



Bournemouth and Poole

**PRIMARY CARE
DENTAL COMMISSIONING STRATEGY
FRAMEWORK**

**Commissioning to improve Oral Health for NHS
Bournemouth and Poole
(2009 - 2014)**

AUGUST 2009

NHS BOURNEMOUTH AND POOLE
DENTAL COMMISSIONING STRATEGY 2009 - 2014

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SECTION ONE
INTRODUCTION

1. Introduction

1.1 Primary Care Trusts (PCT) have the responsibility to understand the needs of their population in order to commission effective evidence-informed programmes and services to reasonably meet local needs. In November 2005, the Department of Health published *Choosing Better Oral Health – an Oral Health Plan for England*. The principles within this publication have provided the basis for the development of the oral health strategy for Bournemouth and Poole (2009 - 2014) and the subsequent development of an oral health action plan. This strategy document seeks to address service priorities identified in the oral health strategy from a commissioning perspective and identifies the key issues that will enable Bournemouth and Poole to become stronger commissioners of dental services. It uses policy guidance and local feedback to set out and explore the issues facing Bournemouth and Poole and seeks to improve the NHS dental services network used by local residents .

2. The vision for oral health and primary dental care

2.1 The overarching aim of the Oral Health Strategy for Bournemouth and Poole (2009 – 2014) is:

To reduce current oral health inequalities and achieve sustained improvements in oral health for Bournemouth and Poole residents.

2.2 This aim is underpinned with the following key objectives:

- Prioritising the reduction of inequalities in oral health and access to good quality care
- Raising the profile of oral health so that dentistry is seen as an integral part of general health
- Continually developing partnership working to deliver oral health improvement
- Involving communities through engagement and consultation and improving available information
- Developing skills, valuing, sustaining and improving the workforce and supporting dentists to improve the quality and range of services offered
- Engaging with research and development and by adopting evidence based approaches
- Evaluating new initiatives
- Ensuring that there is appropriate information available on local health needs
- Accessing appropriate dental public health and dental practice advice to drive the strategy forward.

- 2.3 The oral health strategy, and therefore this complementary commissioning strategy, is to reduce both the prevalence of oral disease and oral health inequalities across all age groups in Bournemouth and Poole and to ensure that dental services are accessible, of good quality, convenient and appropriate to meet the needs of the local population, including vulnerable, disadvantaged and socially excluded groups who face particular problems.
- 2.4 The oral health strategy reinforces that oral health is intrinsically linked to general health. It emphasises that the main focus must continue to be on prevention, given that tooth decay and periodontal disease are the two main dental diseases and that they are largely preventable and controllable. Oral health must therefore remain in the context of overall general health. Only through working in partnership can the oral health needs of the residents of Bournemouth and Poole be fully addressed. To improve oral health, as with general health, requires that things are done differently. There needs to be a multifaceted approach for oral health improvement that brings about early gains, such as developing equity in access to and uptake of services and promoting lifestyle changes via consistent, timely and accurate messages to the local population. In the longer term, sustainable improvement will be achieved by contributing to work tackling the determinants of oral health and changing systems to have health improvement as a goal.
- 2.5 A number of key issues were highlighted throughout the new oral health strategy. A summary of these can be found in **Appendix 1**. From a commissioning perspective, there is a need to reconsider dental commissioning approaches, taking account of both local oral health needs and primary care dental services in their entirety.

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SECTION TWO
POLICY CONTEXT

1. Background Policy documents

1.1 Implementing ¹*Delivering Better Oral Health*, first published in September 2007, should be integral to the process of commissioning to improve oral health. There are a number of wider policy initiatives which must be taken into account when developing commissioning intentions for dentistry. These include:

- Options for change - (Department of Health (DH), 2002)
- NHS Dentistry: Delivering Change - (CDO, July 2004)
- The NHS Improvement Plan - (DH, 2004)
- Report of the Primary Care Workforce Review - (DH, 2004)
- Creating the Future: Modernised Careers for Salaried Dentists in Primary Care (DH, 2004)
- Choosing Health - (DH, 2004)
- Standards for Better Health - (DH, 2004)
- Implementing a Scheme for Dentists with Special Interests (DwSIs) (DH, 2004)
- Creating a Patient-led NHS - (DH, 2005)
- Commissioning a Patient-led NHS - (DH, 2005)
- Choosing Better Oral Health - (DH, 2005)
- Health reform in England: commissioning framework - (DH, 2006)
- Effective Interventions - (NICE)
- World Class Commissioning: Improving dental access, quality and oral health (DH, 2009)
- NHS Dental Services in England – An independent review by Professor Jimmy Steele (DH, 2009)

1.2 The key themes of these documents include:

- Improving dental access for everyone
- Trying to reduce oral health inequalities
- Changing the way dentists work and are paid
- Engaging and involving the community in determining policy
- Developing the dental team through skill mix
- Integrating dentistry within the NHS family
- Improving public information to help people find an NHS dentist

1.3 A number of more recent policy changes designed to facilitate improvements in both general and oral health are considered in more detail below.

¹ Delivering Better Oral Health- An Evidence Based Toolkit for Prevention (DH, 2007)

2. Primary dental service reforms

- 2.1 The recent reform of primary dental services reflects the background of the wider NHS change agenda. Regulations governing dental contracts (both GDS contracts and PDS agreements) were laid before Parliament on 9 December 2005. These regulations came into force on 1 January 2006 for the agreement of contracts, and from 1 April 2006 for the provision of services. The regulations governing the three-banded system of patient charges were also agreed and came into force on 1 April 2006.
- 2.2 The changes to local commissioning of dental services presents the opportunity to reorientate services towards prevention and to concentrate on working more “upstream” in order to prevent and control oral disease and conditions, a major area of gain. As the PCT now holds local contracts with dentists, the foundation to influence and change the culture of the majority of the primary dental care teams has come into place.
- 2.3 The new contractual changes are designed to facilitate improvements in oral health and *Choosing Better Oral Health* underpins and supports PCTs to meet their new responsibilities for dental services under the Health and Social Care (Community Health and Standards) Act 2003. This legislation extends their remit to assessing local oral health needs and commissioning the appropriate services to tackle long standing oral health inequalities.
- 2.4 The new dental contracting arrangements give Bournemouth and Poole dental practices stable funding and scope to plan and shape services, and an end to the “fee for item” system of remuneration. The new arrangements significantly reduce outmoded treatment incentives.
- 2.5 The PCT and the dental team can now focus on improving oral health overall, ensuring preventative measures at population individual level are strengthened. This will lead to a reduction in poor oral health, address inequalities in oral health experience and facilitate access to NHS dental care - especially in the child population where there is the most to gain from improvements.

3. NHS Operating Plan

- 3.1 For the first time, *The NHS Operating Framework for the NHS in England 2008/09*, identified specific goals and targets for NHS dentistry. These included the need for PCTs to ensure :

²*“Robust commissioning strategies for primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS dental services (as measured by quarterly data published by the Information Centre on the number of people receiving primary dental services within the most recent two-year period).”*

- 3.2 Following the publication of the Operating Framework in December 2007, further dental guidance was issued by the Department of Health in January 2008 on how to achieve the objectives set out in the framework (Gateway

² The Operating Framework for the NHS in England 2008/09. Department of Health.

reference: 8903). This guidance provided the following messages around dentistry to PCTs:

- If a service is not offering good quality or, exceptionally, is risking patient safety, it is by definition poor value for money
- Plans need to cover all local dental services – not just those covered by independent contractors
- The new local system (of contracting) allows PCTs to vary contracts to meet particular needs
- PCTs will wish to establish a rolling cycle of reviews with providers
- The local framework (of reviews) should enable PCTs and providers to review contracts against the criteria in the PCTs' locally formulated commissioning plan
- PCTs should operate a culture of “no surprises”
- PCTs may reward providers who demonstrate high levels of commitment to the NHS, for example developing incentives for practices that deliver “above and beyond” contractual expectations
- PCTs need to have established a local way of informing people about NHS dental services, in a way that explains the choices available. PCTs might consider a local dental access helpline (or similar mechanism for improving attendance rates).

3.3 The dental approaches set out in the 2008/09 Operating Framework were reinforced in the 2009/10 Framework, published in December 2008. This stated that more needs to be done to improve access to dentistry, as well as the quality of care and oral health in the community. Doing so “³Will include reviewing dental commissioning strategies, ensuring open and transparent procurement for all significant new investments in dental services, in order to provide access to anyone who seeks help in accessing services.”

4. World Class Commissioning

- 4.1 Effective commissioning of local health services is one of the most critical functions of the modern NHS. The purpose of the World Class Commissioning (WCC) programme is to improve rapidly the commissioning processes and performance of PCTs, with the aim of improving health outcomes and reducing health inequalities.
- 4.2 A key element of the WCC programme is the requirement for every PCT to develop an overarching five year strategic plan, clearly setting out each PCT's vision, its priorities and how they will be delivered.
- 4.3 World class strategic plans will need to articulate clearly what the high level “patient offer” is. This “offer” will set out what the PCT will deliver on behalf of the local community. In effect it is a social contract between the PCTs and its stakeholders, setting out what the PCT expects to be held to account for delivering.
- 4.4 WCC strategies will also give a clear overview of what delivering the local patient offer will entail, including the service models that will be developed –

³ The Operating Framework for the NHS in England 2009/10. Department of Health

in other words, what services will be provided, where they will be available, and who will provide them.

4.5 In addition to its strategic plan, each PCT will need to prepare an annual operating plan. This plan will set out in some detail what will be done in the coming year to implement its strategy. A key element of the annual operating plan will be specifying the changes that the PCT has committed itself to in order to improve primary care services

4.6 The WCC vision can be summarised as delivering the following:

Better health and well-being for all:

- People will live healthier and longer lives
- Health inequalities will be dramatically reduced.

Better care for all:

- Services will be evidence-based and of the best quality
- People will have choice and control over the services that they use, so they become more personalised.

Better value for all:

- Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources
- PCTs will work with others to optimise effective care.

5. World Class Commissioning: impact on oral health and dental care

5.1 It is vital that PCTs develop a clear vision of dental primary care that is firmly rooted in the broader strategic context. The ultimate test of the success of WCC in respect of oral health and dental care, will be an improvement in oral health outcomes and a reduction in dental health inequalities.

5.2 The distinctive features of commissioning primary dental care are set out in ⁴*Primary care and Community Services: Improving dental access, quality and oral health*. The guidance states that in order to make improvements to primary dental care services, a baseline needs to be established. The three key stages to mapping the baseline include:

- Assessing needs
- Mapping existing services,
- Identifying what needs to change.

5.3 These key areas allow for identification of:

- Service gaps
- Potential for redesigning services,
- Level of resources required.

⁴ World Class Commissioning: Improving dental access, quality and oral health (DH, 2009)

- 5.4 **Stage 1 Assessing local needs** – the paper sets out processes for determining oral health needs and assessing demand for dental services. It recognises that assessing demand for dental services is not straightforward. The current access indicator - the number of people using services within a two year period - is not an accurate proxy for levels of unmet need or demand. It is suggested that the simplest way of gauging unmet demand is to set up a well publicised dental access helpline for both people seeking urgent care and those seeking a regular NHS dentist, monitor the nature of the requested needs and the ability to offer services to meet them.
- 5.5 **Stage 2 Mapping existing services** – this refers to gaining a clear understanding of how services are currently provided, their quality, and any gaps that need to be addressed.
- 5.6 **Stage 3 Identifying what needs to change** – a comparison of the needs assessment with existing service provision will highlight what needs to change. Whilst differing for every PCT, common themes will include:
- Levelling access and improving choice for the segments of the population who cannot access or have difficulty accessing services
 - Addressing areas of poor health
 - Developing specialist services
 - A stronger focus on commissioning preventive services.
- 5.7 With respect to dental services, World Class Commissioning should ultimately support:
- Delivering better oral health and well-being
 - Enabling people to live healthier and longer lives and therefore keep their teeth longer
 - Reducing oral health inequalities.

6. Independent Review of NHS Dentistry in England (2009)

- 6.1 In December 2008, the former Secretary of State for Health, Alan Johnson commissioned Professor Jimmy Steele to lead a review of NHS dentistry. His report was published in June 2009.
- 6.2 The report recognises that access to dental care is a problem for particular areas of the country and recommends that the NHS should continue to address specific capacity shortages through the dental access programme, such as the procurement of new services in line with the Operating Framework objective of providing dental services to everyone seeking them.
- 6.3 The report also makes recommendations on improving public information to help people find an NHS dentist and what to services they can expect to receive. It goes on to recommend that NHS primary care dentistry provision should be commissioned and delivered around a staged pathway of care. The proposed pathway would seek to encourage continuity of the relationship between patients and dentists, built around the most appropriate recall interval for the patient and uses oral health as an outcome. Patients would be registered in a continuing care relationship with a practice and have an absolute right to return to that practice for both routine and urgent care.

- 6.4 With respect to the dental contract, the report recommends that they are developed with much clearer incentives for improving health, improving access and improving quality. This would require the development of the current contract to include payments for continuity care responsibility, alongside rewards for quality and activity with quality outcomes being supported by nationally derived quality measures. Such contracts should be piloted and evaluated thoroughly.
- 6.5 The report recognises that the process and skills in the NHS associated with commissioning dental services has been highly variable. It therefore recommends that PCTs should be required to demonstrate good organisation structure, including senior leadership and strong clinical engagement.
- 6.6 As technology can help facilitate the collection and organisation of data, the report recommends that PCs are used in all dental surgeries within a three year period and are centrally connect to allow clinical data to support shared information on quality and outcomes.
- 6.7 The next steps are to implement the vision, starting with the piloting of the new dental contract. The timetable is not yet known, however, the future will bring significant changes in the contracting framework. It is essential that Bournemouth and Poole PCT keep up to date with national developments to ensure that both they and local providers are best placed to manage the change.

