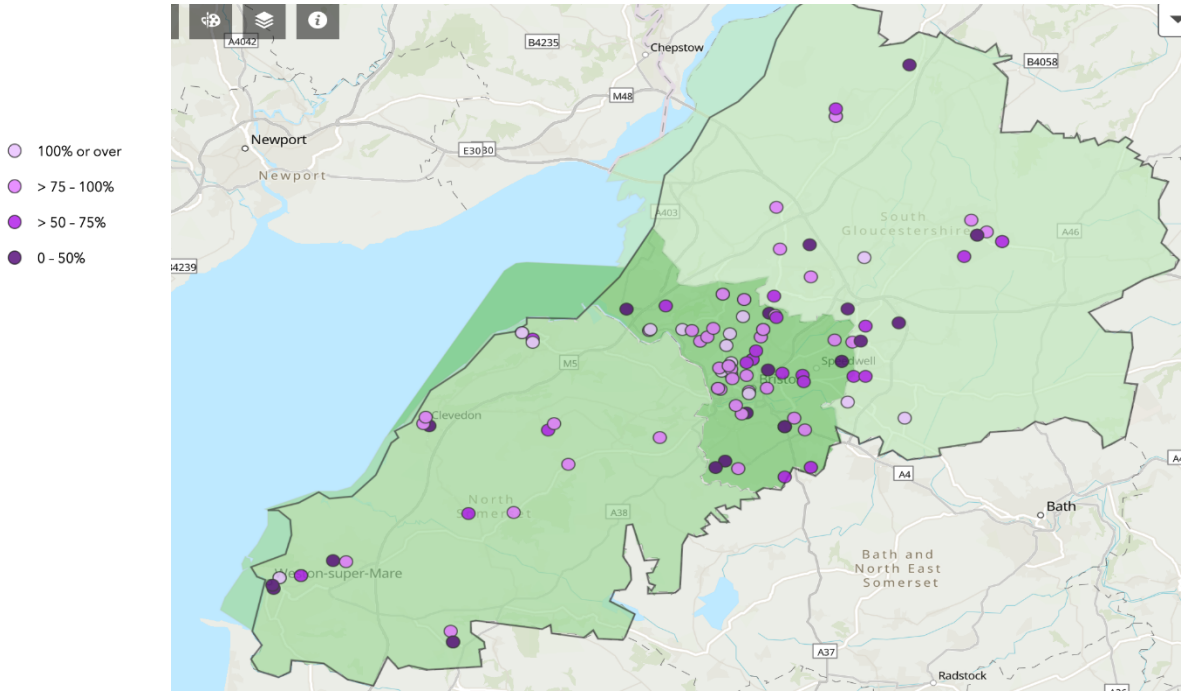


Figure 6 BNSSG Dental locations and reporting from January-June 2024

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, as well as 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 national epidemiological survey. This survey takes place every 2 years in order to collect oral health information of 5 year olds who attend mainstream, state-funded schools across England and is carried out as part of the OHID National Dental Epidemiology Programme (NDEP).

The aim of the survey was to measure the prevalence and severity of dentinal caries among 5 year old children within each lower-tier local authority (data shown on page 9). This was to provide information to local authorities, the NHS and other partners on the oral health of children in their local areas and to highlight any inequalities.

3.3. Bristol Dental School

University of Bristol Dental School offers both undergraduate and postgraduate training and is ranked 3rd in the UK for dentistry (Complete University Guide Subject Rankings 2025).

Bristol Dental School moved to a £36million purpose-designed clinical training facility near Bristol Temple Meads station in September 2023. The state-of-the-art 119 dental chair clinical training facility supports students to put theory into practice in a primary care environment, working with the local community and NHS stakeholders to offer treatment free-of-charge to patients who meet the training needs of the Dental School.

A new operating model (including CQC registration) enables Bristol Dental School to deliver clinical activity provided by dental students and provides flexibility to manage the space and patient lists. Engagement with dental students, local communities, Healthwatch BNSSG, Bristol City Council, local, regional, and national NHS bodies was instrumental in the development of its new operating model.

There continues to be a strong link between Bristol Dental School and Bristol Dental Hospital through specialist placements for undergraduate and postgraduate students who work alongside NHS Consultant clinics. Bristol Dental Hospital continues to provide specialist secondary and tertiary level NHS services.

In the first 10 months of operating the Dental School, dental undergraduates have delivered nearly 17,000 patient appointments and have seen 1,500 Urgent Dental Care patients referred through NHS111. Bristol Dental School students have treated nearly 500 patients referred from local general practices and have accepted nearly 400 children following patient recruitment in local primary schools. Bristol Dental School students have been engaging with local care homes to provide Oral Health Education to carers in partnership with the charity Bridge2Aid. The students have provided this to over 100 carers at 16 care homes and 2 reablement centres who provide care for over 700 residents across Bristol. Bristol Dental School will continue to expand its portfolio of education activity to support the NHS long term workforce plan, and to equip dental professionals with an enhanced skillset through their postgraduate programmes.

4. Key themes for developing an Oral Health & Dental Strategy in BNSSG

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

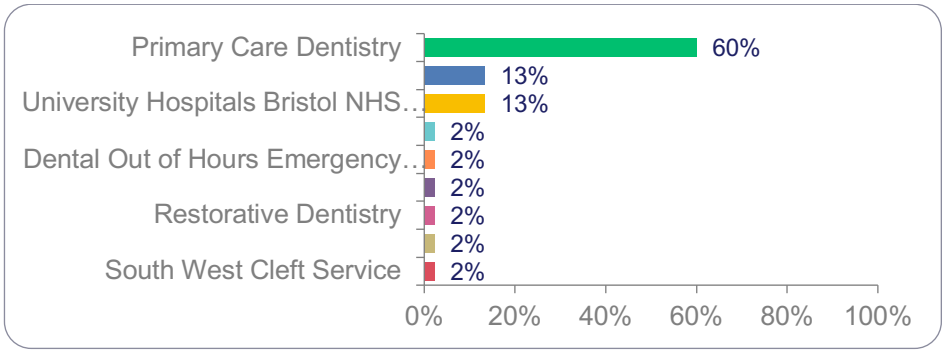
The second workshop prioritised each area under the headings of:

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

4.1. 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:

4.2. 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

5. Strategic Plan

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

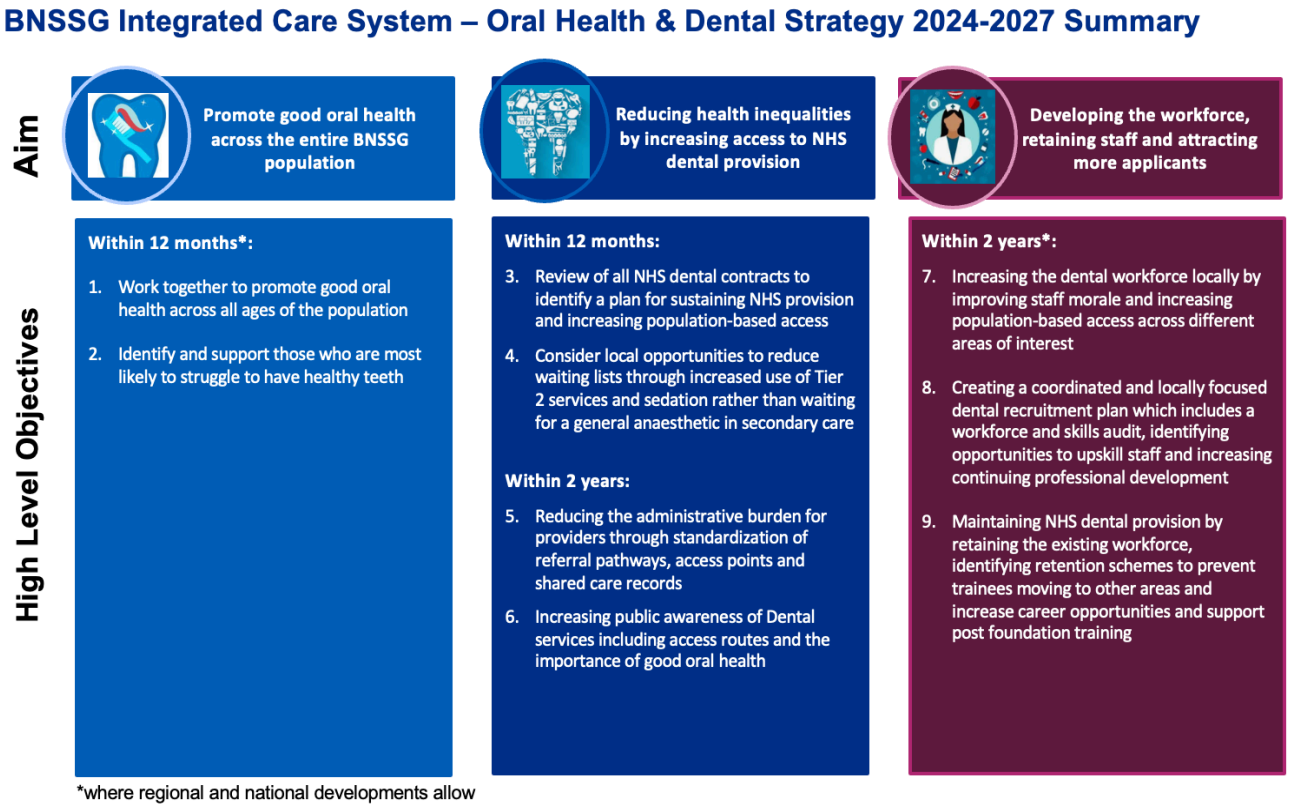


Figure 7 BNSSG ICS Strategy summary

Please see the strategic plan in appendix 1 which describes the actions, outcomes, metrics to evaluate impact, investment identified so far and the working groups responsible.

6. Conclusion

The workshops, survey and further engagement 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.

Positive progress has been made in BNSSG regarding increasing the number of UDAs delivered, recovery of underperforming contracts and reducing contracts where possible to release activity. The intention for the next steps of the strategic plan is to ensure that access is further increased in areas of most need or universally where this may not always be possible. The affordability of the possible options need to be further assessed following the notification from NHS England on 21 February that the ICB is required to purchase 19076 additional urgent care appointments over and above the current baseline (awaiting confirmation of current baseline from Business Services Authority). The ICB is fully committed to increasing access where the current financial allocation and national contract allows.

The ICB continues to work closely with providers across the integrated care system and colleagues from the Local Dental Committee (LDC) on the actions needed to improve population oral health throughout 2024-2027. This has included offers of further support and flexible commissioning within the current contract where this meets the population needs and enables providers to remain with the NHS.

The governance structure required to manage this programme is as follows:

Proposed Governance Structure For BNSSG Dental Programme 2024-2027

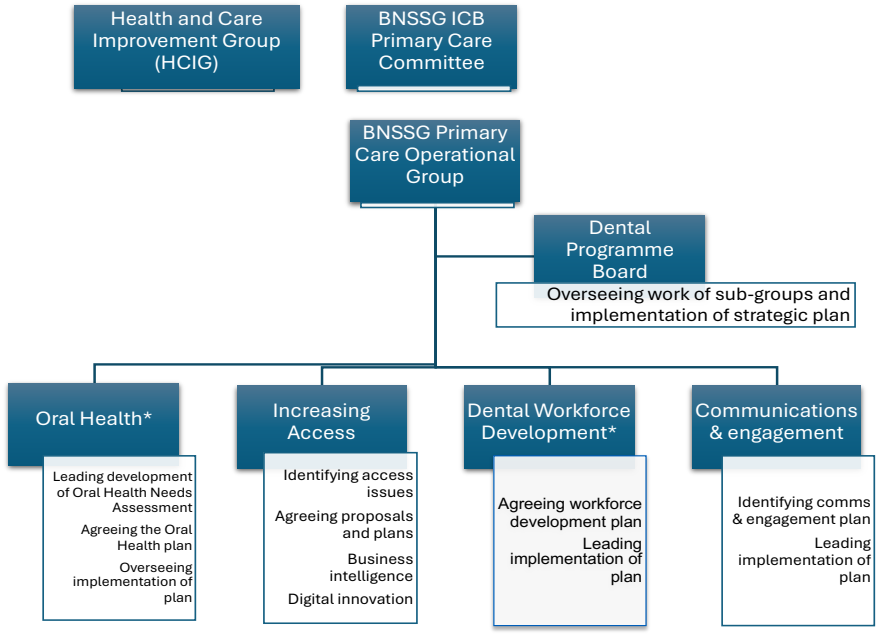


Figure 8 Proposed Governance Structure for BNSSG Dental Programme 2024-2027

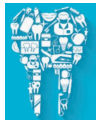
7. Appendices

7.1. Appendix 1: High level strategic plan

Status Key
Completed
On Track
Mainly on track with some issues
Not on track with major issues

Strategic Aim	Objectives	Action	Outcomes	Metrics	Investment	Owner	Completion Date	Status
 **Promote good oral health across the entire BNSSG population**	**High Level Objective 1:** **Work together to promote good oral health across all ages in our population by:** **1. Identifying existing local data and insights regarding population needs** **2. Completing local needs assessments and oral health surveys** **3. Developing evidence-based, integrated, co-created and targeted local action plans with stakeholders across the system**	1.1 Identify opportunities to embed oral health in other areas of service provision (including commissioning training & development of specifications): Child examples (building on First Dental Steps Programme): 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, the substance misuse service, care home policies, asylum seeker services, stop smoking services, leisure centres, and MECC (make every contact count) in pharmacies and primary care.	1.Targeted interventions leading to improved outcomes in high need areas (to be further identified, children to be a priority) 2. Increased access to support services for high risk population 3. Supporting patients accessing the right care at the right time 4. Local authorities & ICB will meet statutory requirements in terms of access and annual reporting 5. Making use of existing resources 6. Link with other work programmes strategic objectives such as Healthy Weight on working with policy makers 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.	Number of children and settings benefiting from targeted interventions such as supervised toothbrushing A&E attendance and admissions data for dental issues/decay (in particular children) Percentage of children with visually obvious dental decay (latest oral health survey) Intelligence on toothbrushing patterns for children and adults Oral cancer prevalence rates in each area Increase in achievement of related statutory requirements for Local Authority & ICB Records of collaborative working across all areas of the BNSSG system Increased data intelligence & insights from underserved communities	Supervised Toothbrushing Programme: £257,000 Children in care additional services: £140,000 Cancer Action Support Practice pilot: £250,000	System Wide Oral Health Working Group	Dec-25	Mainly on track, could be some challenges given long term ambition to increase data collection and national context outside of system control
		1.2 Identify opportunities to influence the emerging national, regional and local policies (including national contract lobbying)						
		1.3 Agree a plan for a cost-effective, sustainable & evidence-based oral health promotion programme for early-years and Key Stage 1 children (which may include, but not limited to, a whole school / setting-based approach to oral health including creating a supportive environment, supervised toothbrushing, toothbrush distribution, fluoride varnish programmes)						
		1.4 Identify a plan which seeks to reduce oral cancer risk and incidence (in particular in Bristol). For example: optimising Human Papilloma Virus vaccine uptake, work closely with services such as alcohol and substance misuse services and stop smoking						
		1.5 Develop an evaluation plan to assess the effectiveness of oral health promotion programmes. 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**	2.1 Work with the voluntary sector and other key stakeholders to improve 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.						
		2.2 Identify cost effective, evidence-based, targeted oral health promotion initiatives and programmes for those most as risk of poor oral health						
		2.3 Agree a plan for sustainable delivery of oral health promotion programmes for >8 years developing existing voluntary sector links, training staff and carers, and developing of environments supportive to good oral health (informed by needs assessments due to be completed in September 2025)						

Status Key
Completed
On Track
Mainly on track with some issues
Not on track with major issues

