NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Board Meeting

Date: Thursday 1st February 2024
Time: 12:30 – 15:45
Location: University of the West of England, Enterprise Park 1, Lecture Theatre, Long Down Avenue, Stoke Gifford, BS34 8QZ

Agenda Number :	6.6	
Title:	BNSSG Draft 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)	
Purpose: For Information		
Key Points for Discussion:		
• To review the BNSSG Draft Dental strategy, note any further updates from the Primary Care Committee which took place on 30 January (verbal) and consider the key points for further consideration		
Recommendations:	The Board is asked to: • Review the information included in the draft strategy noting further patient and staff consultation required • Note the verbal update from the Primary Care Committee of 30th January 2024 • Agree any further actions not already identified (noting the regulations described within this paper)	
Previously Considered By and feedback:	The information in this paper reflects the outputs from both workshops held in September and November 2023 plus the ICB Dental Staff Survey also completed in November. A paper was presented to the Primary Care Committee on 30 January, a verbal update on this discussion will be provided.	
Management of Declared Interest:	None to consider given the information contained within this paper require further public consultation and do not have specific funding decisions required at this stage.	
Risk and Assurance:	There are 11 risks included on the Primary Care Committee risk register relating to Dental provision in BNSSG. 9 of the risks have a score of 12 and mainly relate to access and waiting times. 2 are above 15 and relate to the capacity of the regional hub and ICB to support transformation with the current resource available.	
Financial / Resource Implications:	The Dental budget in BNSSG is circa £56million with a predicted underspend in 2023/24 of £8.1million. Please note specific regulations regarding the flexibilities of the national contract and related spend.	

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. Further work is required which seeks to further reduce health inequalities.
How does this impact on Equality & diversity	No implications to note
Patient and Public Involvement:	Strategy development informed by existing user feedback and staff survey. Protect Our NHS representative attended second workshop and contributed to prioritisation exercise. Further public involvement intended as part of the next phase.
Communications and Engagement:	Initial communication and engagement needs identified and detailed in strategy. Plan to be further developed as part of implementation.
Author(s):	Claire Ripley, Interim Programme Consultant, BNSSG ICB
Sponsoring Director / Clinical Lead / Lay Member:	David Jarrett, Chief Delivery Officer

Bristol, North Somerset and South Gloucestershire Integrated Care System

Draft Dental Strategy

January 2024
v0.1

Shaping better health

Executive Summary

Why have we produced this strategy?

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.

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”.

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.

The latest national report from August 2023 (up to June 2023) shows that the percentage of adults not seen within the previous 24 months in BNSSG is 56.8% which is a reduction from 61.4% in 2022 but slightly higher than 55.6% in 2021. The percentage of children not seen within the previous 24 months in BNSSG is 43.5% which is a reduction from 50.8% in 2022 and over 20% less than 2021. The data for Children in Care shows a significant shortfall of the 100% target to have seen a Dentist in the last 12 months particularly in North Somerset.

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

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

Services, previously termed 'flexible commissioning'. The 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**).

Further information on this guidance can be found in Appendix 2.

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

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

BNSSG ICB acknowledge how important it is to improve access to NHS Dental services for the local population and to identify plans which seek to reduce health inequalities. The development of this strategy has included two workshops which involved stakeholders across all areas of Dental provision, NHS England and Local Authority leads. A staff survey was also completed, and the feedback has been integral to the development of this draft strategy. Further work is needed to ensure further patient feedback is incorporated into any plans.

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 inequalities. In Bristol there are higher levels of Oral Cancer at 17.28 per 100,000, higher than the England and South West rates, in North Somerset it is 12.49 per 100,000 and in South Gloucestershire it is 11.91 per 100,000 both lower than the South West rate and the England rate. Higher incidence is associated with non-healthy behaviours such as alcohol consumption and smoking.

The draft strategy described within this paper is focused on the priorities for the next two years, but it is expected the work required will span three years given the scale of change required. The required consideration of the national regulations relating to this strategy should not be underestimated.

It is important to note that although some areas have been prioritised as commencing within 12 months compared to commencing within 2 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.

Delivering this strategy will require a robust governance structure to be in place which continues to bring together all key stakeholders across the ICB. The resource required to manage, oversee, and implement this requires further consideration and determination.

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

1. What is driving our strategy?

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

These risk factors include but are not limited to:

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

The NHS England South West Oral Health Needs Assessment published in January 2021 identified the following needs for BNSSG:

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

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

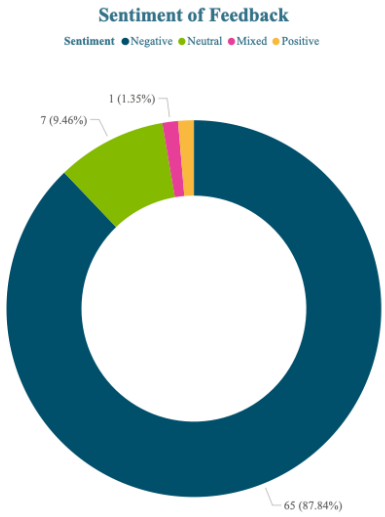
Accessing NHS Dental Services in BNSSG

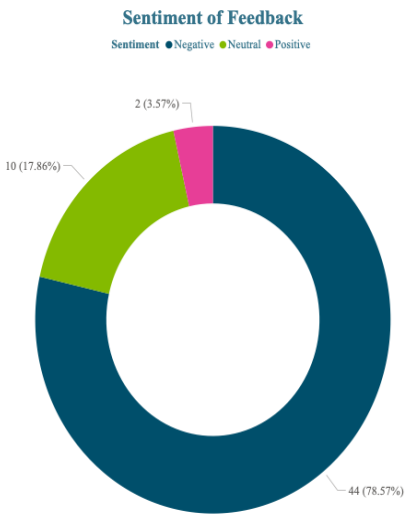
The Dental contract data provided by the South West Collaborative Commissioning Hub suggests that the volume of unique contracts identified as failing to achieve at least 30% of contracted activity at mid-year point has continued to increase over recent years. Indicative data for mid-year 2023/24 also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

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

The feedback on Dental provision Healthwatch received during 22/23 reflected that the majority was related to access to NHS Dentistry, deregistration related to Covid or privatization of normal dental practice.

BNSSG Healthwatch Feedback 2022-23





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

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

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

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

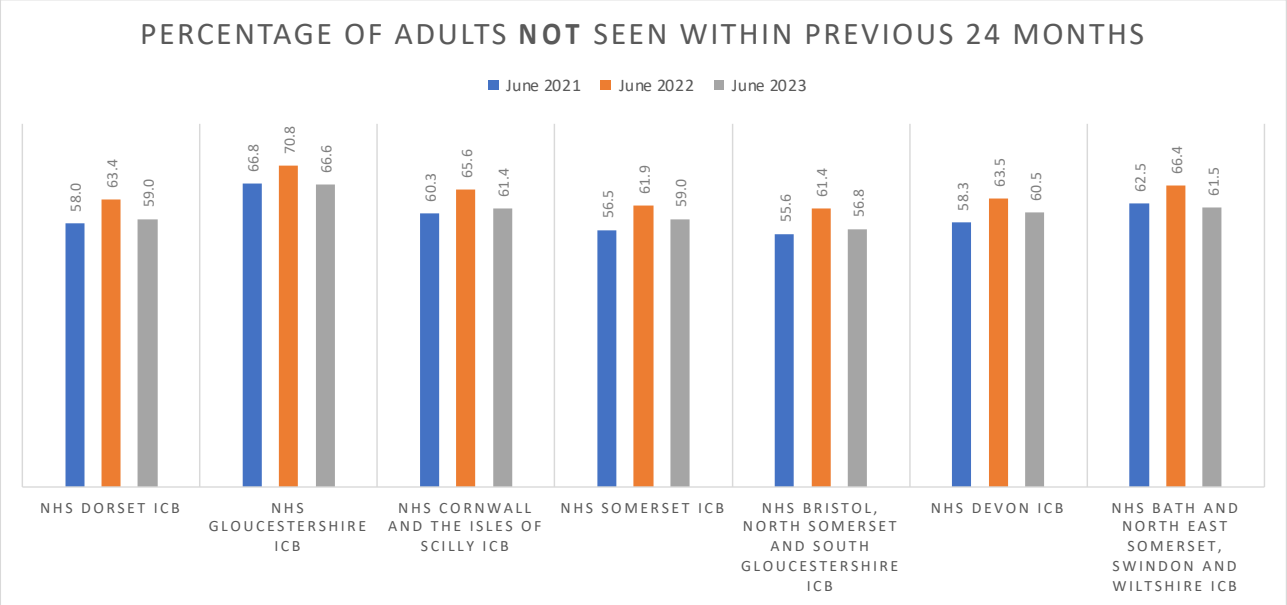
Many of the constituents shared concerns about the worsening state of NHS dental care, and the way in which the Government has not adequately funded the dentistry sector more generally. While most

participants said their experiences of emergency dentistry were positive, several were shocked at how much they had to pay – particularly when further treatment (e.g. fitting of crowns, root canal work) was needed.

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

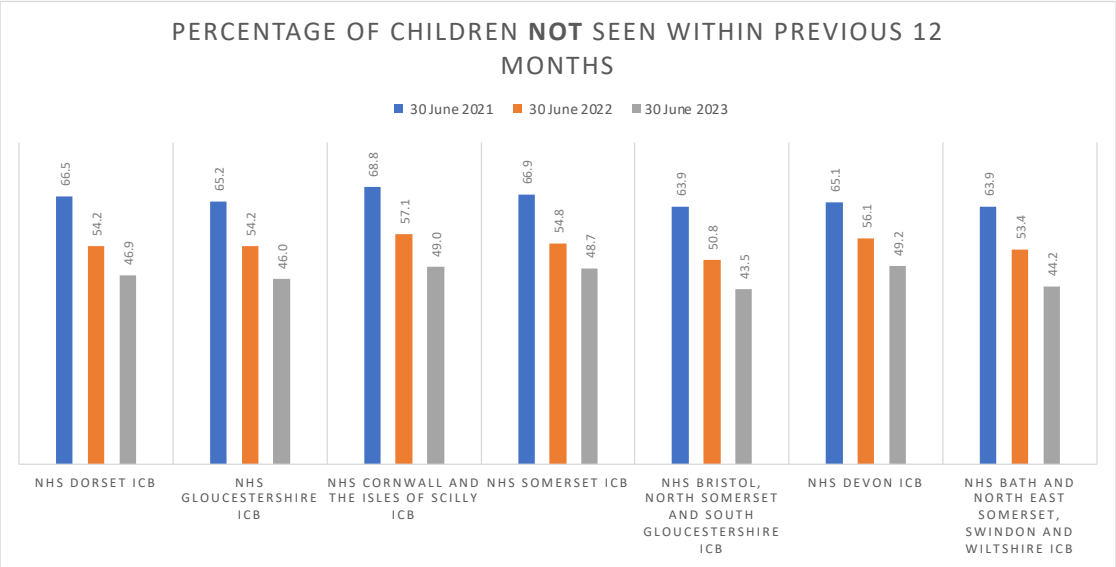
BNSSG Access Data

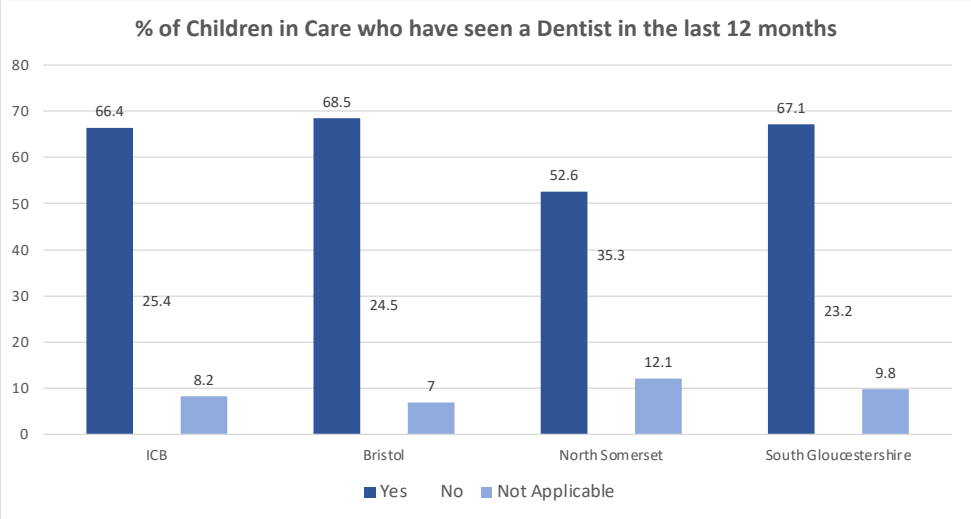
The latest national report from August 2023 (up to June 2023) shows that the percentage of adults not seen within the previous 24 months in BNSSG is 56.8% which is a reduction from 61.4% in 2022 but slightly higher than 55.6% in 2021. Regionally BNSSG performs quite well but given the South West region has the lowest access rates of the seven regions together with the level of patient feedback received it is essential that plans seek to improve this position.



Source: NHS Digital Dental Statistics for England, 2022-23, Annual Report Published 25th August 2023

The percentage of children not seen within the previous 24 months in BNSSG is 43.5% which is a reduction from 50.8% in 2022 and over 20% less than 2021. The local data for Children in Care shows a significant shortfall of the 100% target for children to be seen by a Dentist in the previous 12 months particularly in North Somerset.





Core20plus5* – Children & Young People

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

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

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

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

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

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

2. Summary of Progress

2.1 Approach in the Shorter Term

Recognising the challenges across several contracts and needing to maintain NHS provision, the ICB wrote to all Dental practices to offer providers the opportunity to discuss any support they may need. In addition to this a staff survey was undertaken which identified that 67% of respondents did not anticipate working for the NHS in two years and only 10% felt that their service was funded appropriately. The feedback received provided further evidence on why it is vital to identify a strategy which describes how the ICB will maintain NHS provision and increase access wherever possible.

In response to the letter the ICB Dental Leads received requests from 7 practices and have met with them to discuss their concerns. These have all been independent practices rather than corporate groups. Each practice has asked for support with their UDA rates and cited the impact on retention of staff who are able to be paid higher rates elsewhere or to work entirely privately. 4/7 practices have UDA values below £26 per UDA - £25.32 is now the lowest rate following a contract uplift above £25 as requested by the Local Dental Committees across the country. The average for BNSSG is around £29.00.

Flexible Commissioning guidance supports the ability of ICBs to uplift UDAs only within the current total contract value (TCV) but does not provide further guidance for the parameters in doing so. Any uplift in UDA will need to result in a reduction in contracted activity and this needs to be considered given the ICB has a commitment to recover UDA activity levels to pre-pandemic levels.

The BNSSG ICB Primary Care Operational Group recently agreed that the fairest approach in the shorter term was to apply a set of principles to each contract in BNSSG and work is underway on this. The overarching principle is to apply a small uplift to the lowest paid well performing contracts and to rebase contracts with consistent under-delivery. This requires further modelling and consideration to balance access and retention within the existing budget.

The approach was not fully endorsed by the Local Dental Committee (LDC). The LDC has requested funding from the ICB for Occupational Health, Continuing Professional Development (CPD) including costs of courses and travel expenses, peer review and capital funding. The LDC state that the main issues why practices cannot fulfil their allotted contract is the UDA value being significantly lower than needed to cover costs. The LDC suggests that to provide a safe and quality service this needs to be increased to £40 per UDA plus consideration be given to sessional contracts rather than just a UDA contract. Collaboration between the ICB and LDC leads is continuing with further consideration of this feedback part of ongoing discussions and decision making where regulations allow.

Stabilisation

Over spring and summer 2022, NHS England commissioners, clinicians and career development fellows developed a stabilisation pathway, which would ensure patients were able to access care that would stabilise their oral health and would reduce the likelihood of people going in and out of the urgent care system, or of receiving no treatment at all – providing a more permanent solution, improving patient care and improving satisfaction for clinicians.

It is intended that stabilisation will, in time, reduce demand on the urgent care system, ensuring those needing urgent care are able to access the service when they need it most.

In BNSSG there are 10 practices commissioned to provide stabilisation for a total of 27 sessions per week. The ICB leads are reviewing the delivery against these contracts to determine opportunities and plans for 2024/25.

St. Pauls Dental Care in Bristol

In June 2023 Bupa Dental Care closed 85 of its practices including St Paul's surgery in Bristol. Bupa stated this was due to a lack of dentists to deliver NHS care in the UK, in addition to increased running costs caused by inflation and high energy prices.

A direct award of contract was approved for SGA Services Limited to provide dental services in St Paul’s at the ICB Board in November. SGA Service Limited already provide services at Twindent Dental Care in Southmead and Thornbury High Street Dental Practice.