7. The Dental Access Programme

- 7.1 In response to widespread and continuing public concern about the availability of NHS dental services, the Department of Health has stated a commitment to ensuring that any eligible person seeking NHS dental services will be able to access them within a reasonable period of time by March 2011. The Dental Access Programme was therefore launched in March 2009 and sits alongside the review led by Professor Jimmy Steele.
- 7.2 The Dental Access Programme consists of four workstreams:

Developing a **new indicator** for dental access

- Develop an improved indicator of dental access, ensuring that there is clarity about what the programme is aiming to achieve and establishing appropriate and robust measures that are fit for purpose

Supporting additional **procurement** of dental services

- Enable the NHS to increase the capacity of good quality NHS dental services to meet local demand via open and transparent procurements by developing packages of support required by PCTs

Supporting possible gains through **contract management**

- Ensure that high quality services are being delivered as outlined in dental contracts by supporting PCTs to effectively manage their dental contracts for enhanced quality and access

Communications and stakeholder engagement

- Support local, regional and potentially national communications activities to raise patient awareness of the availability of good quality, local NHS dental services and their entitlement to access them.
- 7.3 The workstreams have generated a number of number of outputs, including training programmes. Further publications and guidance are expected during the summer of 2009, including tools to support PCTs assess the performance of their local contractors and tackle specific issues, such as underperformance.
- 7.4 During October 2008, the Department of Health issued an Access Toolkit. Overseen by the Strategic Health Authority, it required each PCT to set out the local gap in access to NHS dentistry and how this might be met by March 2010. The toolkit was then revised and re-issued in June 2009 to assist PCTs to review their forecast demand and current performance. It also provided a straightline trajectory example between current position and the future target position. This trajectory incorporated both number of patients and the anticipated number of Units of Dental Activity (UDAs) required to ensure that anyone who seeks it, is able to access NHS dental services by March 2011.
- 7.5 The revised toolkit allowed PCTs to explore the impact of new procurements, improved contract management and the associated timelags between procurement and delivery of services on the trajectories. This was expected to provide a more realistic assessment of local position and the plans required to support production of plans.
- 7.6 Alongside other PCTs, Bournemouth and Poole completed and returned the local Access Toolkit during July 2009. In it the PCT set out details for ensuring that everyone who wishes to obtain access to NHS dental services can do so by March 2011. In order to achieve this, the PCT estimate that 72% of the population will use NHS dental services within a 24 month period if local supply was able to meet demand at March 2011. This represents an increase of 4% when compared to the 68% of the population using NHS dental services as at March 2009. In terms of numbers, this gap represents an additional 11,000 patients. The PCT anticipates that adequate services will be in place to meet their need by March 2010 (a year earlier) through a combination of; new dental services that have already been commissioned but whose impact has not yet been fully reflected, managing existing contracts more effectively and procuring new capacity during 2009/10.
- 7.7 The PCT recognises that merely increasing the number of new patients accessing NHS care does not automatically reduce oral health inequalities - unless those with the greatest need form the group of additional patients obtaining care. Unfortunately, those with highest levels of needs are the individuals who are least likely to seek or want dental care. The PCTs recognises a dichotomy exists and that it must balance a central government requirement to increase the number of patients accessing care in line with proposed figures versus the ultimate aim of meeting oral health needs and priorities.

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SECTION THREE

COMMISSIONING FOR ORAL HEALTH

1. Introduction

1.1 Commissioning for oral health in Bournemouth and Poole will require:

- Putting people at the centre of commissioning
- Understanding the oral health needs and demands of populations and individuals
- Using information more effectively and commissioning more as required
- Assuring high quality providers for dental services
- Developing incentives for commissioning for health
- Local accountability - capability and leadership.

1.2 There are a number of key steps that are required if this is to be achieved. These are considered below.

2. Prioritising vulnerable groups and targeting resources

2.1 Tackling oral health inequalities requires the PCT to understand which groups of people in a local community are most at risk of poor oral health and targeting resources to meet their needs, in addition to maintaining universal access.

2.2 In light of the findings of the oral health strategy, those groups most at risk of poor oral health across Bournemouth and Poole will include:

- **Children** (especially the young)
- **Vulnerable people:**
 - Older people
 - Individuals with special needs: physical, mental or medical conditions or disabilities
 - Socially excluded groups, for example:
 - addicts - such as IV drug users and alcoholics,
 - those with poor educational attainment
 - asylum seekers
 - the homeless
 - individuals who are housebound.
- **Those residing in areas with the highest levels of deprivation**

2.3 Published by the Department of Health in 1994, the former *National Oral Health Strategy* incorporated targets for the oral health of five and 12year-old children, and adults, in England by 2003. Beyond this period, PCTs could set local targets - but not all have done so. No local oral health targets are in place for Bournemouth and Poole and the PCT needs to consider is whether

any should be set for the future. An example of local oral health improvement targets set by other PCTs is provided below for reference.

Figure 1: Oral health improvement targets by 2014 – examples set by other PCTs

For pre-school children	80% with no obvious decay
For five year olds	60% with no obvious decay
For 10-14 year olds	80% with no unmet orthodontic need
For adults	100% free from chronic dental pain or discomfort
Vulnerable groups	100% access to appropriate responsive dental services

2.4 The PCT should **consider whether oral health targets are set on a local basis**. Irrespective of this, in order to access oral health outcomes, it is essential that Bournemouth and Poole PCT have **systems in place to monitor improvement in oral health**.

3. Developing local dental services in line with needs

3.1 Bournemouth and Poole PCT need to develop a **clear definition of what universal dental services look like. They should then work with the local profession to systematically achieve goals** around developing both service and practice infrastructures.

3.2 This will include the need to come to a common understanding regarding:

i. Where services are located

- In addition to universal access, it is essential that primary care services are adequately distributed in areas with the greatest oral health needs and the poorest accessibility.

ii. What services are provided

- PCTs have a statutory duty to secure primary care dental services to the extent that it considers necessary to meet all reasonable requirements of the population. General dental services across Bournemouth and Poole should therefore provide services to all NHS patients, complemented by salaried community and specialist services. All services provided should be quality driven and based on preventative approaches.

iii. Practice infrastructure

- As there is a need to ensure that that all premises (including those of the salaried dental service) are of suitable standard, clear criteria about suitability of premises should be developed and a commitment to support and/or monitor change in the future.

4. Recognising the importance of safety net services

4.1 High street dental practices are the most significant primary care dental providers across Bournemouth and Poole. However, not all local residents will

be willing or able to receive dental care in this setting. **In order to meet the needs of local vulnerable groups**, unable to access general dental services, **it is essential that appropriate safety net services are available.**

4.2 To achieve this will require a fundamental review of existing salaried dental service, ensuring that:

- Clinical and outreach services are reviewed in light of most effective interventions and approaches
- Evidence based screening services with health outcomes are further developed.

5. Patient experience

5.1 The experience of patients and the public when using primary care dental services is of vital importance and effective feedback on service quality is required to support continuous service improvement.

5.2 Patient experience is currently collected in a number of different ways including satisfaction surveys (national and local), helpline services and complaints trends. However, this information needs to be better linked to planning and commissioning decisions locally.

5.3 As of March 2009, patient experience is being monitored in all primary care providers using a structured and clear framework that enables benchmarking and trend analysis over time and takes into account of findings from the new Local Involvement Networks (LINKs).

5.4 All PCTs should develop a robust framework to assess and monitor patient experience across five key domains:

- Access and waiting
- Safe, high quality co-ordinated care
- Building better relationships
- Better information, more choice
- Cleanliness, friendliness and comfort

5.5 These domains have been developed by drawing on extensive social research involving service users and represent the most important factors to patients and the public (Department of Health, 2006).

5.6 It is essential that the PCT is **clear about what local residents seek from dental services** and ensures that it is **able to “get the message across” to people about oral health and the availability of local services** in a way that they can relate to and which is relevant to their needs.

5.7 The PCT should consider the following requirements:

- The best ways of gathering local residents’ views regarding their concerns, barriers and aspirations about local services. For example, any community forums should continue to include dentistry.

- There is a need for local residents to have accurate information regarding access to emergency, urgent and routine NHS dental care. For example, the practice information on NHS Choices should be up to date and the local PALS and helpline service should have accurate information and signpost individuals correctly to those practices accepting new NHS patients.
- The need for a dedicated marketing strategy, implemented consistently over at least two years. Such a strategy should be relevant to the priority groups and linked to other strategic communication strategies such as tobacco control and smoking cessation . The PCT would first need to consider whether it has the marketing expertise in house or whether investment will be required in outsourcing this programme.

6. Facilitating partnerships

- 6.1 It is essential that the PCT is committed to working with a range of partners to improve the health of the population and to ensuring that services are delivered in an integrated manner. All too often, patients are under the care of a variety of services and agencies, which are neither co-ordinated nor provide holistic care. Clinicians and other staff are often frustrated by organisational boundaries and inadequate communication. This needs to change.
- 6.2 In order to maximise the contribution of primary care and its impact upon the health and well-being of Bournemouth and Poole residents, **primary care professionals will need to develop strong and effective relationships with a wide range of partners in secondary care, community services, and social care.**
- 6.3 **Increasingly, links will need to be made with other agencies within Bournemouth and Poole** in order that primary care can support partners to address some of the underlying determinants of health, such as employment, housing and education.
- 6.4 It is important that **existing networks are also reviewed** in line with the future direction of dental services, as set out in the new oral health strategy, oral health action plan and dental commissioning strategies.

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SECTION FOUR
CAPACITY PLANNING

1. Understanding capacity planning

- 1.1 All commissioning plans need to be underpinned by an understanding of the level of current resources, what they can be used for, what they are currently delivering, and (using benchmarking) what constitutes value for money.
- 1.2 Key strategic financial considerations for 200/10 and beyond include the recurring use of an increased allocation for NHS dentistry of 8%.
- 1.3 The 2009/10 NHS Operating Framework makes it clear that dental resources are to be spent across the entire dental services network to secure the highest quality and highest increases in dental attendance. Details of recent central devolved funding and expenditure for Bournemouth and Poole PCT is provided in Figure 2..

Figure 2: Devolved funding and expenditure– NHS Bournemouth and Poole PCT

Year	Indicative Gross Budget £ 000's	Indicative Patient Charge Revenue £ 000's	Net Allocation £ 000's	UDAs - Indicative
2006/07 AWP	17,378	5,745	11,633	618,813
2007-8 AWP	17,648	5,438	12,209	604,870
2008-9 AWP	19,377	5,739	13,638	638,821

Source: NHS Bournemouth & Poole

- 1.4 The above figures do not include the funding and expenditure associated with Bournemouth and Poole's baseline allocations used to finance secondary care dental services.
- 1.5 Through the completion of quarterly returns to the centre, known as the FIMS return, each PCT will provide an update on the expenditure of its dental allocation which is then reported back to both the PCT and the SHA as part of quarterly vital signs report. The increasing importance on improving access will be monitored on an individual PCT level via the quarterly vital signs reports. For this reason, the PCT should closely monitor its vital signs reports to ensure that key access and quality targets are being met.
- 1.6 **PCTs must fulfil the requirements of the Operating Framework.** In order to do so Bournemouth and Poole PCT will need to ensure that:
 - There is a good understanding of all of its dental expenditure, including services commissioned or hosted on its behalf, including the salaried

service, out of hours urgent care services and secondary care dental services.

- Future patterns of expenditure should reflect the strategic direction of dental services and the commitment set out by the PCT as part of the Access Toolkit exercise.
- It is securing value for money from all of its contracts by using rigorous performance management.
- It has planned to commission increases (and indeed decreases) in activity in the areas of dental services that have been prioritised (or de-prioritised).
- Systems are in place to closely monitor key performance indicators available via vital signs and BSA NHS Dental Services' reports and e-reporting system.

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SECTION FIVE

COMMISSIONING CARE PATHWAYS

1. Introduction

1.1 Commissioning in the NHS is in a transitional period. It is moving from a focus on commissioning a portfolio of services, where the relationship is with the provider; to commissioning a "pathway" of services that ensures the patient's journey through different services is cost-effective and a good experience. Strong, successful commissioning now requires excellent working relationships with both providers and patients.

1.2 This section focuses on what the overall portfolio of commissioned services looks like in Bournemouth and Poole - and how that portfolio might develop in the light of the strategic imperatives described earlier.

1.3 The network of dental services providers in Bournemouth and Poole comprises of the following NHS services:

- General dental services (including specialist orthodontic services)
- Salaried dental services
- In and out of hours unscheduled urgent services
- Hospital dental services

1.4 A map setting out the location of all primary care dental services can be found in **Appendix 2**, overlaid on deprivation, and in **Appendix 3**, overlaid on population density.

1.5 On initial assessment, it appears that the wards with the highest level of deprivation with the least accessibility to NHS primary care dental services include:

- Hamworthy West (Poole)
- Strouden Park (Bournemouth)

1.6 It should also be noted that there is currently no primary care dental provision across the ward of Merley and Bearwood. This is one of the least populated wards, however, local residents - including those in need of urgent dental care - will have to travel the greatest distance to access NHS dental care.

2. General Dental Practitioners

2.1 General Dental Practitioners (GDPs) are the most significant primary providers of dental care for the population of Bournemouth and Poole, with 232 (performers) dentists working out of 52 practices. Of these 52 practices, 41 provide routine NHS care, seven provide both NHS orthodontic and routine care, and one practice provides orthodontic services only. Of the 52 practices 14 restrict their NHS activity only to children and exempt groups.

Most practices will provide a mixture of both private and NHS services to patients.

2.2 A breakdown of the contracts held by the PCT is shown below.

Figure 3 – details of dental contracts held by NHS Bournemouth and Poole as at March 2009

Total Number of Open Contracts @ 31/03/09	58
Number of GDS Contracts	44
Number of PDS Agreements	14
Number of General Contracts	50
Number of General and Orthodontic Contracts	7
Number of Orthodontic Contracts	1
Number of Contracts where sedation services are commissioned	1
Number of Performers	232

Source: NHS Dental Services 2009

3. Accessibility to general dental services

3.1 Given the difference acceptance policies of local practices, the map in **Appendix 4** distinguishes those practices accepting new NHS patients and those whose lists (as of 2008) were closed and no new NHS patients were being accepted. This changes the accessibility picture, and leaves the following wards without an NHS dental practice for local residents not currently receiving care:

- Merley and Bearwood
- Broadstone
- Creekmoor
- Hamworthy West
- Hammworthy East
- Oakdale
- Penn Hill
- Canford Cliffs
- Newton
- Canford Heath East
- Moodown
- Throop and Muscliff
- Strouden Park
- Littledown and Iford
- Queen's Park
- East Southbourne and Tuckton
- Redhill and Northbourne
- Boscombe East
- East Cliff and Springbourne
- Branksome West

3.2 The map in **Appendix 5** aims to set out gaps in accessibility across Bournemouth and Poole, based on local residents travelling a three mile, and then a five mile, radius from each dental practice in contract with the PCT (irrespective of their acceptance status). As can be seen, there are no gaps in based on these distances. When the same exercise is repeated by drawing a 1mile radius around all dental practices (**Appendix 6**), gaps appear for the residents living in the following wards:

- Merley and Bearwood
- Hamworthy East
- Hamworthy West
- Canford Cliffs
- East Southbourne and Tuckton
- Littledown and Iford

This assessment looks at access availability in practices within NHS Bournemouth and Poole only.

3.3 However, as not all these practices are accepting new patients, the map in **Appendix 7** draws a one mile radius around only those practices accepting new patients. The wards with accessibility gaps now further extend to:

- Strouden Park
- Broadstone
- Penn Hill
- Queens Park

3.4 It is important for the PCT to **consider and agree on the distance and time which is reasonable for local residents to reach a dentist accepting new patients**. These targets will need to differ for rural and urban areas and should continue to be monitored carefully.

3.5 Figure 4 sets out the actual number of children and adults who accessed dental treatment locally within a 24 month period during March 2006 to September 2008. Not all these individuals will be residents of Bournemouth and Poole.