Strategic Aim	Objectives	Action	Outcomes	Metrics	Investment	Owner	Completion Date	Status
 Reducing health inequalities by increasing access to NHS dental provision	High Level Objective 3: Review of all NHS dental contracts to identify a plan for sustaining NHS provision and increasing population-based access	3.1 Identify areas of most need based on access rates, deprivation profiles and number of practices performing in the area to inform further investment / procurement for additional activity (rapid procurement process to be completed by April 2025) 3.2 Review all existing contracts and related performance to identify opportunities to release activity for areas of high need 3.3 Complete an assessment of current UDA rates to agree a minimum value and/or enhanced rate (prior to national contract reform). Completed and implemented in October 2024. 3.4 Consider opportunities for targeted access additional services starting with children in care and consider other population groups such as care homes (building on previous examples), those experiencing homelessness (building on support of outreach services), asylum seekers and those with Learning Disabilities. Children in care commenced in August 2024. 3.5 Review the current provision of stabilisation and urgent care to ensure it meets patient demand and the referral pathway is robust (related to objective 6 regarding a communication plan to ensure patients are aware of the services available) 3.6 Review local and national data to understand the reasons patients do not attend for their appointments and increase attendance where possible under the current contract in order to reduce wasted appointments (recognising that this is particularly an issue in more deprived areas and abuse towards staff has increased when patients are told after not attending on several occasions they cannot be seen). 3.7 Identify further opportunities for digital innovation being mindful of the digital poverty that exists and restricted availability of digital solutions in dental services	1. Increasing access at scale and proportionate to the degree of need 2. Creating a positive relationship between the ICB & practices 3. Releasing activity from consistently underperforming practices to reinvest 4. Ensuring contracts are deliverable reducing the level of debt practices accrue 5. Improved outcomes and reduced pain for the relevant populations 6. Understanding the demand for services to ensure capacity is aligned (where financial allocation allows) 7. Reducing abuse towards staff due to lack of access 8. Ensuring productive pathways of care supported by digital innovation and robust capacity planning 9. Attracting and retaining staff by feeling valued and increased opportunities 10. Meeting Operational Plan trajectory to return to prepandemic levels of access	Number of UDAs & UOAs commissioned and delivered (to align to operational planning trajectory) Improved access rates in areas of most need Increased percentage of children in care seeing a dentist within 12 months Number of urgent care / stabilisation appointments commissioned and delivered A&E attendance and admissions for dental issues/decay (in particular children)	New practice in Winterbourne: £867,300 Increasing access: £3,200,000 for enhanced rate & £630,000 for permanent UDA uplift Orthodontics: £247,372.83 Stabilisation: £698,300 Urgent Care: £545,809	Increasing Access Working Group	Apr-25	Mainly on track, could be some challenges given national context outside of system control
	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	4.1 Working collaboratively with the Bristol Dental Hospital and Managed Clinical Networks to understand the main reasons BNSSG patients are waiting for treatment in secondary care and developing a mutually agreed remedial action plan (reflecting all recommendations made by Getting It Right First Time which include guidance on activity recording, coding, skill mix and digital referrals) 4.2 Co-design solutions which may include further utilising the Tier 2 services available and introducing a local sedation pathway as an alternative to general anaesthesia	1. Reduced waiting times for patients waiting in secondary care 2. Improved patient outcomes related to reduced waiting times 3. Making best use of resources 4. Reduced need for general anaesthesia creating less risk to patients 5. Releasing capacity for those requiring secondary care 6. Local sedation pathway (designed collaboratively)	Reduced waiting times and patient numbers for relevant procedures Increased tier 2 / sedation activity	To be confirmed once need identified	Increasing Access Working Group / BNSSG ICB & Bristol Dental Hospital	Apr-26	
	High Level Objective 5: Reducing the administrative burden for providers through standardisation of referral pathways, access points and shared care records	5.1 Review existing referral pathways and access points to identify a more streamlined approach which may include a Digital Electronic Referral System for referrals from primary to secondary care (linked to 4.1) 5.2 Identify opportunities to share records to improve patient care through increased availability of information and reduce duplicate administration (where national regulations and mandated processes allow)	1. Streamlined/digital referral pathway with auditable data 2. Improved patient care enabled by shared records (where possible)	Number of digital referrals made to secondary care Number of triaged referrals and related outcomes	To be confirmed once need identified	Increasing Access Working Group	Apr-26	
	High Level Objective 6: Increasing public awareness of dental services including access routes and the importance of good oral health	6.1 Develop a public communication and awareness plan including: > a roadmap on how to access services and the importance of good oral health > describing what primary care dentistry is, what UDAs are and how they were set for contracts > increases understanding and appreciation of the finite funding and resources available 6.2 Create a communications plan which considers different levels of understanding and language needs, exploring community champions for translation	1. Public roadmap of services agreed and communicated widely 2. Increased understanding and appreciation of dental services available in BNSSG (for general public and areas of the population with specific needs)	Increased uptake of services available (measured in activity) Reduced abuse to staff through increased appreciation of challenges	To be confirmed once need identified	Communications & Engagement (enabler across all groups)	Apr-26	

Status Key
Completed
On Track
Mainly on track with some issues
Not on track with major issues

Strategic Aim	Objectives	Action	Outcomes	Metrics	Investment	Owner	Completion Date	Status
 **Developing the workforce, retaining staff and attracting more applicants**	**High Level Objective 7:** Increasing the dental workforce locally by improving staff morale and increasing population-based access across different areas of interest	Agree a plan to improve staff morale including: 7.1 Building a support network to enable staff to share common challenges and mutually agree solutions (acknowledging the limited time to attend in person events this needs to ensure that the approach reaches as many staff as possible within the current constraints) 7.2 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 (linked to 1.1 and 3.4) 7.3 Explore further opportunities for improving workplace health & wellbeing (informed by staff network and collaboration with Local Dental Committee leads)	1. Reduce the number of staff leaving NHS dentistry for private or other careers 2. Increased interest in working for the NHS 3. Collaborative and integrated working across primary care NHS services 4. To increase compliance with the recommended training cycle as set out by the General Dental Council (funding provided to practices in 24/25) 5. Increased understanding of how NHS dentistry works and is funded 6. Increase in uptake for apprenticeship schemes 7. Increase in overseas recruitment (where within local gift) 8. Collaborative working with Bristol Dental School to enhance the curriculum and skills of students in the area 9. Skills audit completed which informs capacity planning (if possible given previous challenges) 10. Making best use of resources 11. National contract reform reflecting lobbying 12. Improved staff morale 13. Increase in foundation dentists remaining in the area	Number of NHS staff compared to previous years (where data comparison allows) Number of staff leaving the NHS Additional services activity in areas of high need Increased compliance with General Dental Council training requirements Number of apprentices working in the area Number of staff recruited from overseas Percentage of staff surveyed who see their future with the NHS (using 2023 survey as a baseline) Number of foundation dentists remaining in the area post training	Dental Recruitment Incentive Scheme (Golden Hello): £151,000 Funding for continuing professional development: £1,200,000 Overseas dentist support: £25,000 Clinical Lead for programme: £52,000 Practice Peer Review: £10,000	Dental Workforce Development Working Group	Dec-26	Mainly on track, could be some challenges given long term ambition to increase data collection and national context outside of system control
	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	8.1 Agree a dental recruitment and retention plan identifying a coordinated approach at local level focused on areas of most need 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 (*given challenges with workforce data collection previously this may be too ambitious so further scoping is required)						
		8.2 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	9.1 Further identify retention schemes to prevent trainees from London moving back including guaranteed employment and managing expectations (where within local gift)						
		9.2 Explore opportunities for salaried staff, increases in pay and access to the NHS Pension through national lobbying and appeals for contract reform						
		9.3 Agree combined training offer for dental staff on the areas recommended by the General Dental Council and for clinical staff in business management.						
		9.4 Identify opportunities to increase career support post foundation training focused on population needs						
		9.5 Consider an approach regarding flexible working opportunities to increase work/life balance for staff which is workable for providers (linked to upskilling staff, it may not be possible to identify a solution which works for all parties)						

7.2. Appendix 2: Please see attached presentation describing the outputs from both workshops and the staff survey results.

7.3. Appendix 3: 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/

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

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

Outputs from the Phase 1 & 3 Workshops and staff survey results

Created by
Claire Ripley, Programme Consultant, working on behalf of BNSSG ICB

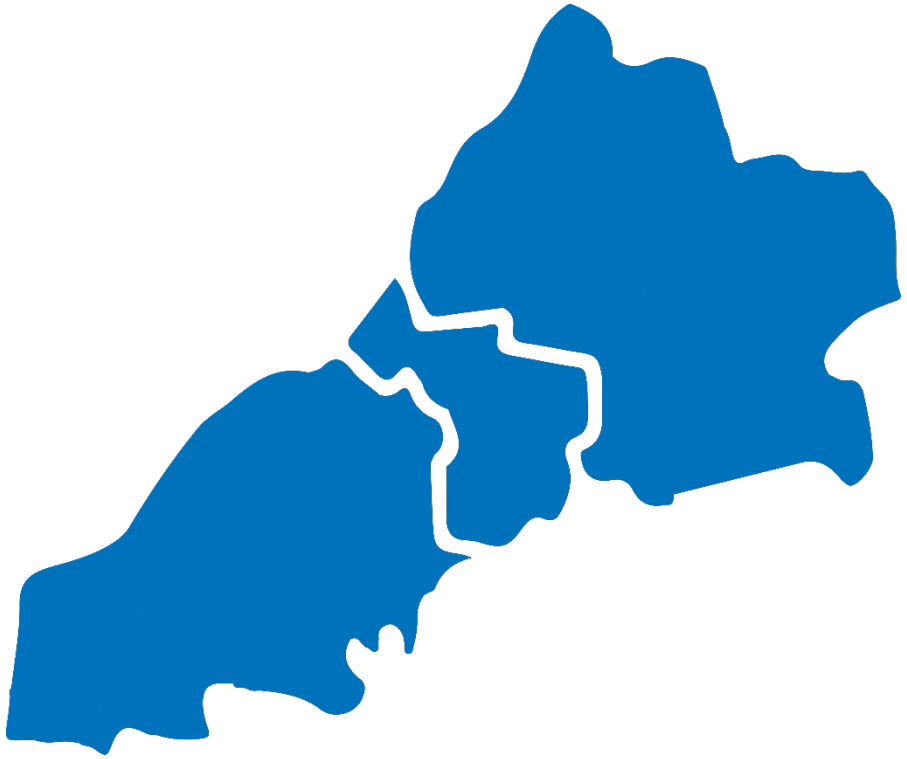
Plan for the development of a BNSSG Oral Health & Dental Strategy

Workshop 1: Breakout Session Outputs - Overall Summary

Improving Access & Addressing Variation	Workforce	Population Level Oral Health Interventions	Integration & Collaboration
Need to undertake a geographically focused review of capacity, contracts and associated local provision to identify aspirations for targeted access particularly for urgent care & hard to reach communities (mix of UDA and sessional rates)	Increase understanding of dental pathways and roles	Complete demand and capacity modelling	Explore opportunities to embed Oral Health in primary care including GP practices and pharmacies (particularly if co-located) and increase awareness between services
Explore opportunities to release funding in some areas to focus elsewhere	Review career progression pathways and upskilling of staff in particular therapists and consider increasing advanced care practitioners	Increase oral health education in care homes, nursing homes and schools	Review opportunities for any possible underspend on Local Authority prevention budgets
Review and standardise referral pathways and access points	Promote career opportunities in schools including apprenticeships	Consider community engagement plans, other Local Authority areas (i.e. healthy weight) and early years services to find opportunities to include Oral Health	Develop urgent care shared care records and referral processes
Explore opportunities to utilise Digital technology	Coordinated approaches to recruitment across the area and focused on applicant work/life balance needs	Complete a skills audit to understand scale of opportunity for the population including outreach services and education	Identify opportunities for the various dental roles to be part of the Enhanced Health in Care Homes Framework
Increase public and professional awareness of how dentistry works	Create opportunities for workforce networking, wider community partnerships and enable staff to feel part of the NHS	Further consider national evidence such as the Advanced Dental Care Review and NICE guidance recommendations on tooth brushing schemes	Review opportunities for utilising existing services such as Diabetic Retinal Screening
Consider health champions in the community which may be building on existing schemes for related areas	Review possibility of salaried positions and access to NHS Pension	Increase HPV vaccine uptake to reduce Oral cancer rates	Explore opportunities for dental students going out to schools, care homes and focus on specific areas
Review reasons patients do not attend and look at reducing rates	Broaden specialty focus including related areas such as Diabetes	Consider Tier 2 services to reduce waiting lists	Utilise existing voluntary sector links with hard to reach communities such as the homeless and asylum seekers
	Focus on retention particularly nurses & therapists	Consider care access routes such as urgent care, 111, stabilisation and opportunities to focus on population needs	Review opportunity for increasing sedation rather than general anaesthetic

Workshop 2, Breakout Session 1:

Gap Analysis



Shaping better health

Breakout Session 1: Gap Analysis

Group 1

- Need increased focus on domiciliary care (including capital investment) and older people plus oral health through ageing
- Consider specific focus on vulnerable adults and children
- Access / urgent care, demand for Dental Hospital
- Consider 20% of flexible commissioning to be focused on 5% urgent care, 5% children, 5% stabilisation – build across all contracts include salaried sessions
- Tier 2 Endodontics is important as well as oral support
- Child friendly dental practices
- Cleft support & cancer supportive practices, post oncology & radiotherapy support
- Referrals to hospital, paediatric referrals are so high that this impacts on urgent care pathway for adults and complaints re high number of rejected referrals (also mentioned within survey)
- Need a roadmap of how to access dentists
- Translation of forms, use community champions and work with other agencies to promote

Breakout Session 1: Gap Analysis

Group 2

- Combine objective 1f (reduce community dental service waiting times for people with Learning Disabilities) with 1a focused on increasing population based access
- Need to explore 3-5 years pilot from Devon considering dataflows and links to Business Services Authority reporting
- Consider child friendly scheme in Greater Manchester, enhanced UDA rates and peer support
- Look at dentist to dentist referral opportunities (Cheddar model)
- Review of stabilisation and sessional rate opportunities
- Consider increased focus on Children in Care, asylum seekers
- Increased peer support from dentists or therapists

Breakout Session 1: Gap Analysis

Group 2 continued

- Base renumeration on time spent with patients – complex needs means double appointment length i.e. autistic child
- Look at spaces large enough for the whole family rather than just child
- Consider opportunities for dental school as low cost but high output, could screen children
- Understand why children are not being referred when needed and ending up in A&E or GP practices
- Prioritise upskilling of workforce and train more dental therapists with the appropriate level of funding
- Further consider links with primary care including GPs and pharmacists

Breakout Session 1: Gap Analysis

Group 3

- Need to further consider the evidence base in order to inform decisions
- Increase understanding of the behaviours of the 51% of those funded and the remaining 49% - how many are entitled to NHS treatment but opt to go private
- Need to increase investment in the workforce i.e. nurses
- Explore opportunities to retain workforce starting in Dental school and foundation training to ensure after 5 years of being qualified staff continue to work for the NHS
- Identify ways to attract more people to train as Therapists (no applicants in some areas)
- Need to look at opportunities for incentives within the current constraints of the contract

Workshop 2, Breakout Session 2:

Prioritisation

Shaping better health

Breakout Session 2: Prioritisation

The 6 considerations:

1. Strategic fit
2. Clinical effectiveness
3. Anticipated health benefits/gains
4. Impact on Health Inequalities / Delivering Health Equity
5. Cost effectiveness (inc. comparison to alternative service models)
6. Help the NHS support broader social and economic development.

The scores determine the following timescales:

Low (< 3 years)	**High** (within 1-2 years)	**Very High** (< 12 months)
15-27.5	28-39.5	40-52

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

Within 12 months*:

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

Within 12 months:

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

Within 2 years:

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

Within 2 years*:

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

Bristol, North Somerset and South Gloucestershire (BNSSG) Dental Strategy: Dental Staff Survey

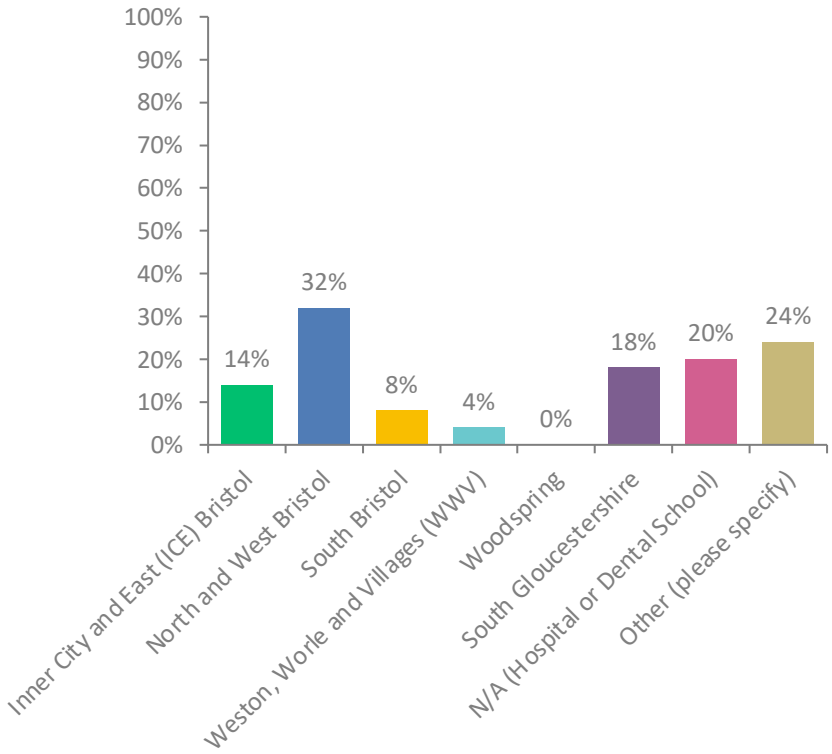
Analysis of 50 responses

Shaping better health

Respondents Profiles: Location and Provider Type

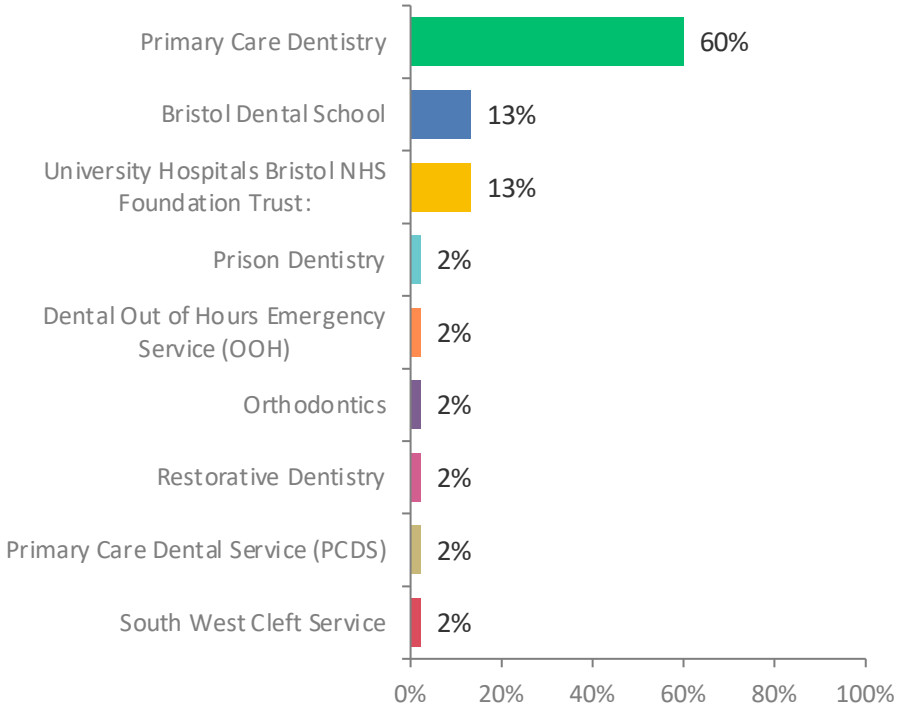
Q1: Which locality do you work in?

