Report to the Oxfordshire Health Overview and Scrutiny Committee

Date: **Thursday 20th April 2023**

Title: **NHS Dental services in Oxfordshire**

Author: **Hugh O'Keeffe, Senior Commissioning Manager - Dental, NHS England (South-East)**

Introduction:

On 1st July 2022 the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board took on delegated responsibility for Dentistry, alongside Pharmacy and Optometry. Integrated Care Boards (ICBs) have an explicit purpose to improve health outcomes for their whole population and the delegation will allow the ICB to integrate services to enable decisions to be taken as close as possible to their residents. The ICB is working to ensure their residents can experience joined up care, with an increased focus on prevention, addressing inequalities and achieve better access to dental care and advice.

The ICB discharges its responsibility for dental commissioning in partnership with NHS England who provide operational leadership within ICB governance structures.

Clinical engagement is achieved via a Local Dental Network (LDN) covering the Thames Valley area. This is a clinically led group involving Dentists, Dental Public Consultants, representatives from Health Education England and the Local Dental Committees and service commissioners. Reporting to the LDN are specialist led Managed Clinical Networks for Oral Surgery, Orthodontics, Restorative Dentistry and Special Care and Paediatrics

1. Oral Health

Tooth decay remains the leading reason for hospitals admissions among 5 to 9-year-olds in England. Tooth decay and gum disease are two of the most common diseases in the world in adults. Tooth decay doesn't occur in people who don't consume sugar and reducing both the amount and frequency of sugar consumed reduces the risk.

Gum disease is caused by bacteria in plaque gradually destroying the gums and bones around teeth leading to tooth loss. People who smoke are far more likely to suffer from gum disease.

People who brush twice a day with a fluoride toothpaste are less likely to suffer from tooth decay or gum disease.

Oral Cancer research suggests that more than 60 out of 100 (more than 60%) of mouth and throat cancers in the UK are caused by smoking and around 30 out of 100 (30%) are caused by drinking alcohol. The combination of smoking and alcohol use increases the risk of oral cancer further, and poor diet is another risk factor.

The recommended time between dental 'check-ups' is between 3 months and 2 years depending on risk factors for oral disease. Dentists check for early signs of decay, gum disease, oral cancer and other abnormalities so people who don't attend often have more severe disease.

Children who live in deprived areas are far more likely to suffer from tooth decay than children in less deprived areas. This is mainly due to differences in sugar consumption, tooth-brushing habits, and dental attendance.

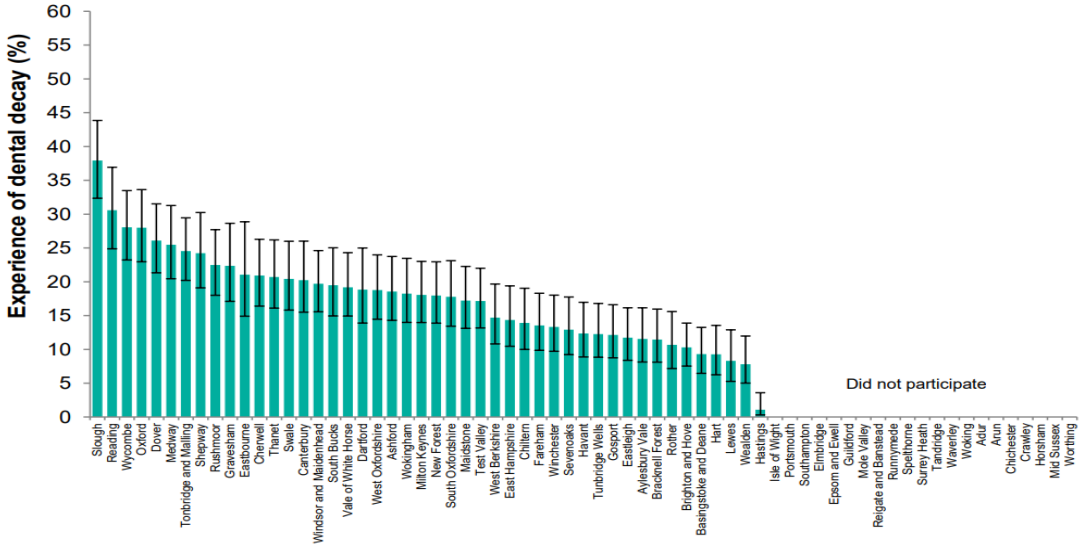
In addition to pain, toothache can cause children to stop eating and sleeping, and reduces concentration and/or school attendance. All these effects can increase existing inequalities between children in the most and least deprived areas.

Tooth decay is the most common reason for hospital admission amongst children aged 0 – 19 with between 40,000 – 45,000 children being admitted in England per annum.

Since 2013, Local Authorities have also commissioned epidemiological surveys as part of a national programme to monitor the oral health of the country. Not all local authorities take part in these surveys.

The latest survey data relates to information collected for children aged 5 in 2019.

Figure 11: Prevalence of experience of dental decay in 5-year-olds in the South East by lower-tier local authority area, 2019.



Of the 46 local authorities in the South-East who took part in the survey, the Oxfordshire District Councils ranked as follows in terms of the % of 5 year old population with experience of dental decay:

District Council	Rank	Approx % experiencing decay
Cherwell	11	22%
Oxford	4	28%
South Oxon	24	18%
Vale of the White Horse	17	20%
West Oxon	19	19%

Older people are far more likely to have lost teeth due to gum disease and dental decay. This is because gum disease increases with age, and fluoride toothpaste (which protects teeth from decay) only became widely used in the UK in the 1970's.

The oral health of people in care homes was the subject of a national Care Quality Commission (CQC) report, *Smiling matters: Oral health care in care homes*.

Older people in care homes are particularly at risk of oral pain and disease because:

- People needing residential care are often less able to brush their teeth effectively and there is variation in how well care staff provide toothbrushing.
- People in care homes often increase the frequency and amount of sugar in their diet, and tooth loss/pain can make it more difficult to eat nutritious food.
- Access to dental services for people in care homes is highly variable, and dentists are limited in the amount of dental surgery (extractions etc.) they can provide outside of CQC regulated practices.

The influence of ethnicity on oral health

People from non-White groups have poorer oral health overall than people in White groups. However, deprivation is the key factor for poor oral health and people in non-White groups are more likely to live in more deprived areas.

In contrast with most health inequalities, when the effects of deprivation are removed, people from non-White groups in England were found to have better oral health than people in White groups. The differences could be partially explained by reported differences in dietary sugar.

Other priority groups

People with Severe Mental Illness are estimated to be 2.8 times more likely to have lost all their teeth compared with the general community.