Figure 4 – Number of children and adults who accessed dental treatment locally within a 24 month period during March 2006 to September 2008

	Adults	Children	Total	% change on previous quarter
At 31/03/06	142,909	48,457	191,366	
At 31/06/06	147,932	49,472	197,404	3.2%
At 30/09/06	150,982	50,340	201,322	2.0%
At 31/12/06	152,272	50,467	202,739	0.7%
At 31/03/07	154,626	51,230	205,856	1.5%
At 30/06/07	155,363	51,174	206,537	0.3%
At 30/09/07	155,098	50,863	205,961	(0.3%)
At 31/12/07	153,518	50,371	203,889	(1.0%)
At 31/03/08	152,452	50,045	202,497	(0.7%)
At 30/06/08	151,620	49,591	201,211	(0.6%)
At 30/09/08	152,294	49,362	201,656	0.2%
Change in patients numbers between March 06 and Sept 08	9,385	905	10,290	5.4%

Source: NHS Dental Services 2009

- 3.6 Figure 4 confirms that, during the period March 2006 through to the end of September 2009, an additional 10,290 people accessed care within a 24month period, the majority (9,385) of whom were adults.
- 3.7 When considering this increase as a percentage of the PCT's population, Figure 5 shows that, during the period March 2006 to December 2008, the number of patients accessing NHS dental services increased overall by 2.9%. This average is made up of 3.5% for adults and 1.1% for children. These positions represent a more positive position when compared to the South West SHA average and the England average. Both experienced overall decreases in the percentage of the population accessing NHS dental services during the same period.

Figure 5: Patients seen as a percentage of the population as at 31 December 2008

Bournemouth & Poole PCT	Adults	Children	Total
to 31/03/06	59.5%	84.4%	64.3%
to 31/12/08	63.0%	85.5%	67.2%
Difference	3.5%	1.1%	2.9%

South West SHA	Adults	Children	Total
to 31/03/06	48.0%	73.5%	53.3%
to 31/12/08	47.3%	70.4%	52.0%
Difference	(0.7%)	(3.1%)	(1.3%)

England	Adults	Children	Total
to 31/03/06	51.6%	70.7%	55.8%
to 31/12/08	49.0%	69.2%	53.4%
Difference	(2.6%)	(1.5%)	(2.4%)

Source: Information Centre May 2009

- 3.8 As not all those seeking dental treatment locally will reside in NHS Bournemouth and Poole and, likewise, as not all Bournemouth and Poole residents will obtain care locally, it is important to review patient flow information to understand if this may account for any changes in access numbers.
- 3.9 As shown in detail in the oral health strategy, during 2007/2008, 92.7% of Bournemouth and Poole residents who obtained dental treatment, did so locally with just 6.26% of residents seeking care in Dorset during the same period.
- 3.10 There appears to be little pattern of change in patient flow during 2006/07 and 2007/08. Therefore, any commissioning changes implemented by the PCT that impact on the provision of primary care dental services are most likely, in the majority, to affect the local population.
- 3.11 It is essential that **patient flow information is closely monitored by the PCT on an ongoing basis, alongside patient access numbers.** This will ensure that the PCT is able to assess accessibility to NHS dental services by Bournemouth and Poole residents, both within and outside the PCT boundaries.

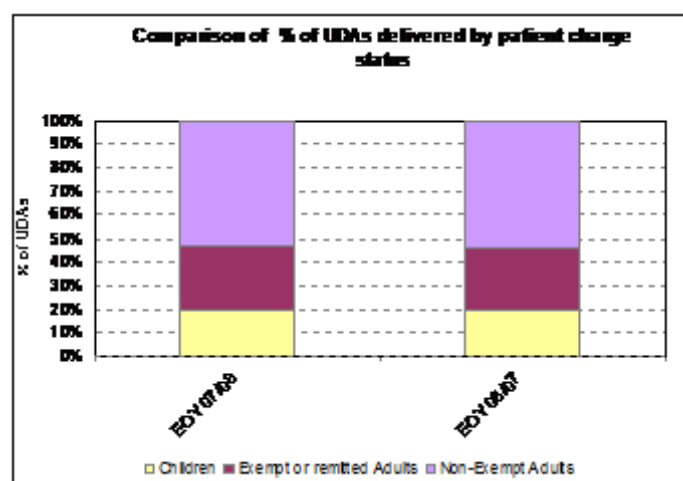
4. Contracted and delivered general dental service activity

- 4.1 The primary care dental contract introduced on 1 April 2006, placed a statutory responsibility onto PCTs to formally review the performance of NHS dental providers against the requirements of their General Dental Services (GDS) contracts and Personal Dental Services (PDS) agreements.
- 4.2 Each contract includes an agreed total number of units of dental activity (UDAs) and/or units of orthodontic activity (UOAs). The value of these units make up the total contract value and the provider is paid one twelfth of the contract value each month. Providers are expected to deliver the units of activity evenly throughout the year to avoid either under or over delivery at year end. Regular monitoring should take place throughout the year to ensure that the contract is performing on target.
- 4.3 Whilst providers are required to deliver 100% of their contracted activity, the dental contract Regulations allows providers to under delivery by up to 4% of their annual UDA / UOA activity, with the provision that this under-delivered activity is provided in the following year.
- 4.4 Overall, NHS Bournemouth and Poole commissioned a total of 577,592 units of dental activity (UDAs) in 2008/09. A map setting out contracted activity from dental practices during this period is found at **Appendix 8.**

- 4.5 The year end activity reports received from NHS Dental Services provides a detailed breakdown of contract performance against the commissioned level of activity. Analysis of the data confirms that for 2007/08, local dental providers delivered an average of 96% of contracted activity
- 4.6 However, merely delivering UDAs is not an indication as to the number of patients being treated; the groups of patients being treated, nor the types of care being provided. Also, as those coming forward for dental care are predominantly demand led and not need led, attaining UDAs does not necessarily mean that the needs of priority groups are being met. More investigation of the available data is therefore required.
- 4.7 Figure 6 analyses the treatment by patient charge status for those individuals who obtained dental care during the periods 2006/07 and 2007/08. It confirms that there has been a small reduction in the treatment provided to children during the period, and also to those adults who are exempt from paying fees for their dental treatment.

Figure 6: Analysis of treatment by patient charge status

Patient Charge Status	% of UDAs EOY 2007/08	% of UDAs EOY 2006/07
Children	19.6%	20.1%
Exempt or remitted adults	27.0%	26.0%
Non-exempt adults	53.4%	53.9%
TOTAL	100.0%	100.0%



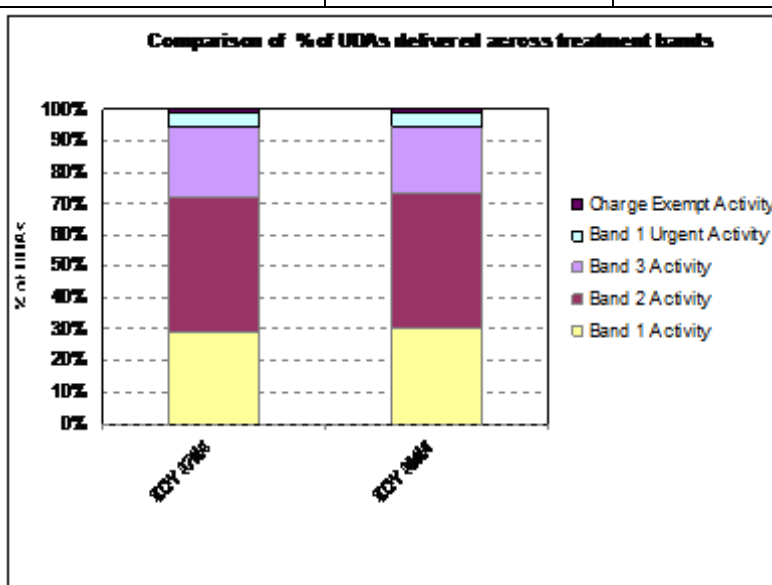
Source: NHS Dental Services 2009

- 4.8 Figure 7 reviews the treatment by charge band during the period 2006/07 and 2007/08.
- 4.9 The shift in treatment away from the more simple courses of treatment to Band 3, and the more complex, would suggest that more individuals

presenting for treatment have greater oral health needs and therefore require more treatment.

Figure 7: Analysis of treatment by treatment band

Treatment by bands	% of UDAs EOY 2007/08	% of UDAs EOY 2006/07
Band 1 activity	29.2%	30.0%
Band 2 activity	42.8%	43.8%
Band 3 activity	22.2%	20.8%
Band 1 urgent activity	4.8%	4.5%
Charge exempt activity	1.0%	1.0%
TOTAL	100.0%	100.1%



Source: NHS Dental Services 2009

4.10 There are a number of **steps that the PCT must take in order to commission for better oral health**. These include the need to:

- Ensure more emphasis is placed on prevention across dental practices – ie: the “upstream approach”. This should be put into place before the implementation of the Steele Review recommendations
- Support practices to implement the recommendations in *Delivering Better Oral Health*,, including:
 - Increasing fluoride availability
 - Healthy eating and advice
 - Smoking cessation advice
 - Accessing alcohol misuse support

- In the absence of fluoridated water supplies, fluoridation across the board should become a primary priority for the PCT. This includes, integrating the application of fluoride in daily practice by local primary care dental providers
- The PCT should now define its commissioning intentions, and to use contract flexibilities to encourage and reward contractors who are best able to meet the needs of the local population, whilst delivering high quality services.
- Resources should be identified to enable recurring UDAs to be commissioned (in line with national/local procurement policies) from existing and or/new practices in areas of greatest need across the PCT. Based on the analysis shown earlier, this appears to include the wards of
 - Strouden Park
 - Broadstone
 - Penn Hill
 - Queens Park
- Commission services only from practices willing to see all categories of new NHS patients
- Develop, consult and implement the ground rules for investing in practice premises over the next five years. In order to do this, the PCT will need to undertake a review of the current stock of practices (including salaried service clinics).
- Be familiar with potential changes that may arise from the national dental reviews, particularly those aspects which have a direct impact improving the oral health of the population.

5. Workforce

- 5.1 A diverse and skilled workforce is needed to implement this commissioning strategy.
- 5.2 The *Primary Care Dental Workforce Review* (DH, 2004) estimated the future demands for supply of, and training needs for, the dental workforce. The review predicted an undersupply in clinical time in the range of 16% to 21% by 2011. However, the impacts of the current contractual arrangements for the provision of primary care NHS dentistry, and the further push - highlighted in the Steele review - towards a service that is focused on prevention, have yet to be taken fully into consideration. The workforce review made recommendations for the development of the dental workforce concentrating mainly on dental attendance and dental treatment provided by dentists, dental therapists and dental hygienists. The review did not include information on numbers of oral health promoters and their training needs. Consideration will need to be given to including this staff group in any updating of the review.
- 5.3 Figure 8 sets out the number of dentists per 100,000 head of the population across Bournemouth and Poole during 2006/07 and 2007/08 compared to both the South West SHA and England averages. As can be seen,

Bournemouth and Poole has less dentists per head than both comparators. However, it should also be noted that merely counting the number of dentists does not provide an indication of the commitment of each individual contractor to the NHS, but simply indicates that they hold a contract with the PCT.

Figure 8: Number of Dentists per 100,000 head of population

	06/07	07/08
Bournemouth and Poole PCT	59	65
South West	43	45
England	40	41

Source: Information Centre

- 5.4 With regard to the gender of dentists, as can be seen from Figure 9, a smaller proportion of those dentists working in Bournemouth and Poole are female, compared to the London SHA and England averages.

Figure 9: Percentage of dentists with NHS activity by gender

	2006/07			2007/08		
	Female	Male	Total	Female	Male	Total
Bournemouth and Poole PCT	37.1%	62.9%	100.0%	38.1%	61.9%	100.0%
South West SHA	38.3%	61.7%	100.0%	39.2%	60.8%	100.0%
England	38.8%	61.2%	100.0%	40.1%	59.9%	100.0%

Source: Information Centre 2009

- 5.5 As demonstrated by Figure 10, the majority of dentists in contract with Bournemouth and Poole PCT are aged 35 to 44 years, higher than the South West SHA and England averages. A lower percentage of dentists (10.8% of the workforce) are aged 55 and over in Bournemouth and Poole than those across the SW and England.

Figure 10: Age breakdown of dentists providing NHS activity – 2007/08

	Under 35	35 - 44	45 - 54	55 and over	Total
Bournemouth and Poole PCT	29.4%	34.5%	25.3%	10.8%	100.0%
South West	33.0%	26.8%	25.3%	14.9%	100.0%
England	35.7%	27.7%	23.6%	13.0%	100.0%

Source: Information Centre

- 5.6 A number of key actions are required to **ensure a workforce fit for purpose**, including the need to:
- Undertake a workforce review for all dental staff
 - Ensure that the PCT is engaged with the local Deanery and pursues other opportunities for outreach teaching
 - Take into account professionals complementary to dentistry (PCDs) when considering workforce capacity

- Identify the training needs of all staff and the associated training programmes that need to be supported and developed
- Consider the most appropriate ways in which the PCT can promote and develop skill mix opportunities in dental practices, including therapists, hygienists and orthodontic therapists
- Consider the scope for local Continued Professional Development (CPD) and training support programmes
- Support a programme for Dentists with Special Interests (DwSIs) in order to encourage the development of specialist capacity.

6. Domiciliary services

- 6.1 The number of people in the population living with physical or mental disability, and other chronic diseases that reduce their mobility, is increasing owing to advances in medical science that are helping the population to live longer. Additionally,, improvements in oral health over the last thirty years mean that an increasing proportion of people have their own teeth – and hence require a more comprehensive oral health service than previously (BSDH, 2000). This will have direct implications for workforce **skills and equipment required to provide a modern domiciliary service**.
- 6.2 It is difficult to establish the need for domiciliary care. There is no easy formula for calculating this from population numbers, and there is a lack of data on the oral health needs of people requiring care. The 2001 census reported on voluntary care provided to look after, help or support family members, friends, neighbours or others affected by long term physical or mental ill health or disability, or problems relating to old age.
- 6.3 The oral health strategy highlighted the growing elderly population base. The majority of elderly people tend to live at home. This means the PCT will need to implement ways of identifying these individuals and putting adequate services in place to meet their needs, including chair-side services.
- 6.4 During 2007/08, 603 Bournemouth and Poole’s residents received a course of treatment involving a domiciliary visit. Of these, 515 were provided by a practitioner based in Bournemouth and Poole.
- 6.5 The salaried dental service, hosted by Dorset Healthcare Foundation, also provide domiciliary services. Pressure on this service will increase in line with the population changes and therefore early consideration should be given to the role and service needs of this “safety net” service.
- 6.6 During August 2009, Bournemouth and Poole hosted the launch of the national domiciliary guidance produced by the British Society for Disability and Oral Health. It is hoped that this launch will highlight the needs of those individuals requiring domiciliary and raise awareness locally.
- 6.7 With regard to domiciliary services, it is recommended that the PCT should:
- Recognise that the cohort of local residents requiring domiciliary services is going to continue to rise in line with the changing population and that pressure on domiciliary services will continue

- Review local capacity in light of the need for increased activity, targeted appropriately, and to forge associated links with other care providers
- Further review the experiences and level of service provided by the salaried services in light of the need for increased activity
- Consider the results of the local adult health survey (2009/10) and the national adult survey in helping to understand the needs of older people locally.
- Consider other data that may help to understand local needs such as:
 - Data from social services about people in receipt of a care package
 - Data from district nursing caseloads
 - Data from a snapshot of GP surgeries regarding the number of housebound patients
- Ensure that all care homes are appropriately served by NHS dental services
- Use the launch of the national domiciliary guidance in 2009 as a stepping stone to create awareness of the need and availability of domiciliary services.