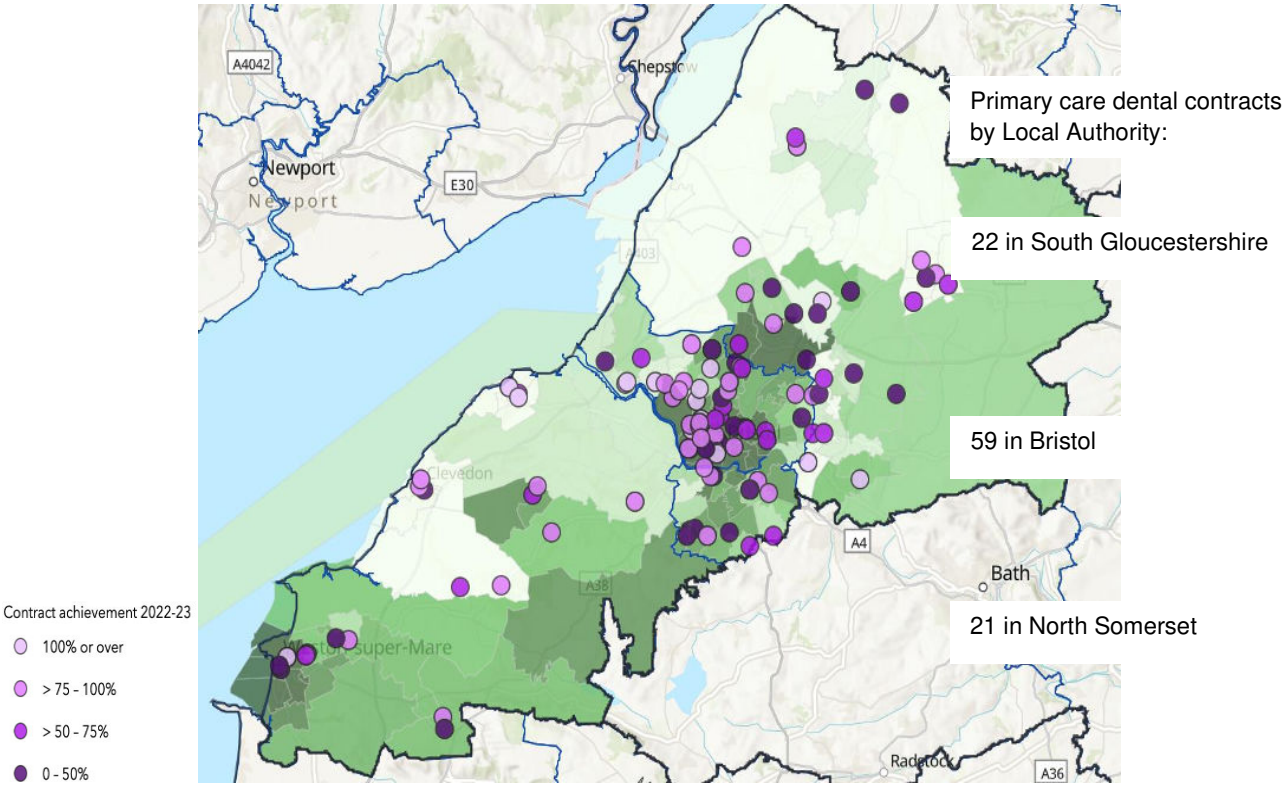
Monthly meetings between the ICB, St Paul’s Dental Action Group and Councillor Cole have taken place together with close working with Bristol City Council and the local community. The contract is split between mandatory services (routine check-ups for patients on the practice books) and stabilisation (treatment courses to get people dentally fit). This will allow more people to be treated over and above those on the practice books thereby allowing more people overall to be supported with treatment. It is hoped that the practice will open by the end of February 2024.

2.2 Collaborating to Form a 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 ICB and its partners of the plan of action needed to 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, and oral health improvement across the 3 local authorities, to create a joined-up integrated whole system dental strategy that delivers on better oral health and care for communities across BNSSG.

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



The above map is taken from the South Central West geospatial dental mapping tool which uses national reporting data from the latest national report to the end of March 2023. Not all practices shown have continued to provide NHS services in 2023/24, two contracts ended at the end of March and the Bupa St Pauls contract was handed back in June 2023 (please see later section on the new provider). The reports to November 2023 suggest that those providers not achieving 50% of their annual contract is 45% in Bristol, 38% in North Somerset and 50% in South Gloucestershire.

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

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

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

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

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

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

Bristol Dental School

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

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

- Dental clinics with 119 dental chairs
- Clinical skills suite
- Prosthetics teaching and dental production laboratories
- Computer suites
- Teaching spaces
- Informal study spaces
- Social areas
- Large changing facilities and locker spaces
- Large bike storage and maintenance

The focus is high-quality training for dental professionals to prepare them for work in primary care dentistry. The new model ensures they have an exclusive space specifically designed to support

clinical education and training but retaining a strong partnership with Bristol Dental Hospital. The newfound flexibility to manage this space and patient lists, means they can expand intakes and introduce new programmes as well as engage with underrepresented communities, delivering patient care and oral health education through their students, and by promoting access to training through established widening participation routes. There will continue to be a strong link between Bristol Dental School and the Dental Hospital on Lower Maudlin Street, through specialist placements for undergraduate students and for postgraduate students who work alongside NHS Consultant clinics. The Dental Hospital will continue to treat NHS patients requiring specialist care.

High Level Plan For the Development of a Dental Strategy in BNSSG

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

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

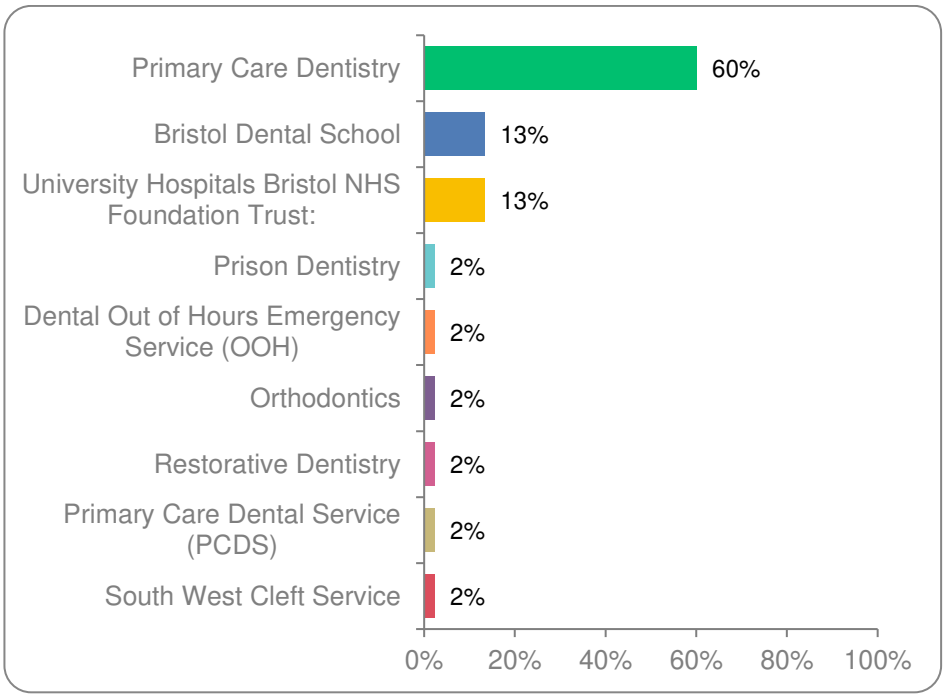
- Improving access and addressing variation
- Workforce
- Population level oral health interventions
- Integration and collaboration

The second workshop prioritised each area under the headings of:

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

BNSSG Dental Staff Survey Headlines

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



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

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

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

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

55% have an interest in working with vulnerable people but 41% feel there are not the opportunities to do so with 75% saying this was due to funding. When asked which groups they would like to work with (but are not currently) respondents said those with dental phobia, migrants and asylum seekers and Children in Care closely followed by those in care homes, people with learning disabilities, medically compromised individuals and people experiencing homelessness.

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

Please see appendix 1 for the full results.

2.3 Draft Strategy

The diagram below shows the Draft BNSSG Dental strategy on one page and summarises the areas agreed as part of the development so far and the associated timescales:

How will we deliver on these aims and objectives?

Priority Action 1: Review of all NHS provision in order to identify approach to sustaining NHS Dental provision and increasing population-based access

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

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

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

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

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

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

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

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

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

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

Priority Action 3: Reducing the administrative burden for providers through standardisation of referral pathways, access points and shared care records

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

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

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

Priority Action 4: Increasing public awareness of Dental services including access routes and the importance of good oral health

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

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

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

Priority Action 5: Increasing the dental workforce locally by improving staff morale and increasing population-based access across different areas of interest

Priority Action 6: 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

We need to improve staff morale by increasing 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.

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

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

Priority Action 7: Maintaining NHS Dental provision by retaining the existing workforce

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

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

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

There needs to be consideration of training for clinical staff on business management.

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

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

Priority Action 8: Increasing Oral Health promotion through partnership working with other services and identifying beneficial new roles to embed Oral Health Promotion throughout the population

The development of the draft strategy has included partners from each Local Authority. To devise a robust plan a working group specifically focused on Oral Health promotion is recommended.

We need to review the existing Oral Health promotion schemes and their impact. We need to consider schemes in other areas and how they could benefit the local population.

There needs to be increased working with Primary Care Networks/GP practices, pharmacies, and opticians to embed Oral Health promotion particularly if co-located.

We need to utilise existing voluntary sector links with hard-to-reach communities such as those experiencing homelessness and asylum seekers and consider existing community engagement plans and opportunities to include Oral Health.

We need to increase work with all early years services to increase Oral Health promotion exploring opportunities to work with midwives, health visitors and part of the Staying Well programme.

There needs to be integration with other health promotion services such as Healthy Weight and joined up messaging regarding diet & healthy eating. There should be closer working with Diabetes services.

We need to consider the need for Oral Health Specialists or whether this can be provided within the scope of existing roles i.e. dental nurses or school nurses.

We need to consider training of staff/carers involved with Children in Care.

There needs to be further consideration of the provision and contracts for care and nursing homes and domiciliary care identifying opportunities for the various dental roles to be part of the Enhanced Health in Care Homes Framework.

We need to increase oral health education in schools and the development of training models.

We need to identify additional ways for staff to feel part of the NHS. Work with other NHS organisations to identify opportunities to upskill and work with peers. Broaden opportunities for people to focus on specialties of interest (i.e. Diabetes).

We should explore opportunities for General Practice Oral Health Champions, students as oral health educators and Dental nurses working within GP services and multidisciplinary teams.

There needs to be a public and professional awareness campaign to increase awareness between services of what the services provide.

Further consideration is needed regarding the opportunities to improve oral health in prisons and post release.

Priority Action 9: Identifying targeted interventions to improve the oral health of the population

There needs to be a review of the evidence for targeted fluoride varnish programmes, provision of toothbrushes and toothpaste, water fluoridation and other interventions which seek to reduce health inequalities.

Given the high rates of oral cancer in Bristol there needs to be a campaign to increase HPV vaccine uptake and identify close working with alcohol and substance misuse services.

3. Further Considerations

The workshops and survey have enabled the production of this strategy and provided useful insights into the areas stakeholders felt we need to focus our strategy on and the timelines for doing so.

Further consultation with patients as part of the developing strategy is required but it should be noted that incorporating any feedback will need to be within the national contractual regulations which are outside of the ICBs control. Further community engagement is also required following the publication of this draft strategy. Integration of dental services and oral health, firmly embedded as part of the 'four pillars of primary care', with GP, Pharmacy and Optometry as well as integrating oral health in a range of wider care pathways is intended to be a key feature of our developing strategy. This needs to take place over the remaining months of the financial year to ensure that a plan is deliverable from April 2024.

Further work is also needed to align the draft strategy to evidence given that evidence-based practice in the NHS is the integration of best research evidence with clinical expertise and patient values.

As described within this paper, BNSSG ICB have already commenced work on applying the flexible commissioning opportunities where possible to the contract. This has so far included a review of UDA rates and requests for support to seek to sustain dental provision and maintain the workforce across BNSSG. New initiatives focused on reducing health inequalities such as increasing provision for Children in Care are being considered. The ICB continues to work closely with colleagues from the Local Dental Committee (LDC) on further areas of investment which would encourage staff to continue with their NHS contract.

To implement this strategy from April 2024 it will require a robust governance structure to be in place which continues to bring together all key stakeholders and partners across the Integrated Care System. A draft governance structure was discussed at the second workshop and could be the basis of this moving forward. The resource required to manage, oversee, and implement this requires further consideration and determination.

Appendix 1:

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

Appendix 2:

NHS England

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

Date published: 9 October, 2023

The following abbreviations and acronyms are used in this document:

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

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

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

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

The contents of this guidance should be considered alongside the Policy Book for Primary Dental Services and the national dental contractual framework. Commissioners should continue to give due

regard to national procurement guidance and organisational standing orders and standing financial instructions should also be observed when implementing any aspects of this guidance.

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

Three types of services are described in both the GDS and PDS Regulations: mandatory, additional and further services. Both mandatory and additional services are defined within the regulations. There is greater scope for commissioners to define the target population, required activity and associated remuneration of further services, including dental public health services, to meet the specific needs of their local populations which go beyond mandatory services.

Mandatory services

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

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

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

Additional services

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

Dental public health services and further services

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

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

Further details regarding the specific regulations can be found here together with examples of how this guidance can be applied:
https://www.england.nhs.uk/long-read/opportunities-for-flexible-commissioning-in-primary-care-dentistry-a-framework-for-commissioners/

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

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

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

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

Plan for the development of a BNSSG Dental Strategy

Workshop 1: Breakout Session Outputs - Overall Summary

Improving Access & Addressing Variation

- 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)
- Explore opportunities to release funding in some areas to focus elsewhere
- Review and standardise referral pathways and access points
- Explore opportunities to utilise Digital technology
- Increase public and professional awareness of how dentistry works
- Consider health champions in the community which may be building on existing schemes for related areas
- Review reasons patients do not attend and look at reducing rates

Workforce

- Increase understanding of dental pathways and roles
- Review career progression pathways and upskilling of staff in particular therapists and consider increasing advanced care practitioners
- Promote career opportunities in schools including apprenticeships
- Coordinated approaches to recruitment across the area and focused on applicant work/life balance needs
- Create opportunities for workforce networking, wider community partnerships and enable staff to feel part of the NHS
- Review possibility of salaried positions and access to NHS Pension
- Broaden specialty focus including related areas such as Diabetes
- Focus on retention particularly nurses & therapists

Population Level Oral Health Interventions

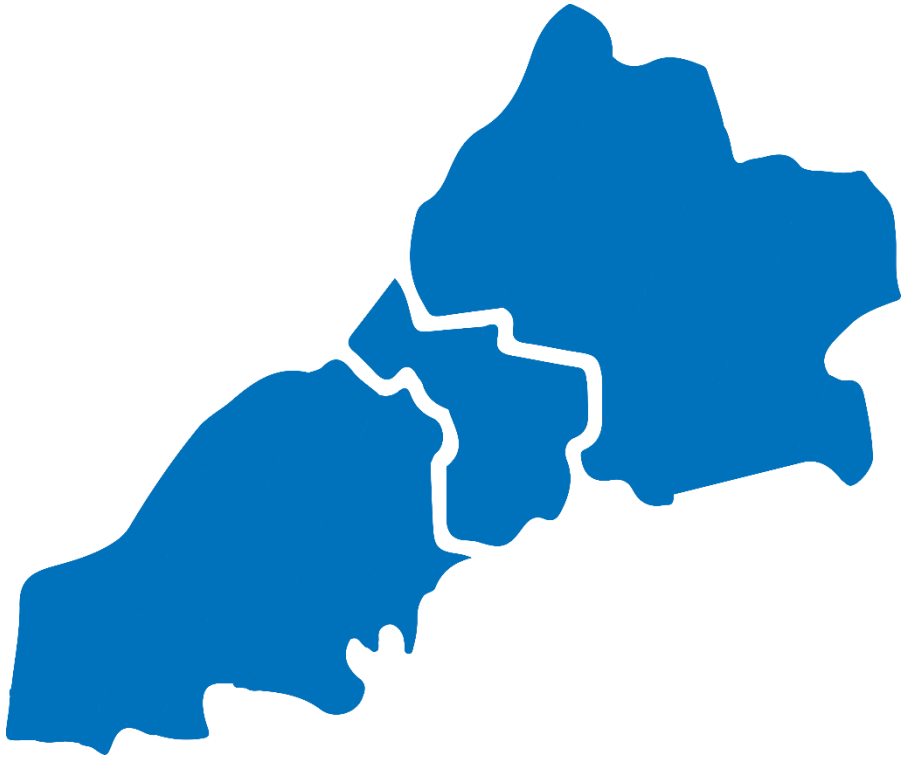
- Complete demand and capacity modelling
- Increase oral health education in care homes, nursing homes and schools
- Consider community engagement plans, other Local Authority areas (i.e. healthy weight) and early years services to find opportunities to include Oral Health
- Complete a skills audit to understand scale of opportunity for the population including outreach services and education
- Further consider national evidence such as the Advanced Dental Care Review and NICE guidance recommendations on tooth brushing schemes
- Increase HPV vaccine uptake to reduce Oral cancer rates
- Consider Tier 2 services to reduce waiting lists
- Consider care access routes such as urgent care, 111, stabilisation and opportunities to focus on population needs

