Report to the Health Overview and Scrutiny Panel

Date of Meeting: 14 March 2024

Subject of Report: An update on the development of a Dental strategy in Bristol, North Somerset and South Gloucestershire

Officer Presenting: Jenny Bowker, Deputy Director of Primary Care at Bristol, North Somerset and South Gloucestershire Integrated Care Board

Recommendations

North Somerset Health Overview and Scrutiny Panel are asked to:

- Consider the ongoing work of BNSSG ICB and the NHS South West Collaborative Commissioning Hub which seeks to address access issues and improve the oral health of the population
- Consider how the panel can contribute further to finalising the strategy
- Consider how best to monitor progress which demonstrates an impact locally.

1. Background

The North Somerset Health Overview and Scrutiny Panel received a report on access to NHS Dental Services in October 2023. This report provides a further update on provision and the development of a Dental Strategy for Bristol, North Somerset and South Gloucestershire (BNSSG).

The Panel is requested to note that the responsibility for commissioning dental care has been delegated to Integrated Care Boards as of 1 April 2023. Since this change BNSSG ICB have been working with the support of the NHS South West Collaborative Commissioning Hub on implementing national policy and initiatives across the south west regional footprint together with developing a local strategy for the next three years.

The delegation of primary care commissioning functions to Integrated Care Boards (ICBs) from 1 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.

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 1.

*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. BNSSG ICB has worked with stakeholders across local authorities, primary, community and secondary dental services, the Bristol Dental School and NHS England as well as undertaking a staff survey to facilitate the co-development of a local three-year dental strategy which seeks to drive improvements in oral health and accessing dental care within the area. The aim of the strategy is to provide a roadmap for the ICB and its partners of the plan of action needed over the next three years to achieve these improvements.

The strategy is available in draft form and further consultation on the strategy is planned. Further public consultation is also planned with the support of Healthwatch.

Service Provision

Dental services are provided in North Somerset in three settings:

1. Primary care – incorporating orthodontics
2. Secondary care
3. Community services – incorporating special care.

Primary care (high street) dental practices are themselves independent businesses, operating under contracts with NHS England. Many also offer private dentistry. All contract holders employ their own staff and provide their own premises; some premises costs are reimbursed as part of their contract. People are not registered with a dentist in the same way they are registered with a GP, so often do not realise they are free to attend any dental practice they choose if they have capacity to see and treat you. Dental contracts are commissioned in units of dental activity (UDAs).

There are 25 contracts for NHS dental services in North Somerset who provide NHS dental services (five of the practices provide stabilisation or urgent care services, one orthodontics)

- Total units of dental activity (UDA) commissioned for North Somerset 23/24 is 366,392 value £10,095,204.93
- Total units of orthodontic activity (UOA) commissioned for North Somerset 23/24 is 10,414 value £848,536.12

Unfortunately, none of the providers providing routine NHS services are currently accepting new NHS patients, but BNSSG are working on additional schemes to increase access and ensure the continuation of urgent care and stabilisation services (please see progress to date).

Access

Over recent years there has been a steady fall in the number of patients in North Somerset who have been able to access an NHS dentist. The percentage of adults seeing an NHS dentist in the last two years in North Somerset has decreased from 42.8% to 41% in the latest 12 months (data available from June 2022 to June 2023). However, the access rate for the adult population of North Somerset (41%) is higher than the access rate for England as a whole (40.1%). The number of children who have seen a dentist in North Somerset in the last two years (data available from June 2022 to June 2023) has decreased slightly at 53% from 53.6% but is still an increase from 45.2% in 2021 (it is 53.6% on average for England). For further details on these statistics, please see: https://commonslibrary.parliament.uk/dentists-dental-practices/

Recent local data shows North Somerset has particularly low rates of Children in Care / Children Looked After who had their teeth checked by a dentist in the previous 12 months with this being 52.6% out of a target of 100%. The national benchmarking data from 2022/23 for

the previous 2 financial years showed that North Somerset are in the bottom quartile of all ICBs for this standard.

The evidence available suggests that children in care / children looked after are at higher risk of dental decay and pain. In 2021, Public Health England reported on inequalities in oral health in England and although evidence was limited, found children in care / children looked after to have poorer oral health and access to care. Research has shown that the children from backgrounds of neglect and abuse have missed many of the primary dental care and preventive services that should be available to all children, as well as acquiring additional difficulties because of their experiences which include poor diets and nutritional deficits.