7. Sedation services

- 7.1 Conscious sedation is one of a variety of strategies for managing anxiety and pain. The procedure involves the use of a drug, or drugs, to depress the central nervous system. This enables treatment to be carried out, at the same time allowing verbal contact with the patient to be maintained throughout. The drugs and techniques used to provide conscious sedation for dental treatment should carry a margin of safety wide enough to render loss of consciousness unlikely (Department of Health, 2000). Sedation may be administered as a gas for inhalation (inhalation sedation) or by injection of a drug into the bloodstream (intravenous sedation). The procedure may be undertaken by the dentist who provides the dental treatment in question – alternatively, one dentist may provide the dental treatment whilst an additional dentist or doctor administers the sedation.
- 7.2 Nationally there is no reliable way of deducing the need for sedation services from information about a population. The number of sedation procedures undertaken in the general dental services across the country varies significantly and appears to be dependent upon the availability of services. This suggests that access to sedation services is supply led and not needs led.
- 7.3 With regard to the provision of sedation by Bournemouth and Poole's local general dental service, the PCT currently commissions one practice only to provide courses of treatment involving the procedure. During 2007/08 a total of 1,162 residents received sedation as part of a course of treatment, With the exception of four people, everyone involved received it locally.
- 7.4 The local salaried dental service also provides sedation services to the residents of Bournemouth and Poole as a result of dental practices referring

patients in need of more complex care. At the same time, the salaried service acts as the gateway for local residents who may require dental treatment under general anaesthesia (GA) in a hospital setting. The waiting list for GA services has been rising and the salaried service report growing pressure to meet local demand. Patients referred for GA, or those identified by the salaried dental service as requiring a GA, fall within the consultant-led, national 18 weeks rule.

- 7.5 Fear of dental treatment can be a significant barrier for some patients. There may be a number of residents of Bournemouth and Poole requiring sedation because they are either unable or unwilling to access services as a result of anxiety about what will happen to them.
- 7.6 All dental patients have a right to expect adequate pain and anxiety control when undergoing dental treatment. Conscious sedation techniques have an important role in this regard - particularly for those individuals who would otherwise be reluctant to seek dental care. It therefore important to understand and identify patients who would benefit from conscious sedation as an adjunct to receiving dental treatment when planning the delivery of appropriate sedation services. **The introduction of a care pathway approach based on assessment of need will help to ensure that appropriate treatment is being delivered to those with highest need.**
- 7.7 The following recommendations are suggested with regard to sedation services across Bournemouth and Poole:
- A consistent care pathway should be developed across the primary dental care network based on assessment of need to ensure that appropriate treatment is being delivered to those with highest need. This includes clear criteria for the referral of patients (fast tracking those in urgent need) based on, for example, the Indicator of Sedation Need Tool (IOSN) in which the need for sedation is based on three sets of information:
 - Anxiety score
 - Medical history
 - Treatment complexity
 - Patients should also be offered alternative ways of managing pain and anxiety. The PCT will therefore need to also consider training opportunities for dental teams in the range of ways of managing dental anxiety
 - There is a need to understand the contribution of the salaried dental service in meeting local needs of residents requiring a course of treatment that includes sedation
 - Annual assessments of sedation providers should be undertaken to ensure all requirements are being met. This should also include understanding waiting times for treatment and referral patterns.
 - Patients referred for GA, or those identified by the salaried dental service as requiring a GA, must receive treatment within 18 weeks. There is therefore a need to review the current pathway in line with compliance with this consultant-led target.

8. Specialist orthodontic services

- 8.1 Orthodontics is the treatment of dental irregularities such as crowding. Although some irregularities can effect the function of the teeth or damage oral health, the main effect of orthodontic treatment is on the quality of life and psycho-social well-being.
- 8.2 Orthodontic treatment now needs to be assessed using the index of Orthodontic Treatment Need (IOTN). IOTN measures the severity of a case by looking at its dental health component (DHC- graded 1-5) and aesthetic component (AC – graded 1-10). It measures clinician-defined (normative) need, indicates severity, but does not necessarily relate to the complexity of treatment. From April 2006 only those individuals falling within IOTN 4 and 5 or IOTN 3 with an aesthetic component of 6 are eligible for NHS orthodontic treatment, unless at the dentist's discretion.
- 8.3 Under new contracting arrangements the total annual sum due to each orthodontic contractor is paid in twelve monthly instalments, one month in arrears. Payment is for completed courses of treatment. As cases are completed, new cases are started in order to maintain the agreed caseload. The number of cases started is determined by the number of units of orthodontic activity in the PDS agreement.
- 8.4 In planning orthodontic services, PCTs have been advised by the Department of Health to be aware that the 2003 National Child Dental Health Survey found that 35% of 12 year olds are likely to have a need for treatment (8% of children surveyed were already receiving active treatment). Not all parents and children agree with a professionally assessed need for treatment and, conversely, a smaller proportion feel that treatment is needed when no need is recognised clinically.
- 8.5 Locally there is one dental practice that restricts its activity to orthodontic treatment, and seven who provide both routine and orthodontic treatment. During 2007/08 a total of 3,310 Bournemouth and Poole residents received orthodontic primary care dental services. Of these, 2,511 received their care locally, and a further 775 obtained care in Dorset. During 2008/09 the PCT has commissioned additional orthodontic activity from a local practice
- 8.6 Local secondary care orthodontic services are provided by the Royal Bournemouth Hospital Foundation Trust. Referral guidelines were developed in 2006 by East Dorset Oral Health Advisory Group for referrals to both specialist and consultant-led orthodontic services. Referrals to secondary care include IOTN 4 and 5s.
- 8.7 The first stage of a draft review of local orthodontic services was completed by Bournemouth and Poole PCT in October 2007. Waiting times during 2008 were also reviewed. As a result, it was confirmed that there are up to 12 months for the start of treatment delivered by secondary care services provided by the Royal Bournemouth Hospital Foundation Trust.
- 8.8 Given that all consultant-led orthodontic patients should receive definitive treatment within 18 weeks, orthodontic services are not currently able to meet this target, nor the 8 weeks (with a maximum wait of 15 weeks) local target and this should therefore be flagged as a risk for the PCT. The development

of clear pathways and robust referral management arrangements should be a key feature of orthodontic networks in the future.

8.9 Key recommendations associated with specialist orthodontic services include:

- In light of the fact that the PCT has recently increased its primary care orthodontic service capacity, this capacity should be closely monitored to assess the impact on waiting times locally
- The local clinical network group should consider the pathways spanning primary and secondary care services with the development of referral management arrangements
- The recommendations of the draft 2007 PCT orthodontic review should be revisited. This should include working with existing primary care providers to validate their waiting lists. There is also the need to agree a prioritisation programme of patients, and to produce a patient information leaflet for local orthodontic patients.
- The PCT should closely monitor the attainment of the 18 weeks national, and 8 weeks local, targets in relation to consultant-led orthodontic services to ensure that orthodontics does not pose a risk to the PCT and providers.

9. Salaried Dental Services

9.1 Bournemouth and Poole's salaried dental service hosted by Dorset Healthcare Foundation is relatively small in relation to some other services nationally. The current workforce includes: 4.5 whole time equivalent (wte) dental officers, 1.3 wte therapists and 8.8 wte dental nurses.

9.2 Commissioned under a number of separate service level agreements (SLAs), the local salaried service provides:

- A range of public health functions (including epidemiology)
- Primary care dental services (in the form of a "safety net" service for those having difficulty accessing dental treatment)
- Domiciliary services
- Sedation services (for both children and adults)
- Minor oral surgery (one day a week)
- Oral health promotion (targeted at priority vulnerable groups)
- Restorative dental services (provided once a month, the service includes advice and treatment planning for local dentists)
- Cardiac services (approximately 12 patients a year)
- Care to homeless and vulnerable patients (services include visits to shelters in Bournemouth with the use of the mobile unit)
- Management and staffing of the urgent out of hours dental care service (the service are responsible for arranging the rota of local dentists and providing nursing support).

9.3 Chair-side salaried dental services are currently provided from three clinics based in Poole (Poole Clinic, Parkstone Clinic and Canford Heath). In

addition, the service also has the use of a mobile dental unit. In the past, services were available from a larger network of fixed clinics..

- 9.4 A map setting out the location of the salaried dental clinics in relation to deprivation can be found in **Appendix 10**. As can be seen, the existing clinics are not placed in areas of greatest deprivation and restrict easy accessibility for a significant proportion of the population.
- 9.5 Figure 11 sets out the activity data associated with Bournemouth and Poole residents during the period 2007/08. The service now completes FP17 forms which are submitted and processed by BSA NHS Dental Services. The data confirms that 5,336 patients received care during the year, of which 270 were treated in their own home. In addition, a further 4,680 individuals (primarily children) received health promotion advice.

Figure 11: Activity in the community dental service – 2007/08

Service	Annual contracted UDAs	UDAs Scheduled	Balance of activity	% of activity delivered	Number of patients treated
Community dental service (CDS)	4,061	5,936	1,875	146.2%	2,077
Primary care access	3,574	1,149	-2,425	32.1%	717
Urgent care	1,000	2,182	1,182	218.2%	2,086
Intermediate care – oral surgery	1,035	1,288	253	124.4%	456
TOTALS	9,670	10,554	884		5,336
Health promotion service					4,680
Domiciliary visits ** activity undertaken is included within the CDS activity above					270

Source: Salaried Dental Services 2009

- 9.6 The local salaried dental service plays an important role in helping to meet the needs of local residents. In **light of the local inequalities in oral health of the vulnerable groups, the specialist functions** undertaken by the service **should not only be maintained but also developed and further targeted to the most vulnerable groups**. This will mean:

- Maintaining and developing the specialist function of the service to further meet the needs of the most vulnerable groups
- Continuing involvement in public health functions
- Involving the service in decisions about meeting the needs of hard to reach and vulnerable groups of people
- Working with the service to ensure that its services are further targeted at reducing inequalities and that patients who could attend a General Dentist are referred on to one
- Continuing the work with children in the local schools with the worst levels of active decay vulnerable groups
- Developing health promotion services
- Developing outreach services for Bournemouth and Poole communities and groups who are unlikely to access high street services
- Continuing to develop evidence based screening services with health outcomes.

- 9.7 In order to achieve all this, a review of the service in its totality is recommended as a matter of priority. This review should also take into account the accessibility to fixed clinics. In addition, the PCT is advised to define future services to be delivered via robust service level agreements.

Unscheduled urgent care

10. Out of hours (OOH) unscheduled urgent care

- 10.1 From April 2006, the responsibility for out of hours urgent care was transferred from general dental practitioners to PCTs. This became the case for patients seen by local dental practices (this may include individuals from outside the area), and for all local residents or visitors to the area.
- 10.2 Out of hours urgent care service in Bournemouth and Poole are provided in conjunction with Dorset PCT. Local residents and visitors are required to ring a number run and managed by the local ambulance service. Following triage by the service using algorithms, patients are then referred to urgent care dental appointments, A & E or provided with advice. Approximately 50% of those calling are provided with advice regarding the self-management of their condition.
- 10.3 Urgent clinical care is available during evenings, weekend and bank holidays at salaried dental service sites. The associated rota of dentists and bank of nurses are managed by the salaried dental service.
- 10.4 NHS Bournemouth and Poole is meeting its obligation associated with provision of out of hours urgent services. It is important that the PCT has in place the mechanisms to ensure that local residents and visitors are directed appropriately to these services.

11. In hours unscheduled urgent care

- 11.1 Traditionally, practices provided unscheduled urgent care to their registered list. Under the new dental contract, practices are able to provide "urgent treatment", a limited range of NHS treatment aimed at taking the patient out of pain, for which they will be accredited units of dental activity.
- 11.2 In hour urgent care dental services are commissioned by Bournemouth and Poole PCT from a number of dental practices, to which patients are referred via the PCT's helpline number. The practices are responsible for making the appointments for the patients. Based on feedback from the PCT and the local dental profession, it appears the service is under utilised with many of the available in hour slots remaining free.
- 11.3 With regard to in and out of hours urgent care services across Bournemouth and Poole it is recommended that:
- The PCT monitors the services to ensure that they are meeting the needs of all individuals, including the most vulnerable groups

- As the current out-of-hour urgent care services are provided from salaried clinics based in Poole, some residents will have much further to travel to receive care (particularly those based in the far north and east of the PCT). The PCT should review the accessibility for such residents.
- The PCT assesses why some individual may be seeking urgent care services on a regular basis. The objective would be to ensure people are not doing this as a substitute for obtaining routine care from a dental practice because they are unable to access services.

12. Hospital dental services

12.1 Hospital dental services (HDS) provide specialist care for local residents. There are two hospital dental provides locally: Royal Bournemouth Hospital Foundation Trust; and Poole Hospital NHS Foundation Trust. Royal Bournemouth provides orthodontic services and Poole Hospital oral and maxillofacial surgery (OMFS) services. In appropriate oral surgery referrals into HDS are redirected to the minor oral surgery service (available in a salaried dental service clinic one day a week).

13. Referral to hospital dental services – outpatients

13.1 Figure 12 confirms that during 2006/07 approximately 5,000 Bournemouth and Poole residents were referred to hospital dental services. The greatest proportion of these were to oral surgery departments.

Figure 12 - 2006/07 outpatient referral numbers for Bournemouth and Poole residents

<i>Specialty</i>	<i>2006/07 Total Referrals</i>
Oral surgery	4,210
Restorative dentistry	30
Paediatric dentistry	3
Orthodontics	840
Oral and maxillofacial surgery (OMFS)	1
Endodontics	0
Peridontics	1
Prosthodontics	0
Surgical dentistry	0
Dental medicine specialties	2
TOTAL REFERRALS 2006/07	5,087

Source: Department of Health, hospital waiting times and referrals

14. Referral to hospital dental services – inpatients

14.1 A summary of inpatient and day case activity for 2006/07 is provided in Figure 13.. As can be seen, all but one referral for inpatient care related to oral surgery or OMFS dentistry. Once again, they account for the majority of day case admittances during the same period.