Answered: 50 Skipped: 0



Q5: Which organisation do you work for?

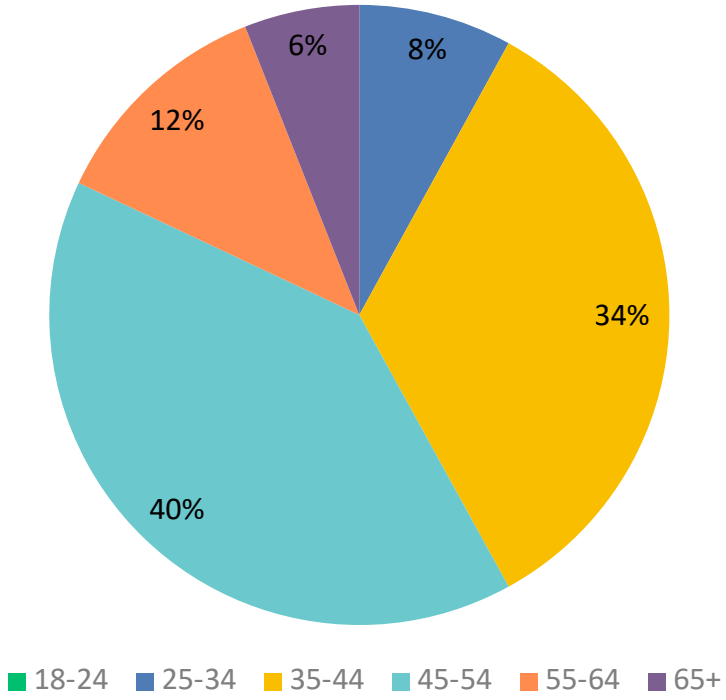
Answered: 45 Skipped: 5



Respondents Profiles: Age and Gender

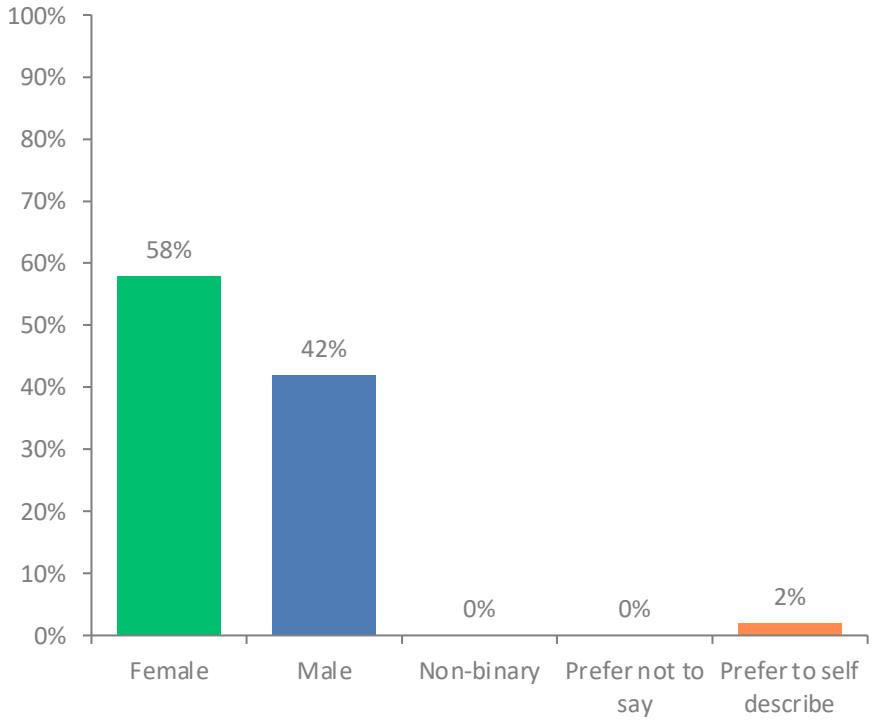
Q2: What age group do you fall into?

Answered: 50 Skipped: 0



Q3: What best describes your gender?

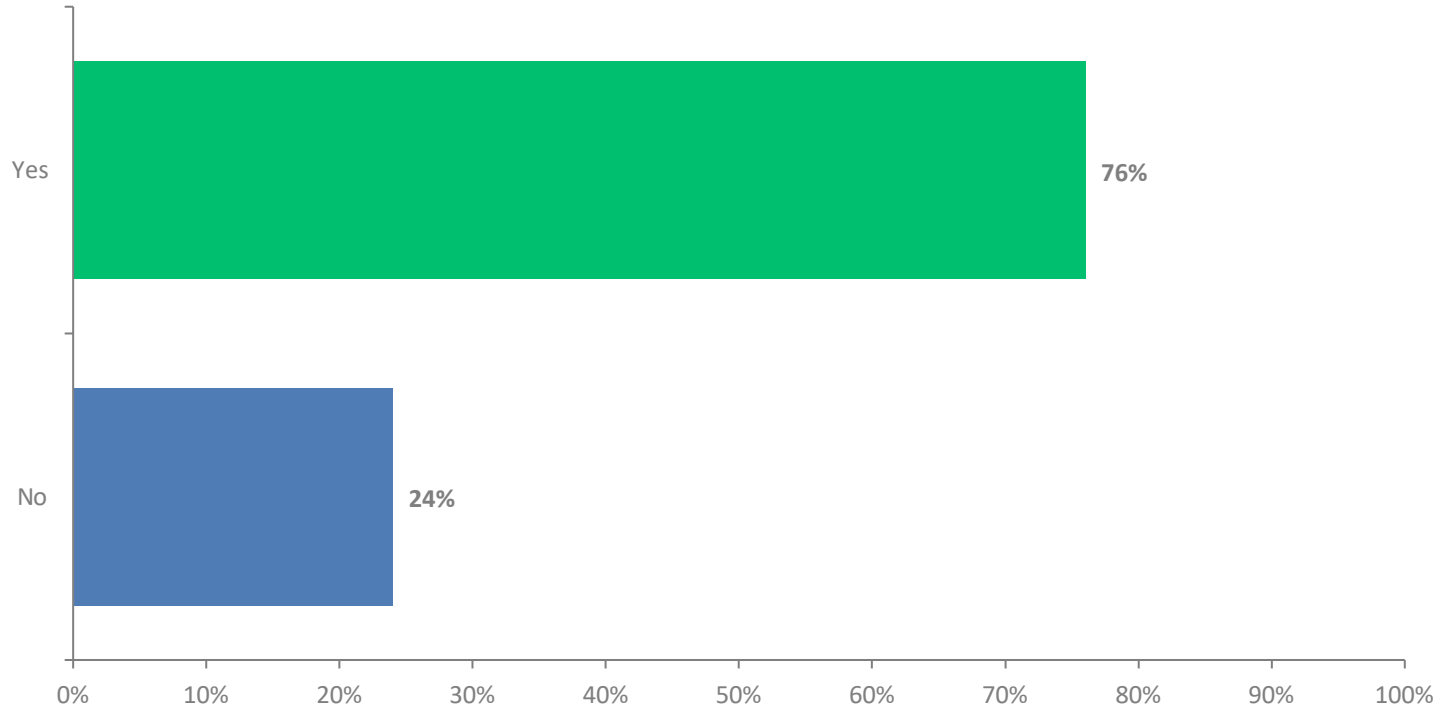
Answered: 50 Skipped: 0



Respondents Profiles: Nationality

Q4: Is English your first language?

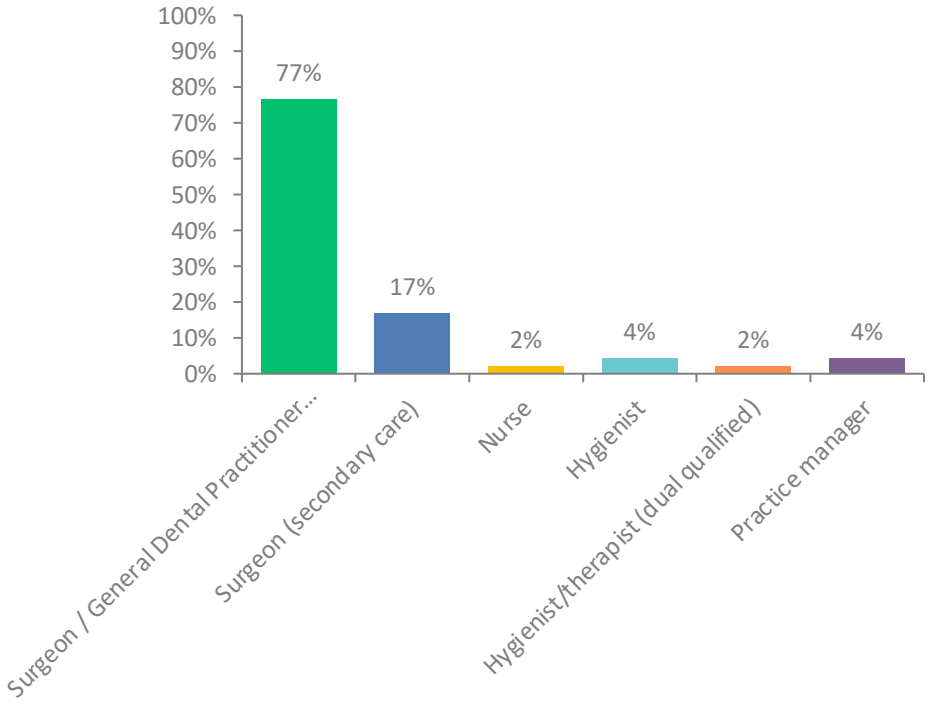
Answered: 50 Skipped: 0



Respondents Profiles: Current Role and Clinical Interests

Q6: What is your primary role?

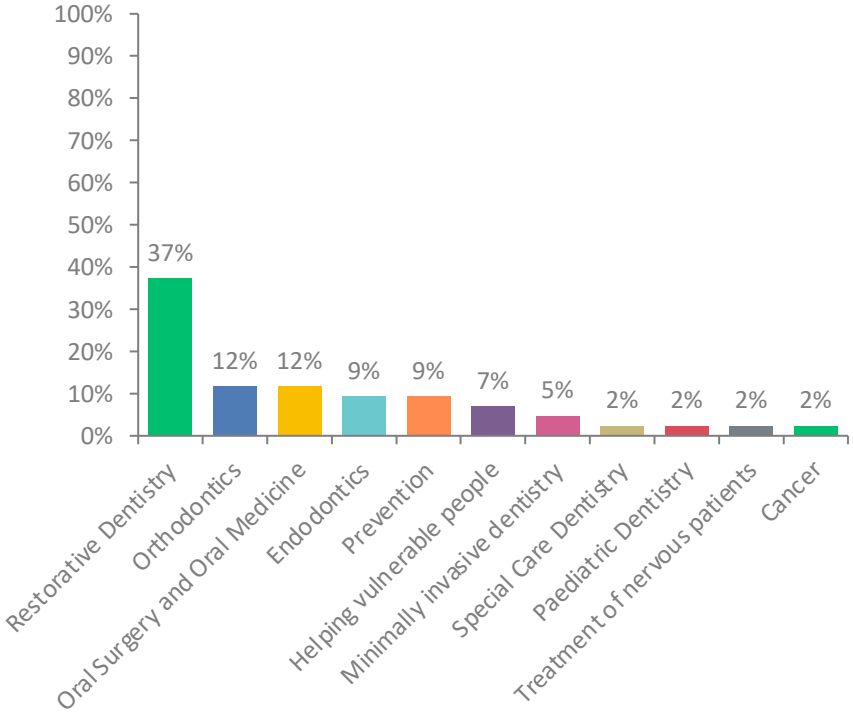
Answered: 47 Skipped: 3



Additional responses: Clinical lecturer, Orthodontist (secondary care), Surgeon (private practices), Dental Tutor, Senior Management in a Corporate

Q8: What are your key areas of clinical interest? (Please tick all that apply)

Answered: 43 Skipped: 7

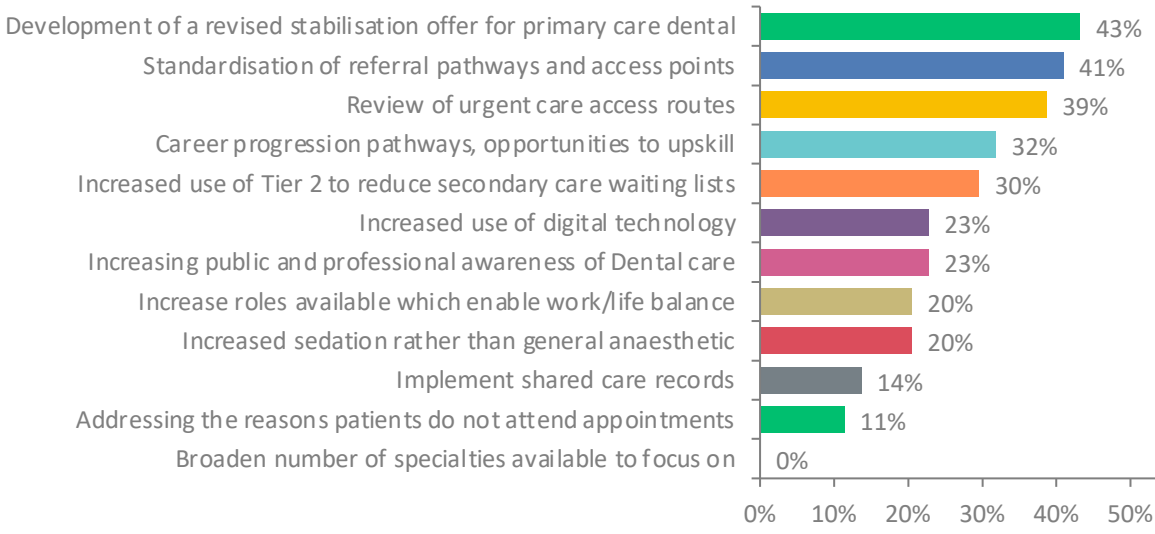


Additional responses: 5 x General Dentistry, General Dentistry, Oral Surgery Sedation, Endodontics / Restorative / Sedation, Specialist in Restorative Dentistry, Prosthodontics, Periodontics and Endodontics, Dental Implantology, Dental Education / Upskilling the workforce

Prioritisation and Barriers

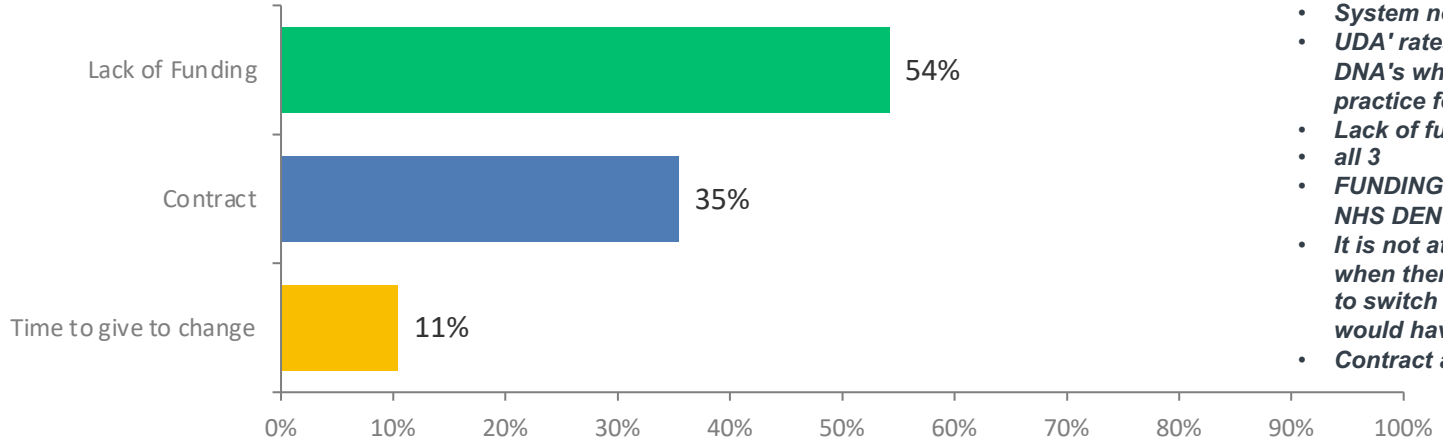
Q9: What would be your top 3 immediate priorities for improving Dental Care in BNSSG?