Integration & Collaboration

- Explore opportunities to embed Oral Health in primary care including GP practices and pharmacies (particularly if co-located) and increase awareness between services
- Review opportunities for any possible underspend on Local Authority prevention budgets
- Develop urgent care shared care records and referral processes
- Identify opportunities for the various dental roles to be part of the Enhanced Health in Care Homes Framework
- Review opportunities for utilising existing services such as Diabetic Retinal Screening
- Explore opportunities for dental students going out to schools, care homes and focus on specific areas
- Utilise existing voluntary sector links with hard to reach communities such as the homeless and asylum seekers
- 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

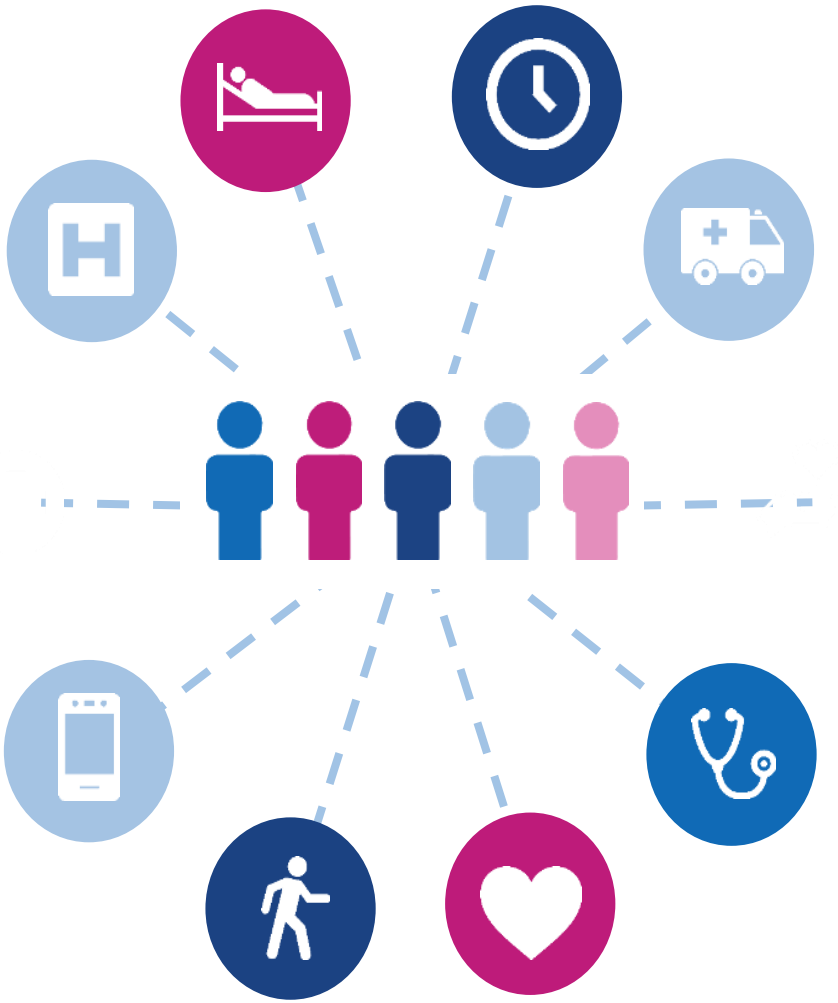
Breakout Session 1: Gap Analysis

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 Dental strategy on a page

Aim

Reducing health inequalities by increasing access to NHS dental provision

Developing the workforce, retaining staff and attracting more applicants

Reducing the burden of dental disease through oral health promotion and integration with other services

High Level Objectives

Within 12 months:

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

- Reducing the administrative burden for providers through standardization of referral pathways, access points and shared care records
- Increasing public awareness of Dental services including access routes and the importance of good oral health

Within 2 years*:

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

Within 12 months*:

- Increasing Oral Health promotion through partnership working with other services and identifying beneficial new roles to embed Oral Health Promotion throughout the population
- Identifying targeted interventions to improve the oral health of the population

*where regional and national developments allow

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

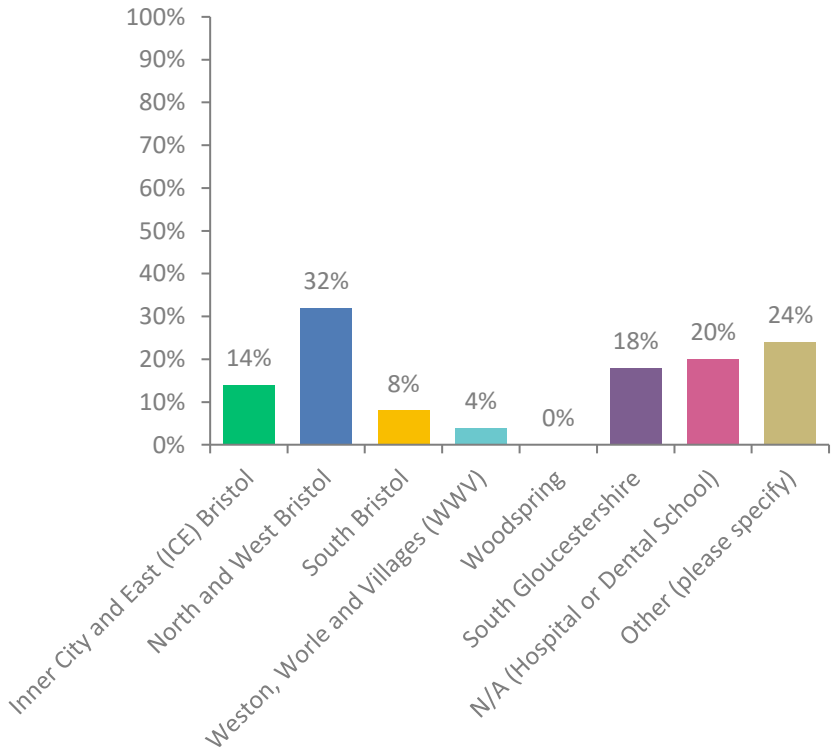
Analysis of 50 responses

Shaping better health

Respondents Profiles: Location and Provider Type

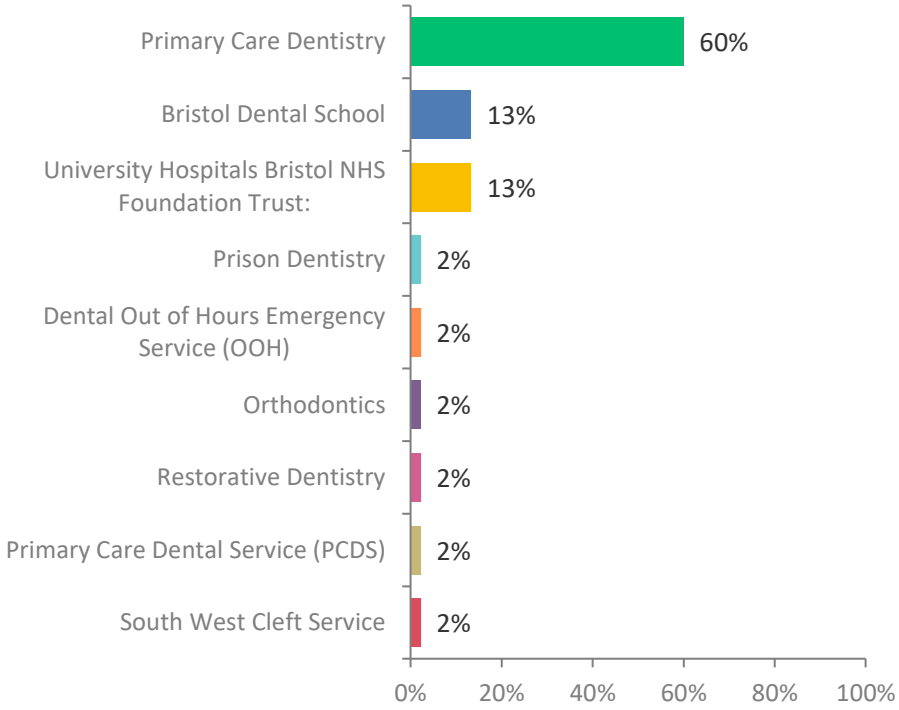
Q1: Which locality do you work in?

Answered: 50 Skipped: 0



Q5: Which organisation do you work for?

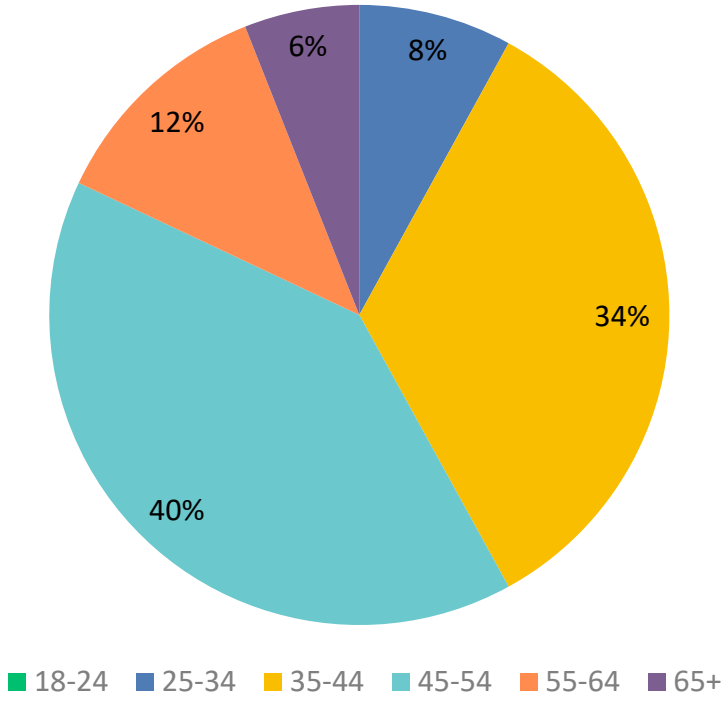
Answered: 45 Skipped: 5



Respondents Profiles: Age and Gender

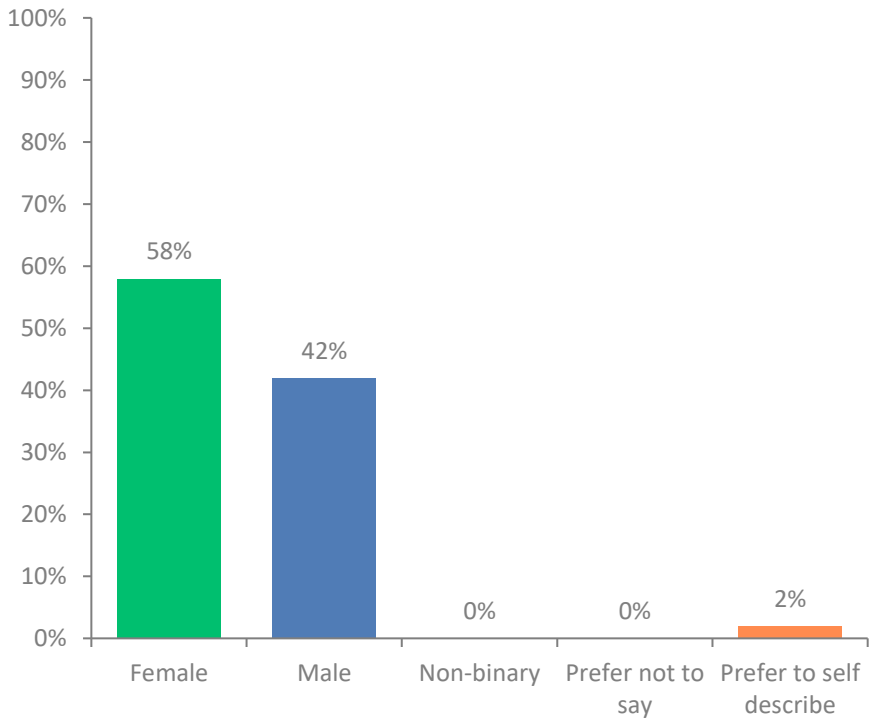
Q2: What age group do you fall into?

Answered: 50 Skipped: 0



Q3: What best describes your gender?

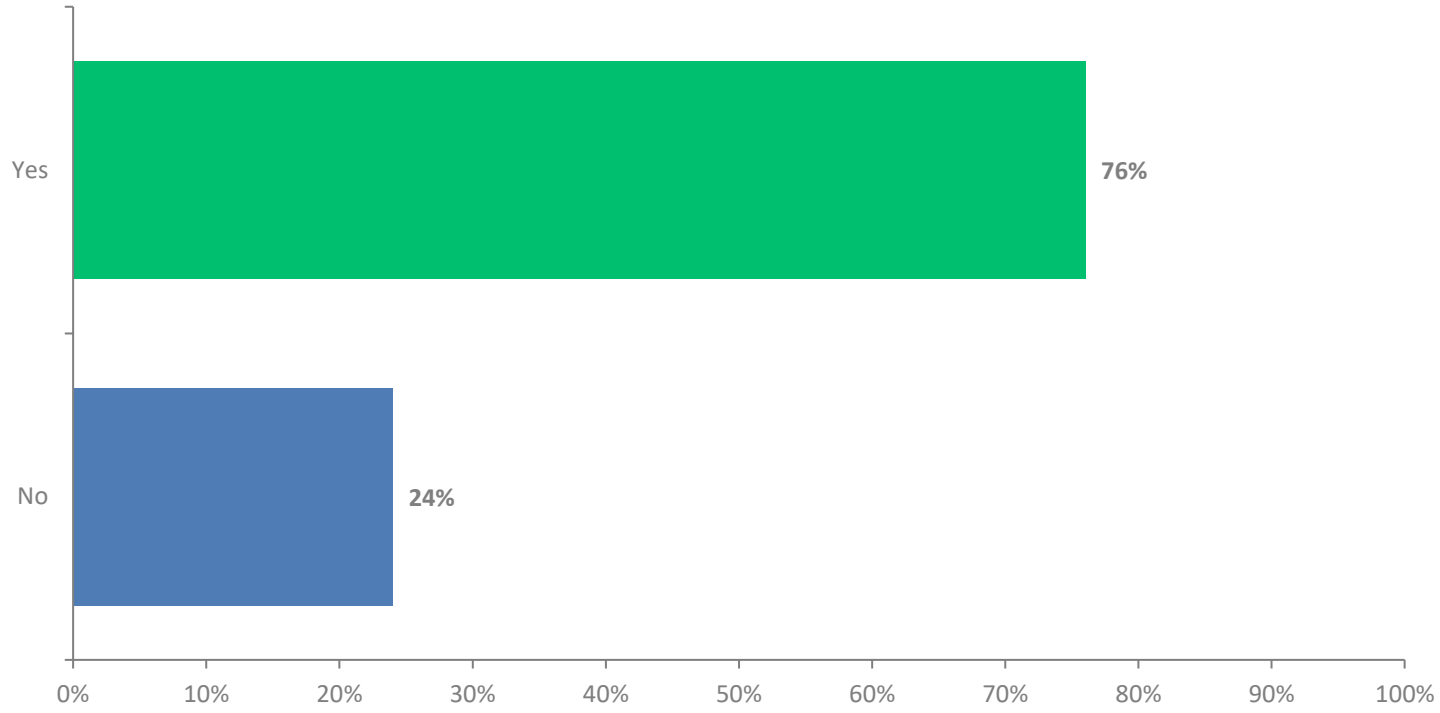
Answered: 50 Skipped: 0



Respondents Profiles: Nationality

Q4: Is English your first language?

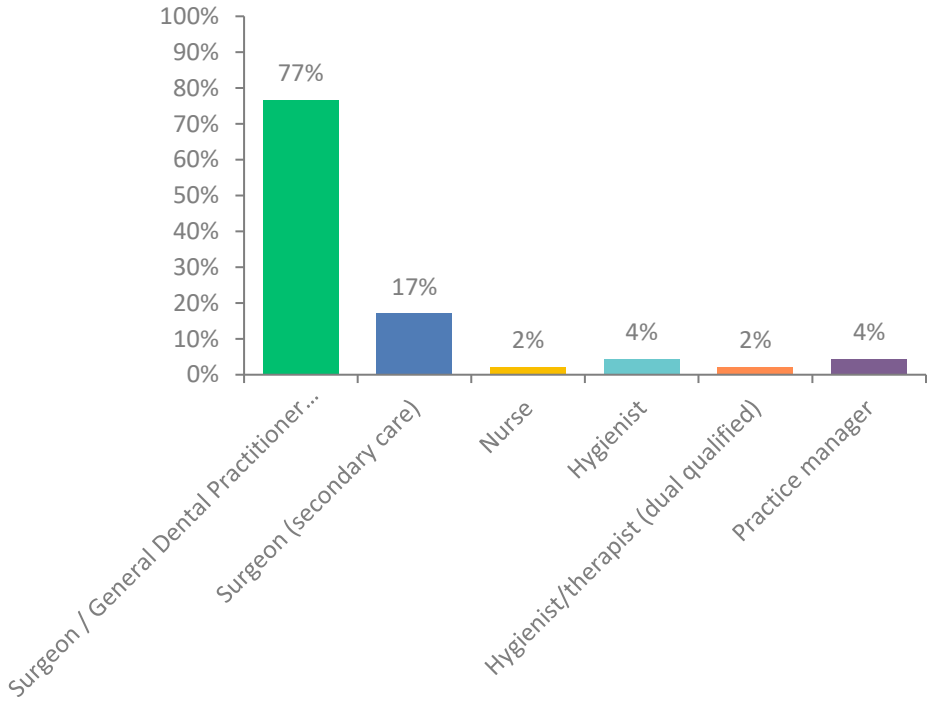
Answered: 50 Skipped: 0



Respondents Profiles: Current Role and Clinical Interests

Q6: What is your primary role?