Figure 13: 2006/07 Inpatient and day case admittance for Bournemouth and Poole residents

Speciality Function	Total Inpatient Admittance 2006/07	Total Daycase Admittance 2006/07
Oral surgery	247	807
Restorative dentistry	0	0
Paediatric dentistry	1	0
Orthodontics	0	0
Oral and maxillofacial surgery	2	2
Endodontics	0	0
Periodontics	0	0
Prosthodontics	0	0
Surgical dentistry	0	0
Dental medicine specialties	0	0
Totals	250	809

Source: Department of Health, hospital waiting times and referrals

15. The 18 week clock target and dental specialities

- 15.1 The underlying principle of 18 weeks is that patients should receive excellent care without unnecessary delay. The target covers pathways that involve, or could potentially involve, care led by a medical, dental or surgical consultant. It sets a maximum time of 18 weeks from the point of initial referral up to the start of any necessary treatment. The target therefore covers all referrals to consultant-led services in dental specialities, including: oral surgery, orthodontics, restorative dentistry, paediatric dentistry, periodontics and prosthodontics. The target also covers referrals to oral maxillofacial services (OMFS), which (although a medical specialty) receives some of its referrals from dentists.
- 15.2 The national 18 weeks target should have been achieved by the end of December 2008. As a milestone, by the end of March 2008 patients should have begun treatment within 18 weeks for 90% of non-admitted referrals and 85% of admitted referrals. Bournemouth and Poole PCT made a further commitment to ensure that the average wait from referral to treatment in secondary care is 8 weeks (with a maximum wait of 15 weeks) by March 2009.
- 15.3 As with other service areas, delivering the target for dental specialities is likely to require fundamental service transformation. Merely doing the same faster will not achieve the target. Where previous targets have focused on a specific phase of the patient journey, 18 weeks looks at the journey from the patient's perspective – ie: from initial referral through to treatment. This is called the Referral to Treatment (RTT) time.

16. Oral and maxillofacial surgery

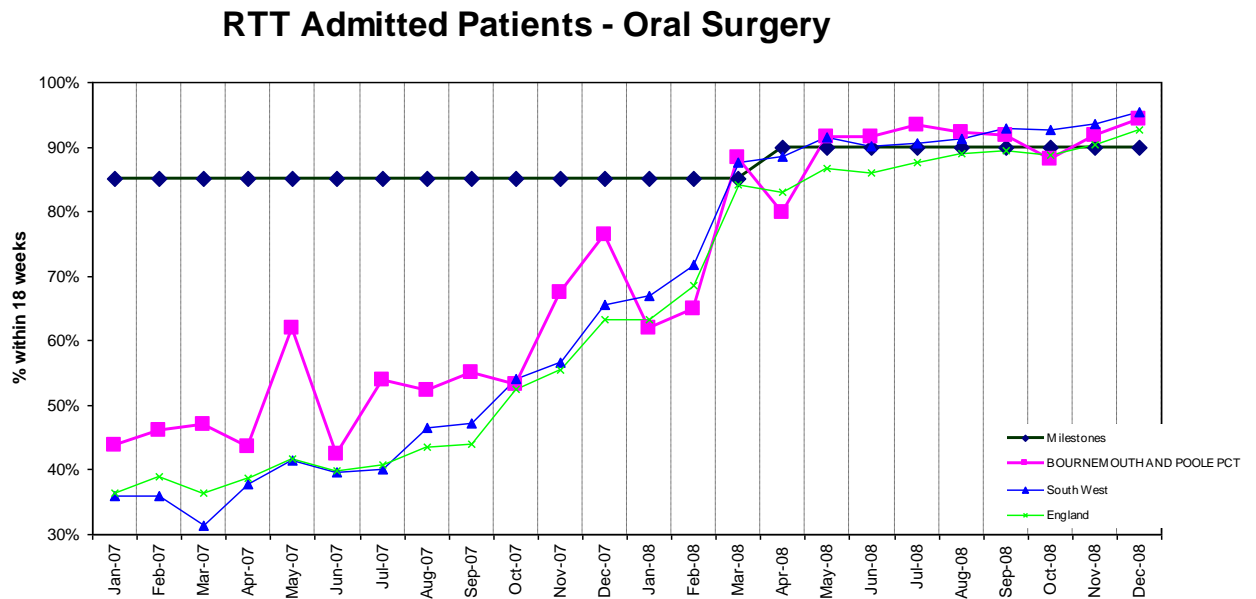
- 16.1 Oral and maxillofacial surgery is a surgical specialty dealing with pathology of the oro-facial skeleton and surrounding soft tissues. The specialty deals with

head and neck cancers, facial skin cancer, facial trauma, reconstructive surgery, orthognathic surgery, diseases of the temporomandibular joint and other more general oral pathology.

16.2 This speciality accounts for the majority of local non-admitted and admitted patient referrals to hospital services within Bournemouth and Poole. Within the minor and intermediate procedure codings, there may be some patients undergoing dento-alveolar surgery procedures. These procedures could be suitable for treatment by an intermediate surgical service, under local anaesthesia (with or without sedation) in the primary care setting. Examples of procedures (coded as C04 and C05) would include: retained and buried roots, difficult extractions, unerupted and impacted teeth including a large proportion of wisdom teeth requiring removal under NICE guidelines. Many PCTs are now successfully **transferring minor oral procedures that traditionally would have been undertaken in the hospital setting to specialist services in primary care. This is also recommended for NHS Bournemouth and Poole.**

16.3 Figure 14 sets out the local attainment of the 18 weeks target for consultant-led oral surgery admitted procedures associated with Bournemouth and Poole residents. It confirms that 94% of local patients were treated within 18 weeks by December 2008, meeting the 90% requirement for admitted patients.

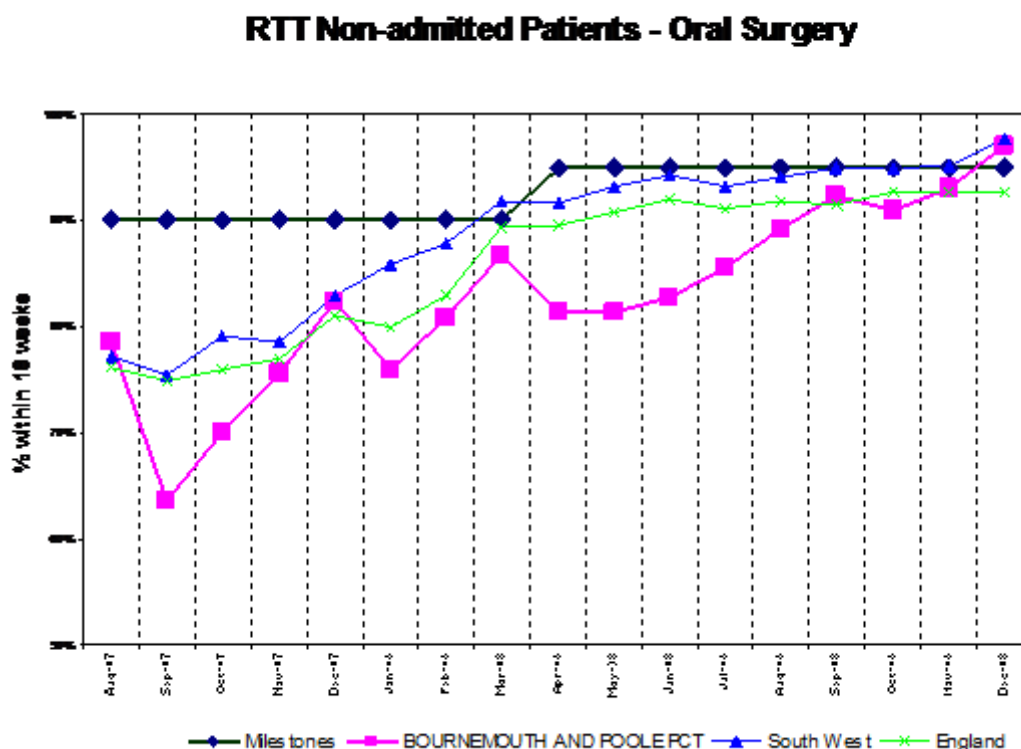
Figure 14:



Source: National 18 weeks reports 2009

16.4 The graph below confirms the attainment of the 18 weeks target associated with non-admitted local oral surgery patients was met by December 2008, with 97% of local residents being seen with 18 weeks.

Figure 15:



Source: National 18 weeks reports 2009

- 16.5 It is recommended that the PCT establish a local clinical network group to consider future commissioning opportunities including:
- Opportunities for reducing secondary care referrals for oral surgical procedures
 - Developing a commissioning pathway across primary and secondary care that includes referral management arrangements
 - Developing specialist services in primary care, by tendering for additional capacity to be delivered by specialists or DwSIs

17. Restorative dentistry

- 17.1 Restorative dentistry includes the mono-specialties of endodontics, periodontics and prosthodontics.
- 17.2 As people are retaining more of their teeth for a longer period of time, there is an increasing need for complex restorative care in primary care and an adequate secondary referral service to support this. Improvements in technology have also increased the potential range of care that can be offered and the support required for general dental practitioners.
- 17.3 Throughout the country, access to specialist restorative services appears limited. No specialist restorative services exist across Bournemouth and Poole, within the HDS or primary care and the PCT commissions out of area

contract. The profession consider access to local restorative dental services as an essential gap in service provision.

- 17.4 In light of the increasing needs of the population, there is a **need to develop specialist services in the field of restorative dentistry on a local basis**. This should be explored further by the PCT, as pressures will continue to grow in this area.

18. Orthodontics

- 18.1 The hospital consultant orthodontic service is involved in the treatment of complex malocclusions, often requiring interdisciplinary treatments. Close liaison with maxillofacial surgeons, restorative dentists, plastic surgeons, speech therapists, paediatricians and ENT surgeons allows treatment of dento-facial deformity, cleft lip and palate, hypodontia and other complex disorders. The consultant service also fulfils an important role in providing advice and treatment planning.
- 18.2 The primary care specialist orthodontists provide a crucial role in providing treatment for the majority of routine orthodontic cases. The specialists have additional qualifications in orthodontics, and they provide highly skilled treatment for a multitude of malocclusions.
- 18.3 Consultant-led orthodontic services represent a risk to the attainment of the national and local 18 and 8 weeks target. There is therefore the need to **review current orthodontic hospital waiting lists to ensure that a co-ordinated orthodontic service is provided locally, and to ensure that local referral criteria and pathways best suit the skills and specialist function of hospital consultant-led services**.

NHS BOURNEMOUTH AND POOLE
DENTAL COMMISSIONING STRATEGY 2009 - 2014

SECTION SIX

PROVIDER MANAGEMENT

1. Introduction

1.1 This section deals with two key aspects of the PCT's ability to commission effectively from providers:

- Relationship development (in order to improve services)
- Contract management (in order to ensure value for money)

Relationship development

2. Working with dentists to improve services

2.1 A key aspect of provider management is **clinical** engagement.

2.2 The PCT will need to consider what meaningful clinical engagement with dentists and their teams might look like in Bournemouth and Poole in the future. For example this may include:

- Creating time limited clinical groups to work on specific issues such as referral protocols, service specifications etc
- Facilitating a regular clinical network for dentists and their teams where the PCT dental team can share information and answer questions
- Running an annual programme of practice visits to review progress, understand aspirations, and facilitate connections.

3. Performance management and monitoring

3.1 Systematic and transparent performance management processes are key to good provider management. The PCT will **need to develop a performance framework that describes its commissioning expectations for all services in the dental network.**

3.2 This needs to be **underpinned by clear contract management strategy** that will describe the points at which the PCT, as commissioners, will intervene. It should include all primary and secondary care services and be discussed with the profession.

3.3 Performance covers a variety of areas, the key ones being:

- Contractual performance (activity and cost)
- Patient satisfaction
- Clinical safety
- Service outcomes.

- 3.4 These require different performance management processes, and both compliance and performance will be improved by comparative information feedback to providers. In order to monitor effectively, there must be ongoing, systematic data collection, plus regular analysis of data across providers and against benchmarks.
- 3.5 To strengthen the commissioning of dental services, there is a need for the PCT to:
- Be fully conversant with the data available to support the monitoring of contracts, both hard and soft. This must include the new e-reporting and dashboard information which has recently been made available to PCTs by NHS Dental Services.
 - Establish a data warehouse for dental activity
 - Explore the scope for a more proactive relationship with key bodies/services such as the Clinical Practice Advisers team within NHS Dental Services.

NHS BOURNEMOUTH AND POOLE
DENTAL COMMISSIONING STRATEGY 2009 - 2014

SECTION SEVEN

SUMMARY OF KEY PRIORITIES AND ACTION FOR THE NEXT FIVE YEARS

1. Developing and maintaining a clear vision for dental primary care that is firmly rooted in the broader strategic context, including:
 - Being a World Class Commissioner of dental services
 - Keeping up to date with national strategic and contractual changes, including those arising from the *Independent Review of NHS Dentistry* in England, led by Professor Jimmy Steele
 - Considering how the PCT meets locally-set new patient access targets reported to the Department of Health, and also the ultimate aim of meeting oral health needs and priorities as set out the oral health strategy, oral health action plan and this commissioning strategy.
2. Agreeing via the PEC/Board which groups of people in a local community are most at risk of poor oral health - and targeting resources to meet their needs, in addition to maintaining universal access.
3. Considering whether local oral health targets should be set locally. Irrespective of this, to have systems in place to monitor improvements in oral health.
4. Ensuring that that all premises (including those of the salaried dental service) are of suitable standard. A clear criteria about suitability of premises should be developed and a commitment obtained to support and/or monitor change in the future.
5. Understanding what local residents seek from dental services and ensure that it is able to get the message across to people about oral health and the availability of local services in a way that individuals can relate to and which is relevant to their needs. This will require:
 - Gathering local resident views
 - Ensuring that local residents have accurate information regarding access to emergency, urgent and routine NHS dental care.
 - A dedicated marketing strategy, implemented consistently over at least two years. Such a strategy should be relevant to the priority groups and linked to other strategic communication strategies, such as those relating to tobacco control and smoking cessation strategies.
6. Facilitating relationships between primary care professionals and a wide range of partners in secondary care, community services, and social care. Links should also be made with other agencies within Bournemouth and Poole, in order that primary care can support partners to address some of the underlying determinants of health, such as employment, housing and education.

7. Reviewing existing networks in line with the future direction of dental services as set out in the new oral health strategy, oral health action plan and dental commissioning strategy.
8. Understanding local dental expenditure, including the salaried service, out of hours urgent care services and secondary care dental services. In addition, ensuring that:
 - Future patterns of expenditure reflect the strategic direction of dental services.
 - Value for money from all of its contracts is secured by using rigorous performance management.
 - Plans are in place to commission increases (and decreases) in activity in the areas of dental services that have been prioritised (or de-prioritised).
 - Systems are in place to closely monitor key performance indicators available via vital signs and BSA NHS Dental Services' reports and e-reporting system.
9. Agree on the distance and time which reasonable for local residents to travel in order to reach a dentist accepting new patients. These targets will need to differ for rural and urban areas and should continue to be monitored carefully
10. The evidence provided in the commissioning strategy indicates that the wards of Strouden Park, Broadstone, Penn Hill and Queen's Park appear to be the least accessible for NHS general dental services. This should be considered further by the PCT.
11. Monitoring patient flow information on an ongoing basis alongside patient access numbers.
12. In order to commissioning for better oral health:
 - Ensure more emphasis is placed on prevention across dental practices – ie: the “upstream approach”. Support practices implementing *Delivering Better Oral Health*, including:
 - Increasing fluoride availability
 - Healthy eating and advice
 - Smoking cessation advice
 - Accessing alcohol misuse support
 - In the absence of fluoridated water supplies, fluoridation across the board should become a primary priority for the PCT. This includes, integrating the application of fluoride in daily practice by local primary care dental providers
 - Define commissioning intentions and the use of flexibilities to encourage and reward contractors who are best able to meet the needs of the local population, whilst delivering high quality services
 - Resources should be identified to enable recurring UDAs to be commissioned from existing and or/new practices in areas of greatest need across the PCT
 - Commission services only from providers willing to see all categories of new NHS patients, including those with the greatest levels of unmet need.