National and international research, summarised by the UK Health Security Agency, shows that people with learning disabilities have poorer oral health and more problems in accessing dental services than people in the general population. People with learning disabilities may often be unaware of dental problems and may be reliant on their carers/paid supporters for oral care and initiating dental visits. Supporters are often inadequately trained for this and may not see oral care as a priority

Evidence consistently shows that people with learning disabilities have:

- higher levels of gum disease
- greater gingival inflammation
- higher numbers of missing teeth
- increased rates of toothlessness
- higher plaque levels
- greater unmet oral health needs
- poorer access to dental services and less preventative dentistry.

People in prison are likely to have worse oral health yet have less experience of using dental services prior to sentence.

2. Dental services and current NHS provision in Oxfordshire

Primary and community dental services are commissioned via contracts which fall within the NHS (General/Personal) Dental Services Regulations 2005. Some of these services provide direct patient access and others are accessed via professional referral. Secondary care (hospital) providers deliver services on referral under NHS standard contracts.

NHS Patient Charge Regulations apply to the contracts falling within the 2005 Regulations, but not to services provided under NHS standard contracts for service delivered in acute hospital settings. The patient charges relate to the bands of treatment delivered in primary care. Services are delivered under treatment Bands 1, 2 and 3. The link below provides more details:

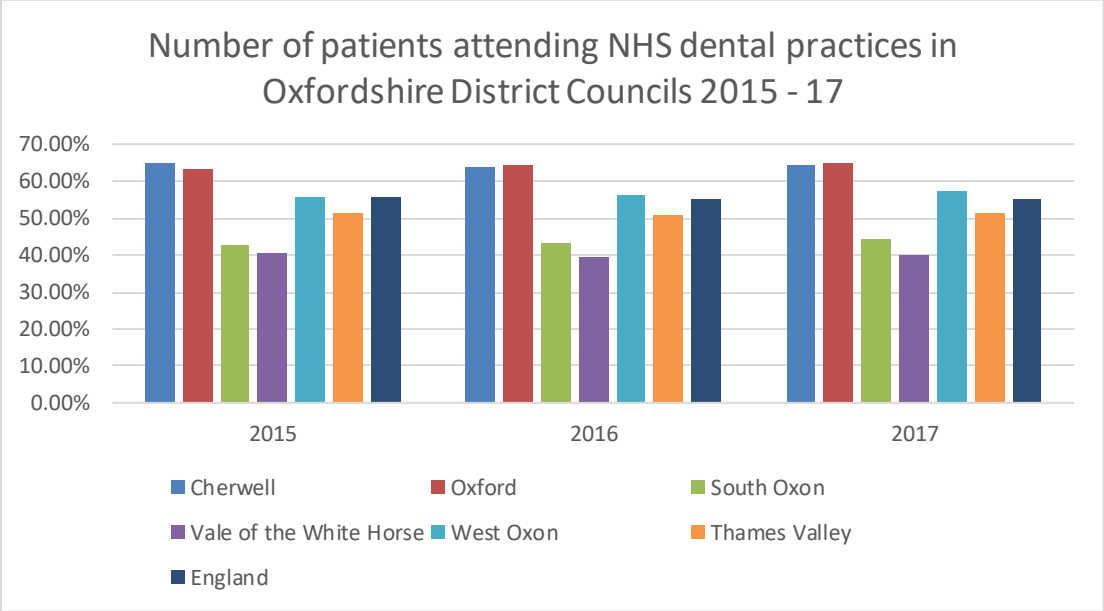
https://www.nhs.uk/nhs-services/dentists/dental-costs/how-much-will-i-pay-for-nhs-dental-treatment/

Providers of NHS primary care services are independent contractors in receipt of cash limited financial allocations from the NHS. All practices also deliver private dental care. Some provide NHS services to all groups of patients, but some are for children and charge exempt patients only. The providers are required to deliver pre agreed planned levels of activity each year, known as Units of Dental Activity (UDAs). The UDAs relate to the treatment bands delivered by the practices.

Patients are not registered with practices but are encouraged to attend at regular intervals with the regularity of attendance based upon their assessed oral health needs. In the Thames Valley area (Buckinghamshire, Oxfordshire, Berkshire East* and Berkshire West) prior to the pandemic, about 1.1m people (52% of the population) attended an NHS Dentist on a regular basis (attendance within a 2-year period).

**Since July 2022 Berkshire East has been part of the NHS Frimley ICB*

The chart below compares access to NHS Dentistry in Oxfordshire area in the period 2015 – 17 (data since 2017 has not been available at District Council level):



The % of the population attending NHS dental services in Cherwell and Oxford was significantly above the England and Thames Valley levels; West Oxfordshire was above the Thames Valley % and in line with NHS England. Attendance was lower in South Oxfordshire and the Vale of the White Horse.

NHS attendance tends to be higher in areas of greater deprivation, where fewer people have the option of private dental care. Oxfordshire County Council has developed a Local Area Inequalities Dashboard. This includes comparative information on Indices of Multiple Deprivation. The update from September 2022 shows that the following wards in Oxfordshire were identified as having

higher IMD scores (means they are more deprived) than the England average of 21.7:

Cherwell

- Banbury Ruscote 34.0
- Banbury Neithrop 26.8
- Banbury Grimsbury 23.9

Oxford

- Blackbird Leys 34.9
- Greater Leys 33.6
- Littlemore and Rose Hill 29.6
- Barton 28.8

These wards account for about 10% of the county's population, but about 25% of the dental activity commissioned in Oxfordshire.

Details of practices providing NHS dental care can be found on: https://www.nhs.uk/service-search/find-a-dentist

In addition to the services delivered in primary care there are other NHS dental services. They are:

- Unscheduled Dental Care (UDC) – most 'urgent' treatment needs are met by the local dental practices. In addition to this there are services that provide back-up in the day and on evenings, weekends and bank holidays. Urgent dental care can be accessed via the practice normally attended by a patient or via NHS 111
- Orthodontics - these services are based in 'primary care' but are specialist in nature and provide treatment on referral for children for the fitting of braces.
- Special Care Dentistry and Paediatrics (also known as Community Dental Services) – services for patients who have additional needs which makes treatment in a primary care setting difficult. This includes treatment both in clinic and in hospital for extractions carried out under General Anaesthetic. This service also provides some of the unscheduled dental care.
- Hospital services – for more specialist treatment needs delivering Oral and Maxillofacial Surgery and Orthodontic services.
- Tier 2 Oral Surgery (more complex extractions) and
- Restorative (Root canal, treatment of gum disease and dentures) – provide more complex community-based treatments than in primary care but do not require treatment in hospital.