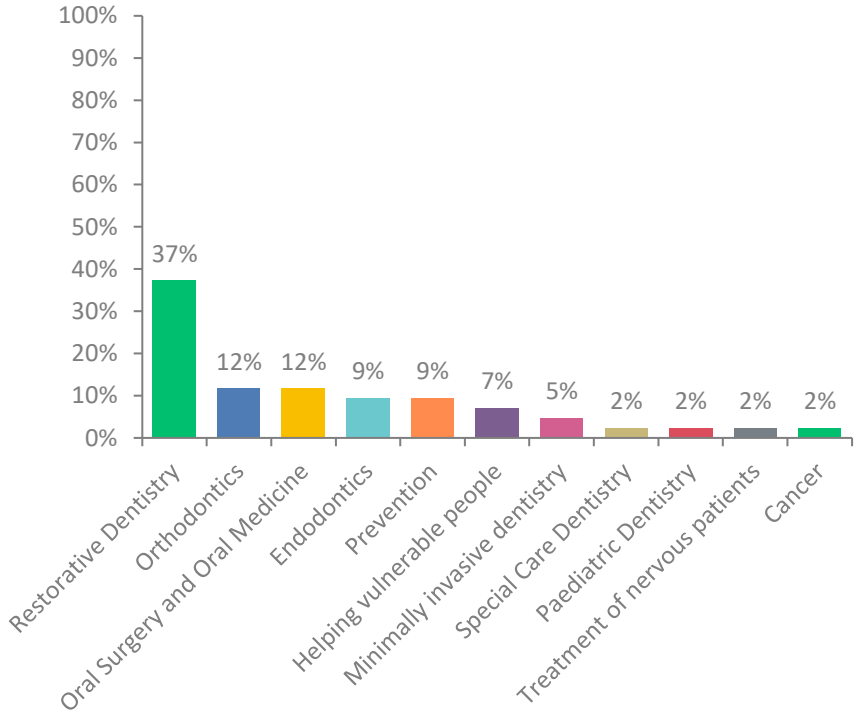
Answered: 47 Skipped: 3



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

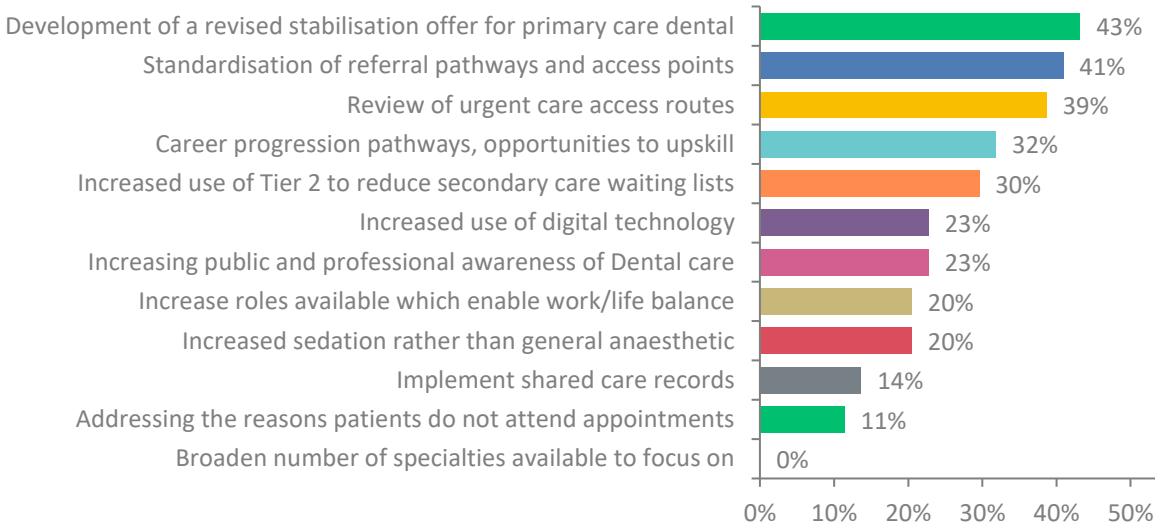


Additional responses: 5 x General Dentistry, General Dentistry, Oral Surgery Sedation, Endodontics / Restorative / Sedation, Specialist in Restorative Dentistry, Prosthodontics, Periodontics and Endodontics, Dental Implantology, Dental Education / Upskilling the workforce

Prioritisation and Barriers

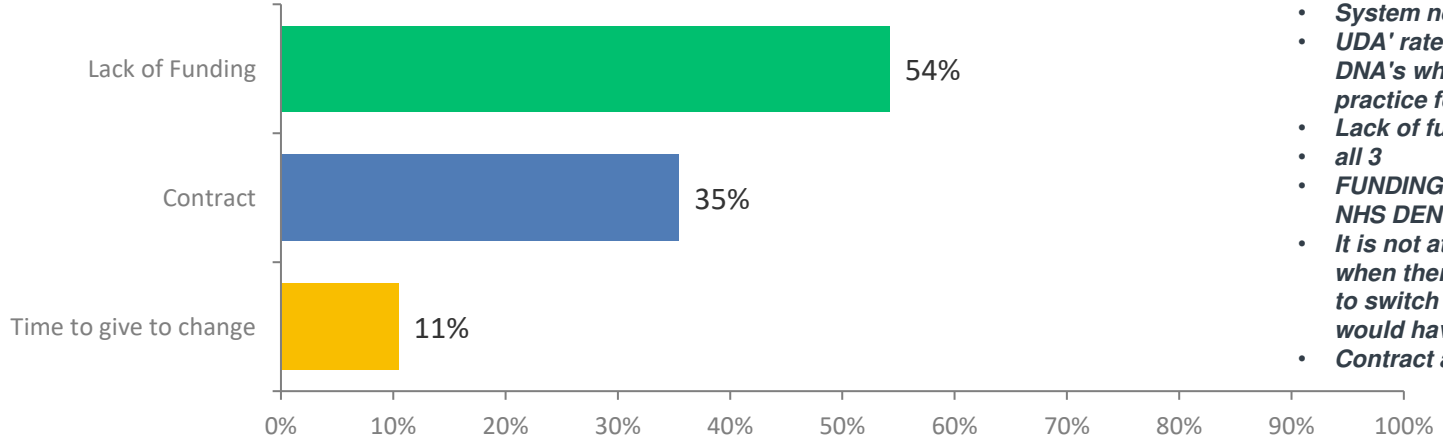
Q9: What would be your top 3 immediate priorities for improving Dental Care in BNSSG?

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:

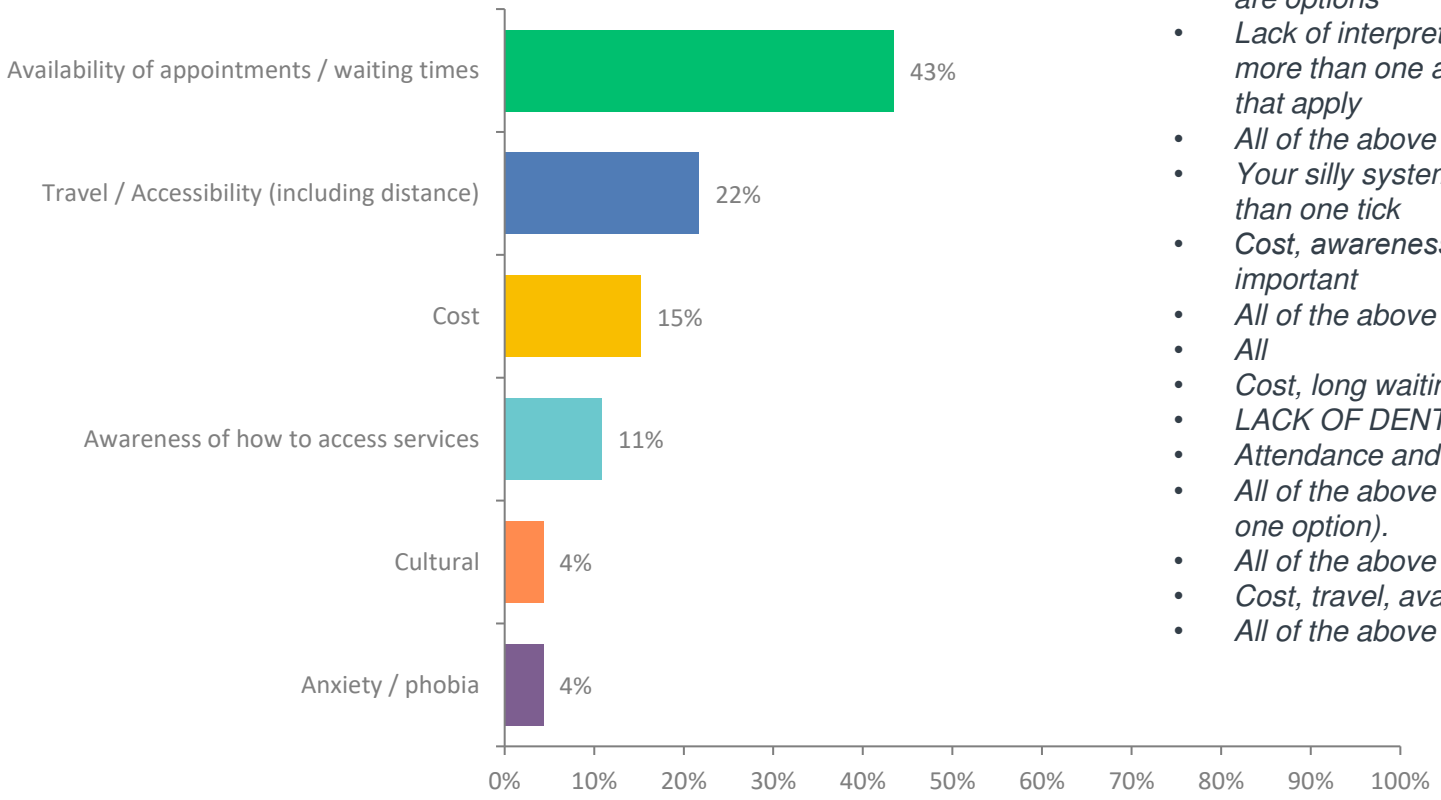


- ***Multiple issues- not enough access to primary care***
- ***System needs reinvention***
- ***UDA' rates very low, High level of DNA's which unfairly penalises a practice for underperformance***
- ***Lack of funding and contract***
- ***all 3***
- ***FUNDING AND COMMISSIONING. NHS DENTISTRY IS DYING***
- ***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%

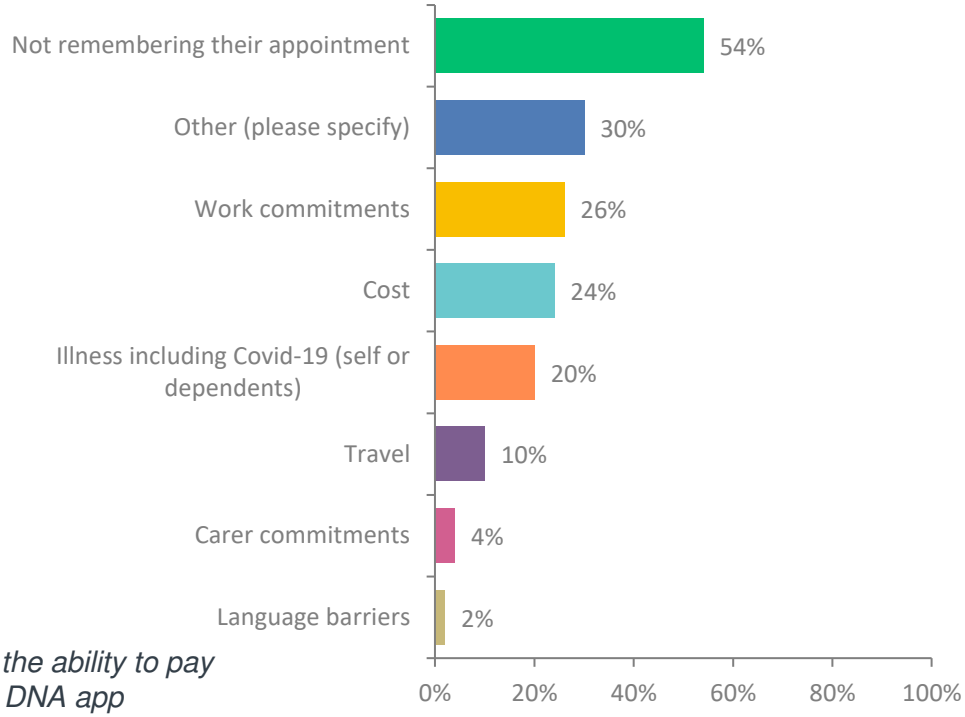
5 x 24-29%

5 x 30-40%

4 x 45-50%

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

Answered: 50 Skipped: 0

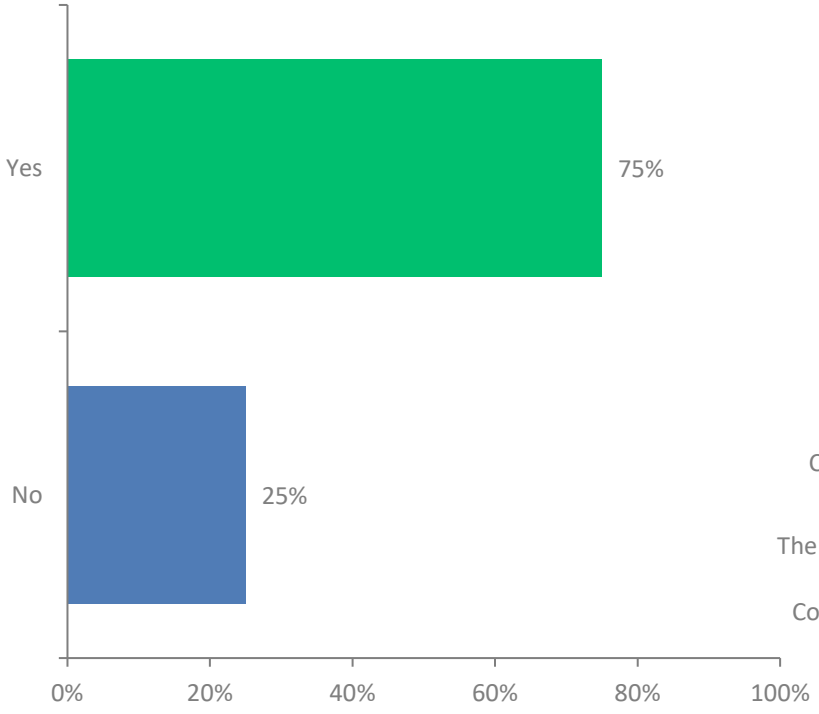


- *Inequalities, chaotic life style, poverty*
- *4 X unsure*
- *No charge for missed NHS appointments*
- *Non attendance in my Private Practice is wholly related to the ability to pay*
- *Doesn't matter, dentists are the ones who get zero pay for DNA app*
- *Anxiety*
- *Patients not encouraged to play 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

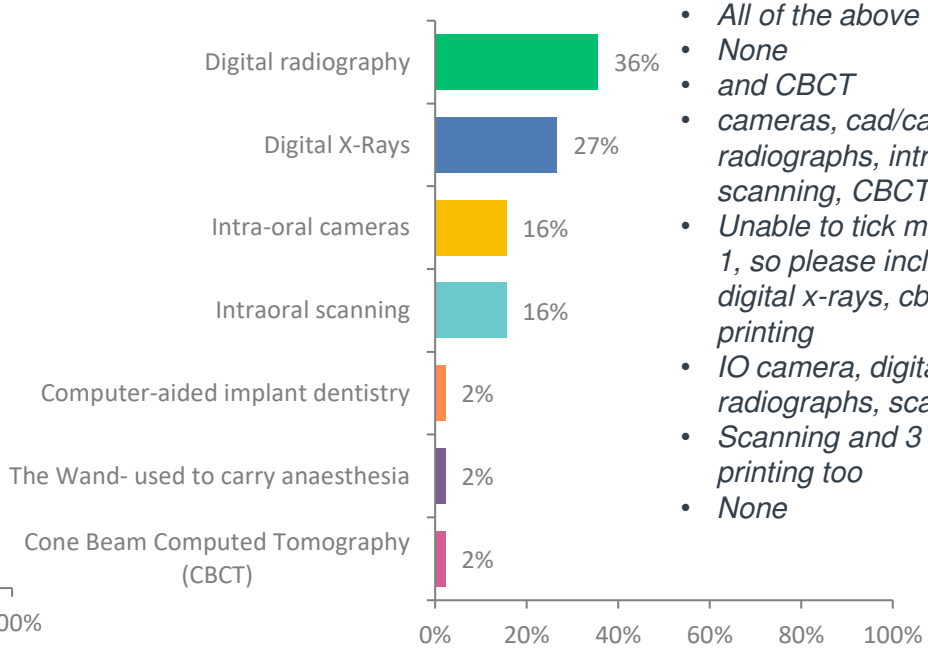
Q25: Do you feel utilising the Digital dentistry tools available is important?