In BNSSG the Primary Care Dental Service provided by University Hospitals Bristol NHS Foundation Trust accept referrals for children in care / children looked after based on routine and emergency care. Referrals are also accepted from Health Visitors via the First Dental Steps programme. However, a dental home is not necessarily offered to the child or young person once treatment is completed, and referrals can be accepted by non-dental professionals. Children in care / children looked after (up to the age of 16 years) can generally wait to be seen for a new patient assessment for up to six months.

Alongside the development of a strategy for the next three years further work has been running in parallel focused on the implementing national policy and initiatives across the south west regional footprint which seek to urgently address access issues. BNSSG ICB recognises that it is important that children in care / children looked after are considered for enhanced prevention and reviewed regularly to enable appropriate provision of dental care. Further details on plans regarding this and other initiatives in the immediate term are included within the progress update.

2. Policy

The information included in this paper should be considered in conjunction with the paper previously presented in October 2023 which focused on the underlying causes of the access difficulties that people are experiencing in North Somerset and across the country.

Primary care dental services are national contracts negotiated between NHS England nationally and the British Dental Association. A Health and Social Care Committee report into NHS dentistry was published in July 2023. The report acknowledged the crisis facing access to NHS dentistry and recommended fundamental reform of the NHS dental contract along with measures to improve workforce recruitment and retention. Contract reform is not anticipated prior to the general election but on 7 February 2024 the Secretary of State launched “Faster, simpler and fairer: our plan to recover and reform NHS dentistry”.

The new plan, supported by £200m* of government funding sets out a commitment as follows:

- NHS work will also be made more attractive to dental teams with the minimum value of activity increasing to £28 (from £25).
- NHS dentists will be given a 'new patient' payment of between £15-£50 (depending on treatment need) to treat new patients who have not seen an NHS dentist in two years or more.
- To attract new NHS dentists and improve access to care in areas with the highest demand, around 240 dentists will be offered one-off payments of up to £20,000 for working in under-served areas for up to three years.
- The plan sets out how the NHS and government will drive a major new focus on prevention and good oral health in young children and deliver an expanded dental workforce.
- The plan describes the intention for the government roll out a new 'Smile For Life' programme which will see parents and parents-to-be offered advice for baby gums and milk teeth, with the aim that by the time children go to school, every child will see tooth brushing as a normal part of their day.
- The public will also be able to see which practices in their local area are accepting new patients on the NHS website and the NHS App. To promote the increased availability of appointments, the government will also roll out a marketing campaign encouraging anyone who has not been seen by a dentist for the past two years to access treatment.
- New ways of delivering care in rural and coastal areas will also be rolled out, including launching 'dental vans' to help reach the most isolated communities.
- A water fluoridation programme will be rolled out by government, which could reduce the number of tooth extractions due to decay in the most deprived areas of the country. Subject to consultation, the programme would enable an additional 1.6 million people to benefit from water fluoridation, first expanding across the North East.
- The health service will build a pipeline of new dentists and other dental care professionals, including increasing dental training places by up to 40% by 2031/32, as part of the NHS Long Term Workforce Plan.
- The plan also includes new measures to attract dentists to work in the NHS, including supporting more graduate dentists to work in NHS care. The government will consult on whether dentists should be required to work in the NHS for a period upon completion of their training.

*please note that further details are awaited on the source of funding.

BNSSG ICB are working with the support of the NHS South West Collaborative Commissioning Hub on implementing the areas described within the national plan starting with the increase of Units of Dental Activity (UDA's) to £28. Practices have been contacted regarding the new patient payment scheme to identify any practices who do not wish to participate. It has been confirmed that the ICB did not qualify for a dental van and further updates are awaited from the national NHS England team on the other areas outlined.

3. Progress to Date

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”.

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.

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 ICB is seeking to utilise the delegated budget for dental services to improve dental access and use flexible commissioning opportunities to maximise spend of the budget. The contract is nationally negotiated and there are legal implications and procurement policies that need to be adhered whilst developing local solutions.