The tables below detail NHS Dental services available in Oxfordshire:

Primary Care services:

Service	Number	Units of Activity	Contract value 22-23
GDS contracts	85	976,249	£27,672k
Full NHS	61	947,583	£26,889k
Child and Exempt Only	4	8,357	£224k
Child only	20	20,309	£559k

Onward referral services:

Service	Number of providers	Contract value 22-23	Provider
Orthodontics	8	£3,271k	Various
Community Dental Services	1	£4,904k	Oxford Health NHS Foundation Trust
Hospital services	1	£6,094k	Oxford University Hospitals NHS Foundation Trust
Tier 2 Oral Surgery	1	£418k	Rodericks Dental Ltd
Tier 2 Restorative	1	£230k	Dr A Rai

3. Investment into NHS primary care dental services

The annual investment into primary care dental services is £27,672k per annum which equates to £40.01 per head for the Oxfordshire population of 691,677. Levels of investment are based upon the provision in each area at the point the locally managed cash limited new NHS (nGDS) contract was introduced on 1st April 2006 plus any subsequent investment after that date. The table below compares financial investment and the amount of primary care dental activity (Units of Dental Activity) commissioned to other areas:

Area	NHS primary care dental funding per head	Units of Dental Activity (UDAs) per head
Oxfordshire	£40.01	1.41
BOB	£36.43	1.27
South-East	£38.98	1.31

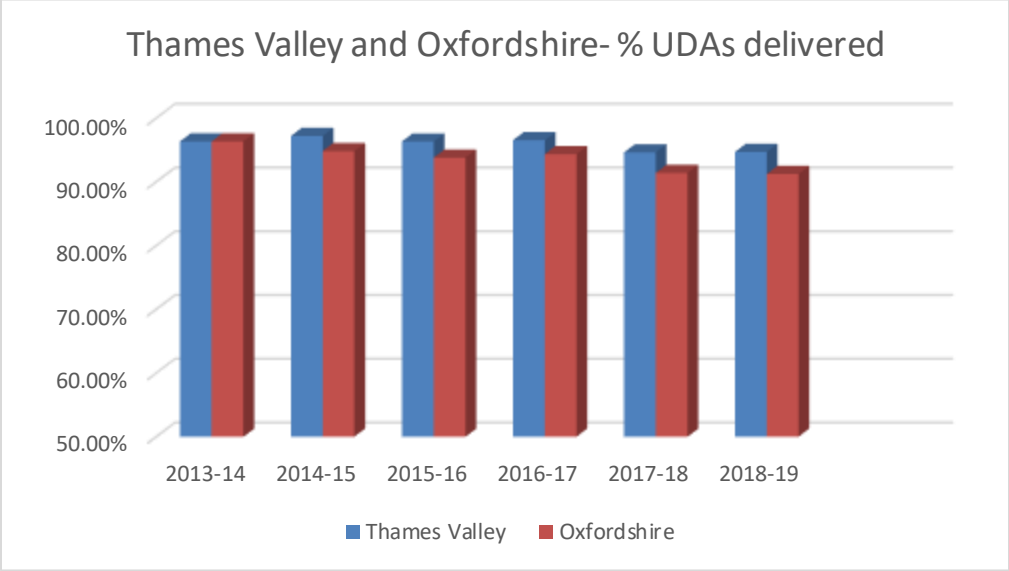
Dental practices each receive a cash limited financial allocation with monthly payments, against which they are required they are required to deliver an

agreed number of Units of Dental Activity (UDAs). If the practices deliver over 100% of their contracted activity, they can receive an additional payment of up to 2% or have their contracted activity reduced by up to 2% in the following financial year. In 2022-23 this was increased to 10%. If they deliver 96% to 100%, they can either repay monies or provide additional activity in the following financial year. If they deliver under 96% the practice must repay monies to the NHS in the following financial year.

The table and chart below describe contract performance in the Thames Valley and Oxfordshire areas in the period 2013 – 2019.

% UDAs delivered

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Thames Valley	96.35%	97.20%	96.33%	96.53%	94.64%	94.70%
Oxfordshire	96.35%	94.84%	93.81%	94.36%	91.41%	91.23%

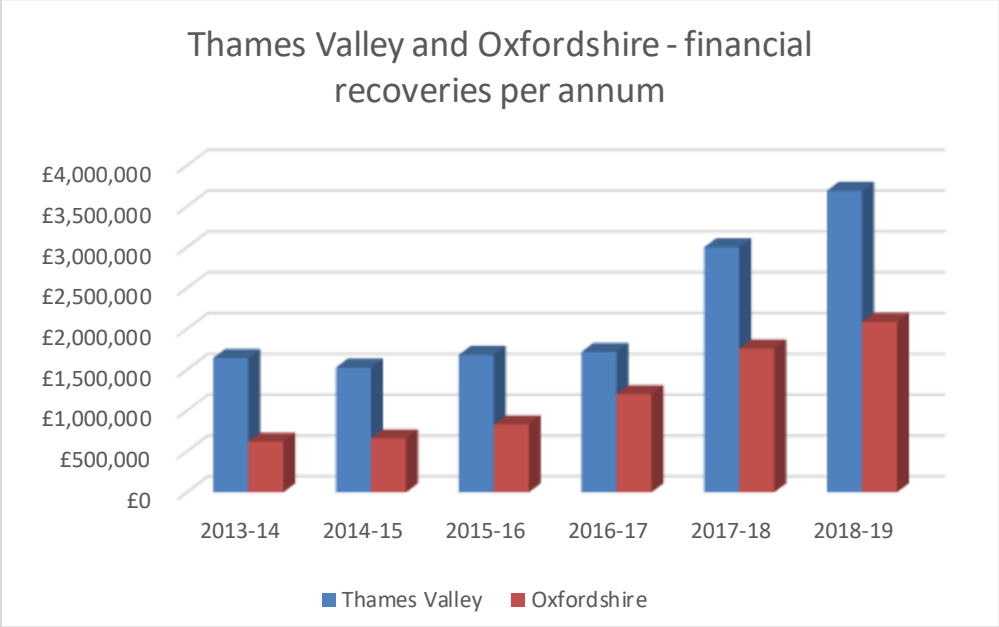


Contract delivery has been consistent across the years with between 2,660k and 2,737k UDAs being delivered in the Thames Valley. The number of UDAs being delivered has fallen in Oxfordshire since 2013-14. In 2013-14 the % of activity delivered in Oxfordshire matched the % delivered across the Thames Valley, but in the last full year before the pandemic it was 3.5% below the Thames Valley average with the number of UDAs delivered falling from 970,484 in 2013-14 to 902,040 in 2018-19.

If practices deliver less than 96% of contracted activity in any financial year these monies are recovered by the NHS. In 2013-14, the NHS recovered £617k from Oxfordshire practices due to contract underperformance; this increased to nearly £2.1m in 2018-19.