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

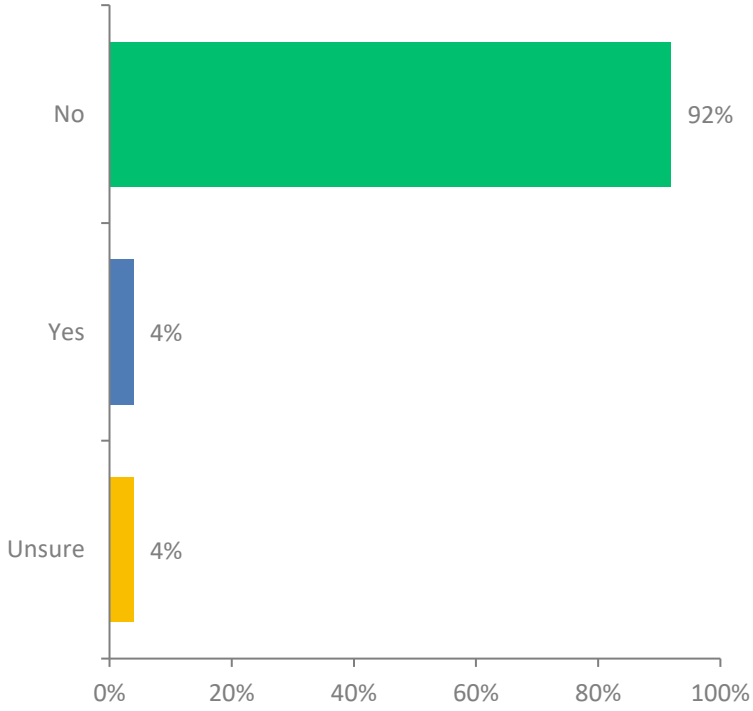


- *Digital x-rays*
- *You cannot tick all that apply*
- *All of the above*
- *None*
- *and CBCT*
- *cameras, cad/cam, radiographs, intra oral scanning, CBCT*
- *Unable to tick more than 1, so please include digital x-rays, cbct, 3d printing*
- *IO camera, digital radiographs, scanning*
- *Scanning and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

Public & Professional Awareness

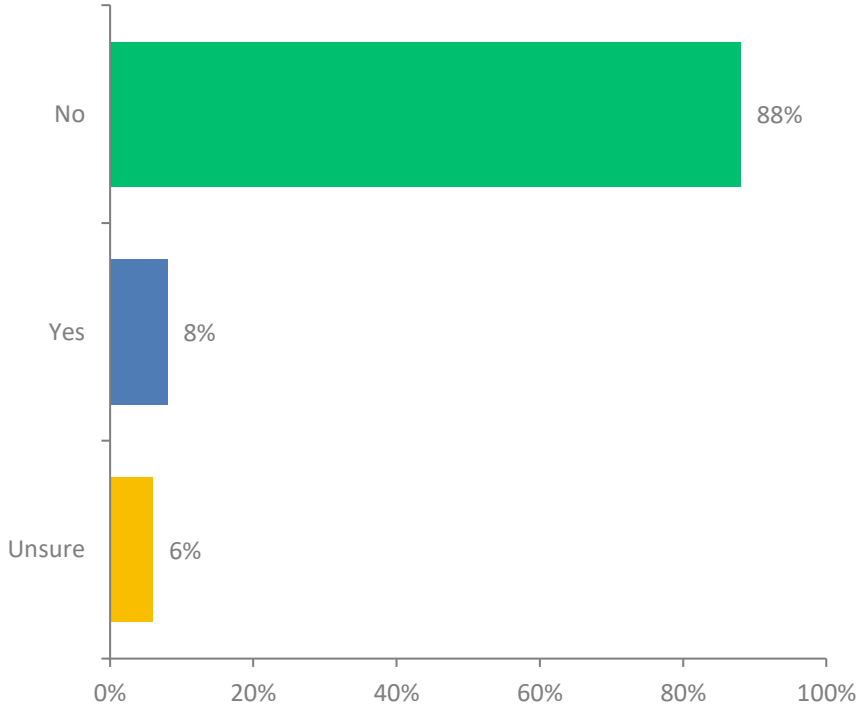
Q27: Do you feel the public understand how NHS dentistry functions?

Answered: 50 Skipped: 0



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

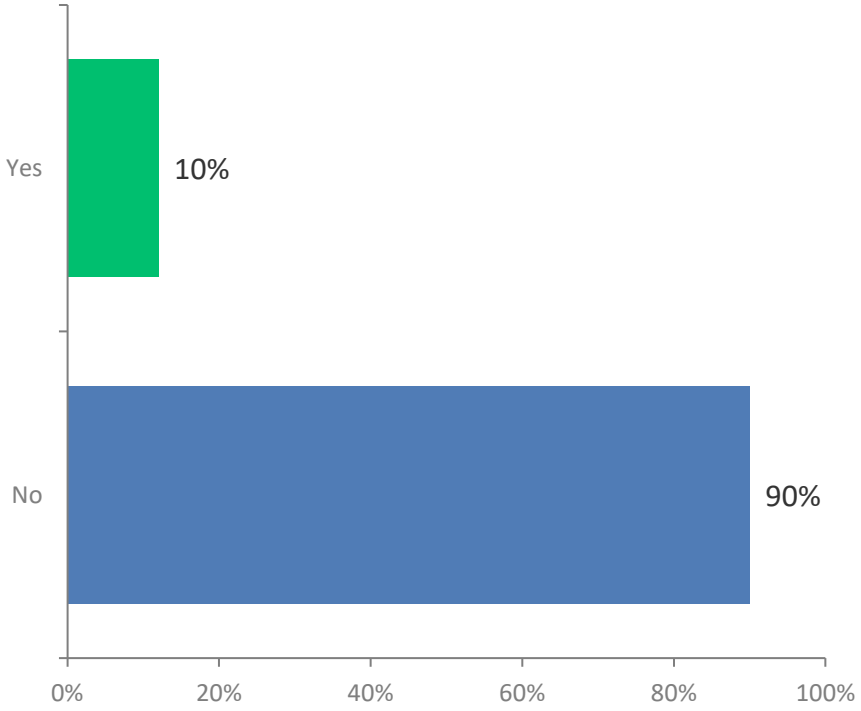
Answered: 50 Skipped: 0



Working for the NHS

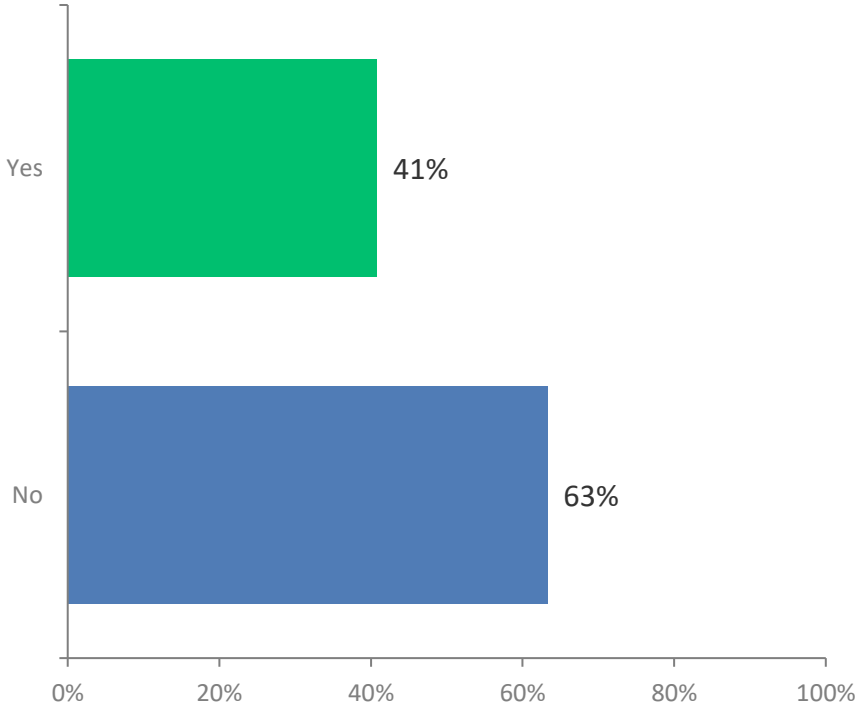
Q13: Do you believe your service is funded appropriately?

Answered: 50 Skipped: 0



Q14: Do you enjoy working for the NHS?

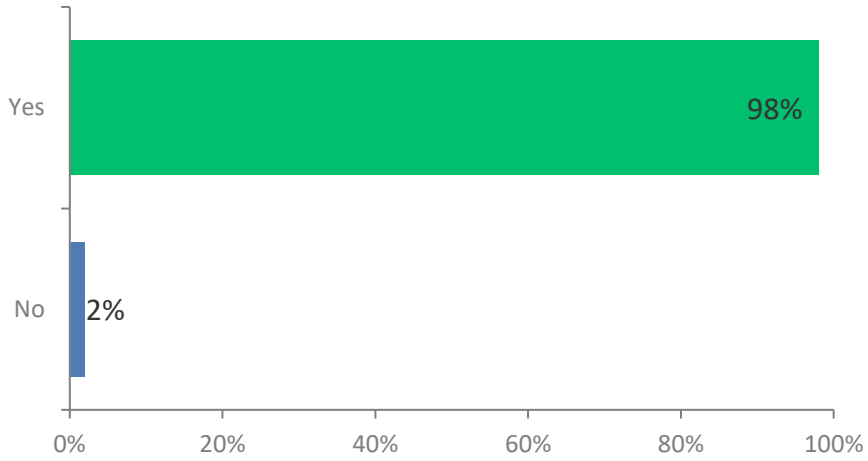
Answered: 49 Skipped: 1



Working for the NHS: Continuing Professional Development

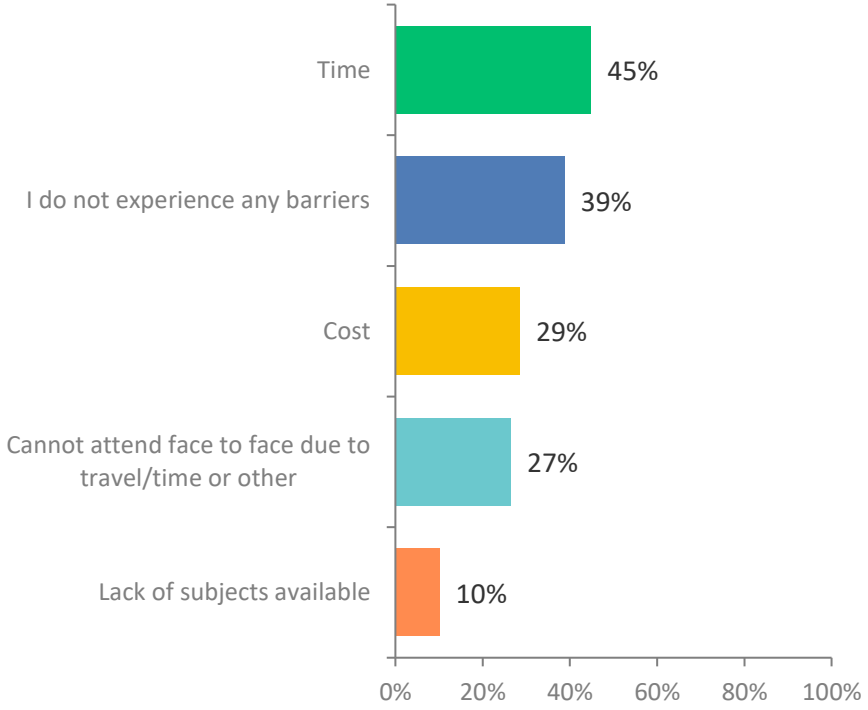
Q11: Have you completed any continuing professional development over the last 12 months?

Answered: 50 Skipped: 0



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

Answered: 49 Skipped: 1

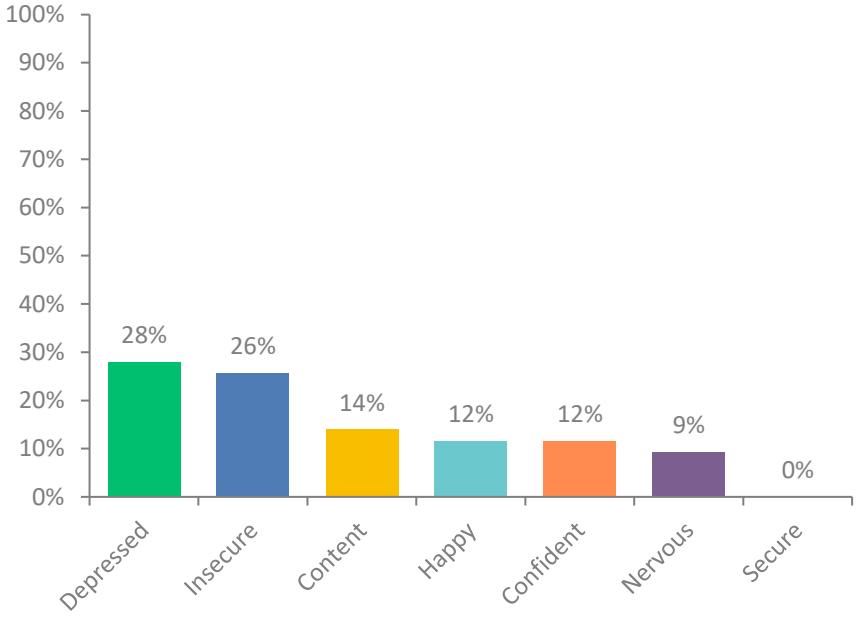


- *going over subjects that you've done many times before*
- *writing reflection and how it will change the way you work*
- *when you've done the job for so long, there is nothing new you can learn and apply to the job.*

Working for the NHS: Satisfaction

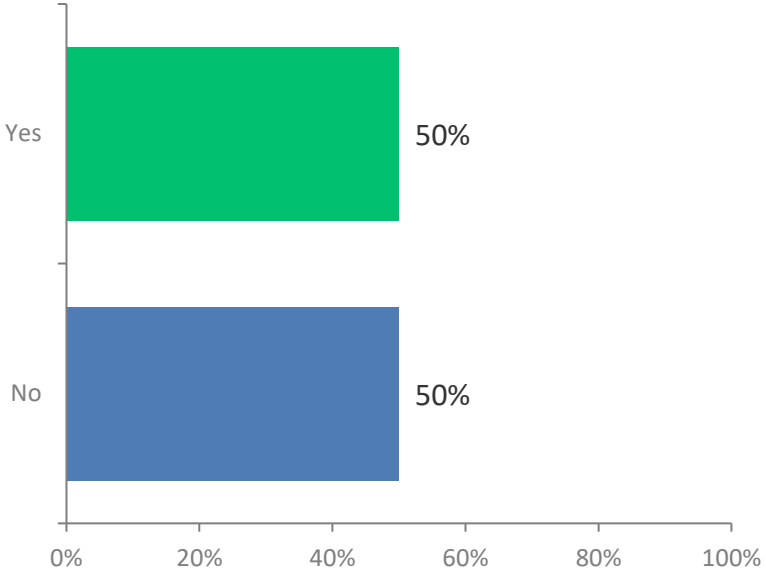
Q15: Do you routinely feel any of the following as a result of your work?