Answered: 44 Skipped: 6



- ***Increase UOAs so we can treat more children***
- ***Increase UDA value***
- ***Get rid of UDAs and change the NHS primary care contract***
- ***Improved access to dental care for inclusion groups***
- ***The ability to recruit more Dentists- international or UK trained***

Q10: Do you view the barriers for innovation as:

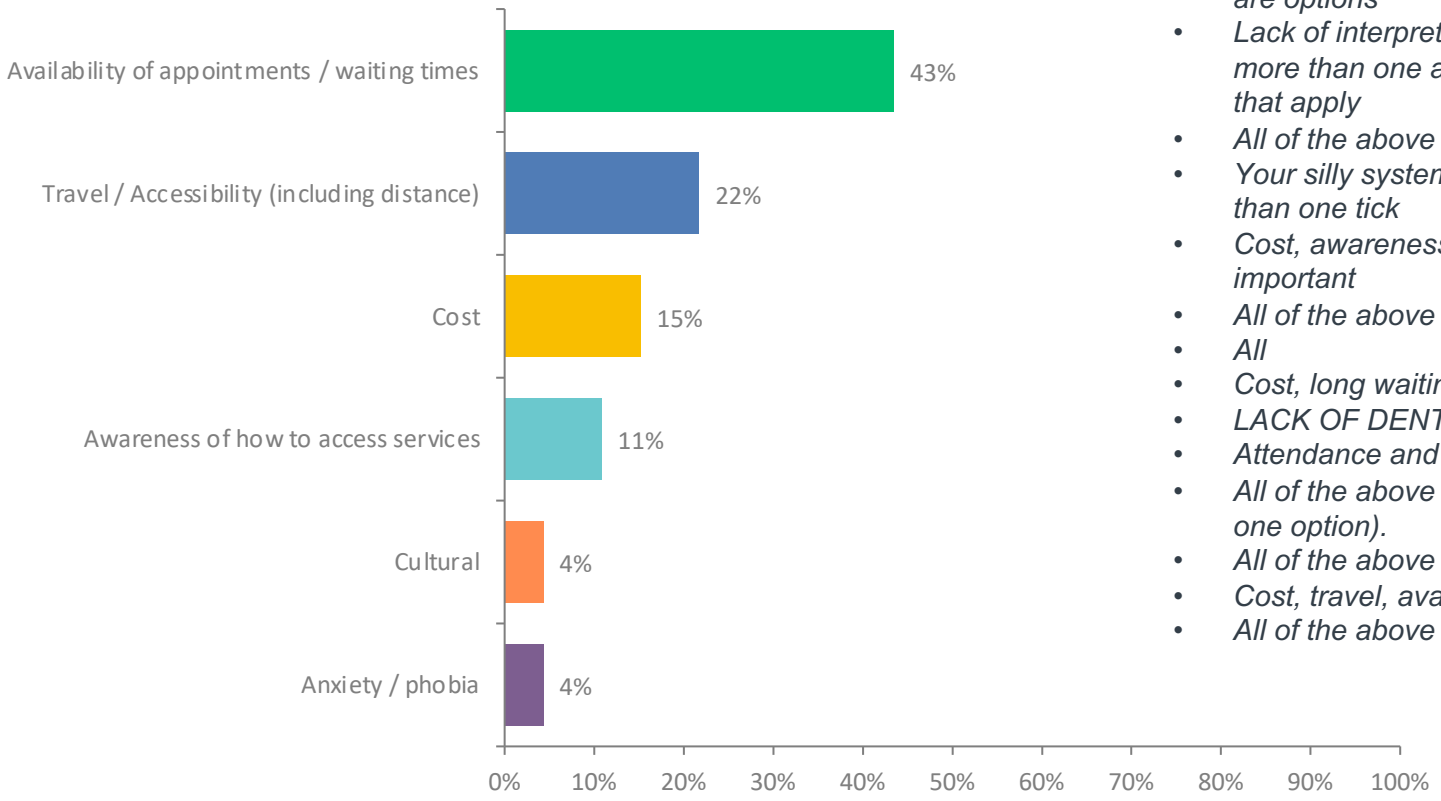


- ***Multiple issues- not enough access to primary care***
- ***System needs reinvention***
- ***UDA' rates very low, High level of DNA's which unfairly penalises a practice for underperformance***
- ***Lack of funding and contract***
- ***all 3***
- ***FUNDING AND COMMISSIONING. NHS DENTISTRY IS DYING***
- ***It is not attractive to work in the NHS when there is a viable Private system to switch to. Otherwise dentists would have gone on strike***
- ***Contract and lack of funding***

Population Based Oral Health: Accessibility

Q23: What barriers do you think these groups face in accessing dental services? (Please tick all that apply)

Answered: 46 Skipped: 4



- *Can't tick multiple options -all of these are options*
- *Lack of interpreters , it won't let me tick more than one above despite saying all that apply*
- *All of the above*
- *Your silly system doesn't allow more than one tick*
- *Cost, awareness, understanding that it's important*
- *All of the above but wont let me select*
- *All*
- *Cost, long waiting time, phobia/anxiety*
- *LACK OF DENTISTS*
- *Attendance and communication barriers*
- *All of the above (unable to tick more than one option).*
- *All of the above - I could only tick one!*
- *Cost, travel, availability of appointments*
- *All of the above*

Population Based Oral Health: Accessibility

Q29: Over the last 12 months, what percentage of patients not attending appointments have you experienced?

Answered: 49 Skipped: 1

Average of 18%

2 x 0%

17 x 1-10%

16 x 13-22%

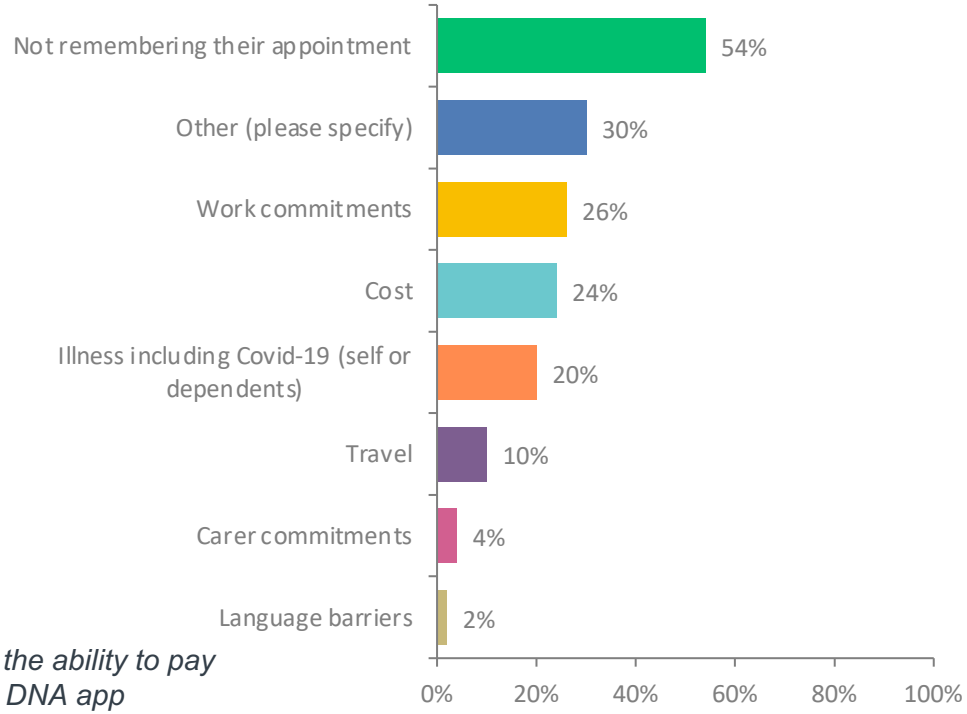
5 x 24-29%

5 x 30-40%

4 x 45-50%

Q30: What are the main reasons for patients not attending appointments?

Answered: 50 Skipped: 0

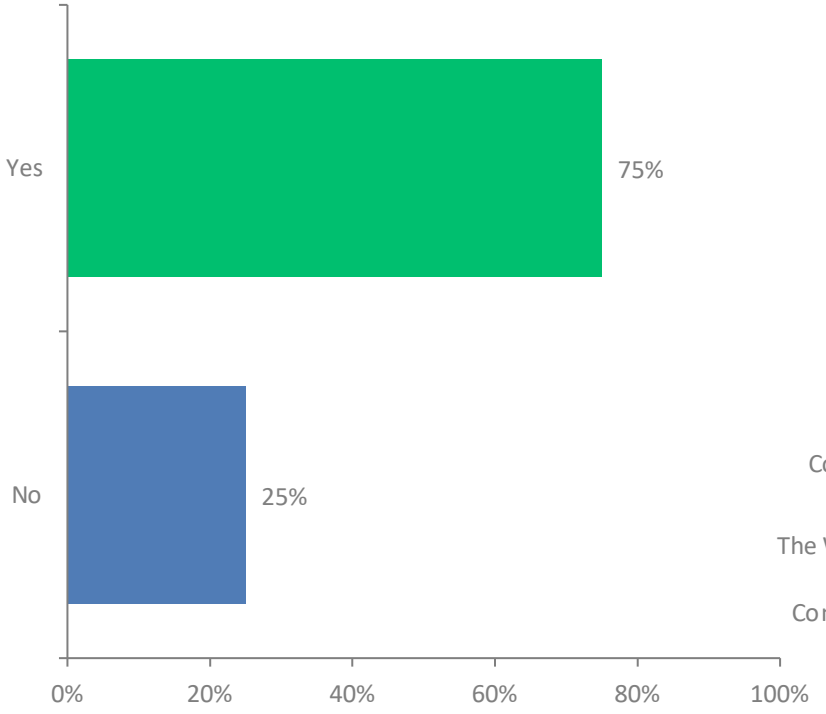


- *Inequalities, chaotic life style, poverty*
- *4 X unsure*
- *No charge for missed NHS appointments*
- *Non attendance in my Private Practice is wholly related to the ability to pay*
- *Doesn't matter, dentists are the ones who get zero pay for DNA app*
- *Anxiety*
- *Patients not encouraged to play a role in their dental health, or their responsibilities in the effective running of a system*
- *Very few - I work in a private practice where pts are called the day before and understand there is a fee for missed appointments*
- *If treatment is free they often don't bother attending, a lot on my attend in pain and only come when they have a problem and want the appointment immediately, they take no personal responsibility*
- *Parents not bringing their children for appointments that they made*
- *other things come up*

Digital Innovation

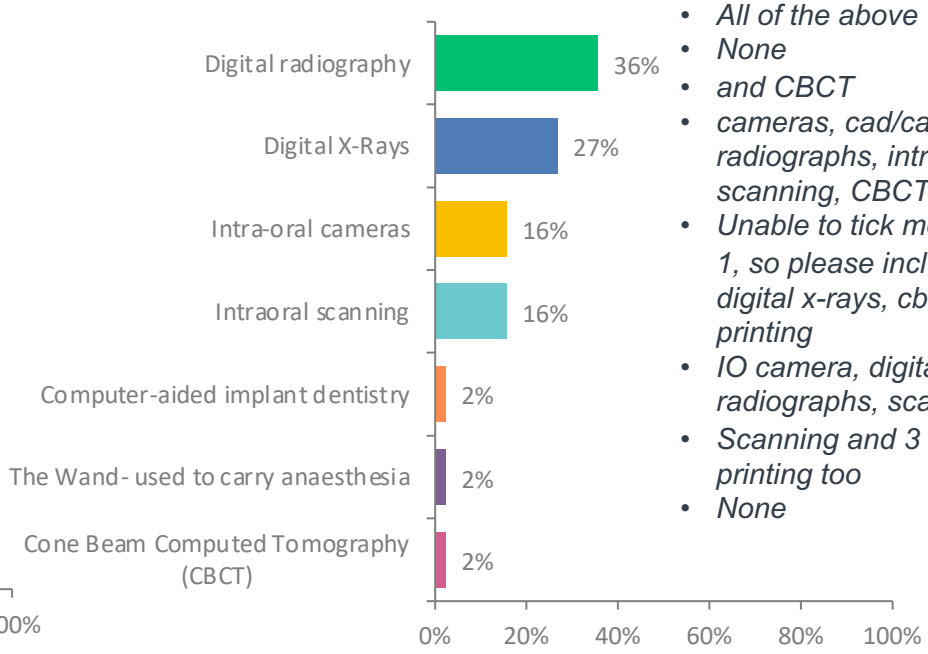
Q25: Do you feel utilising the Digital dentistry tools available is important?

Answered: 48 Skipped: 2



Q26: Please can you tell us which of these digital dental practices you use (please tick all that apply)?

Answered: 45 Skipped: 5

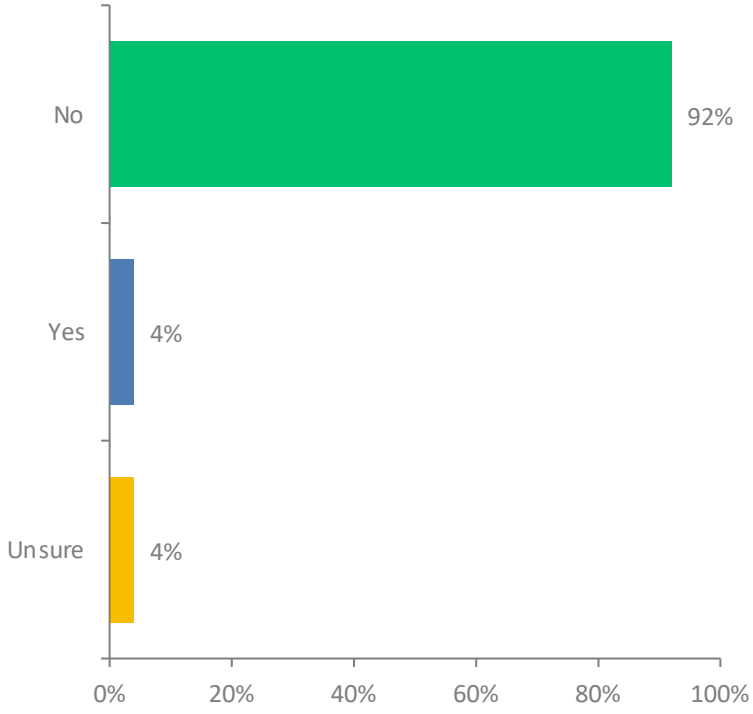


- *Digital x-rays*
- *You cannot tick all that apply*
- *All of the above*
- *None*
- *and CBCT*
- *cameras, cad/cam, radiographs, intra oral scanning, CBCT*
- *Unable to tick more than 1, so please include digital x-rays, cbct, 3d printing*
- *IO camera, digital radiographs, scanning*
- *Scanning and 3 d printing too*
- *None*

Public & Professional Awareness

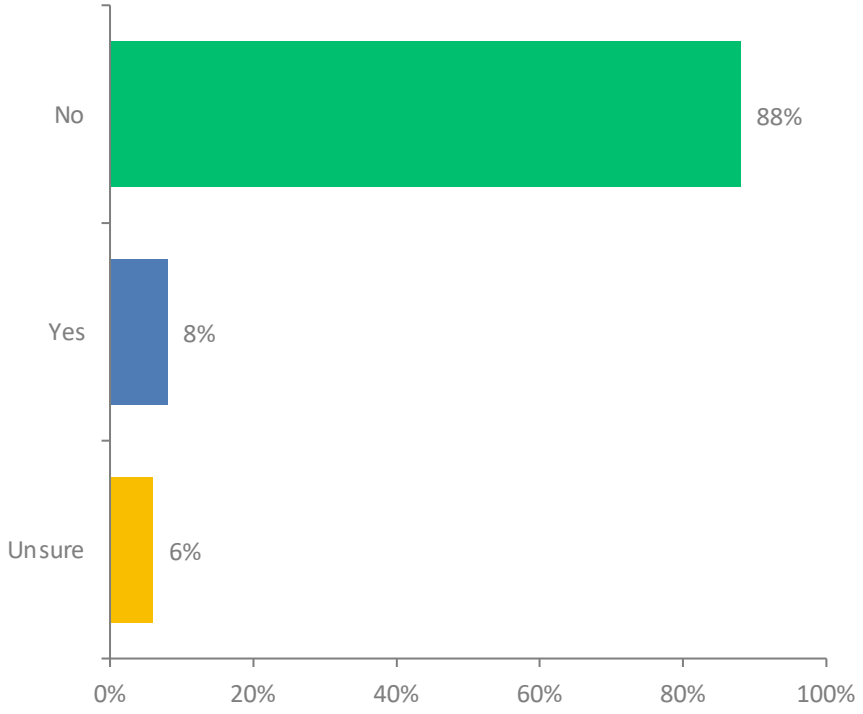
Q27: Do you feel the public understand how NHS dentistry functions?

Answered: 50 Skipped: 0



Q28: Do you feel other professionals in the NHS understand how NHS dentistry functions?