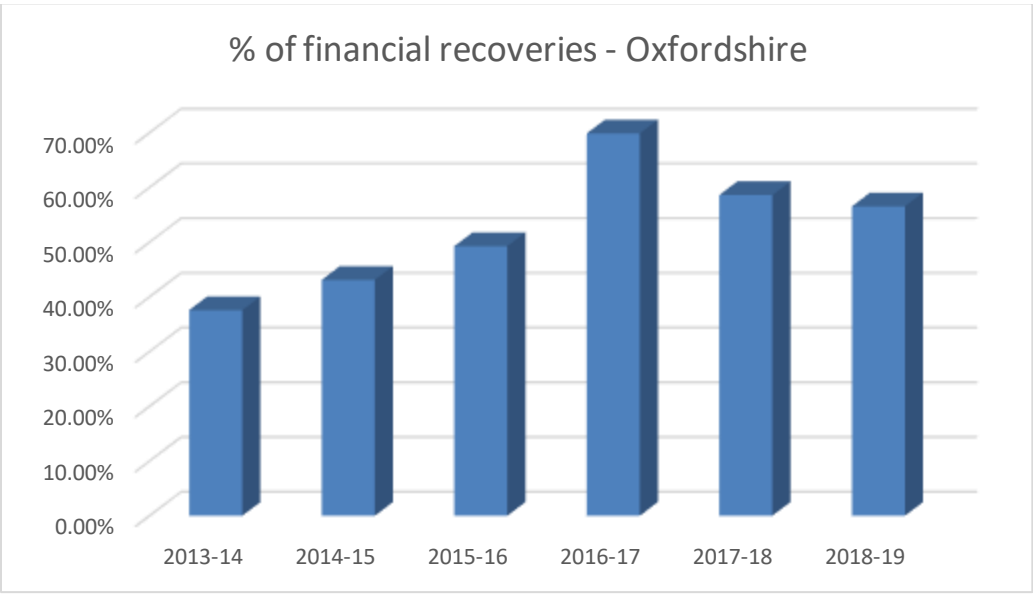
Financial recoveries

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Thames Valley	£1,642,804	£1,525,885	£1,681,469	£1,716,893	£2,999,504	£3,690,222
Oxfordshire	£617,203	£657,778	£828,456	£1,199,834	£1,757,865	£2,086,494



% of Financial recoveries

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Oxfordshire	37.57%	43.11%	49.27%	69.88%	58.61%	56.54%



Oxfordshire's population is about 32% of the Thames Valley total. In 2013-14 the level of financial recovery was matched this as a ratio, but in the last few

years before the pandemic financial recoveries in Oxfordshire increased to about 50% - 60% of the Thames Valley total.

There have been on-going discussions with the dental profession in the county about the possible causes of the relatively low levels of performance in the county. An issue that has been highlighted is the increased challenges with recruitment in the more northerly parts of the county, further from London and the implications this may have private work in addition to the NHS. However, it should be noted that historically access in Oxfordshire has been higher than other parts of the Thames Valley. The table below breaks access down by each of the health systems on the Thames Valley in 2017:

Health system	**Number of patients attending in previous 2 years**	**% patients attending in the previous 2 years**
Buckinghamshire	241,767	45.2%
Oxfordshire	371,586	54.6%
Berkshire West	246,053	51.0%
Berkshire East	221,884	53.3%
Total	**1,081,290**	**51.1%**

Adjustments were made to the dental contract during the pandemic to take account of the reduced capacity. In the first three months of 2020-21 all practices were required by the NHS Chief Dental Officer to close; re-opening at 20% capacity from July 2020 and then at reduced capacity in the period to July 2022 when 100% capacity was restored. This meant that although activity levels fell, lower levels of financial recovery were pursued. However, the reduction in activity delivered over 2-year period has had a significant impact on patient access.

4. Access to NHS Dental services

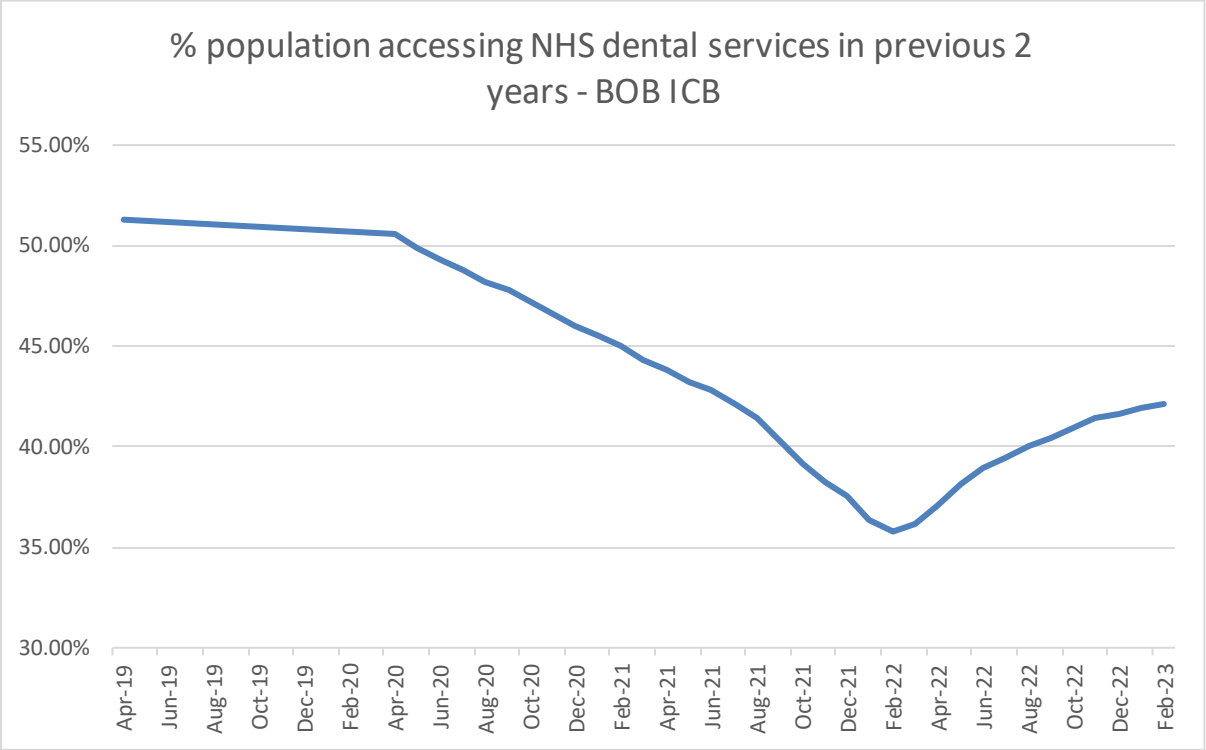
People are not registered with an NHS Dentist and can attend a dental practice of their choice. Some patients seek to access dental practices on a regular basis on a 'continuing care' basis; some attend non-NHS private practices and others will only attend a practice when they have an issue which they think needs treatment. In the period between 2008 and 2012 there was significant investment into NHS dental care as part of the national Dental Access Programme. Access to NHS services is measured by the number of unique patients attending practices over a 2 year period.