Answered: 43 Skipped: 7



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

Answered: 50 Skipped: 0

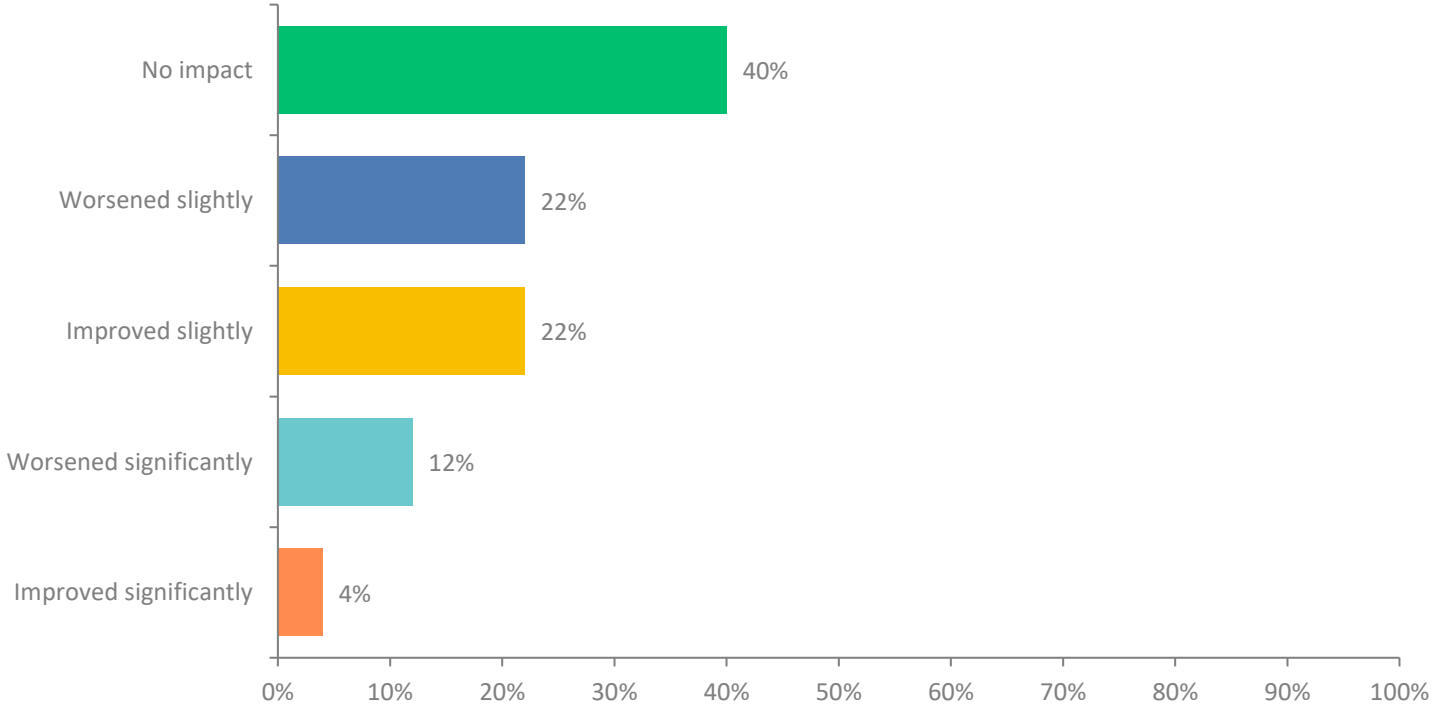


- *Can't tick multiple answers. Probably feel all of those things*
- *None of the above*
- *Overwhelmed*
- *I'm happy because I am a private practitioner*
- *Burnt out*
- *Angry*
- *UNDERVALUED AND MISERABLE. STRESSED*
- *Decreased NHS provision as a result. Now much happier, but depressed when I see 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?

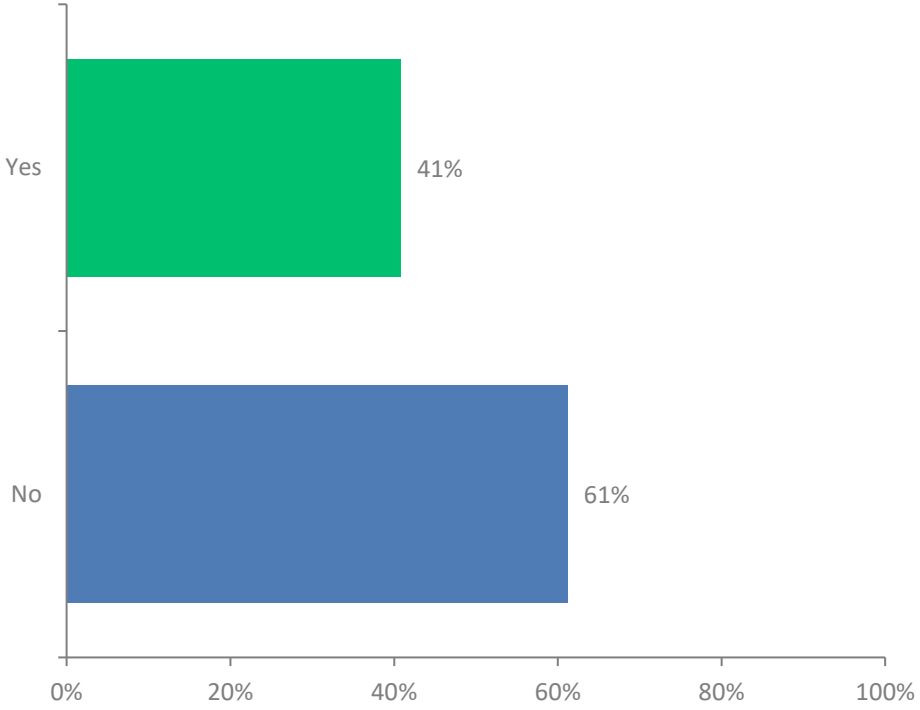
Answered: 50 Skipped: 0



Working for the NHS: Career Progression

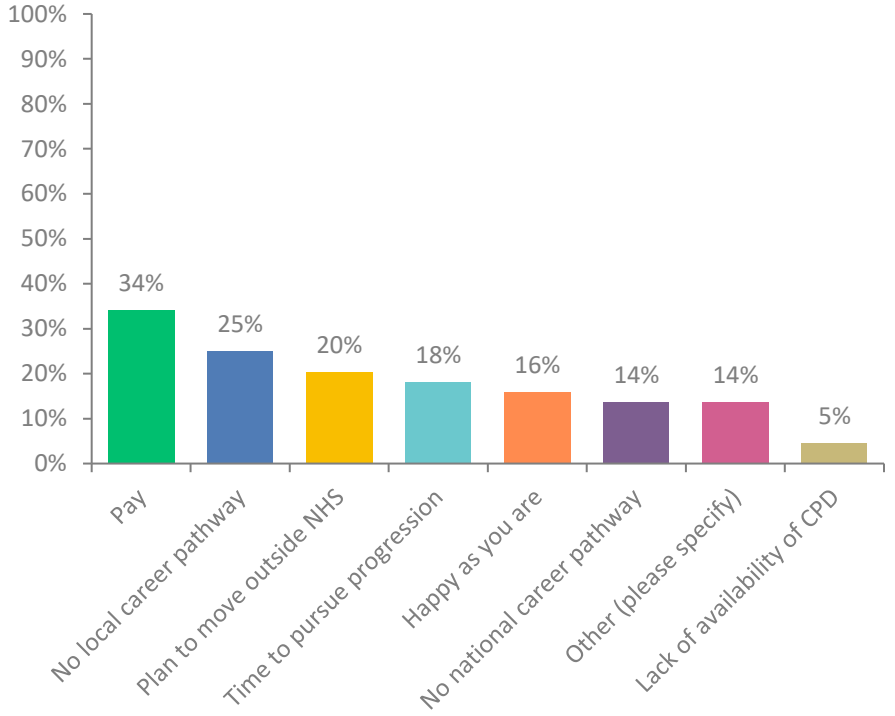
Q18: Do you see a way for your career to progress and develop?

Answered: 49 Skipped: 1



Q19: If no, is this due to:

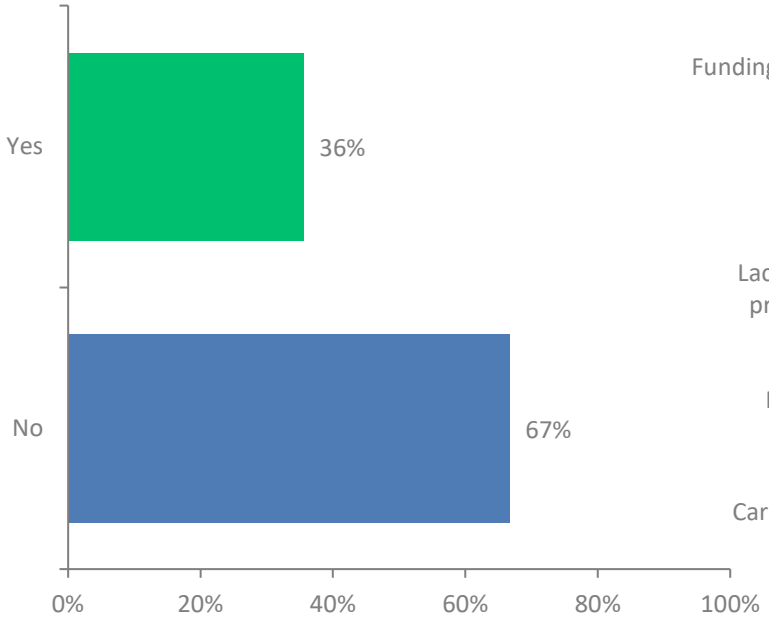
Answered: 44 Skipped: 6



Working for the NHS: Longevity

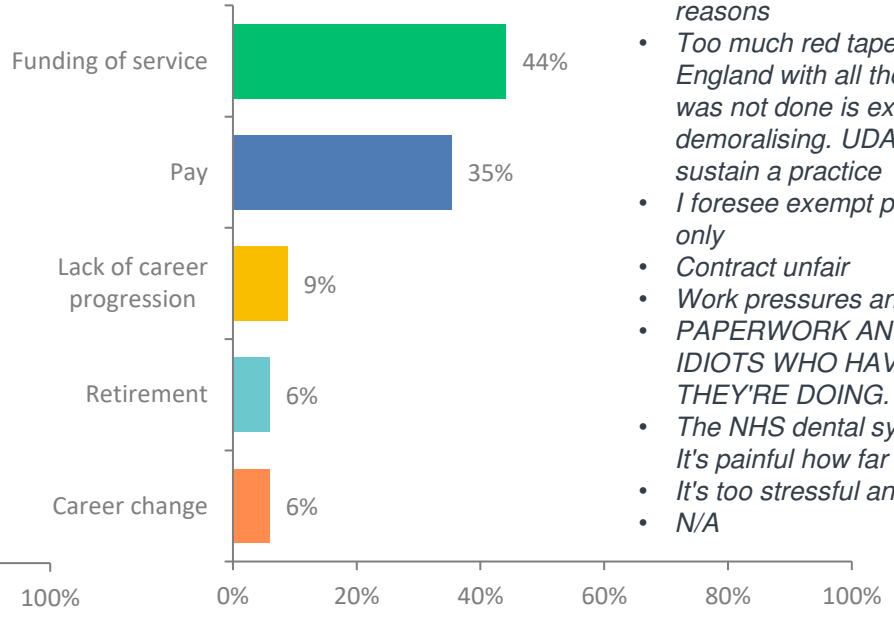
Q20: Do you anticipate working for the NHS in two years time?

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?

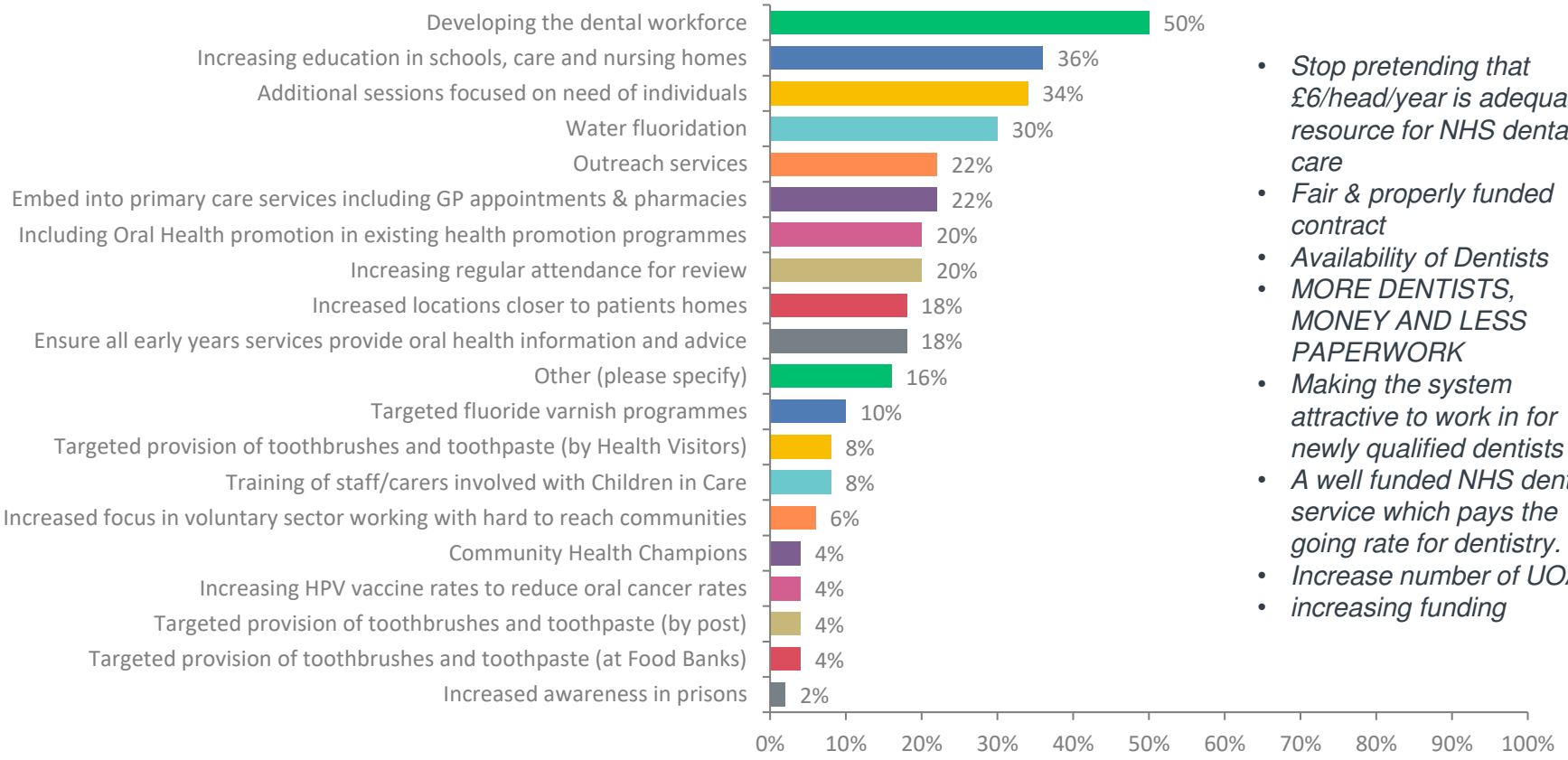
- *Travelling community*
- *Deaf community*
- *Neglected dentally patients*
- *Sex workers*
- *Those in prison*
- *Obese patients*
- *House bound patients*
- *Those from poorer/underprivileged backgrounds*
- *Bedbound and those who spend long time in the hospitals*
- *Children with SEN*
- *Some BAME 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?

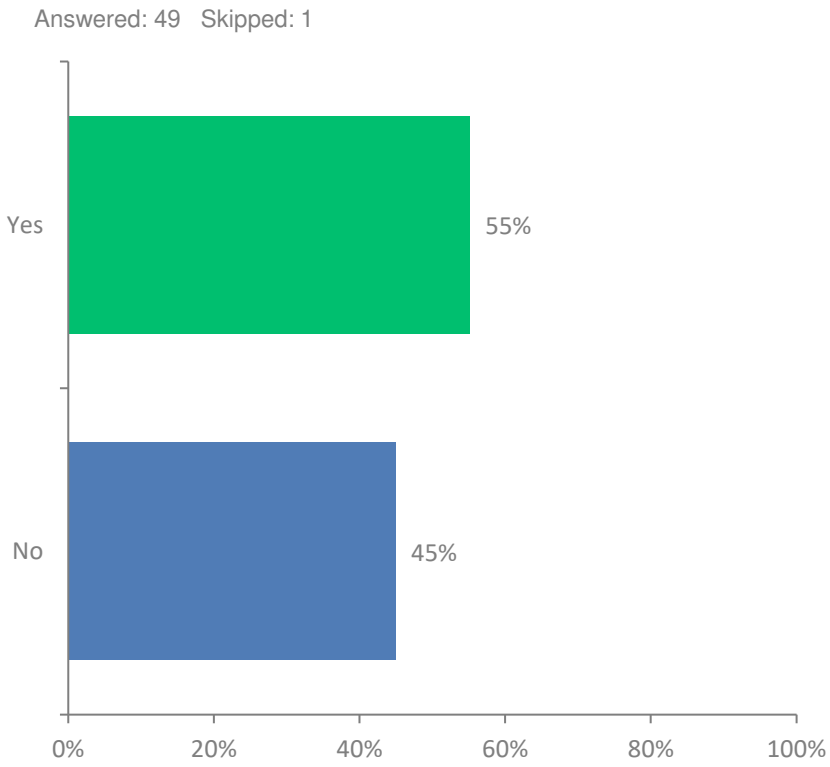
Answered: 50 Skipped: 0



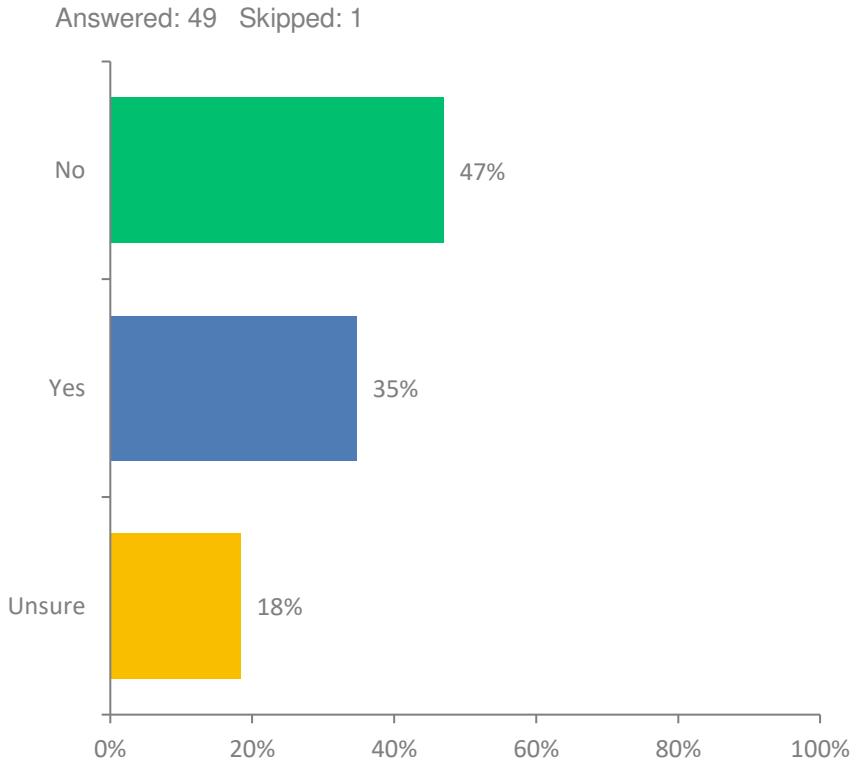
- *Stop pretending that £6/head/year is adequate resource for NHS dental care*
- *Fair & properly funded contract*
- *Availability of Dentists*
- *MORE DENTISTS, MONEY AND LESS PAPERWORK*
- *Making the system attractive to work in for newly qualified dentists*
- *A well funded NHS dental service which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