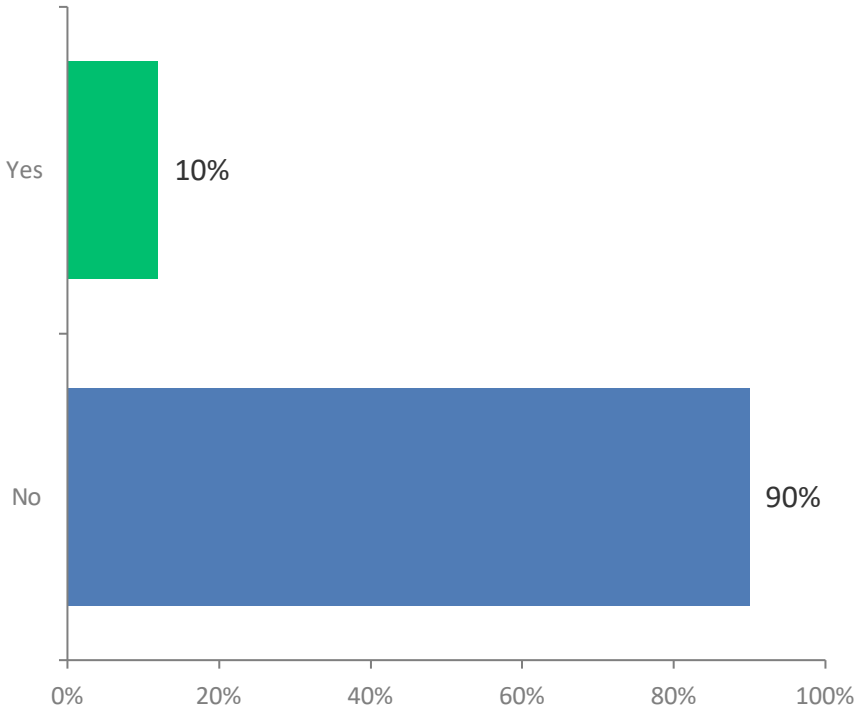
Answered: 50 Skipped: 0



Working for the NHS

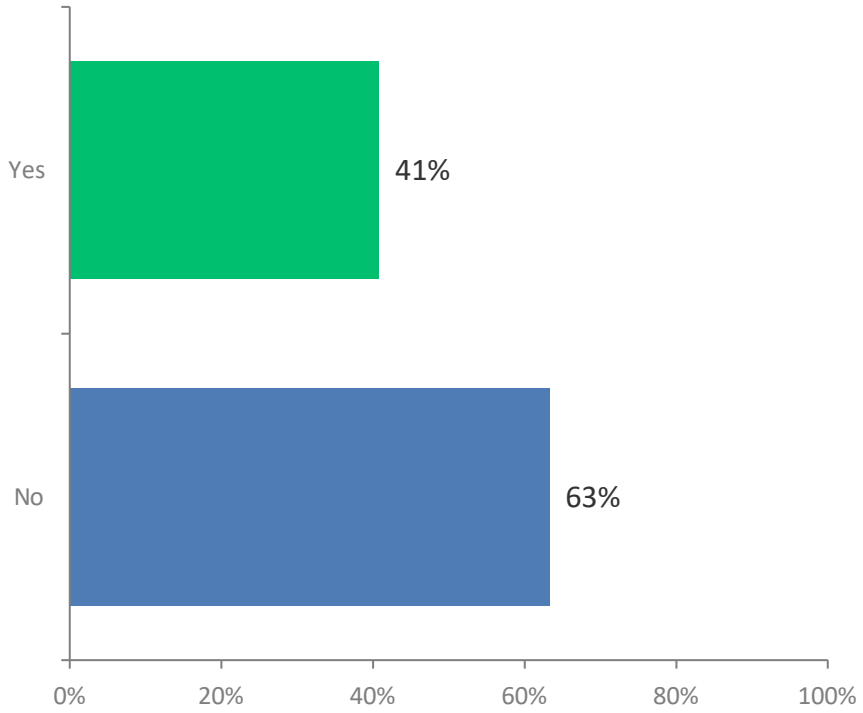
Q13: Do you believe your service is funded appropriately?

Answered: 50 Skipped: 0



Q14: Do you enjoy working for the NHS?

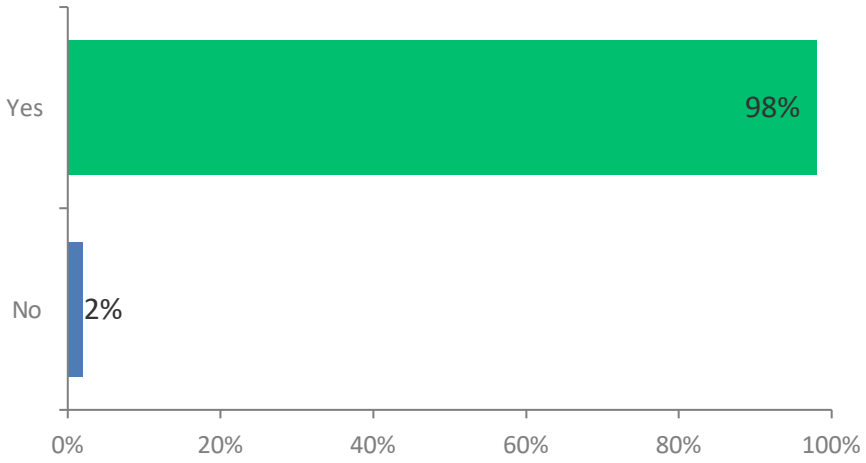
Answered: 49 Skipped: 1



Working for the NHS: Continuing Professional Development

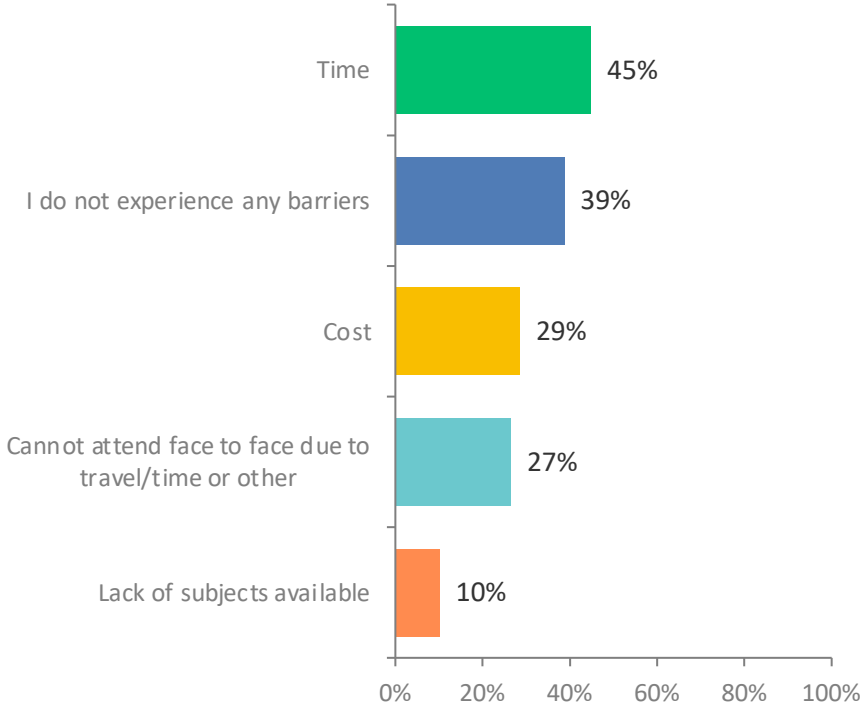
Q11: Have you completed any continuing professional development over the last 12 months?

Answered: 50 Skipped: 0



Q12: What do you see as the greatest barrier to completing continuing professional development?

Answered: 49 Skipped: 1

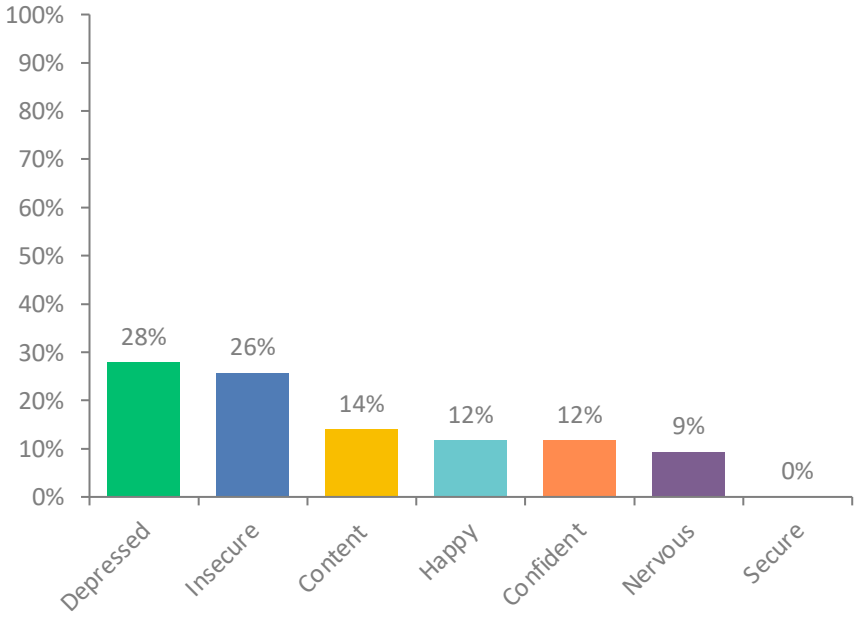


- *going over subjects that you've done many times before*
- *writing reflection and how it will change the way you work*
- *when you've done the job for so long, there is nothing new you can learn and apply to the job.*

Working for the NHS: Satisfaction

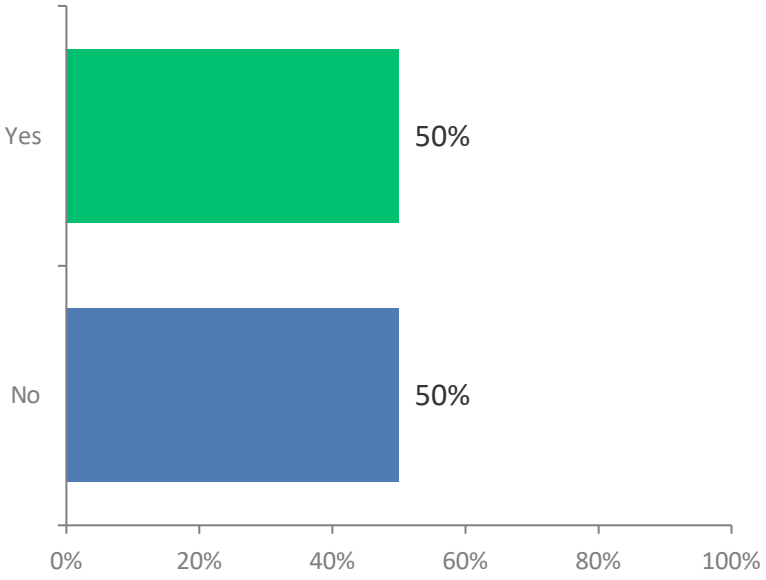
Q15: Do you routinely feel any of the following as a result of your work?

Answered: 43 Skipped: 7



Q17: For NHS dentistry work, do you feel patients value the work you do?

Answered: 50 Skipped: 0

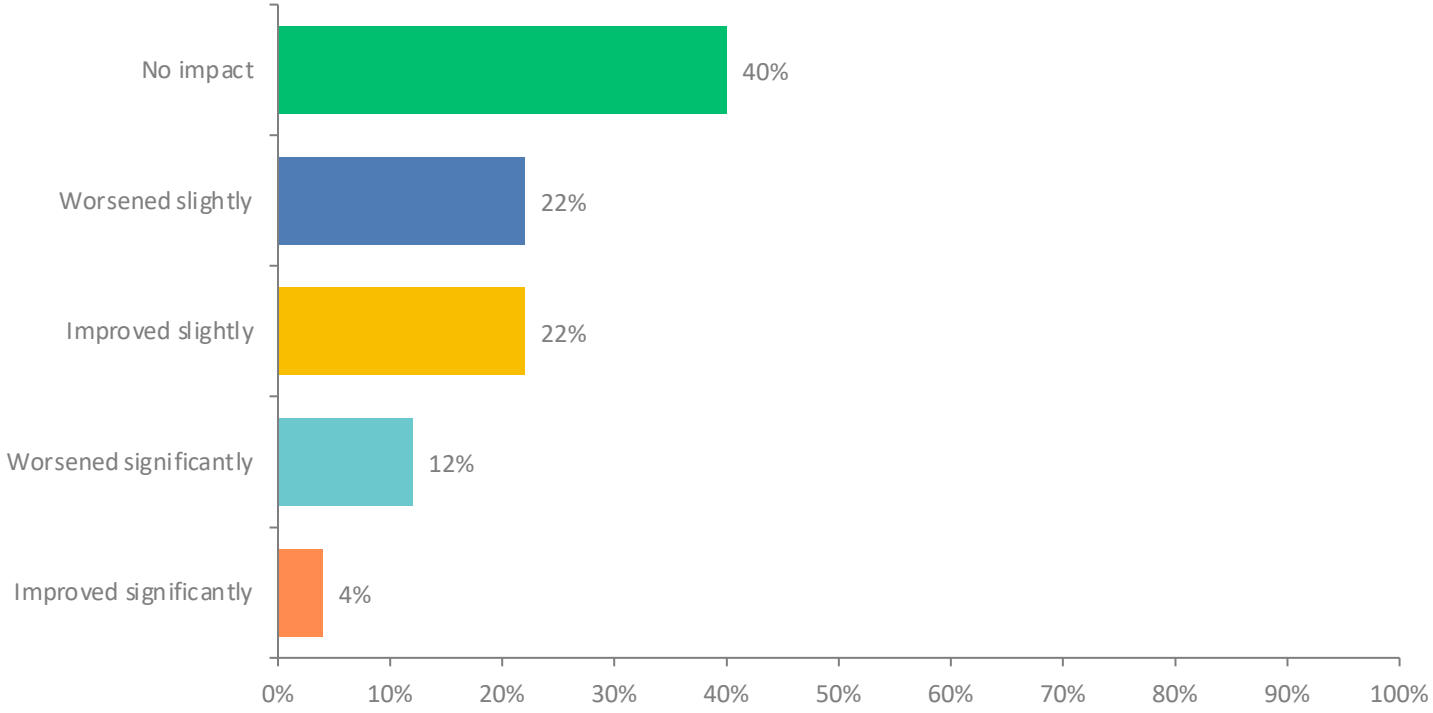


- *Can't tick multiple answers. Probably feel all of those things*
- *None of the above*
- *Overwhelmed*
- *I'm happy because I am a private practitioner*
- *Burnt out*
- *Angry*
- *UNDERVALUED AND MISERABLE. STRESSED*
- *Decreased NHS provision as a result. Now much happier, but depressed when I see the problems which are not being solved*
- *As I am coming to the end of my career, I feel quite content. Whilst an NHS practice owner - I felt anxious and insecure for many years.*
- *downhearted at times, too many rules and regulations that distract from treating patients*

Working for the NHS: Patient Relationships

Q16: How would you describe your relationship with the majority of your patients following the Covid-19 pandemic?

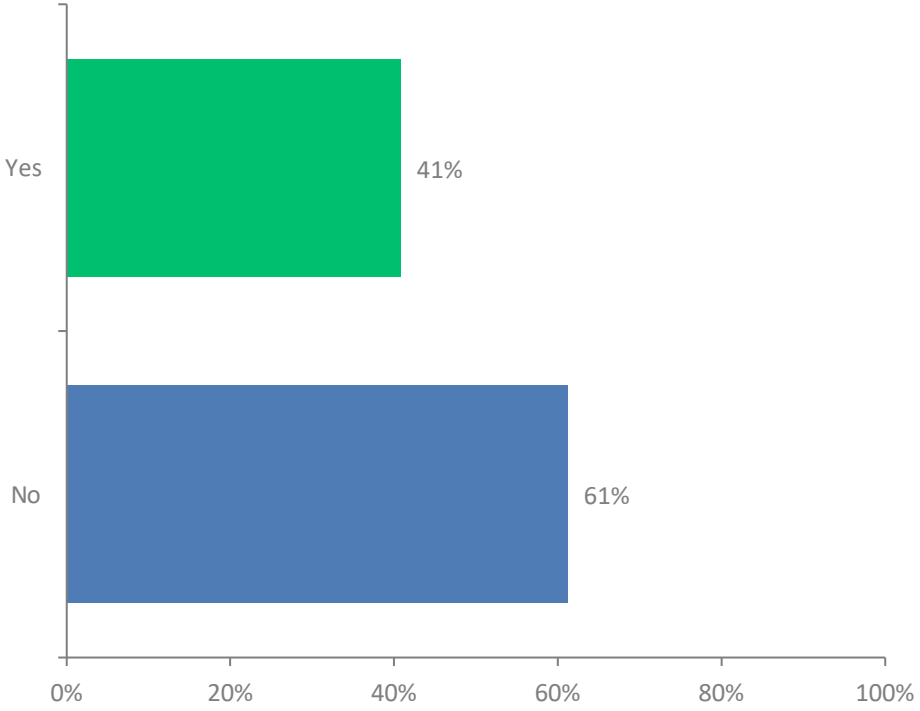
Answered: 50 Skipped: 0



Working for the NHS: Career Progression

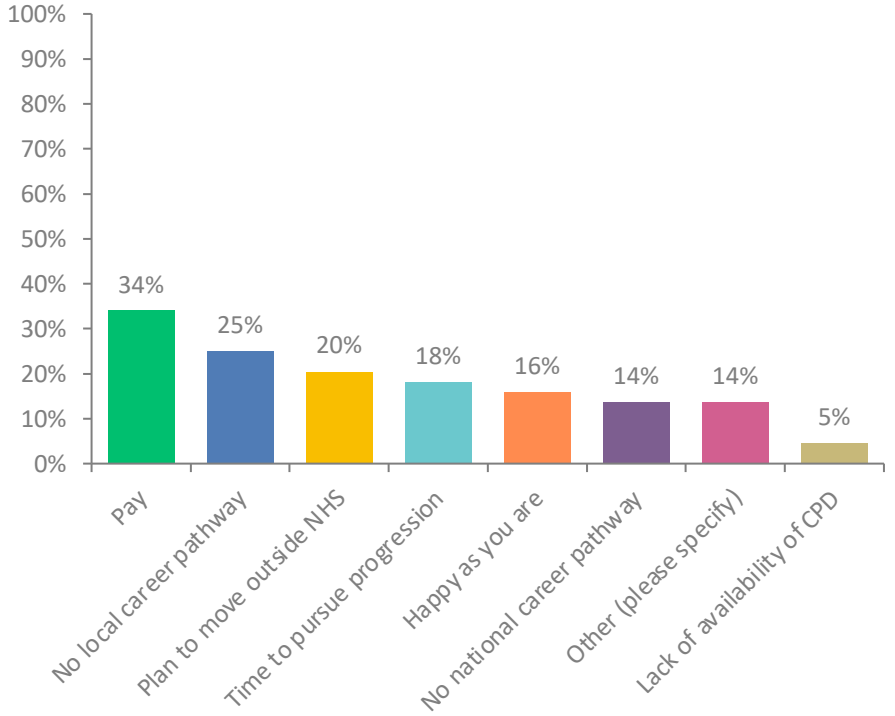
Q18: Do you see a way for your career to progress and develop?