13. Ensuring a workforce fit for purpose, and therefore considering the need to:
- Undertake a workforce review for all dental staff
 - Ensure that the PCT is engaged with the local Deanery and pursues other opportunities for out-reach teaching
 - Workforce planning capacity should take into account professionals complementary to dentistry (PCDs)
 - Training needs of all staff should be identified and associated training programmes supported and developed
 - Consider the most appropriate ways in which it can promote and develop skill mix opportunities in dental practices, including therapists, hygienists and orthodontic therapists
 - Consider the scope for local CPD and training support programmes
 - Support a programme for Dentists with Special Interests (DwSIs)
14. With regard to domiciliary services, to:
- Recognise that the cohort of local residents requiring domiciliary services is going to continue to rise in line with the changing population and pressure on domiciliary services will continue.
 - Review local capacity in light of the need for increased activity, targeted appropriately with associated links to other care providers
 - Review the experiences and level of service provided by salaried services, and review further in light of the need for increased activity
 - Consider the results of the local adult health survey (2009/10) and the national adult survey in helping to understand the needs of older people locally
 - Consider other data that may help to understand local needs such as:
 - Data from social services about people in receipt of a care package
 - Data from district nursing caseloads
 - Data from a snap shot of GP surgeries regarding the number of housebound patients
 - Ensure that all care home are appropriately served by NHS dental services
 - Use the launch of the national domiciliary guidance in 2009 as a stepping stone to create awareness regarding the need and availability of domiciliary services.
15. With regard to sedation services to consider the need for:
- A consistent care pathway based on assessment of need to ensure that appropriate treatment is being delivered to those with highest need
 - Patients are being offered alternative ways of managing pain and anxiety
 - The annual assessments of sedation providers
 - A review of the contribution of the salaried dental service.
16. With regard to specialist orthodontic services, considering the need:
- To monitor the capacity in primary care to ensure that patient needs are being met and waiting times are being improved
 - For the local clinical network group, to consider the pathways spanning primary and secondary care services with the development of referral management arrangements.

- Reviewing the recommendations of the draft 2007 PCT orthodontic review, including working with existing primary care providers to validate their waiting lists
 - To monitor the attainment of the 18 weeks national and 8 weeks local target in relation to consultant-led orthodontic services to ensure that orthodontics does not pose a risk to the PCT and providers.
17. Developing the specialist functions undertaken by the salaried dental service. This will mean:
- Maintaining and developing the specialist function of the service to further meet the needs of the most vulnerable groups
 - Continuing involvement in public health functions
 - Involving the service in decisions about meeting the needs of hard to reach and vulnerable groups of people
 - Working with the service to ensure that its services are further targeted at reducing inequalities and that patients who could attend a General Dentist are referred on to one.
 - Continuing the work with children in the local schools with the worst levels of active decay and vulnerable groups
 - Developing health promotion services
 - Developing outreach services for Bournemouth and Poole communities, and for groups who are unlikely to access high street services
 - Continuing to develop evidence based screening services with health outcomes.
18. With regard to in and out of hours urgent care services across Bournemouth and Poole:
- Monitoring the services to ensure that they are meeting the needs of all individuals, including the most vulnerable groups.
 - Undertaking a review to understand why some individuals may be seeking urgent care services on a regular basis. The objective is to ensure that people are not doing this as a substitute for obtaining routine care from a dental practice because they are unable to access services.
19. Establishing a local clinical network group to consider future commissioning opportunities for oral surgery including:
- Opportunities for reducing secondary care referrals for oral surgical procedures
 - Developing a commissioning pathway across primary and secondary care that includes referral management arrangements
 - Development of specialist services in primary care, by tendering for additional capacity to be delivered by specialists or DwSIs.
20. Developing specialist services in the field of restorative dentistry on a local basis.
21. With regard to hospital orthodontic services, reviewing current orthodontic hospital waiting lists to ensure that a co-ordinated orthodontic service is provided locally and to ensure that local referral criteria and pathways best suit the skills and specialist function of hospital consultant-led services.

22. To consider what meaningful clinical engagement with dentists and their teams might look like in Bournemouth and Poole. For example this may include:
 - Creating time limited clinical groups to work on specific issues such as referral protocols, service specifications etc
 - Facilitating a regular clinical network for dentists and their teams where the PCT dental team can share information and answer questions
 - Running an annual programme of practice visits to review progress, understand aspirations, and facilitate connections.
23. Having in place a clear contract management strategy that will describe the points at which the PCT, as commissioners, will intervene. This should include all primary and secondary care services and be discussed with the profession.
24. Strengthening the monitoring of dental services. There is a need for the PCT to:
 - Be fully conversant with the data available to support the monitoring of contracts, both hard and soft. This will include the new e-reporting and dashboard information.
 - Establish a data warehouse for dental activity
 - Explore the scope for a more proactive relationship with key bodies/services.

Appendix 1

Key priorities identified in the NHS Bournemouth and Poole oral health strategy (2009 – 2014)

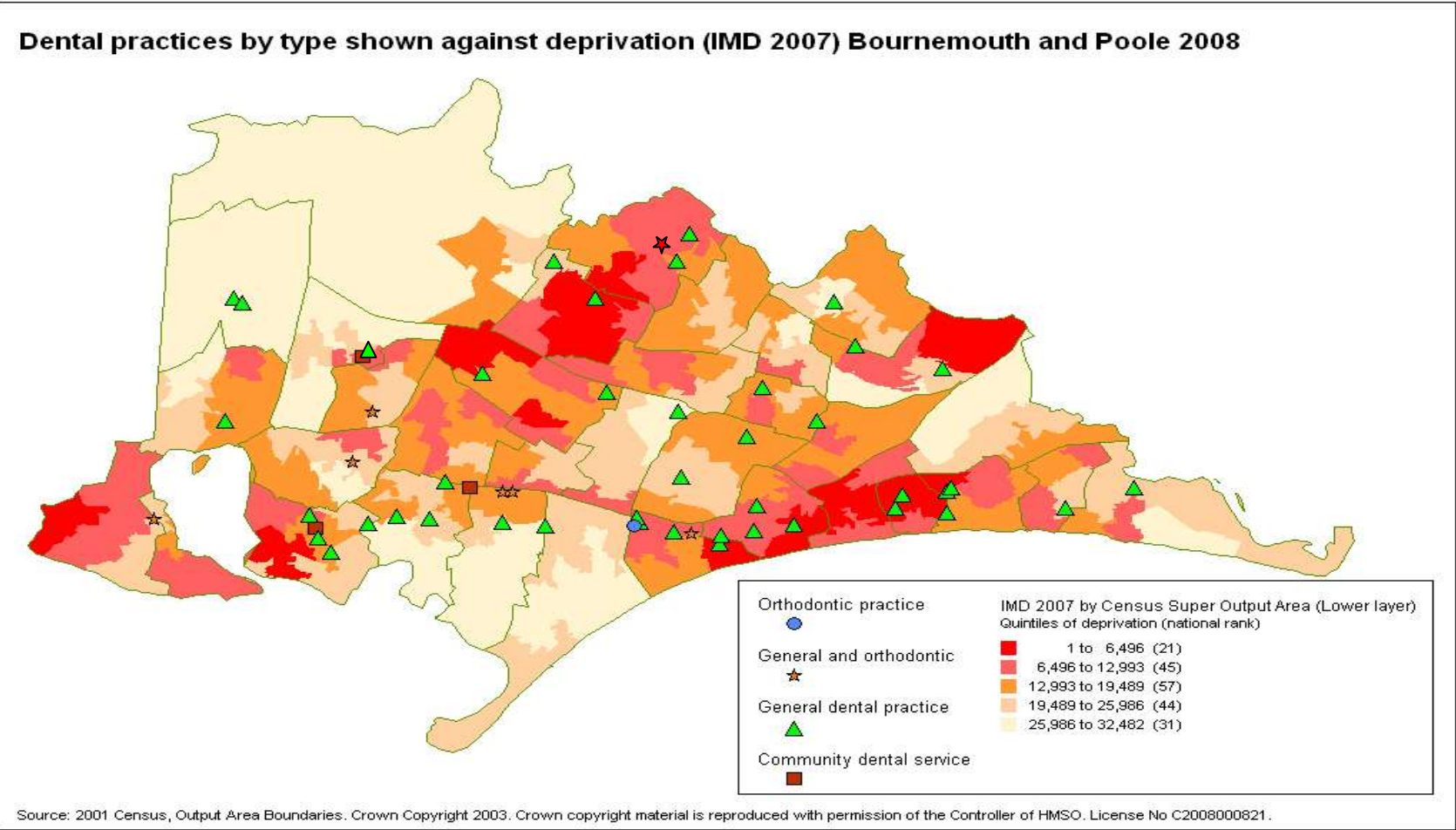
A summary of the key issues identified in the Improving Oral Health Strategy, Oral Health Strategy, Oral Health Action Plan and Dental Commissioning Strategy for NHS Bournemouth and Poole (2009 -2014) are provided below.

Key issues identified in the oral health strategy
Oral health must remain in context as part of general health. The mouth cannot be viewed in isolation, a healthy mouth cannot exist without a healthy body and conversely poor oral health can compromise general health. As with general health, only through working in partnership can the oral health needs of the residents of Bournemouth and Poole be fully addressed.
To improve oral health, as with general health, requires that things are done differently. There needs to be a multifaceted approach for oral health improvement that brings about early gains, such as developing equity in access to and uptake of services and supporting lifestyle changes with consistent, timely and accurate messages.
In the longer term sustainable improvement will be achieved by contributing to work tackling the determinants of oral health and changing systems to have health improvement as a goal.
The prevalence of decay is associated with deprivation and those in people in socially deprived areas are more affected.
At present there is no local epidemiological data for adults. This should be addressed by a local survey in 2009/10 alongside the National Adult Health Survey.
A large proportion of the population are affected by periodontal disease. Skill mix (including the use of hygienists and therapists) within primary care should be developed
There is a cohort of older adults who have no teeth and will require denture care for many years.
There is a growing cohort of middle aged adults who will require ongoing advanced restorative care, often with complex medical conditions.
Evidence based action is required to address risk factors associated with oral cancer, e.g. tobacco use, alcohol and diet.
The early detection of those with cancer is essential
It is important to raise the profile of smoking cessation within primary care
Despite improvements in oral health, inequalities in oral health and access to services still remain for some groups in the community. These groups should be targeted in order to meet their needs.

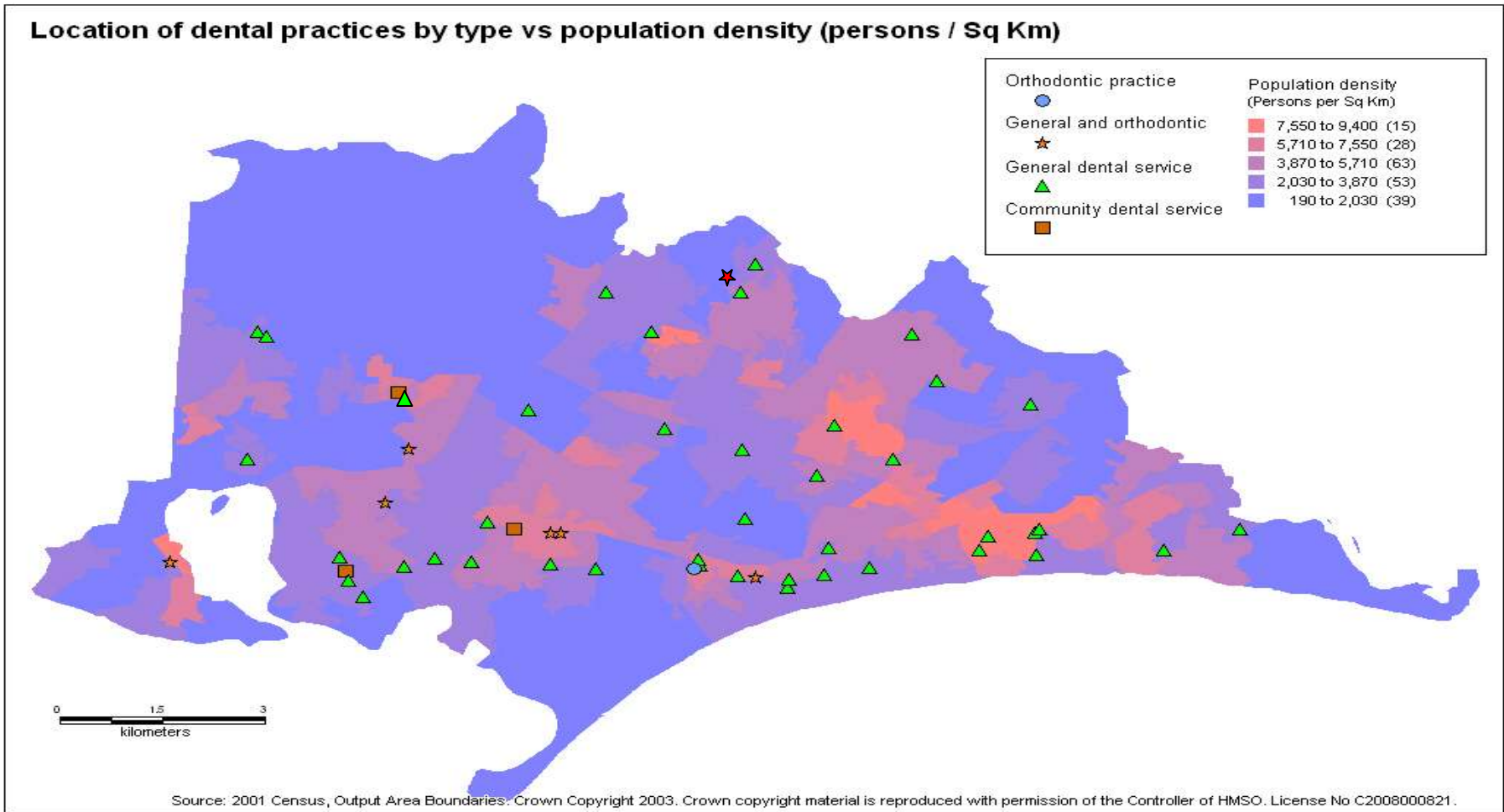
<p>There is still a high prevalence of dental decay amongst children locally. For example five year olds with active decay have on average 2.65 decayed teeth.</p>
<p>Inequalities in oral health exist amongst children within Bournemouth and Poole according to socio-economic status. These gaps must be reduced locally.</p>
<p>It is important to recognise the dietary causes of tooth erosion to enable these to be built into wider public health awareness and preventative programmes.</p>
<p>Whilst not viewed as an oral health priority for Bournemouth and Poole, the treatment for the effects of facial injuries and dental trauma can be complex and expensive to treat.</p>
<p>Children with disabilities and those from vulnerable groups are an identified group in Bournemouth and Poole that require support and therefore a proactive approach should be taken to meeting their needs, including access to dental treatment.</p>
<p>Poor oral health can be affected by a number of behaviour practices including diet and nutrition, oral hygiene, the use of fluorides, and tobacco and alcohol misuse.</p>
<p>Improving oral health is a shared responsibility involving communities, the voluntary sector, health professionals, education, local authorities and the government.</p>
<p>Community involvement is essential to develop and sustain oral health improvement, based on the best evidence.</p>
<p>Implementation of the interventions set out in Delivering Better Oral Health should be planned by the PCT.</p>
<p>The PCT should continue to monitor inequalities in access across Bournemouth and Poole and commission services to meet oral health needs. Through local commissioning, the PCT will increasingly be able to influence the location of services to meet these needs.</p>
<p>The PCT needs to develop contracts with general dental practitioners that address health improvement either within or over and above the new contractual arrangements.</p>
<p>There is a need for the public to have accurate information regarding access to emergency, urgent and routine NHS dental care.</p>
<p>The PCT should continue to monitor the activity and performance of local general dental practitioners to ensure that outcomes are delivered in line with the Oral Health Strategy.</p>
<p>There is a need to consider domiciliary services in more detail in light of the changing needs of the population.</p>
<p>There is a need to consider the current and future contribution of all primary care services when considering how best to meet the increasing need for domiciliary services.</p>
<p>Sedation care pathways should be developed locally to ensure consistently in order that those individuals who require sedation can access treatment and nervous patients have access other forms of anxiety management services.</p>
<p>There is a need to understand the contribution of the salaried dental service in meeting local needs of residents requiring a course of treatment that includes sedation.</p>