The number of patients attending a dental practice in the Thames Valley area increased by 250,000 (30%) between 2008 and 2019.

Access to NHS Dentistry fell significantly during the coronavirus pandemic.

Enhanced infection control procedures, necessitated by the types of procedures carried out in dental surgeries, led to reduced dental capacity. This reduced access to services and increased waiting times for treatment. Service capacity has been very gradually increased as infection rates have dropped. Primary Care services returned to 100% capacity in July 2022, but a significant a backlog of treatments has built up over the 2-year period of reduced capacity.

The charts below show the impact both within the BOB ICB area:



Since February 2022, the number of people attending an NHS Dentist in the BOB area has increased by 110,231 (17.9%).

Access rates are similar across the South-East with each of the ICBs seeing a similar impact and recovery as result of the pandemic. Prior to the pandemic in April 2019, 51.29% of the BOB population attended an NHS Dentist in the previous 2 years'; this fell to 35.78% in February 2022 and has since increased to 42.17% (February 2023).

Whilst access to primary care is improving there are on-going challenges with access.

Improved access has mainly been achieved dental practices recalling patients who had previously attended. For many of these patients they have returned to their previous routine of check-ups at clinically indicated intervals. For some patients, the increased time between appointments has resulted in a deterioration in their oral health and the need for more complex treatment. These courses of treatment have taken longer to complete and there has been an overall impact on the rate of recovery.

For patients who have not attended a local practice for at least two years access has been much more challenging. Some of these may local patients who have previously been irregular attenders only going to the Dentist when they experience pain. Others are people who have moved to the area more recently such as people relocating to a new home; families of Armed Forces personnel moving to the area; Looked After Children and asylum seekers and refugees.

These challenges are being compounded by workforce challenges in the service. Dental practices have found it difficult to maintain their workforce to deliver NHS services. Many Dentists prefer to work fewer days on the NHS and therefore deliver less activity. This would enable them to focus more of their time on private work and in some cases, Dentists are either leaving the NHS or opting not to join at the start of their career.

The Dentists and practices are citing a number of reasons for leaving the NHS. These include:

- The workload involved in catching up with the backlogs
- The focus on treatment with limited time for oral health improvement
- Delays in proposed changes to the contract at national level
- The growing gap between the annual financial uplifts to the contracts and the costs of running their services
- The limited flexibility within the contract to use greater skill mix to deliver care
- The extent of patient dissatisfaction with access to care

This has impacted on the ability of the practices to deliver their contracts, which means they may seek to reduce their NHS commitment or leave the NHS altogether. The table below details the number of UDAs handed back in 2022-23 across the South-East:

ICB	**UDAs handed back 2022-23**	**% of total activity commissioned**
BOB	39,083	1.79%
Frimley	13,782	1.46%
Hampshire and the Isle of Wight	53,559	2.04%
Kent and Medway	87,223	3.74%
Surrey Heartlands	43,136	3.71%
Sussex	49,697	1.98%
Total	**283,480**	**2.41%**

The following practices in Oxfordshire have terminated their NHS contracts during 2022-23:

Practice Name	Location	District Council	Nature of contract	UDAs
Courtrai House	Henley	South Oxon	Child Only	1,308
High Street	Oxford	Oxford	Child Only	200
Blandy House	Henley	South Oxon	Child Only	190
Market Square	Bicester	Cherwell	Full	8,424
Broadshires	Carterton	West Oxon	Full	6,000
Bath Street	Abingdon	Vale of the White Horse	Full	10,982
Total				**27,104**

If practices handback their contracts, then arrangements are put in place to try to find local practices to cover this loss on a temporary basis prior to a procurement exercise to find a replacement but the take-up in Oxfordshire to date has been relatively low.

Nationally changes were made to the NHS contract in late 2022 with the aim of addressing these challenges. The changes will increase NHS capacity by allowing payment for higher levels of performance, increasing payments for more complex treatments, issuing updated advice about recall intervals for patient check-ups, supporting the use of more skill mix and providing more information to patients about access to NHS services.

The Planning and Operational Guidance for 2023-24 states that the NHS will:

Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels

In the BOB area, the ICB is working on a plan to 'flex' contracts during 2023 to provide more capacity to help those often more vulnerable patients who have struggled to achieve access since the pandemic. This will be done by reducing the activity targets they are required to achieve and using that capacity to provide access sessions for new patients. This will provide more time for the Dentists to meet the greater treatment needs likely to be presented. The aim is to test this approach over the year to see it meets the objectives to improve access and reducing health inequalities. It will also start to look at whether this model can then be applied to improve the oral health of patients more likely to have greater oral health needs.

5. Urgent Access

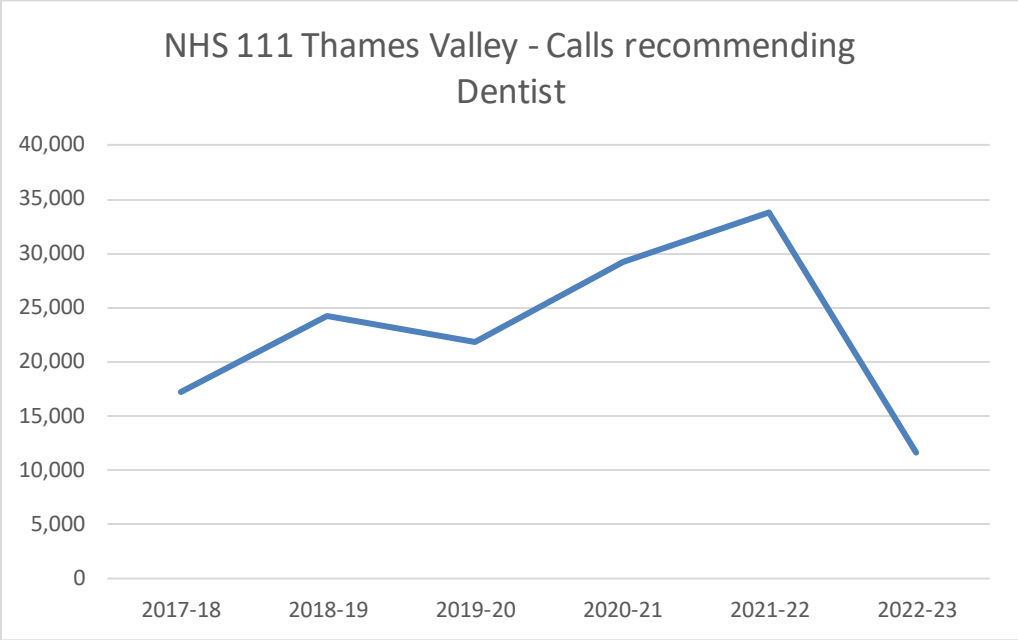
Most patients attend dental practices on a planned basis either to attend for check-ups or treatment. In some cases, patients need to attend on an urgent basis due to an oral health issue, likely to involve pain, swelling or bleeding. In the years preceding the pandemic about 8% of the treatments provided in primary care related to urgent treatments. Most of this treatment is carried out in primary care during normal opening hours. When this was reviewed in the Thames Valley in 2015 it was found that 93% of primary care based urgent care activity was delivered during these hours. The other 7% was provided by either out of hours services or in-hours urgent access services designed to support patients unable to access a primary care dentist.