Answered: 49 Skipped: 1



Q19: If no, is this due to:

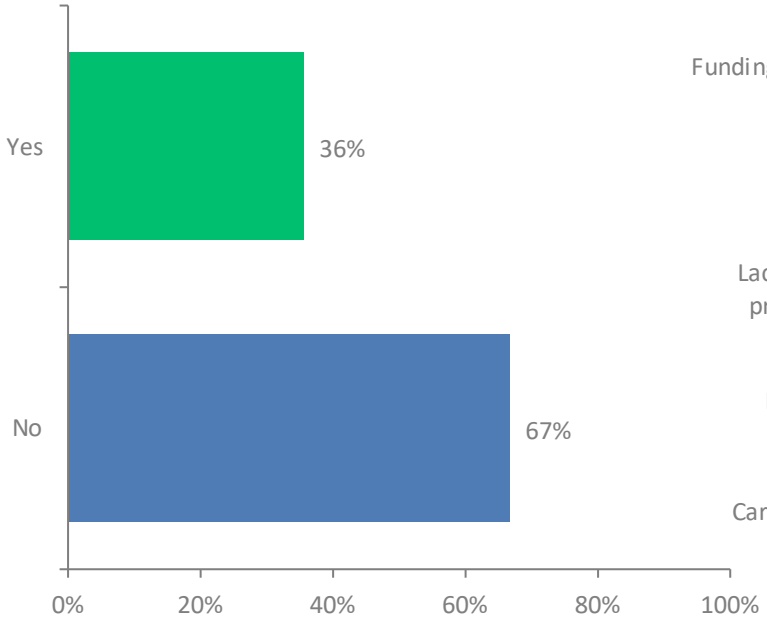
Answered: 44 Skipped: 6



Working for the NHS: Longevity

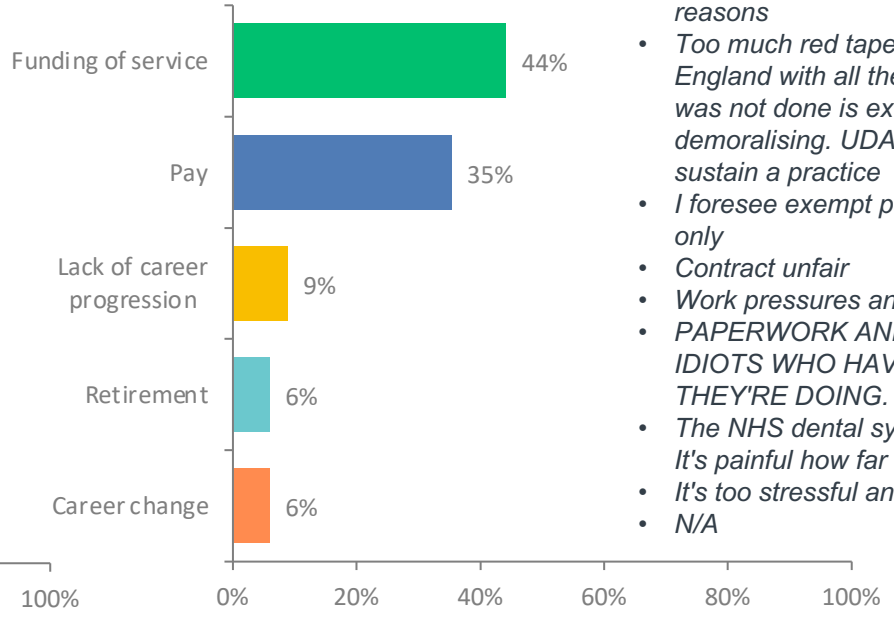
Q20: Do you anticipate working for the NHS in two years time?

Answered: 45 Skipped: 5



Q21: If no, is this due to any of the following reasons?

Answered: 34 Skipped: 16



- *Can't tick multiple options and various reasons*
- *Too much red tape, feel like NHS England with all their stats e.g. why F was not done is exceedingly demoralising. UDA'S alone cannot sustain a practice*
- *I foresee exempt patients and kids NHS only*
- *Contract unfair*
- *Work pressures and time*
- *PAPERWORK AND DEALING WITH IDIOTS WHO HAVE NO IDEA WHAT THEY'RE DOING.*
- *The NHS dental system doesn't work. It's painful how far adrift of reality it is.*
- *It's too stressful and thankless*
- *N/A*

- *It depends on if it gets better or worse*
- *Not if funding or contract doesn't change*
- *I don't think it will be available as it is*
- *Reducing commitment*
- *THERE'S NO MONEY AVAILABLE AND YOU WON'T RESTRICT THE AVAILABLE SERVICES. IT ONLY ENDS ONE WAY.*
- *But only in small capacity*
- *I don't work in the NHS now. Only a very small number of patients.*
- *But not as a clinical dentist - I am much happier in PT private practice (I actually don't earn any more, but I found it impossible to work at the pace necessary to meet contractual requirements whilst providing quality dentistry and a good service to my pts))*
- *Not sure*
- *Retiring*

Population Based Oral Health: Identified Groups

Q22: Based on your experience, can you think of any other vulnerable/seldom heard groups not identified by the South West Oral Health Needs Assessment 2021?

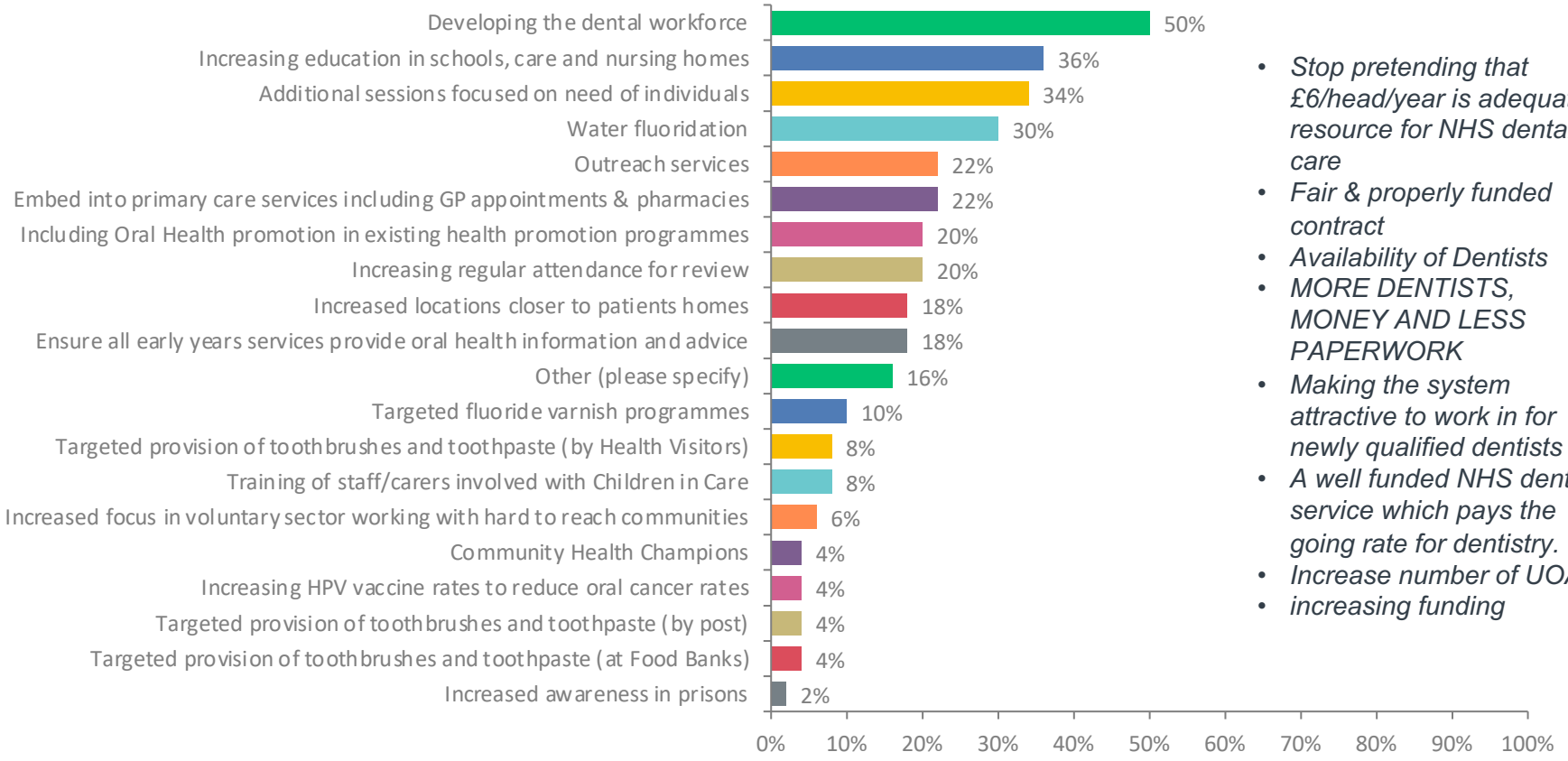
- *Travelling community*
- *Deaf community*
- *Neglected dentally patients*
- *Sex workers*
- *Those in prison*
- *Obese patients*
- *House bound patients*
- *Those from poorer/underprivileged backgrounds*
- *Bedbound and those who spend long time in the hospitals*
- *Children with SEN*
- *Some BAME groups with English not as a first language*
- *people with mobility issues*
- *NHS PATIENTS IN GENERAL, DUE TO LACK OF ACCESS WHICH IS ONLY GOING TO GET WORSE.*
- *Routine family dentistry*
- *Children who are not registered with a dentist and therefore not being referred for orthodontic treatment*
- *children that have no access to dental care*
- *Yes. 'Normal' working families, who aren't defined as vulnerable but no longer have an NHS dentist and simply cannot afford to access regular private care*
- *People who are cared for at home by carers or relatives who cannot access care home help or pcds*
- *People with a life limiting illness receiving palliative and end of life care.*
- *Elderly in their own homes*
- *All children are dependant on being brought to the surgery.*

The above are in addition to: Adults in care homes, People with Learning Disabilities, People experiencing homelessness, Looked after children, Migrant workers, refugees, asylum seekers, medically compromised individuals, those with dental anxiety and dental phobia.

Population Based Oral Health: Opportunities

Q24: What do you see as the top 3 most important opportunities to improve good Oral Health in BNSSG?

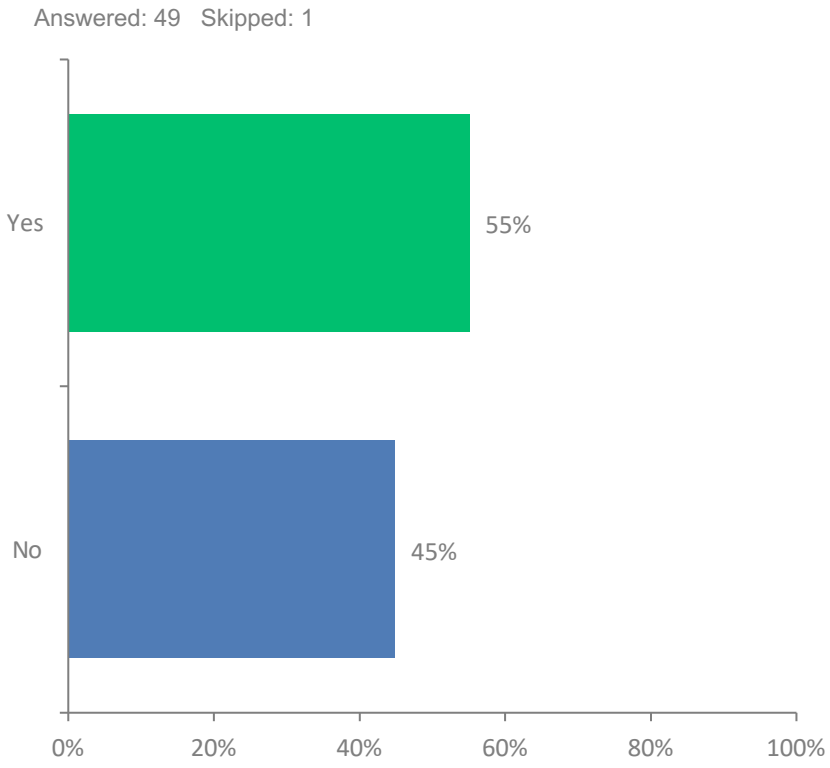
Answered: 50 Skipped: 0



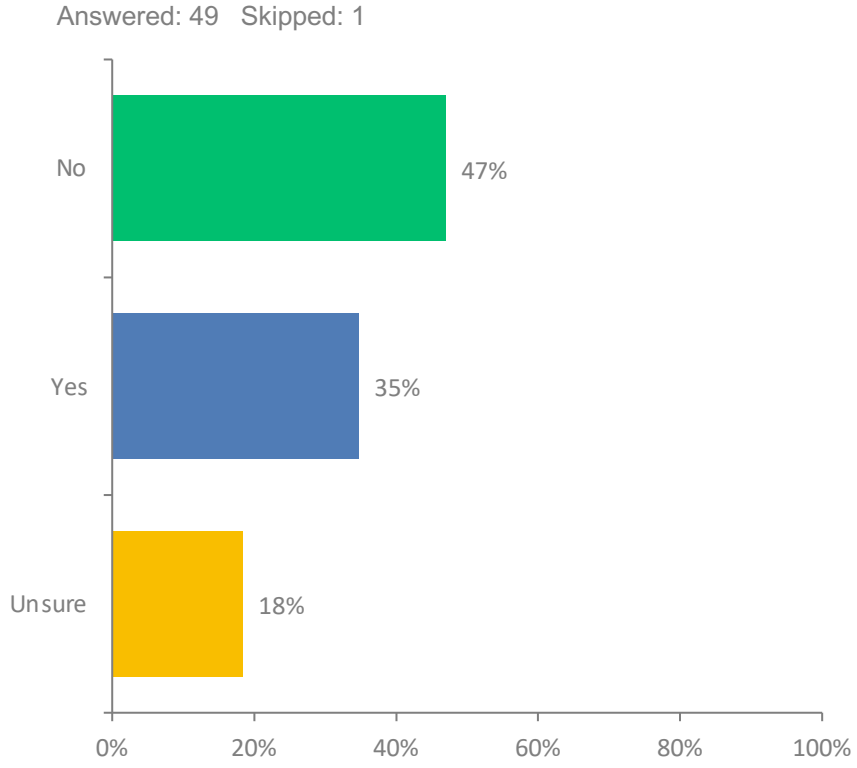
- *Stop pretending that £6/head/year is adequate resource for NHS dental care*
- *Fair & properly funded contract*
- *Availability of Dentists*
- *MORE DENTISTS, MONEY AND LESS PAPERWORK*
- *Making the system attractive to work in for newly qualified dentists*
- *A well funded NHS dental service which pays the going rate for dentistry.*
- *Increase number of UOAs*
- *increasing funding*

Population Based Oral Health: Opportunities

Q31: Do you have an interest in working with vulnerable/seldom heard people?



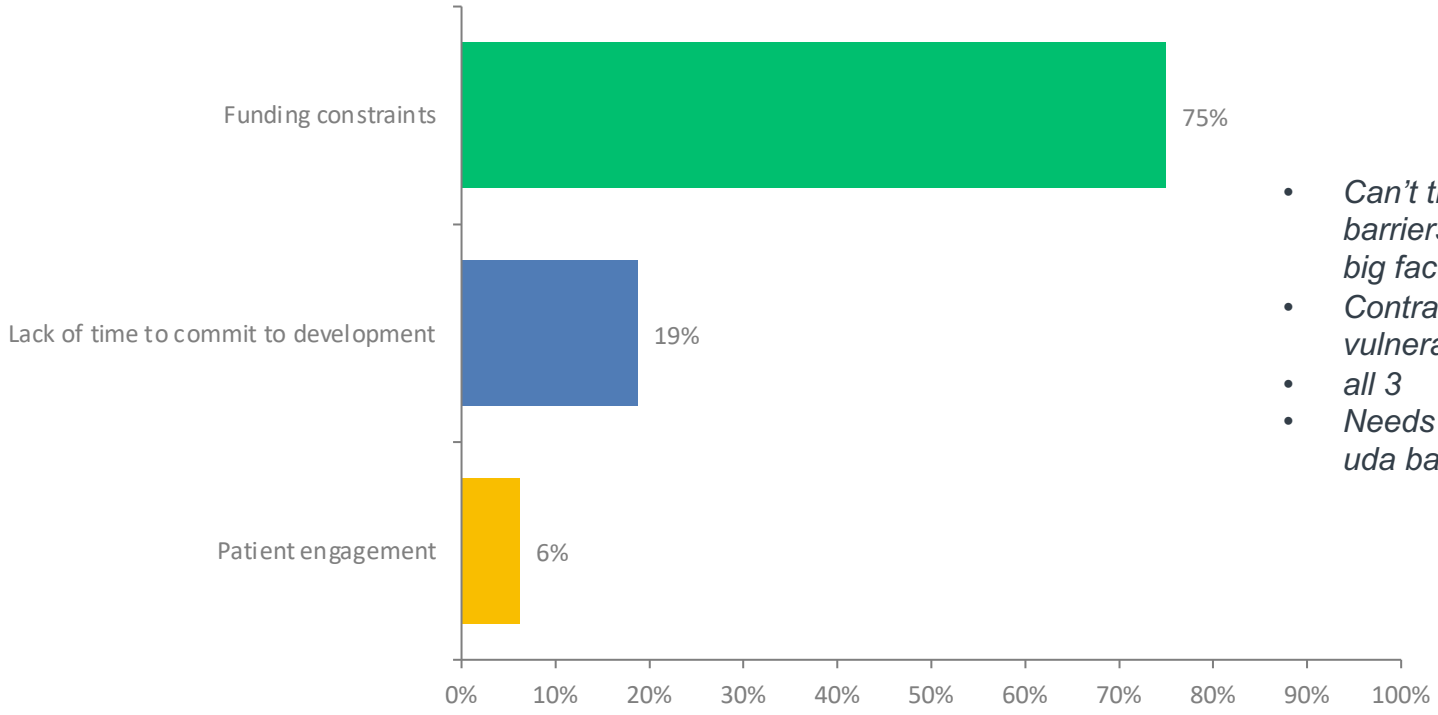
Q32: Do you feel there are opportunities to increase support for vulnerable/seldom heard people?