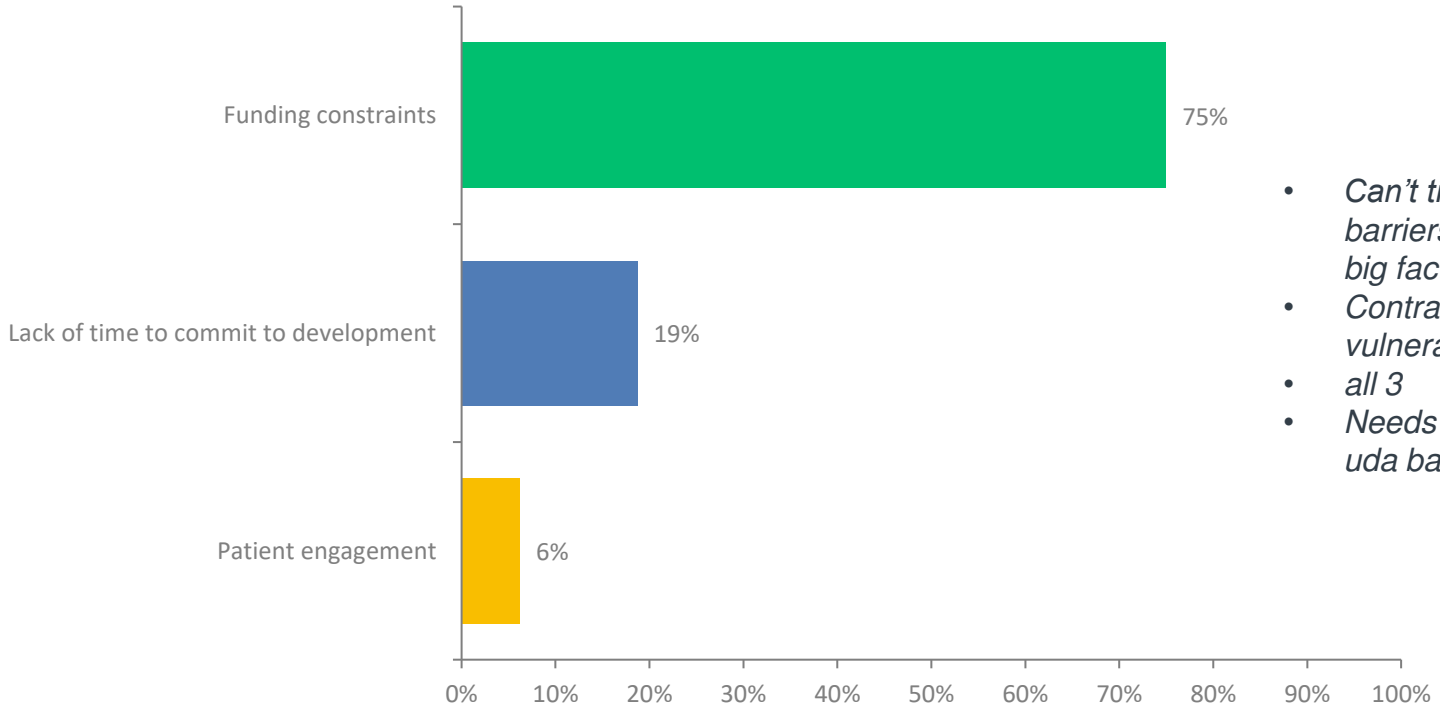
Q32: Do you feel there are opportunities to increase support for vulnerable/seldom heard people?



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

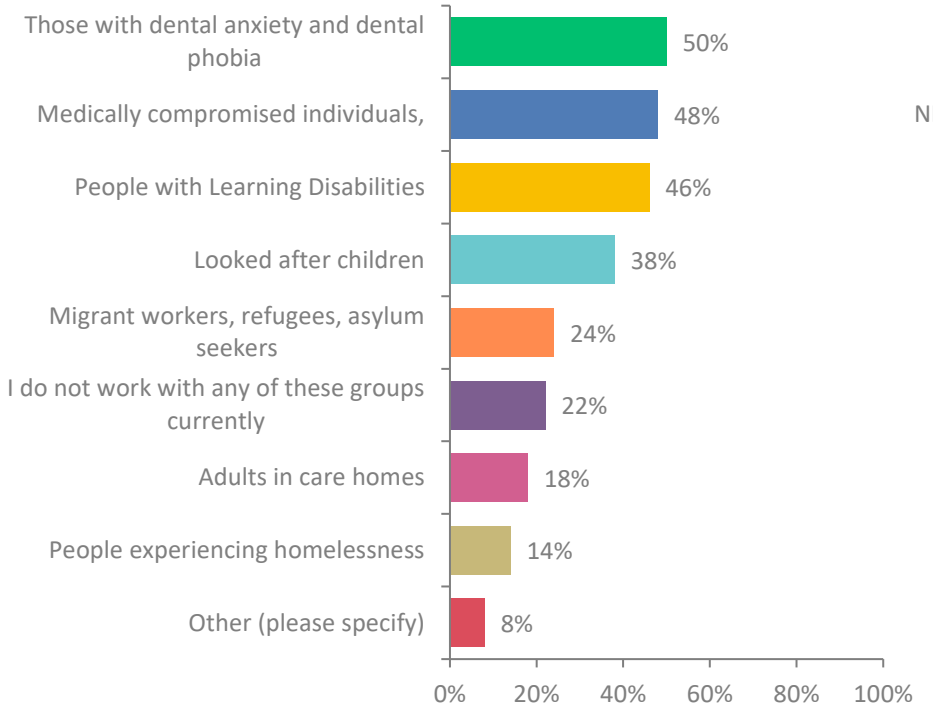


- *Can't tick multiple -all are barriers. Lack of access is a big factor of access are very*
- *Contract is anti-vulnerable/seldom heard*
- *all 3*
- *Needs to be salary based not uda based.*

Population Based Oral Health: Opportunities

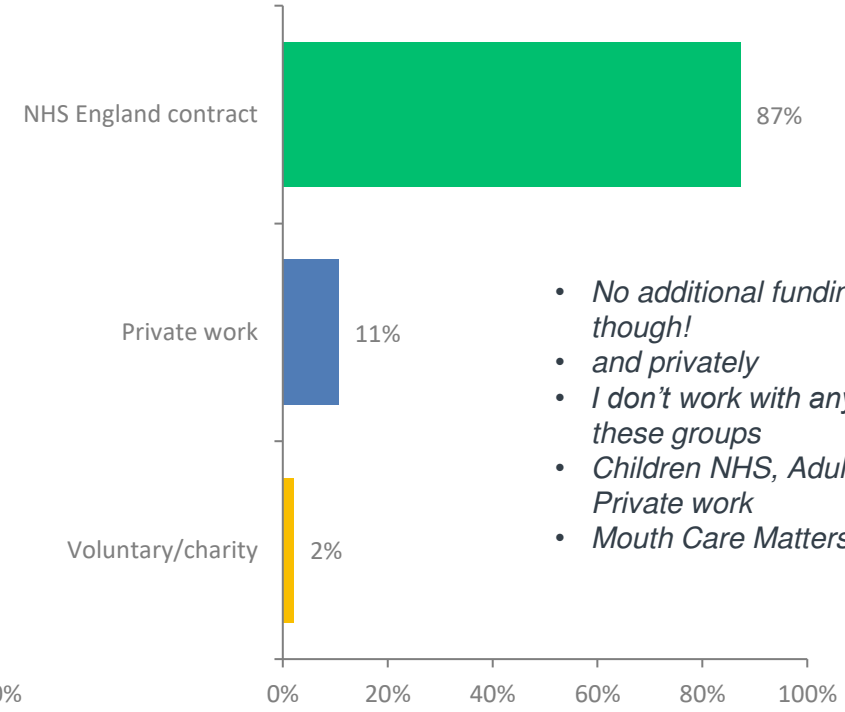
Q34: Which vulnerable/seldom heard groups do you currently work with?

Answered: 50 Skipped: 0



Q35: Is this under/ as part of:

Answered: 47 Skipped: 3



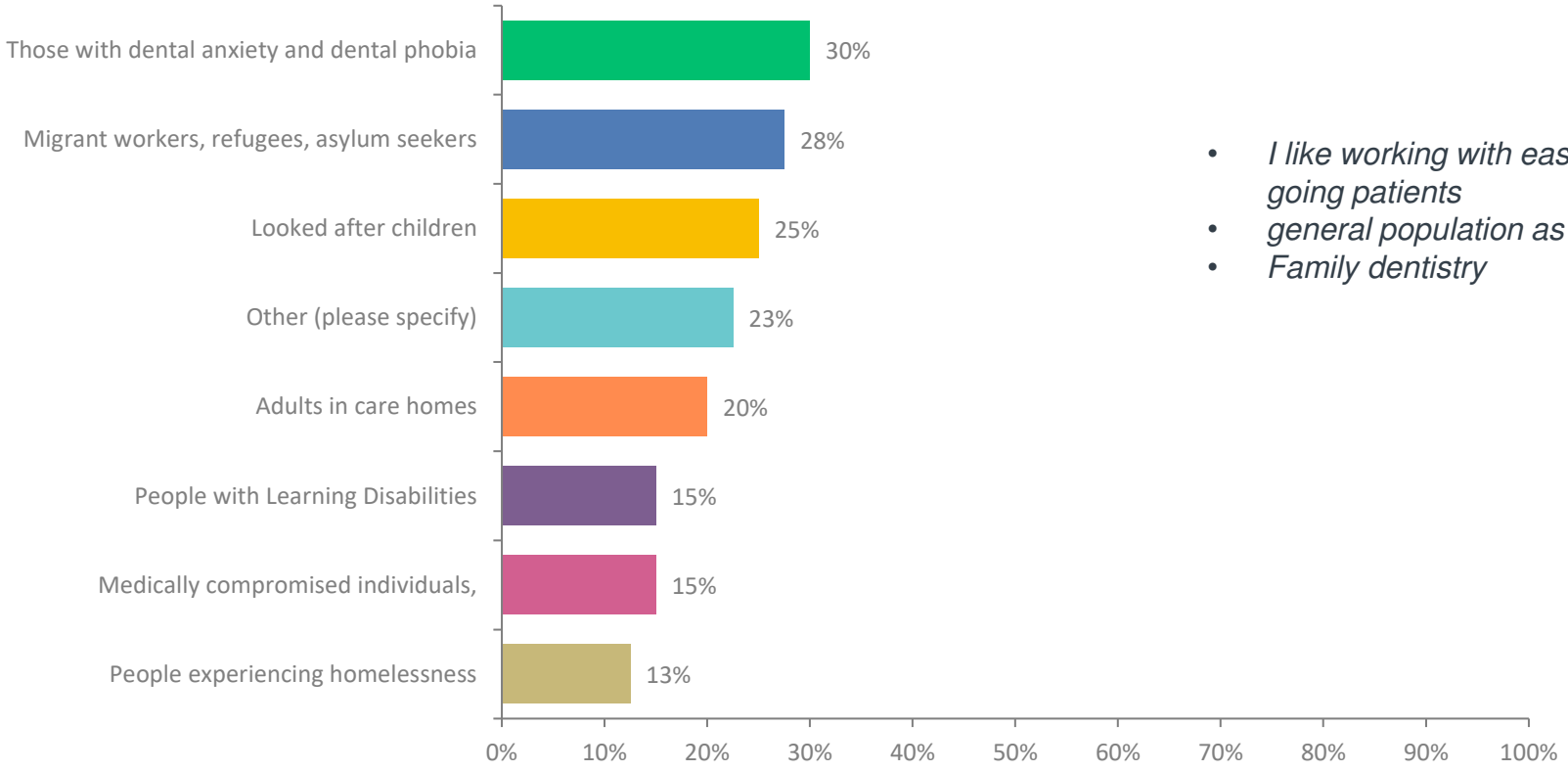
- *No additional funding though!*
- *and privately*
- *I don't work with any of these groups*
- *Children NHS, Adults Private work*
- *Mouth Care Matters*

- *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

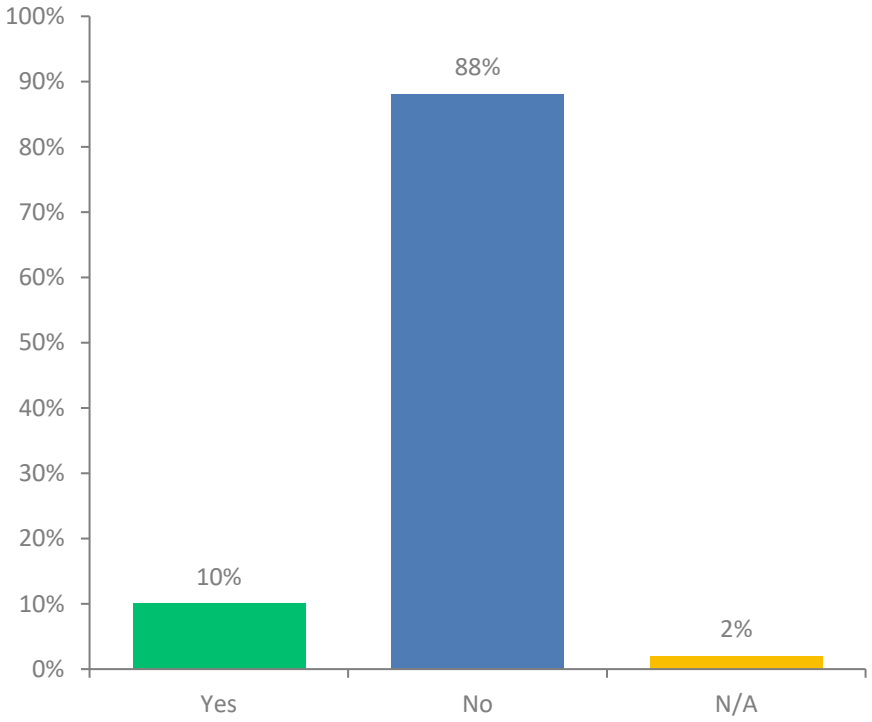


- *I like working with easy going patients*
- *general population as well*
- *Family dentistry*

Integration & Collaboration

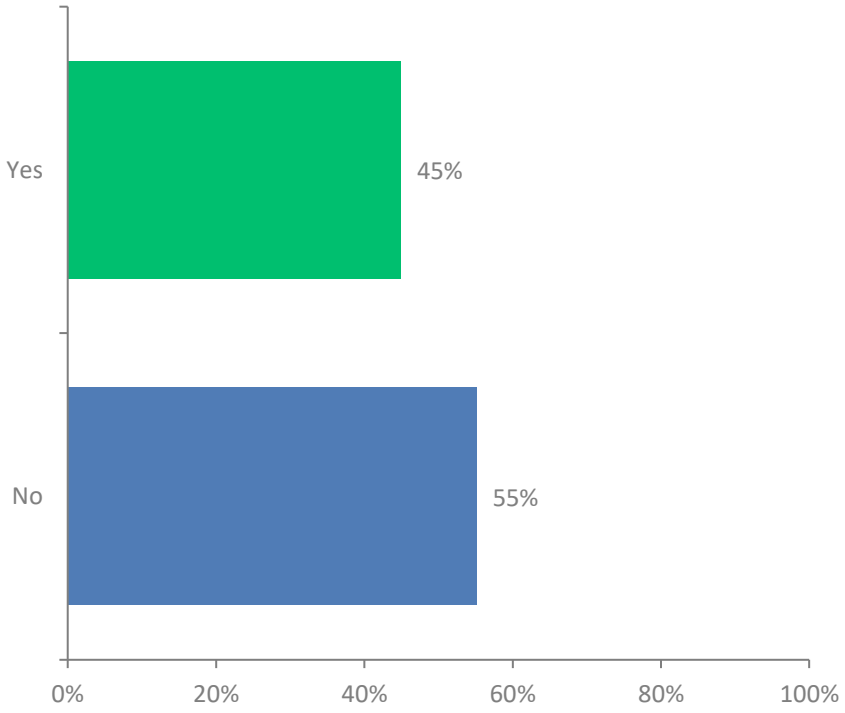
Q37: Are your services co-located with a GP practice/Healthy Living Centres?