<p>Whilst there may not be significant demand for sedation services, this may mask unmet need locally.</p>
<p>Patients referred for general anaesthesia or those identified by the salaried dental service as requiring a general anaesthetic must receive treatment within 18 weeks. There is therefore a need to review the current pathway in line with compliance with the consultant-led target.</p>
<p>Orthodontic services should be considered in the context of commissioning pathways that span primary and secondary care to ensure that patients are referred and treated in the correct setting.</p>
<p>The recommendations of the draft 2007 PCT orthodontic review should be revisited and the implementation plans incorporated within the Oral Health Strategy.</p>
<p>Attainment of the national 18 and local 8 weeks target for consultant-led orthodontic services is a risk for the PCT and should be investigated further by the PCT.</p>
<p>The specialist functions of the salaried dental services should be maintained and developed further to support meet the needs of the most vulnerable groups and support the reduction of oral health inequalities across Bournemouth and Poole. To best achieve this, a review of the service in line with local need is recommended.</p>
<p>Whilst access is available to urgent out-of-hours and in-hour services, the PCT should monitor the services to ensure that they meet local needs, particularly for the most vulnerable groups.</p>
<p>It important to understand why some individuals may be seeking urgent dental care services on a regular basis, for example to ensure that they do not have difficulty assessing routine dental care.</p>
<p>There is a need to consider the opportunities to reduce hospital referrals for minor oral surgical procedures and to review these in light of a commissioning pathway spanning primary and secondary care.</p>
<p>There is a need to develop specialist and sub-specialist services in minor oral surgery within primary care settings.</p>
<p>In light of the increasing needs of the populations, There is a need to develop specialist services in the field of restorative dentistry locally in addition to the existing out of area contracts that are in place.</p>
<p>There is a need to review hospital referrals and waiting lists regularly in line with as part of the co-ordinated approach to orthodontic services across primary and secondary care.</p>

Appendix 2

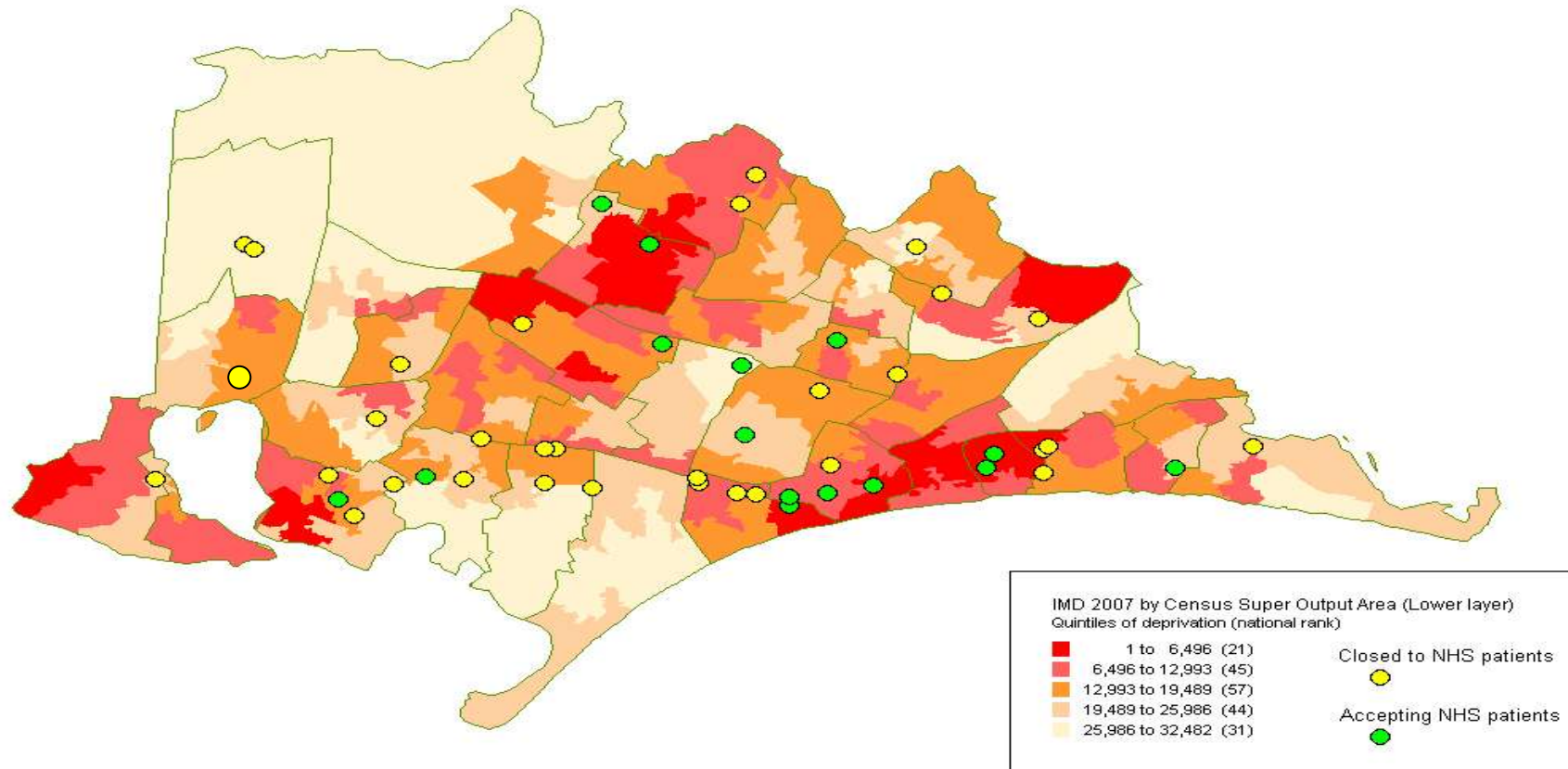


Appendix 3



Appendix 4

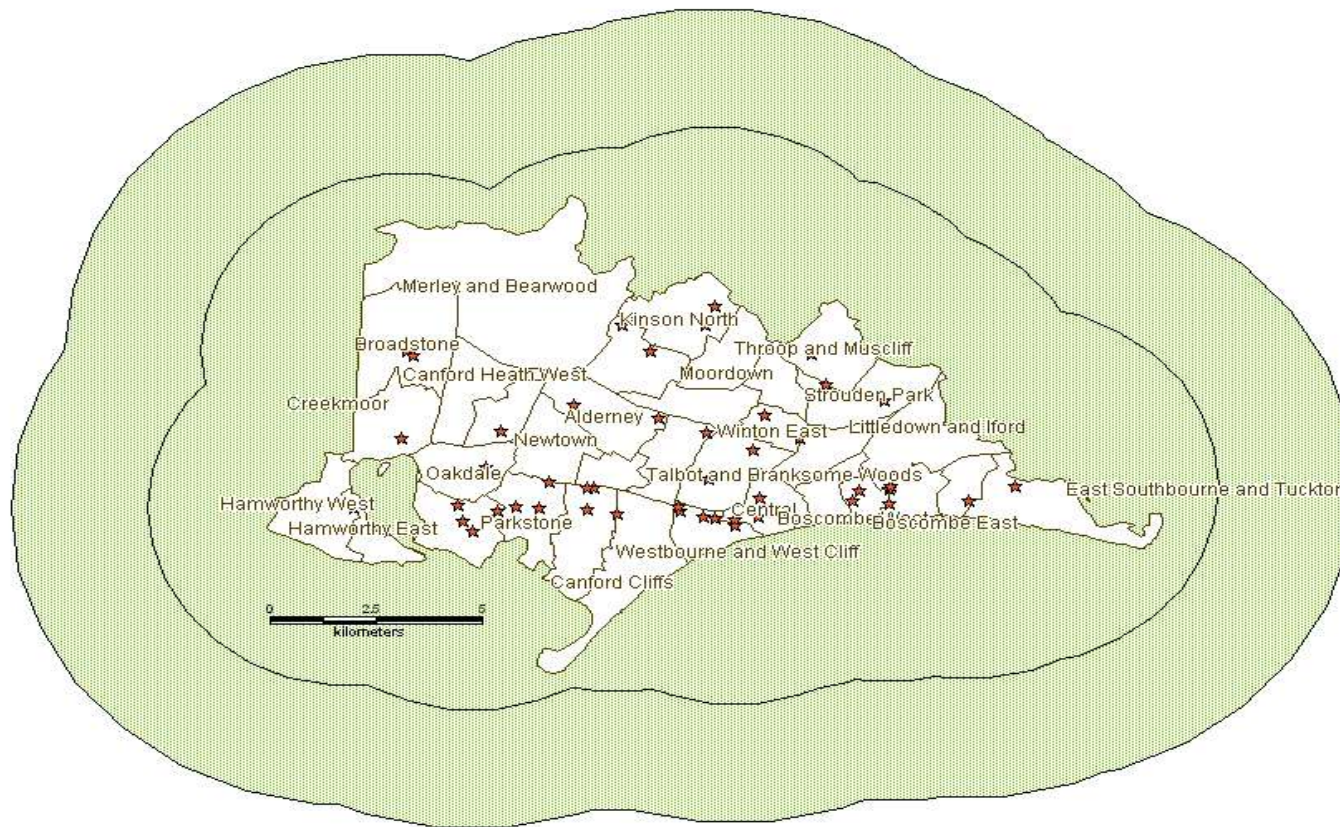
Dental practices and NHS acceptance policy in Bournemouth and Poole 2008



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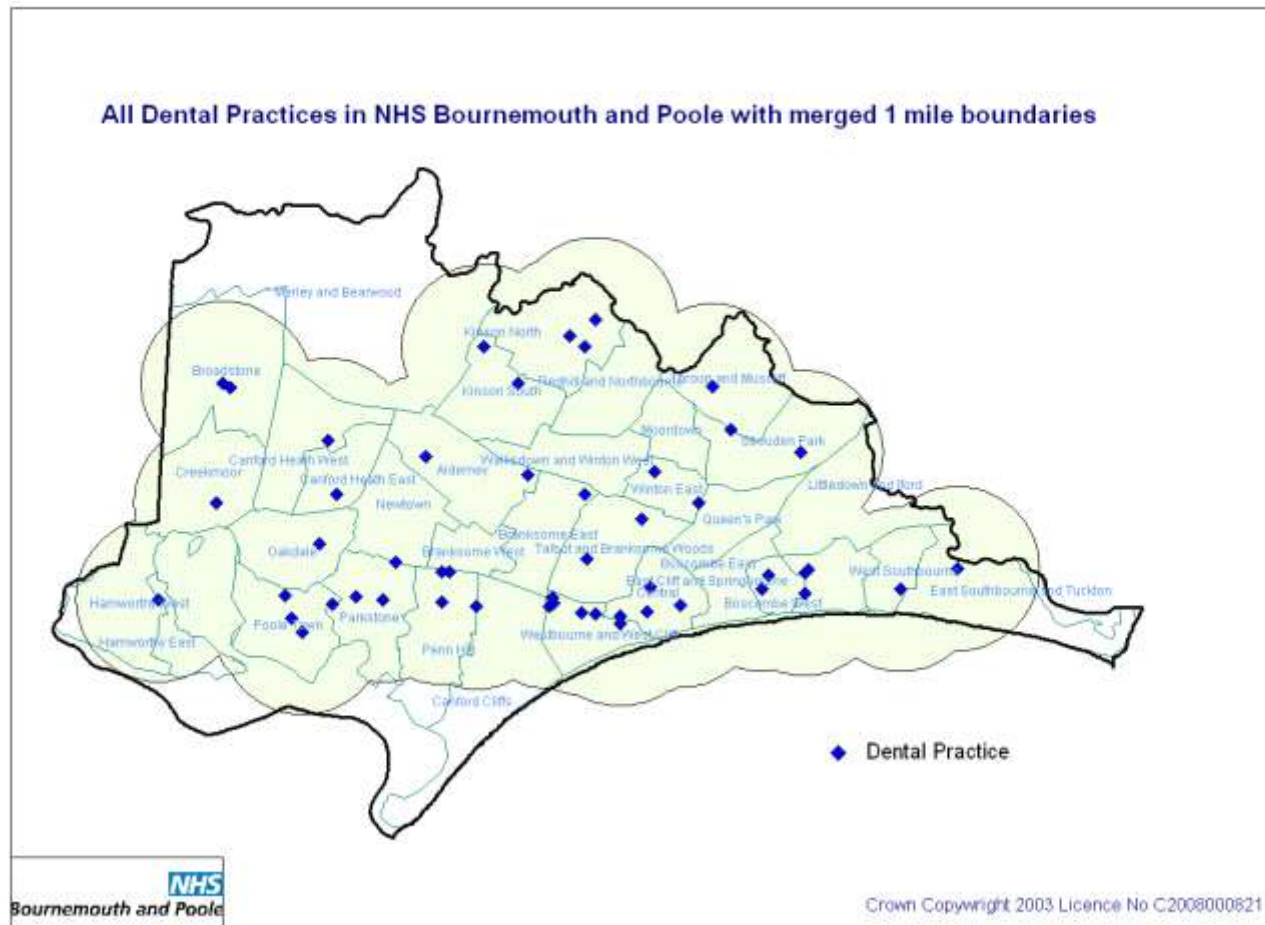
Appendix 5