The proportion of patients receiving urgent treatment increased during the pandemic as the dentists worked within a national Standard Operating Procedure to prioritise patients with an urgent treatment need. The practices were also supported by a range of Urgent Dental Care practices specifically for the purpose of meeting urgent treatment needs. As part of the recovery from the pandemic, practices were approached to provide Additional Access sessions to support patients who have continued to face challenges accessing dental treatment. The locations of these centres in BOB is detailed below:

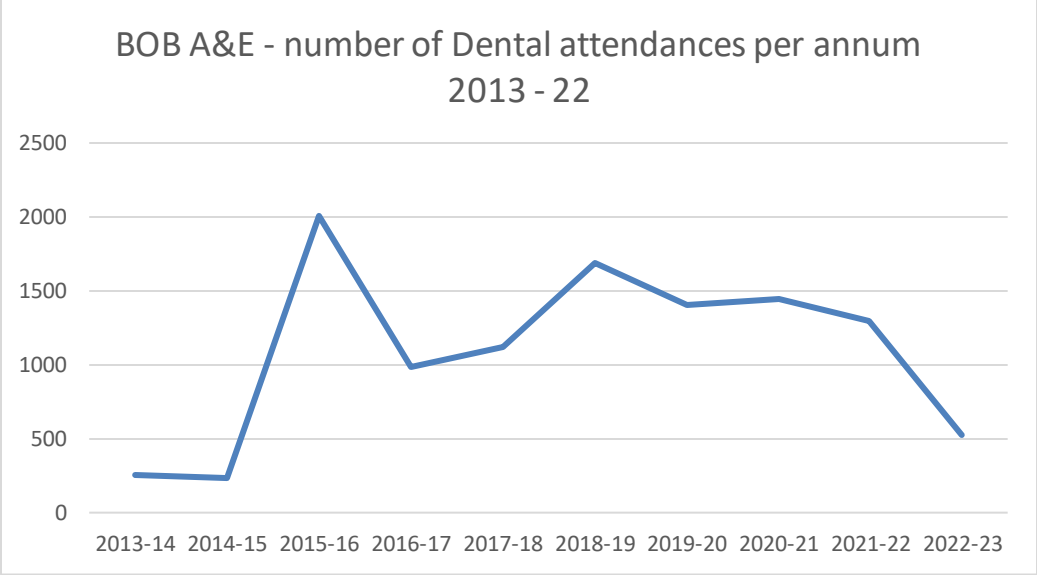
- Haddenham Dental, Haddenham, Buckinghamshire, 01844 292118
- Gentle Dental Care, Reading, Berkshire, 0118 945 2900 / 0118 945 5555

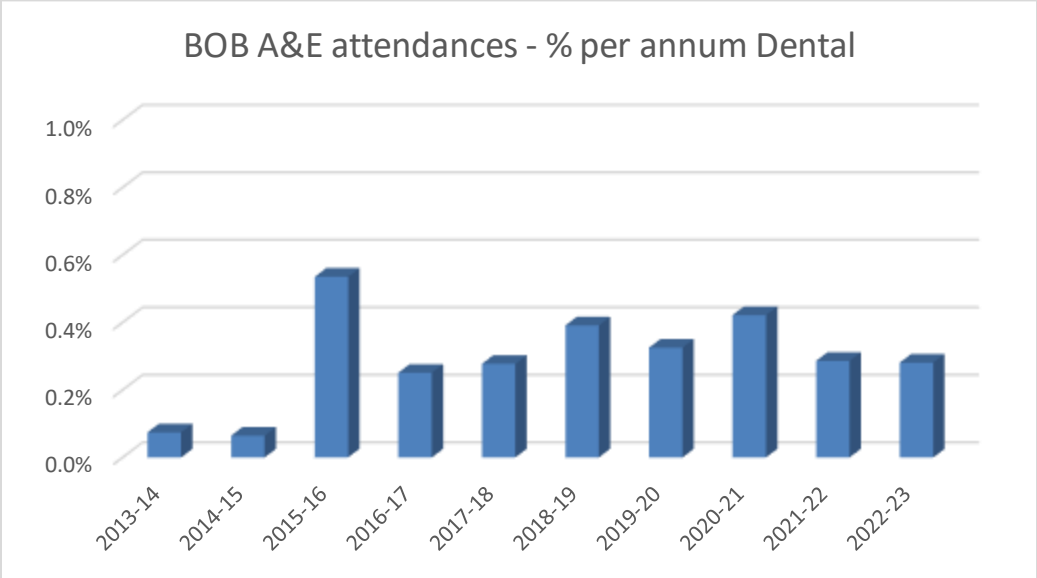
If patients do not regularly attend NHS dental practices or are seeking access out of hours, they can contact NHS 111 who will direct them to the appropriate service. About 3% of all calls to NHS 111 relate to dental matters.

The chart below describes the number of calls recommending that the patient sees an NHS Dentist received each year since 2017. The numbers increased significantly during the pandemic but appear to be falling in 2022-23 as dental practices return to 100% capacity.



Patients may also seek to access treatment via A&E. The charts below describe the number and proportion of A&E attendances in the BOB area since 2015. They indicate that normally there would be about 1,000 – 1,500 attendances per annum (0.2% to 0.3%).