Immediate Focus

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 BNSSG-wide 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 two practices in North Somerset and have met with them to discuss their concerns. 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.

BNSSG ICB are now working at pace with the NHS South West Collaborative Commissioning Hub on implementing the new national plan which includes increasing all units of activity to a minimum of £28.

Work across the region has also included:

- Additional urgent dental care appointments for those without a regular dentist that they can access by calling NHS111. There are over 356 additional appointments every week across the South West.

- Introduction of stabilisation scheme across the South West via NHS 111 for patients who do not have a regular dentist to get seen. Ten providers were commissioned to provide this across BNSSG, one of the providers is based in North Somerset and commissioned for two sessions per week (New Chestnuts, Long Ashton).
- Supervised Toothbrushing schemes will be fully operational by April in schools for 3–5-year-olds (nursery, and reception children) in every Integrated Care Board area in the South West in targeted areas. Schemes are running in Bath and North East Somerset, Swindon and Wiltshire, Devon, Dorset, Gloucestershire, Somerset and starting after Easter in BNSSG and Cornwall and Isles of Scilly.
- First Dental Steps schemes are in place across the South West with Health Visitors in every Integrated Care Board area giving oral health packs to parents of babies and siblings in target areas.
- There are networks of dental clinicians to help develop local plans with a key aim to improve access to NHS dentistry in the region.
- Plans to implement additional support to Care Homes.

Oral health promotion work has already commenced in North Somerset as part of the Oral Health Action Plan which aims to equip children with toothbrushing support, resources and knowledge on good oral health and implementing the Toothbrush Pack Scheme, First Dental Steps and the Big Brush Club. Please see the update on this provided by the Public Health team for further details. BNSSG ICB and the North Somerset Public Health Team continue to work collaboratively as part of the further development of the strategy and implementation plan.

Children in care / children looked after

Integrated Care Boards have a responsibility for providing adequate services to meet the health needs of children in care / children looked after. As stated previously North Somerset are in the bottom quartile for achievement against this standard nationally.

Recognising the importance of increasing access for children in care / children looked after a business case has been approved for additional services across the ICB. The specification for the service includes provision for unaccompanied asylum-seeking children (UASC). An expression of interest is due to be advertised for this as soon as possible with a request for providers in North Somerset in particular to apply.

The aim of this development is to utilise the flexibilities permitted as part of the national contract to increase access for children in care / children looked after over the next twelve months and to utilise the learning from this initiative to create a plan in the longer term which ensures this is delivered sustainably.

Patients can expect to receive courses of treatment which will maintain their oral health. However, courses of treatment may begin with an urgent care appointment if the child or young person is in pain.

The development is the start of further initiatives which seek to use the flexible commissioning guidance to increase access and retain the NHS workforce.

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

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 a local 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.

The outline of the workshops and survey was aligned to the feedback received from Healthwatch which was also cited in the House of Commons Health and Social Care Committee report on NHS Dentistry published on 11 July 2023 and the NHS England South West Oral Health Needs Assessment published in January 2021.

The draft strategy 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 two years this is not to suggest that any of the areas identified are of less importance. The prioritisation involved a range of considerations including the direct impact on patient outcomes and reducing health inequalities to determine these timelines.

Further consultation with the public 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 with 60% coming from primary care dentistry.

44 of the respondents felt that the top five 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 two year's time, 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.

Draft BNSSG Dental 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 people experiencing homelessness, asylum seekers and people 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 and 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.

For oral health promotion work has already commenced in North Somerset as part of the Oral Health Action Plan which aims to equip children with toothbrushing support, resources and knowledge on good oral health and implementing the Toothbrush Pack Scheme, First Dental Steps and the Big Brush Club. Please see the update on this provided by the Public Health team for further details. BNSSG ICB and the North Somerset Public Health Team will continue to work collaboratively as part of the further development of the strategy and implementation plan.

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. This needs to take place during March and April to ensure that a plan is deliverable from May 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 and implemented new services for urgent care and stabilisation. New initiatives focused on reducing health inequalities such as the first initiative to increase provision for children in care / children looked after 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 as well as North Somerset Public Health Team on the Oral Health Action Plan.

Equality Implications EIAs will be undertaken as appropriate and prior to any significant service changes.

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Appendices:

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

Appendix 1:

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/