Answered: 50 Skipped: 0



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

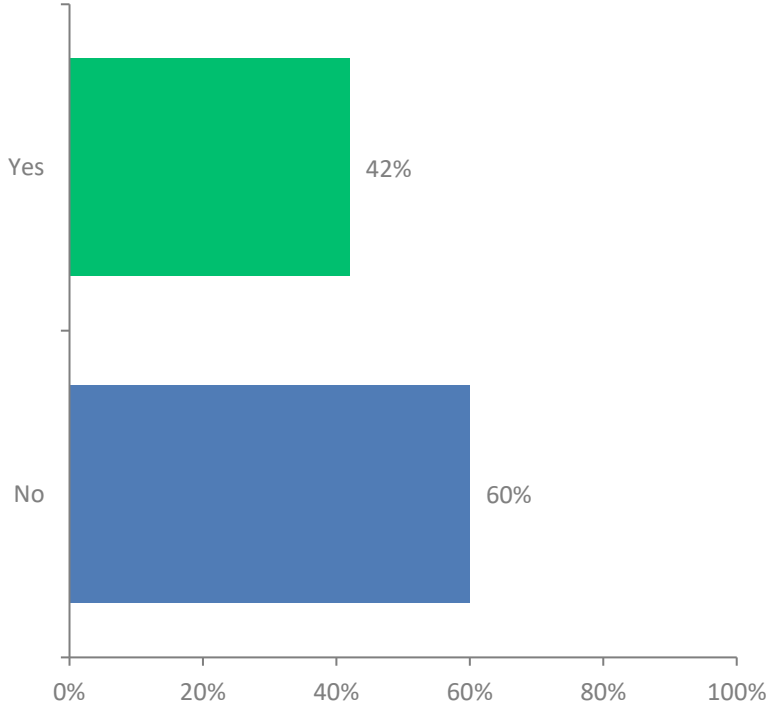
Answered: 49 Skipped: 1



Integration & Collaboration: Opportunities

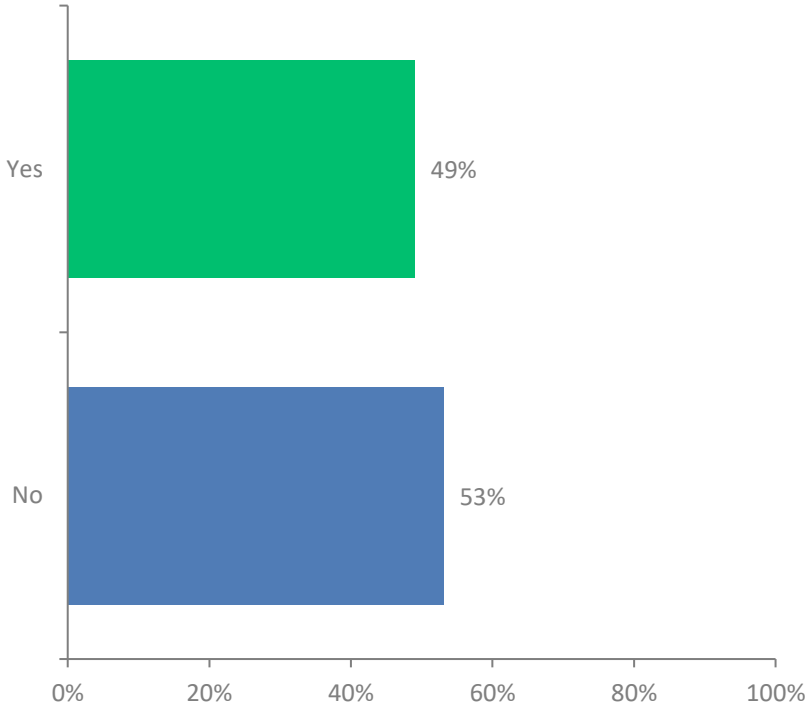
Q39: Do you understand the role of primary care networks?

Answered: 50 Skipped: 0



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

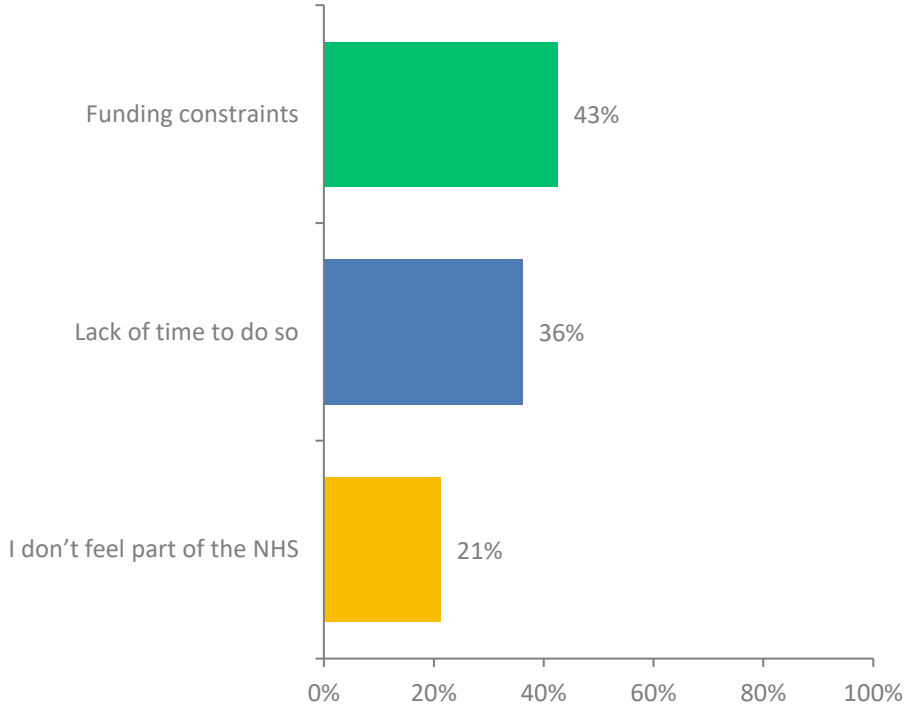
Answered: 49 Skipped: 1



Integration & Collaboration: Opportunities

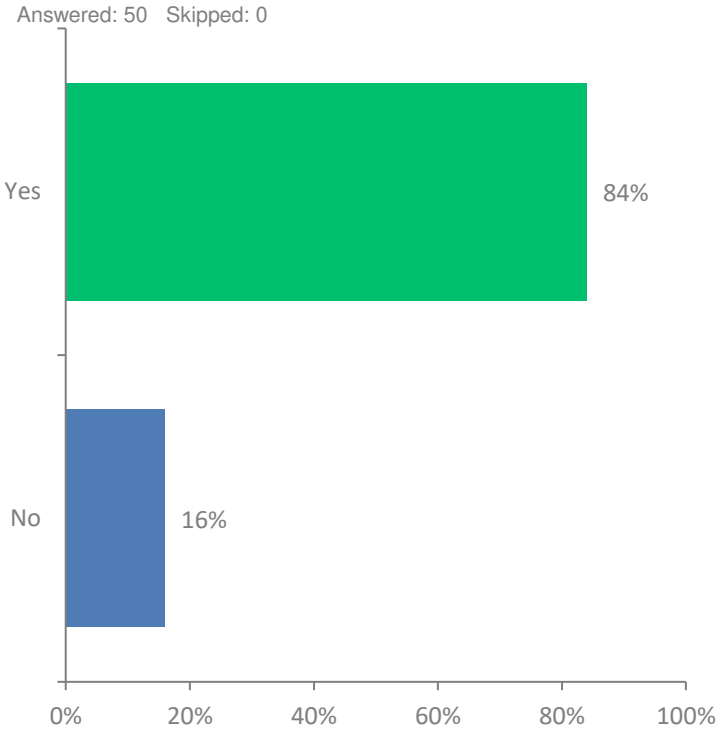
Q41: What do you feel are the main barriers for working with other NHS services?

Answered: 47 Skipped: 3



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

Answered: 50 Skipped: 0

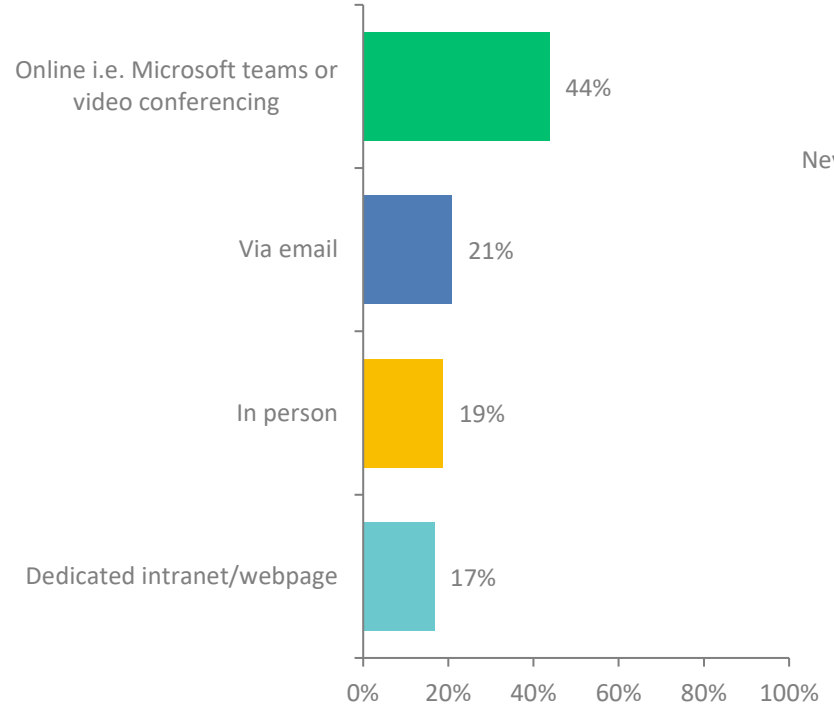


- *We all could work better together but whenever we get together to try to agree, it all comes down to funding, and each speciality focuses on their own funding issues rather than how a bigger system would work.*
- *I am very lucky to alongside colleagues from outside of dentistry in my NHS role. As 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

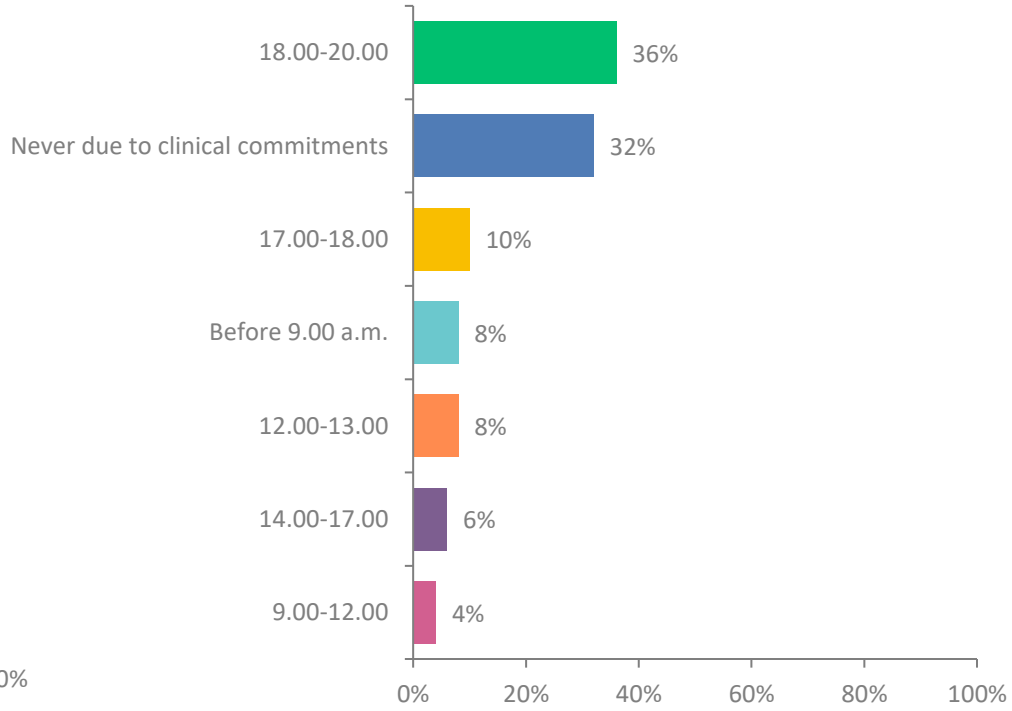
Q43: Given time constraints, how would you like to network?

Answered: 48 Skipped: 2



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

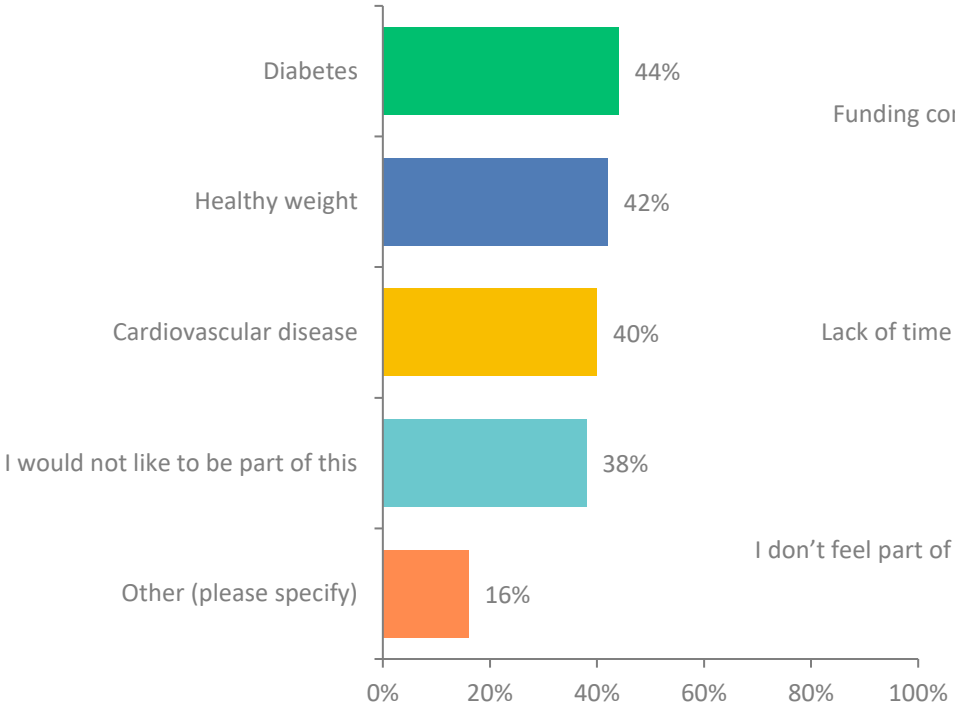
Answered: 50 Skipped: 0



Integration & Collaboration: Opportunities

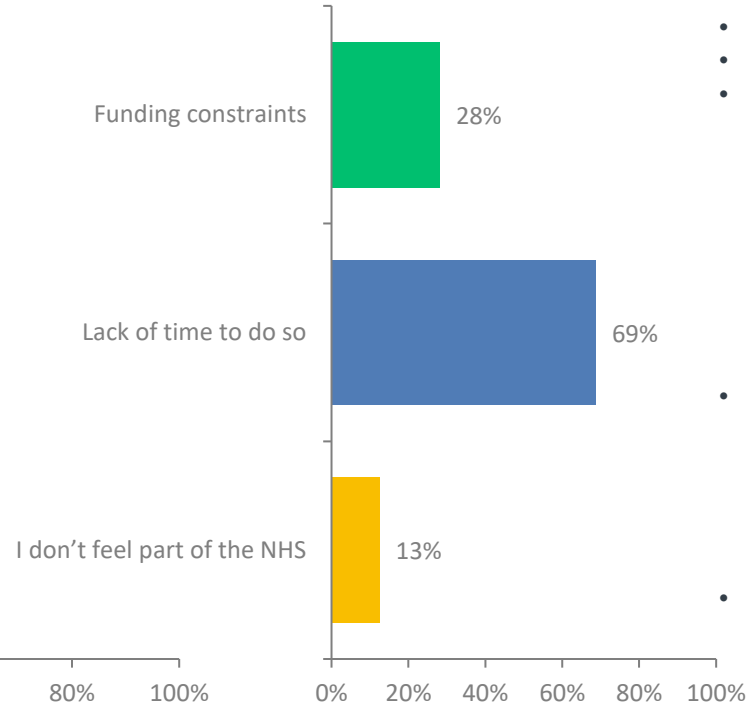
Q45: Would you like to be part of integrated pathways of care for other conditions including:

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.*

Contact us

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claireripley@nhs.net

Shaping better health