Population Based Oral Health: Opportunities

Q33: What do you feel is the main barrier to providing innovative services for vulnerable/seldom heard people?

Answered: 48 Skipped: 2

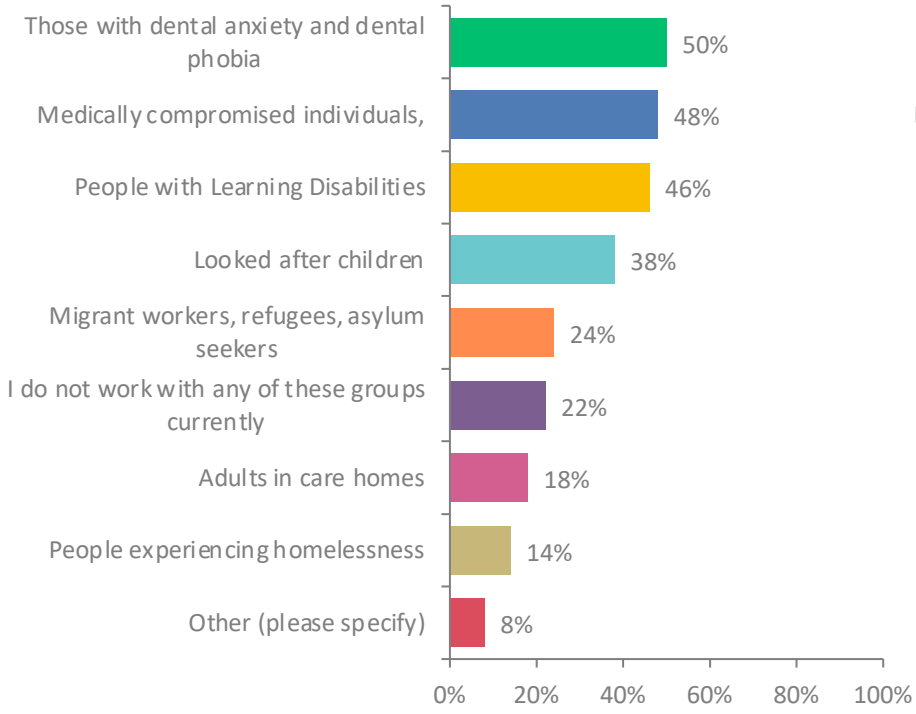


- *Can't tick multiple -all are barriers. Lack of access is a big factor of access are very*
- *Contract is anti-vulnerable/seldom heard*
- *all 3*
- *Needs to be salary based not uda based.*

Population Based Oral Health: Opportunities

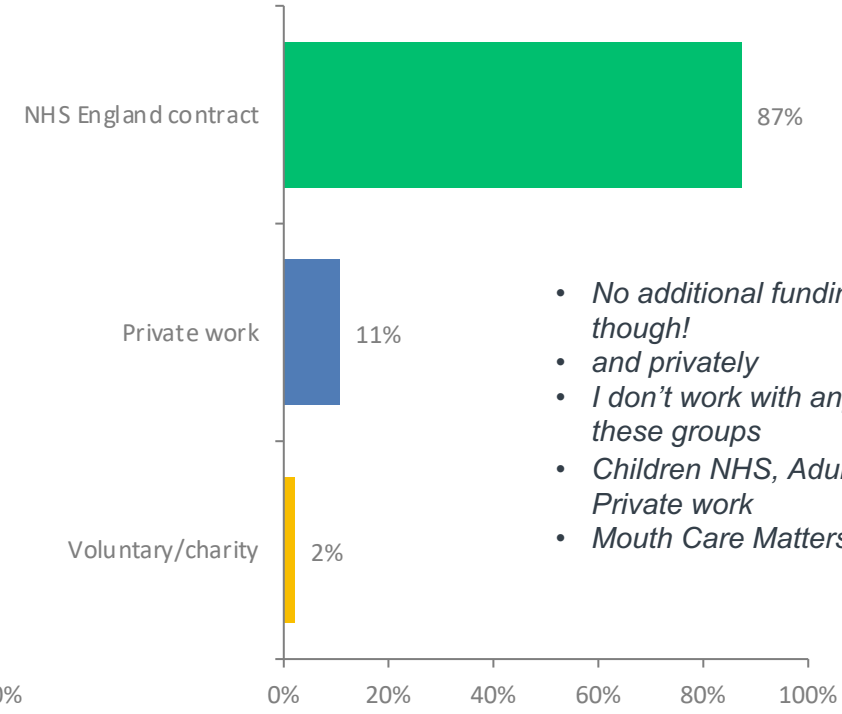
Q34: Which vulnerable/seldom heard groups do you currently work with?

Answered: 50 Skipped: 0



Q35: Is this under/ as part of:

Answered: 47 Skipped: 3



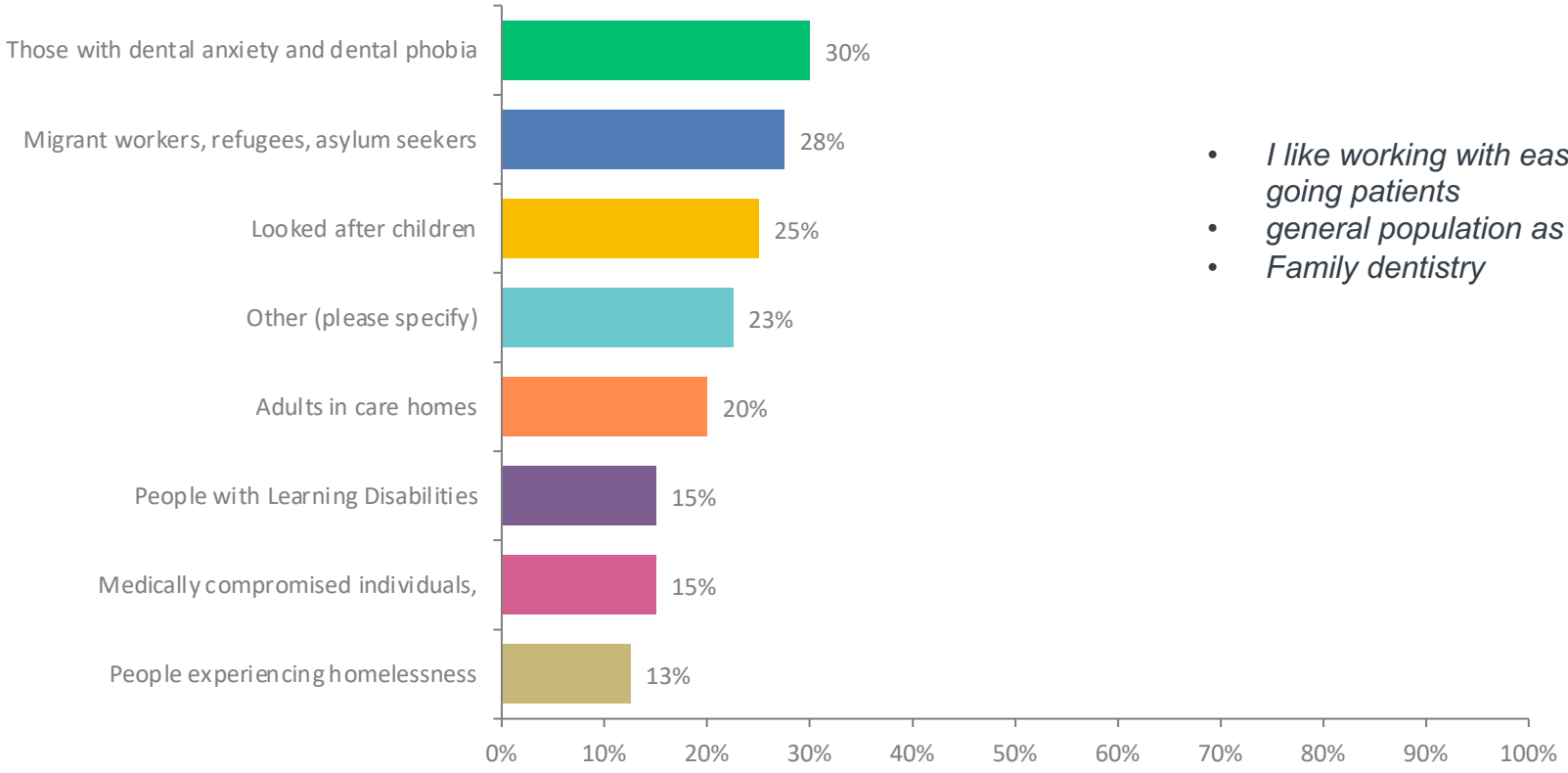
- *No additional funding though!*
- *and privately*
- *I don't work with any of these groups*
- *Children NHS, Adults Private work*
- *Mouth Care Matters*

- *Work in general practice so we see the less extreme of these vulnerable patients*
- *Autistic children and adults*
- *OOH*
- *Since giving up NHS dentistry, I volunteer for Dentaid. Very sad that a charity has to provide services that should really be part of our NHS.*

Population Based Oral Health: Opportunities

Q36: Which groups of the population would you like to work with (but do not currently)?

Answered: 40 Skipped: 10

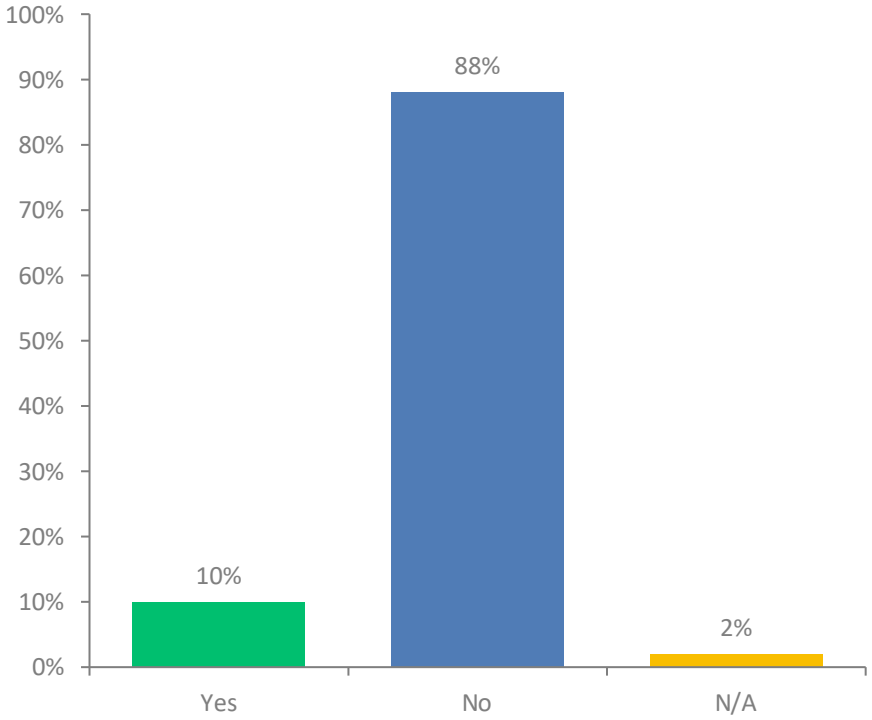


- *I like working with easy going patients*
- *general population as well*
- *Family dentistry*

Integration & Collaboration

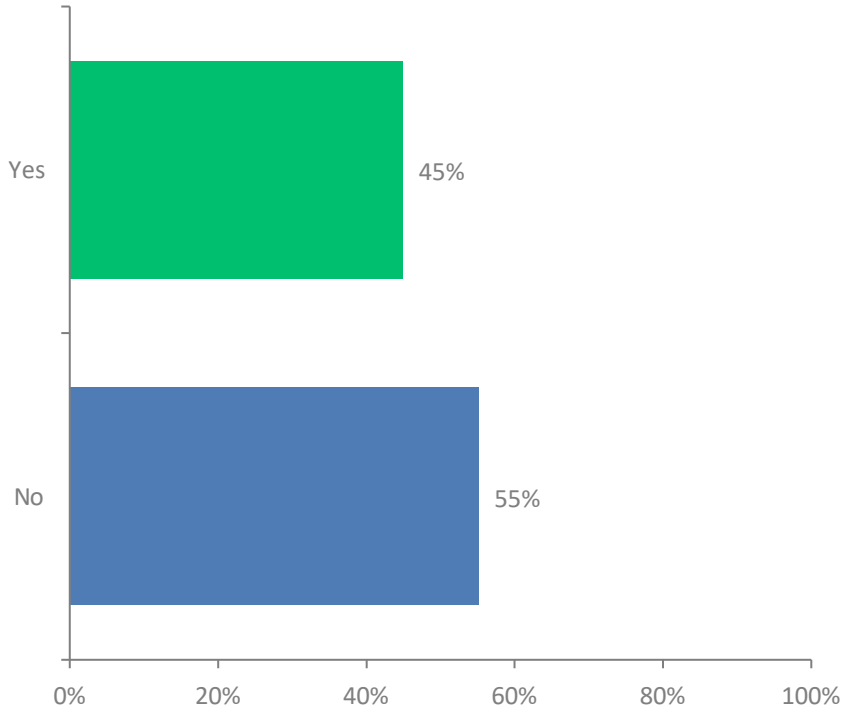
Q37: Are your services co-located with a GP practice/Healthy Living Centres?

Answered: 50 Skipped: 0



Q38: Are you aware of primary care networks in your area?

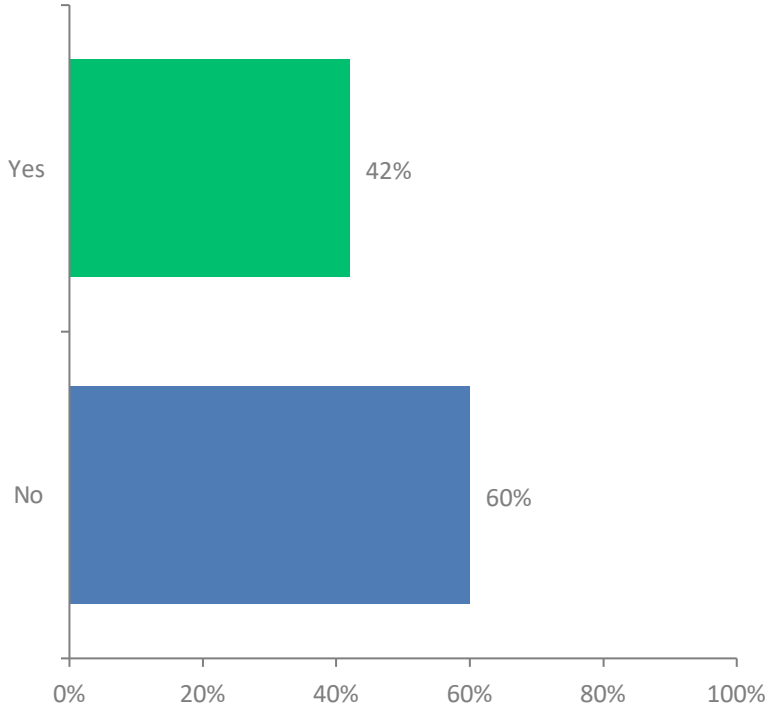
Answered: 49 Skipped: 1



Integration & Collaboration: Opportunities

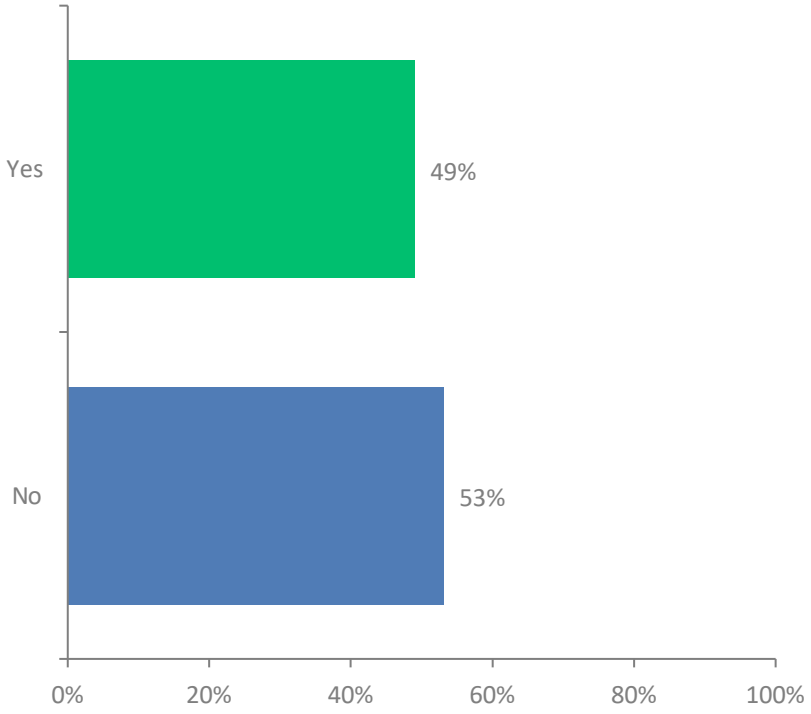
Q39: Do you understand the role of primary care networks?

