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

Oral Health & Dental Strategy (All ages)

2024-2027

February 2025
V1.0

Contents

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

, or

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 pre-pandemic 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:

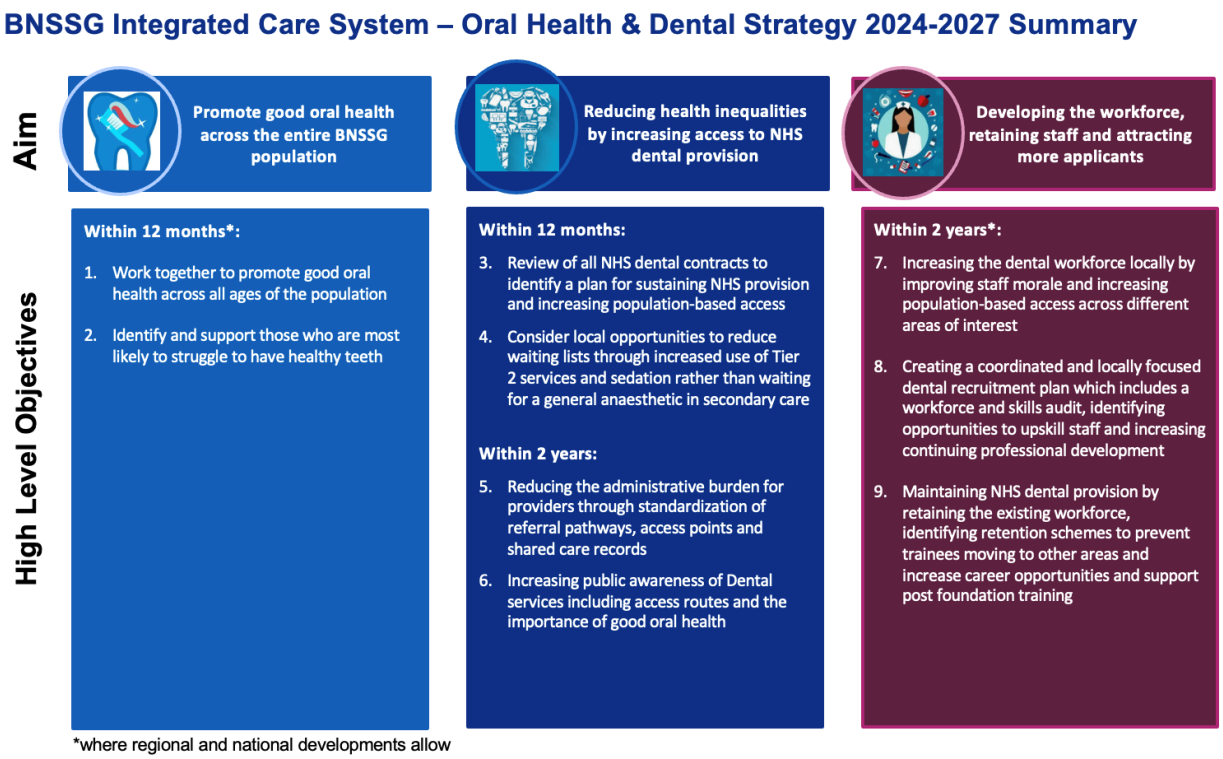


Figure 3 BNSSG ICS Strategy summary

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:

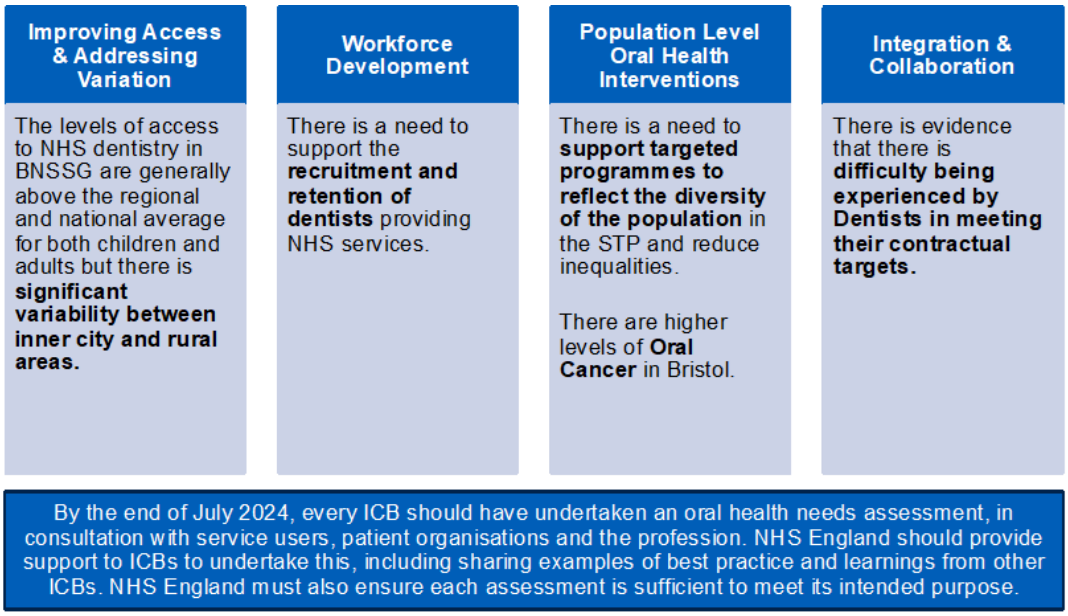


Figure 1 NHS England and NHS Improvement South West of England Oral Health Needs Assessment January 2021: Key recommendations for BNSSG grouped under relevant headings

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.

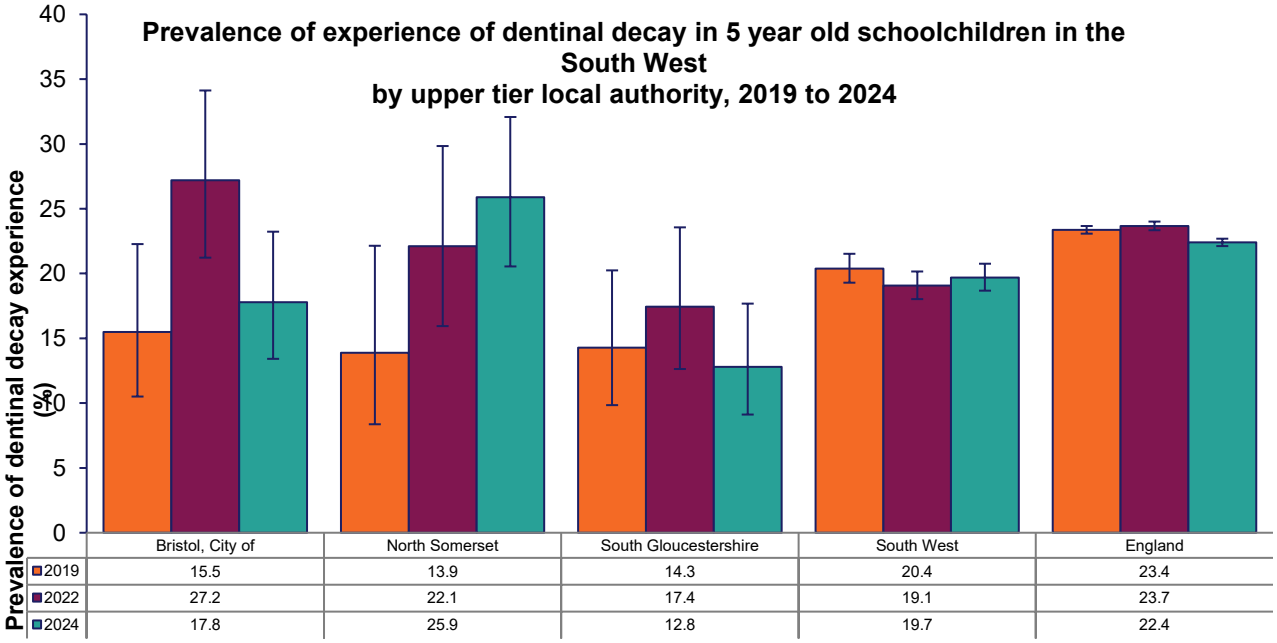
2.3 Core20plus5* – Children & Young People

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 4 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:

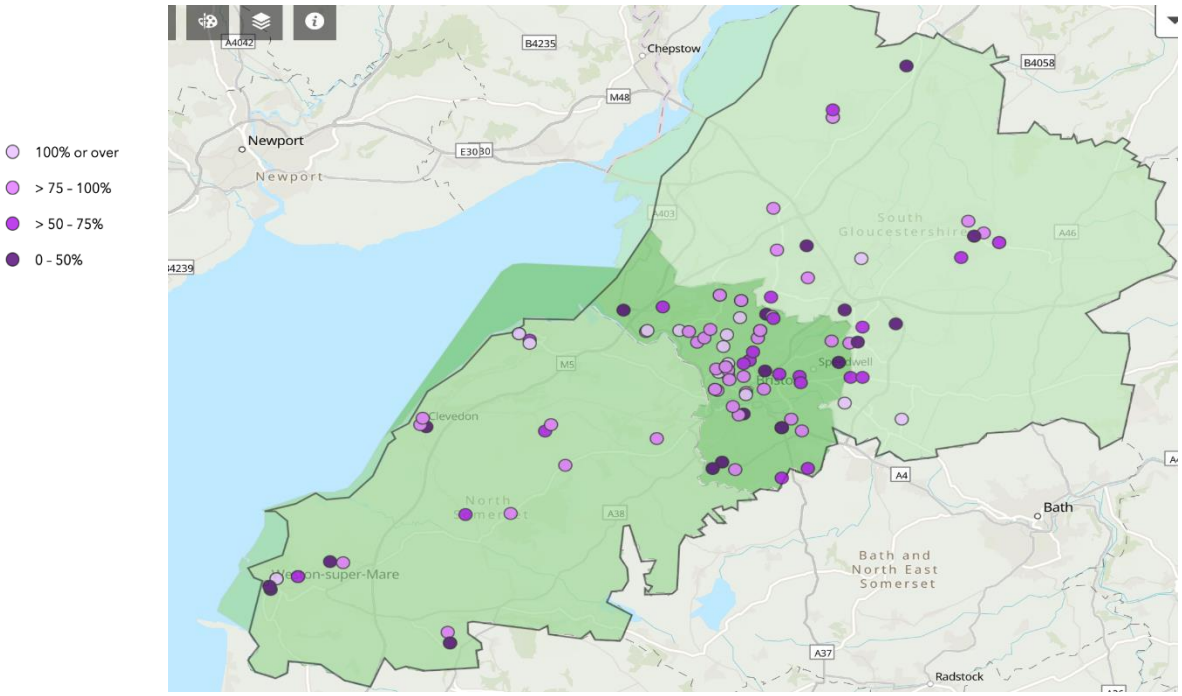


Figure 5 BNSSG Dental locations and reporting from January-June 2024

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

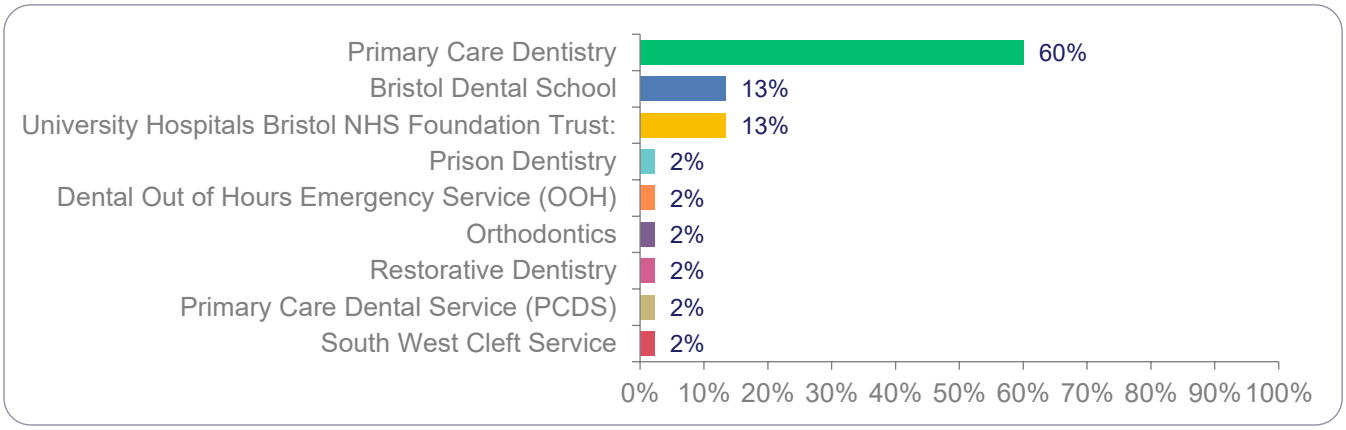
The second workshop prioritised each area under the headings of:

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:

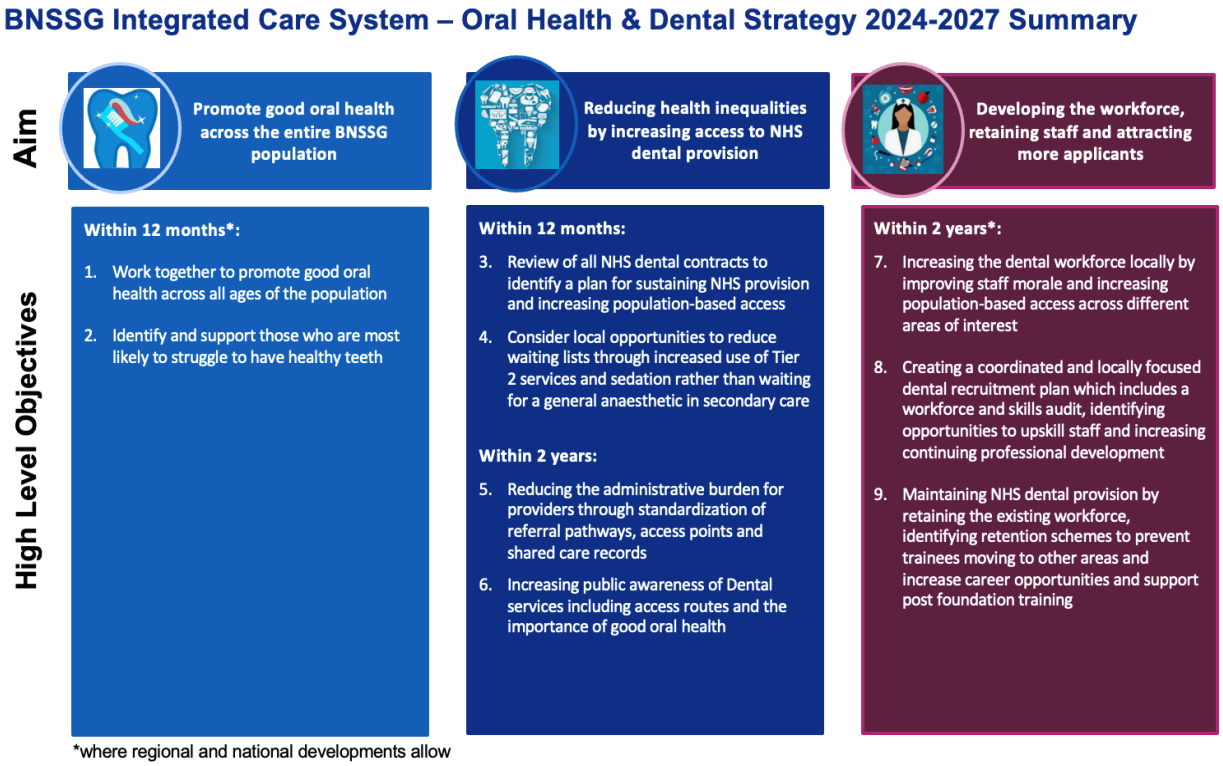


Figure 6 BNSSG ICS Strategy summary

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

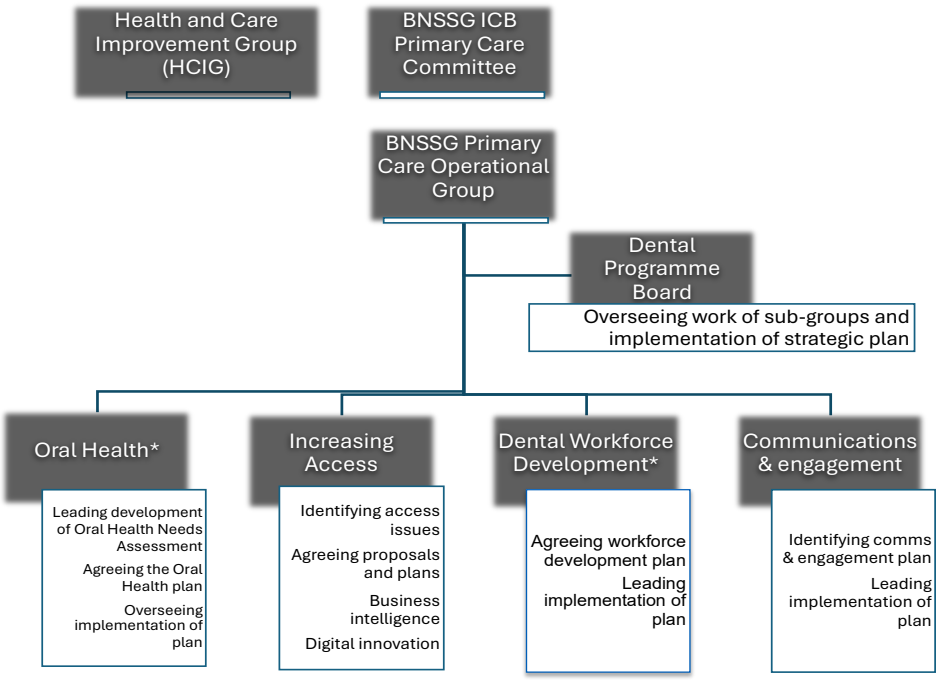


Figure 7 Proposed Governance Structure for BNSSG Dental Programme 2024-2027

7. Appendices

7.1 Appendix 1: High level strategic plan

Download the high-level Bristol, North Somerset and South Gloucestershire strategic oral health and dental plan (xlsx)

7.2 Appendix 2: Presentation describing the outputs from both workshops and the staff survey results

Download the presentation: collaborating to form a Bristol, North Somerset and South Gloucestershire Oral Health and Dental Strategy

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 on the NHS England website, together with examples of how this guidance can be applied.