6. Referral services

The table below details the number of referrals to each of the dental specialties in the period October 2021 – September 2022:

Specialty	Total Referrals	Referrals to Hospital	% to hospital	Referrals to Community based Specialist service	% to Community based Specialist
Oral Surgery (Thames Valley)	20,160	7,108	35.3%	13,052	64.7%
Oral Surgery (Berkshire West)	*4,323*	*1,640*	*37.9%*	*2,638*	*61.1%*
Orthodontics (Thames Valley)	18,614	1,244	6.8%	16,920	93.2%
Orthodontics (Berkshire West)	*5,123*	*203*	*4.0%*	*4,920*	*96.0%*
Restorative (Thames Valley)	3,097	93	3.0%	3,004	97%
Restorative (Berkshire West)	*549*	*No data*	*No data*	*No data*	*No data*
Special Care and Paediatric Dentistry (Thames Valley)	5,502	0	0%	5,502	100%
Special Care and Paediatric Dentistry (Berkshire)	*1,952*	*0*	*0%*	*1,952*	*100%*
Total (Thames Valley)	**47,373**	**8,445**	**17.8%**	**38,928**	**82.2%**

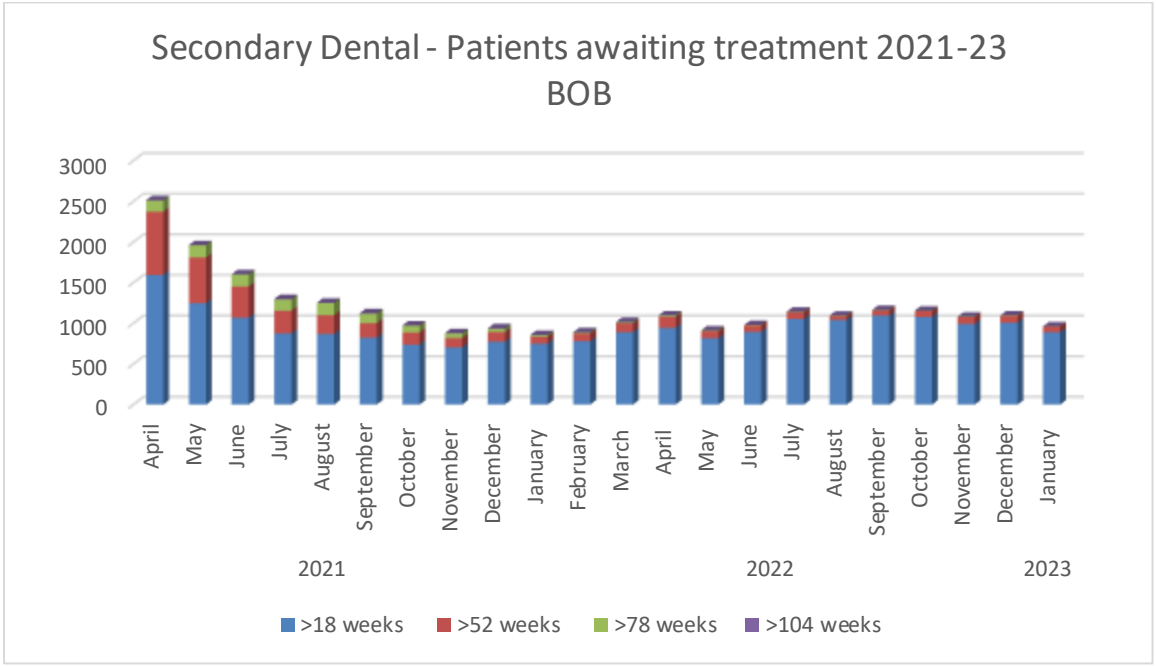
Across the Thames Valley nearly 50,000 referrals were made by Dentists to specialist services in 2021 – 22. Over 80% of the referrals are made to community-based specialist services with less than 20% going to hospital. The destination of referrals is informed by NHS England Commissioning Guides and Standards for the services listed above. Dentists make referrals via a bespoke Dental Electronic Referral System which directs the referrals to the appropriate settings.

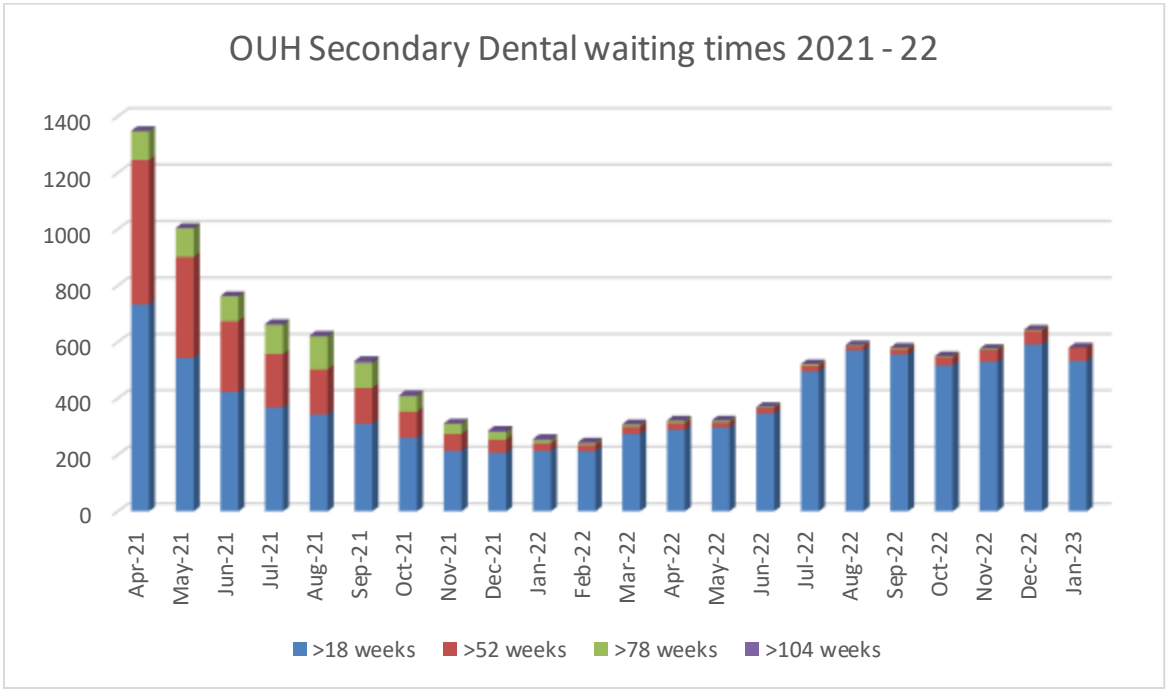
As with primary care dental services, the referral services have also faced capacity reductions because of the pandemic with the resultant backlog that has built up.