Answered: 50 Skipped: 0



Q40: Do you feel there are opportunities to work with other NHS services to improve the health of the population?

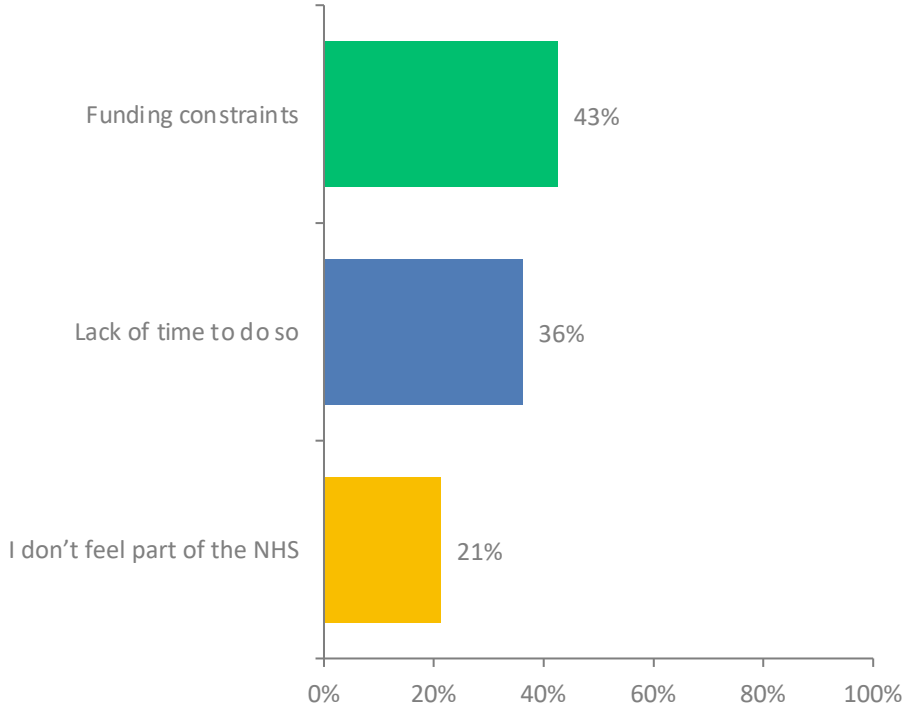
Answered: 49 Skipped: 1



Integration & Collaboration: Opportunities

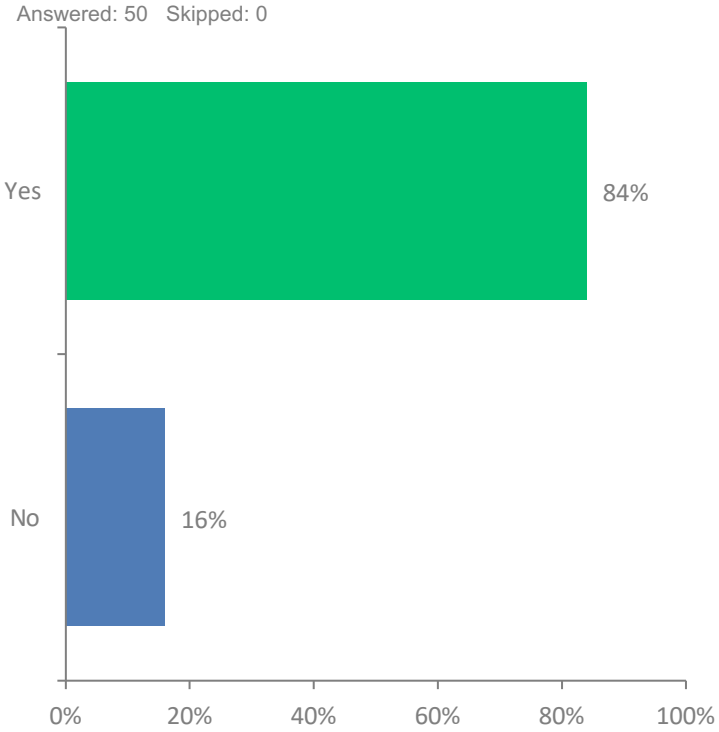
Q41: What do you feel are the main barriers for working with other NHS services?

Answered: 47 Skipped: 3



Q42: Would you welcome the chance to network with GP practices and other NHS services?

Answered: 50 Skipped: 0

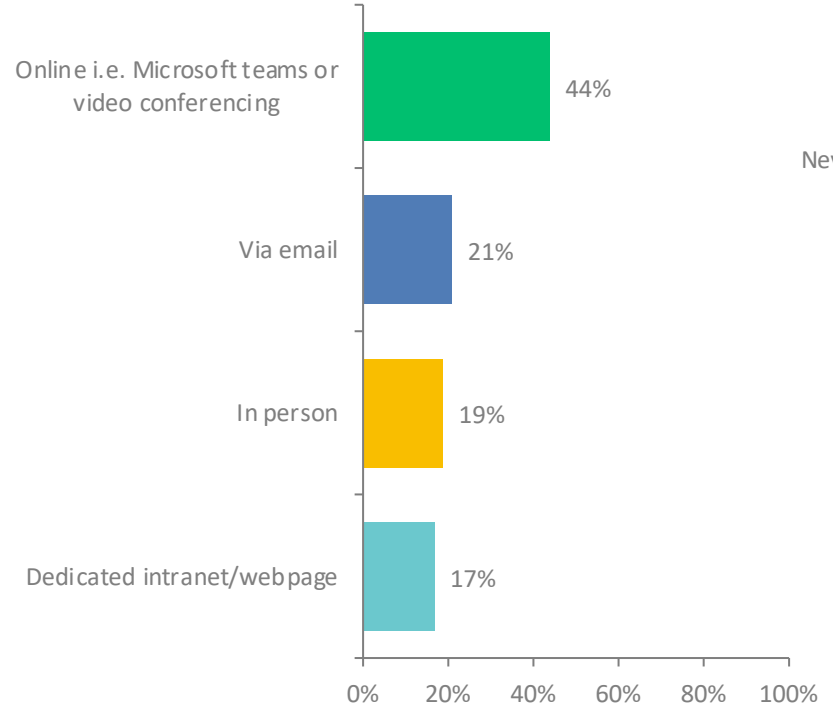


- *We all could work better together but whenever we get together to try to agree, it all comes down to funding, and each speciality focuses on their own funding issues rather than how a bigger system would work.*
- *I am very lucky to alongside colleagues from outside of dentistry in my NHS role. As a practicing dentist, this isn't something that is part of our culture*
- *Medical practitioners do not think dental issues are important and they say they don't have time to integrate basics on oral health in general health into their practices or health visitor etc. Other sectors do not understand the funding of dentistry and how much it costs to run a surgery, the materials etc and think everything is the dentists fault when dentists are seeing so many patients a say it is difficult to squeeze any more in or to work to an appropriate standard*
- *And time constraints*

Integration & Collaboration: Opportunities

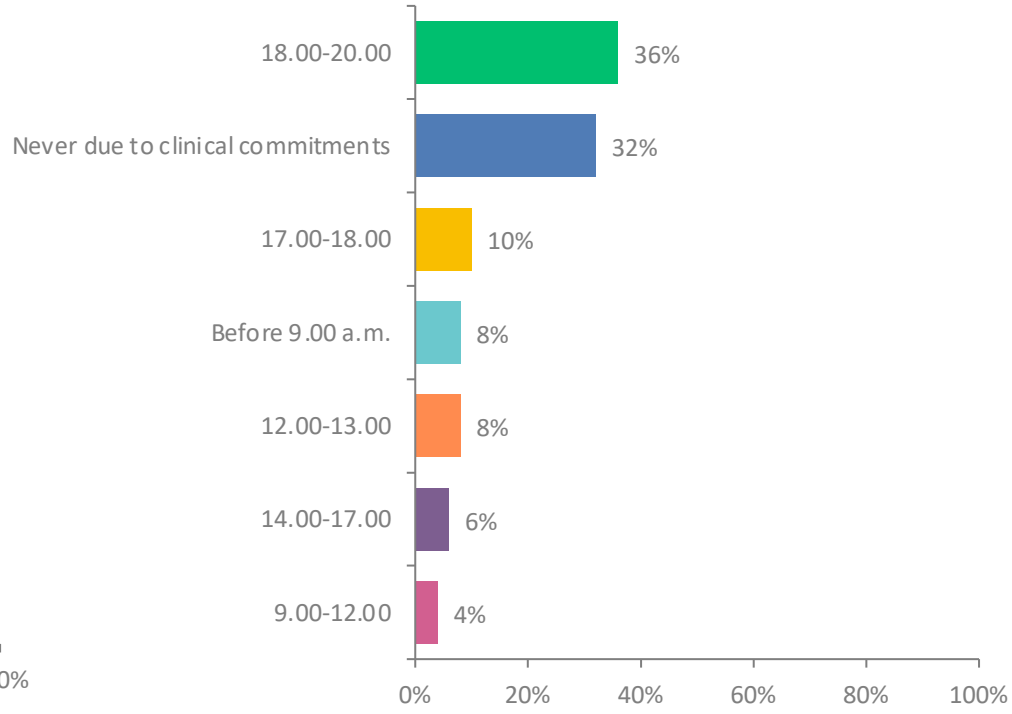
Q43: Given time constraints, how would you like to network?

Answered: 48 Skipped: 2



Q44: Generally, when is the best time for you to network?

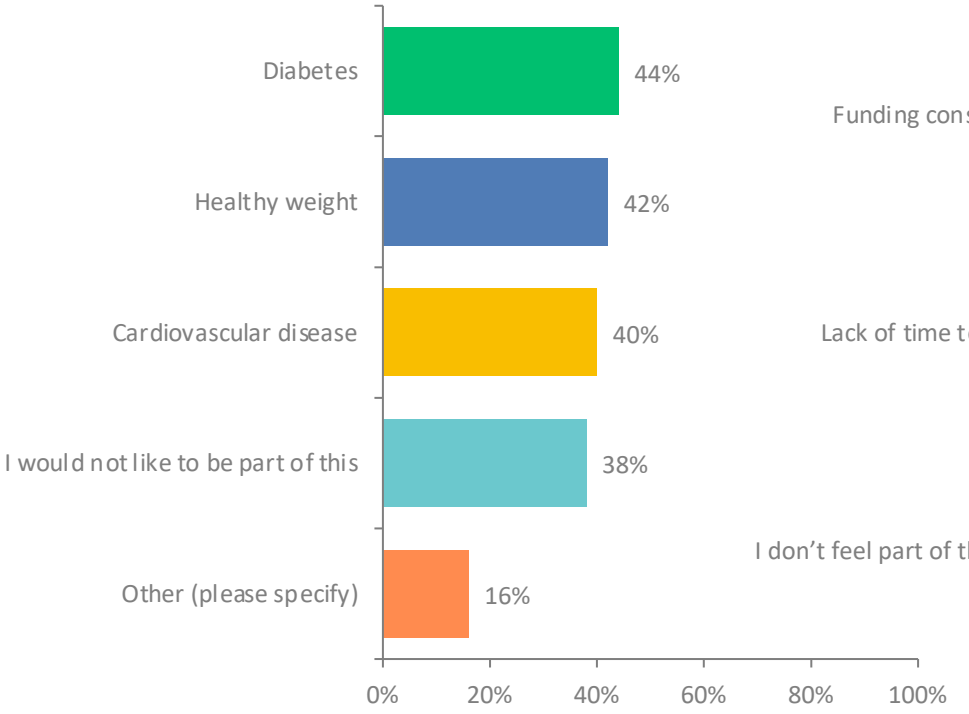
Answered: 50 Skipped: 0



Integration & Collaboration: Opportunities

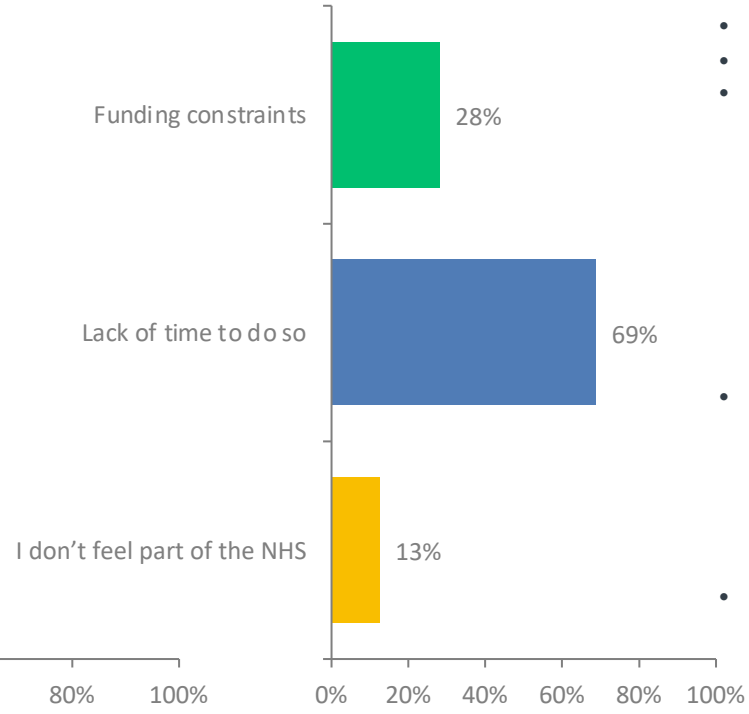
Q45: Would you like to be part of integrated pathways of care for other conditions including:

Answered: 50 Skipped: 0



Q46: If no, please state why:

Answered: 32 Skipped: 18



- *head and neck cancer*
- *I would be prepared to negotiate a contract for providing Specialist Dental Services in Restorative Dentistry, Prosthodontics, Periodontics and Endodontics*
- *Smoking Cessation*
- *Geriatric patients*
- *think as part of a preventative service we could easily provide screening for diabetes and early signs of cardiovascular disease at routine check up. We often see patients when they are well, rather than a GP who sees them when they are ill.*
- *I worry that focusing on targeted groups is ignoring the wider issue. A well funded dental contract would mitigate the need for this approach*
- *This should happen anyway, when I contact GMOs that often don't understand enough about the relationship between these conditions and dentistry so they cant help.*

Please provide any further comments which you feel are helpful to consider for the development of a Dental strategy in BNSSG:

- *More funding for higher UDAs rates and also better funding for Foundation Dentist Training Practices to ensure more Dentists for the future.*
- *Maintain the services that already you have just increase the funding for existing services to able them deliver good quality care*
- *Fund dental services properly. Lack of access is a human rights issue and patients are suffering. Make this a priority as other physical health concerns and fund it properly*
- *All dental surgeons wishing to provide NHS services should be paid salaries*
- *Target high risk areas where their is high neglect. Give us better UDA rates for more complex work Treatment for Dentures on the NHS we are struggling because NHS lab fees have increased Denture repairs and additions we make -£38 NHS practices are struggling especially those on minimum UDA rate Have more flexible commissioning for high risk areas Workforce is extremely stressed and overworked Stop unnecessary admin like WTE forms Start supplying NHS consumables that was a big help Clawback stress is killing practices and increases massive stress load Stabilization programmes need to be extended Provide funding for application of F for school children Oral health promotion Dental Teams would like to encourage other aspects of prevention but then UDA clawbacks would occur. So UDA commitments should be less if other aspects can be achieved.*
- *It is silly for GDP to expect to work for free, nhs does not pay under the uda system not for referrals, not for extra time spent with challenging patients, there is zero incentive for GDP under uda system to work with challenging patients*
- *I consider NHS Dentistry to be unsavable. Too many practitioners have given up on it & won't ever go back*
- *Without contract change there will be no NHS Dentistry soon I'm afraid*
- *NEW REFERRAL FORMS ARE AWFUL, THEY TAKE FAR LONGER TO FILL IN AND CONTAIN A HUGE AMOUNT OF DUPLICATED OR USELESS INFORMATION. THOSE IN CHARGE OF COMMISIONING HAVE NO IDEA HOW DENTISTRY WORKS. NHS IS DYING AND NO-ONE CARES.*
- *An effective system cannot work without engaged dentists. The current system and Practices providing NHS treatment as far as I can tell from speaking to colleagues, many are handing back their contracts. Jumping forward to the next generation of Practice owners, it is difficult to see who will want an NHS contract unless they can see professional and financial benefits of integrating into their business model. All dentists are clinicians, but not all are Practice owners/business minded. The system must allow for this otherwise there will not be anyone wanting the NHS system in their businesses. Family dentistry must not be forgotten.*
- *Retaining staff huge problem. Dentists not wanting to do difficult work for low remuneration. Unrealistic NHS system. The NHS needs to be a salaried basic service leaving private dentistry to do the rest.*
- *Funding to orthodontics*
- *consider increasing funding*
- *There needs to be change to funding, proper remuneration so practices can keep afloat while providing the standard of care that achievable and offered to all, not just the NHS basics that are deemed enough. Or nhs treatment should be free for all for oral health care checks and prevention sessions on a regular basis. Patients should get a diagnosis and (most) pay for all treatment after that, as they will have the information to prevent disease. There needs to be a patient education and responsibility change*
- *Awareness of a Mouth Care Matters team in the South West that are already working towards some of these things. However, funding is uncertain but they are a vital resource and ease pressure on other overwhelmed dental systems.*