Dental services in Bournemouth and Poole plus 3 / 5 mile radius

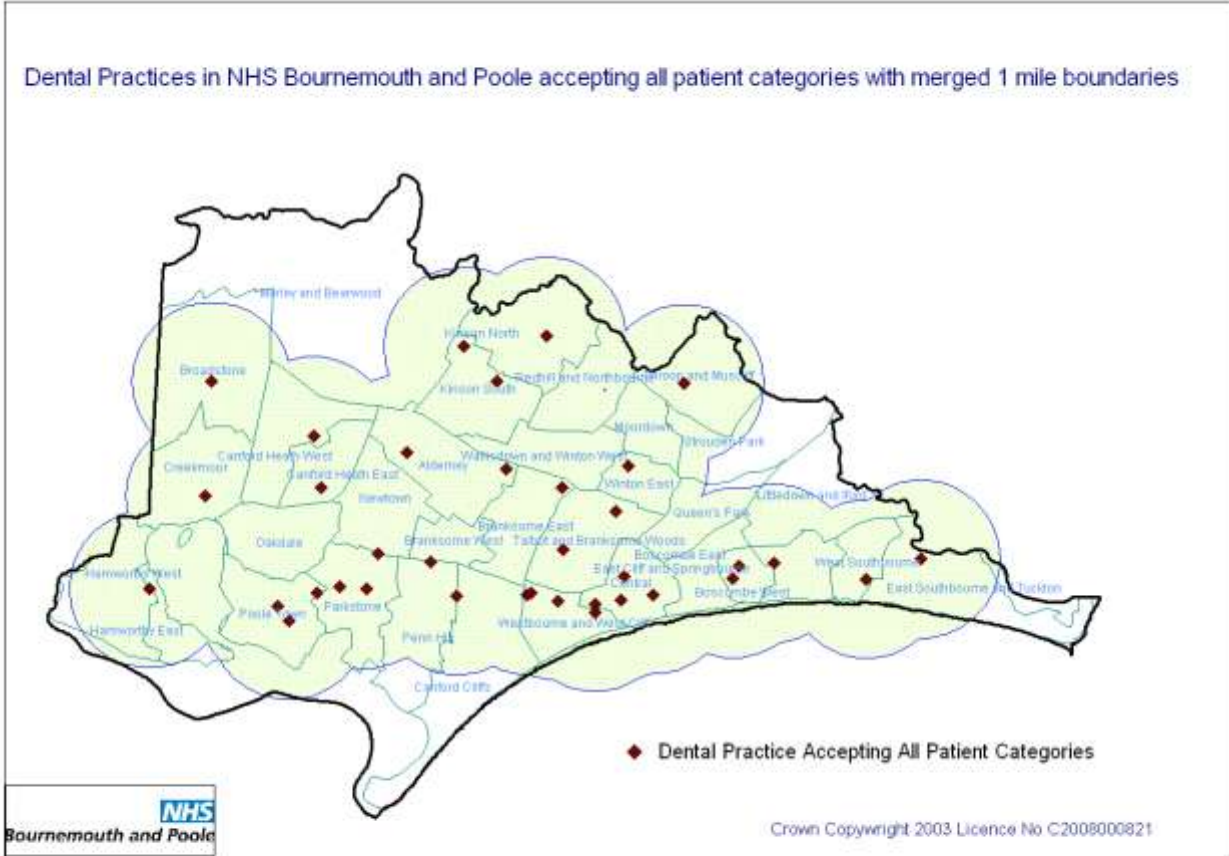


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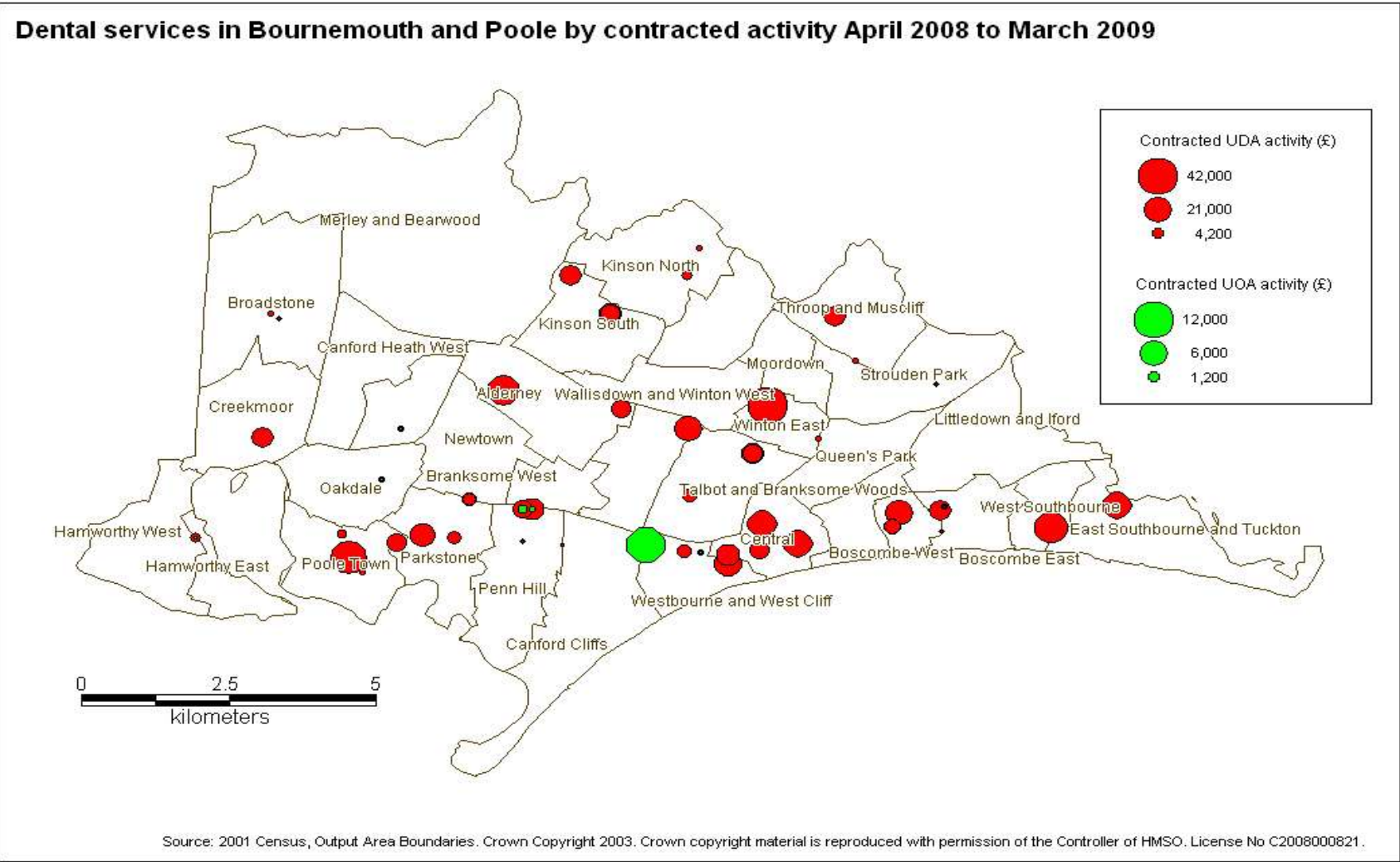
Appendix 6



Appendix 7

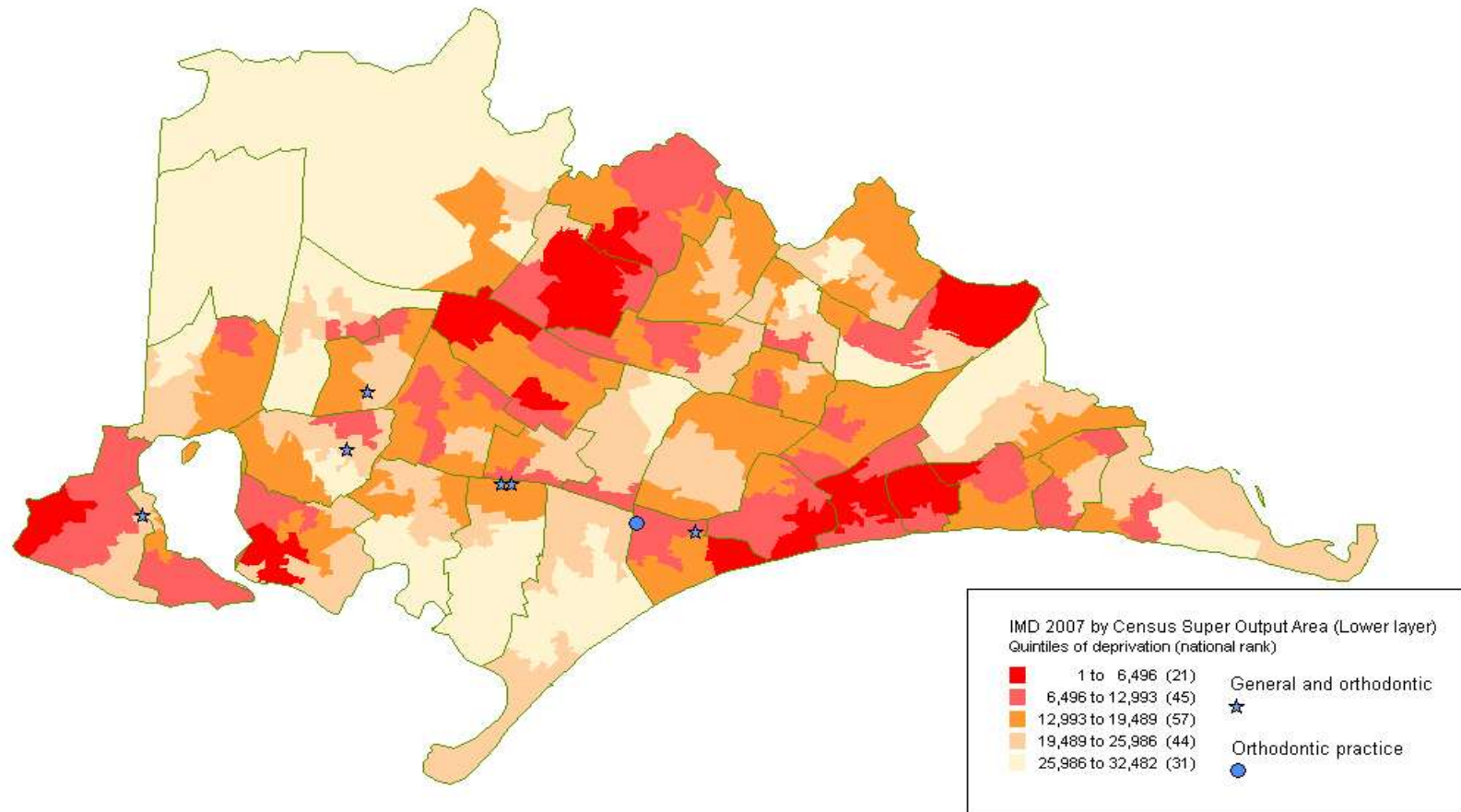


Appendix 8



Appendix 9

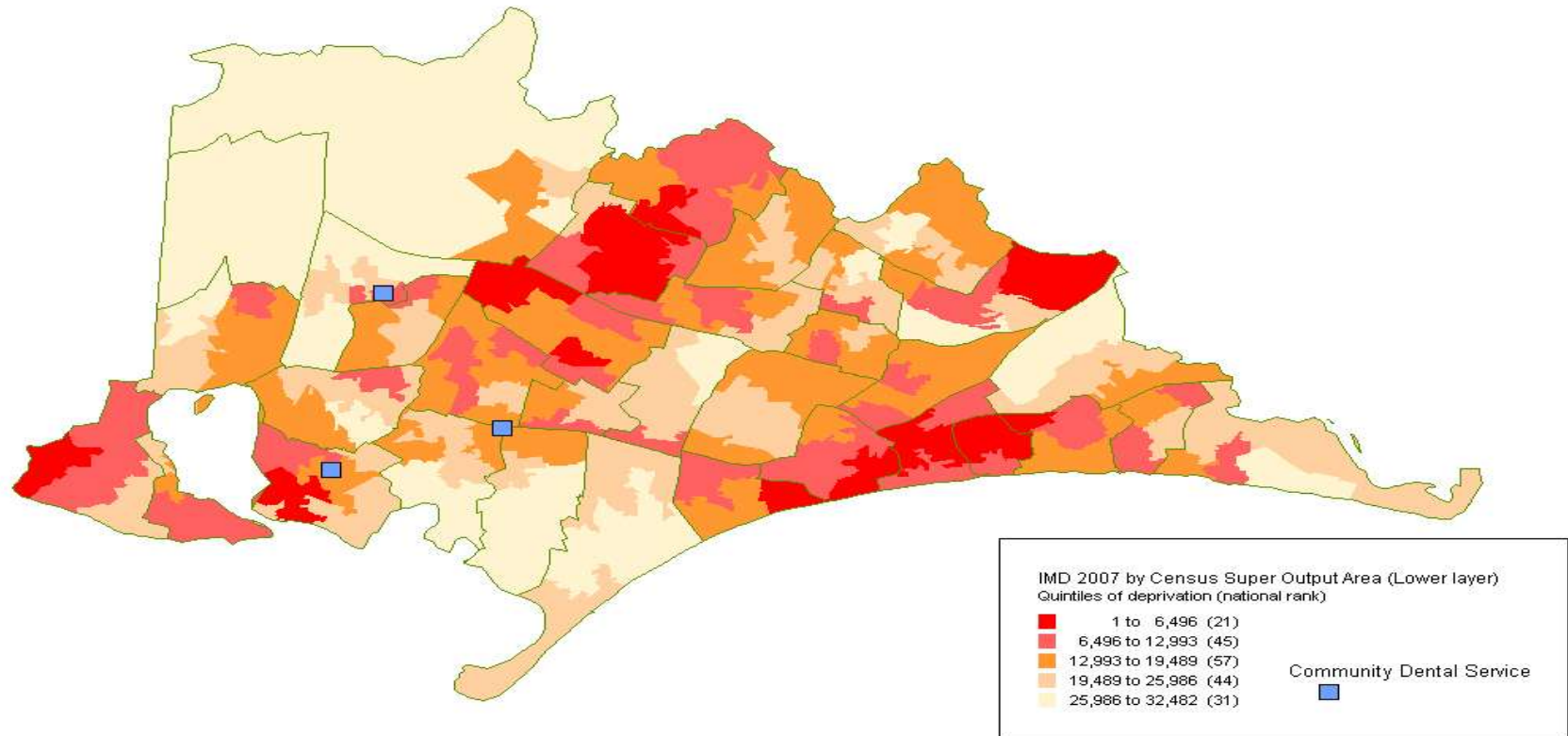
Orthodontic practices shown against deprivation (IMD 2007) Bournemouth and Poole 2008



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Appendix 10

Salaried dental clinics shown against deprivation (IMD 2007) Bournemouth and Poole 2008



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