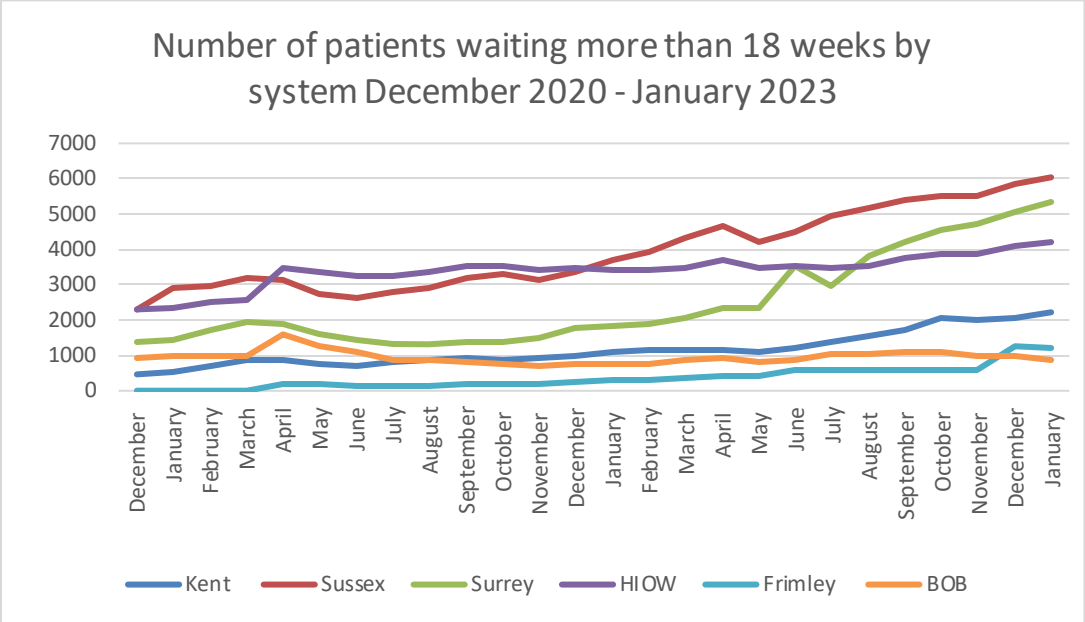
Hospital waiting times are monitored nationally. As part of recovery from the pandemic, Elective Recovery Fund monies have been allocated to hospitals to reduce the number of long waiting patients with the aim of returning to pre-pandemic levels by March 2025 (no patients waiting more than 52 weeks). During 2022-23 the focus has been on patients waiting more than 104 weeks and 78 weeks for treatment. The aim has been to eradicate the number of patients waiting more than 104 weeks by July 2022 and more than 78 weeks by March 2023. The Planning and Operational Guidance for 2023-24 has set the target for no patients to be waiting more than 65 weeks for treatment by 31st March 2024.

For Dental services, the 104 week wait target has been achieved and good progress has been made on reducing the number of patients waiting more than 78 weeks. However, after an initial reduction in the number of patients waiting more than 18 and 52 weeks, the numbers of patients in these waiting list categories have been increasing since last 2021.

The charts below detail the number of patients waiting more than 18 weeks for treatment in BOB and at the Oxford University NHS Foundation Trust. The third chart compares the number of patients waiting more than 18 weeks with the rest of the south-east of England.


Secondary Dental - Patients awaiting treatment 2021-23
BOB
3000
2500
2000
1500
1000
500
0
April
May
June
July
August
September
October
November
December
January
February
March
April
May
June
July
August
September
October
November
December
January
2021
2022
2023
>18 weeks
>52 weeks
>78 weeks
>104 weeks


OUH Secondary Dental waiting times 2021 - 22
1400
1200
1000
800
600
400
200
0
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
>18 weeks
>52 weeks
>78 weeks
>104 weeks



(N.B. Kent, Sussex, HIOW and BOB have similar size populations; 1.71m – 1.87m. The Surrey Heartlands and Frimley populations are smaller; 1m and 0.75m respectively)

Whilst the number of long waiters in BOB is relatively low when compared to other parts of the South-East, there are high numbers of patients awaiting treatment in community-based settings, particularly Oral Surgery and Community Dental Services. Restoration and Re-set monies are also being invested into these services to help address the backlog of long waiters that has built up since the pandemic. This investment has helped to reduce the number of patients waiting more than 52 weeks for treatment.

The Planning and Operational Guidance for 2023-24 states the NHS should:

Continue to address health inequalities and deliver on the Core20PLUS5 approach

The Core20PLUS5 targets are about reducing health inequalities for children and young people and include a specific reference to oral health in terms of addressing 'the backlog for tooth extractions in hospitals for under 10s'.

7. Clinical Engagement

Since its inception in 2013, NHS England has established arrangements for engagement supporting the design and review of services. At national level, this has resulted in the development of Commissioning guides for the following services:

- Oral Surgery and Oral Medicine
- Special Care Dentistry
- Paediatric Dentistry

- Orthodontics
- Restorative Dentistry

These guides inform referral pathways and service standards to be implement ted at local level. The implementation and review of these standards is led by the Thames Valley Local Dental Network (LDN), supported by specialty Managed Clinical Networks (MCNs) covering Oral Surgery, Special Care and Paediatric Dentistry, Orthodontics and Restorative Dentistry. The MCNs have worked with the commissioners to develop Thames Valley referral guides which detail expected provision in primary care and specialist services. These guides are used to underpin the Dental Electronic Referral System (DERS) that is used to process referrals.

NHS England has worked closely with the LDN and MCNs on the development of urgent access arrangements during the pandemic and Restoration and Re-set schemes designed to support recovery of services.

Their support and that of the all the dental practices has been crucial in supporting the recovery that has been achieved in 2022, but significant challenges both in terms of maintaining the recovery and designing sustainable services for the future.

As the new commissioning arrangements take effect following delegation of the responsibility for the commissioning of dental services to ICBs, opportunities will emerge for improvements in oral health to be built into wider health improvement programmes.

8. Next steps and review

Primary Care

- Continue to monitor access to primary care dental services, optimising and developing system partnership level data and reporting, with the aim of maintaining and focussing our efforts to prioritise and improve dental access.
- Implement national dental contract changes at local level to take effect during 2022-23 and use the opportunity of service delegation to influence at a national level to positively affect local population health outcomes.
- Work with the dental profession to consider whether greater flexibilities can be applied locally to the dental contract to facilitate access and support them with workforce challenges.
- Implement the flexible commissioning approach to support access for patients with greater oral health need based on system intelligence, evidence and collaborative agreement.

Urgent access

- Maintain Additional Access sessions

Referral services

- Review impact of Restoration and Re-set investment and implement plans to maintain waiting list reductions in 2023-24
- Agree Secondary Dental contracts with hospitals with the aim of re-establishing pre-pandemic waiting times by 2025, with alignment to the ICB elective care prioritisation framework, as part of system discussions.
- In conjunction with system partners, and our local populations, implement a programme of re-commissioning key referral services to achieve sustainable access and to meet needs of key patient groups, such as children, patients with more complex treatment and management needs and older patients.

All services

- Implement Planning and Operational Guidance in relation to dental services in 2023-24
- Continue to engage with stakeholders such as Healthwatch, supporting them to provide information to patients about access to care, using this local intelligence to identify priority focus areas.
- Review the impact of housing growth in Oxfordshire with responses that support timely and proactive access to treatment.
- Work with other stakeholders to strengthen oral health improvement arrangements through contribution to other health improvement programmes and other interventions that may impact such as water fluoridation.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

April 2023