Oral Health Improvement in NEL

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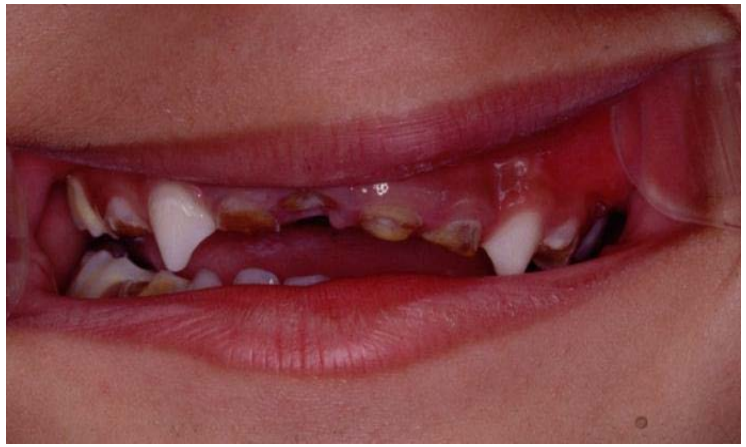
Background

- Although dental caries (tooth decay) is preventable it is still the most common oral disease in children and affects 23% of 5 year-olds (2017).
- It starts early in life with 12% of three-year olds having tooth decay (2013) with, on average, 3 teeth affected.
- Whilst the oral health of five-year-olds is improving in England, those in the most deprived areas have twice the level of decay than those from the least deprived areas.
- Some groups are more at risk of poor oral health, such as, looked after children, those with certain health conditions, those with learning and physical disabilities, and some BME groups
- Other risk factors include:
  - Poor diets, especially if high in free sugars
  - Inadequate exposure to fluoride including via tooth-brushing less than twice per day with toothpaste that has the right level of fluoride
  - Tobacco use
  - Harmful use of alcohol
- Almost 9 out of 10 hospital tooth extractions in 0-5s are due to preventable tooth decay and tooth extraction is the most common reason for hospital admission in 6-10 year olds
- In the financial year 2015 to 2016, the cost of tooth extractions, mainly due to tooth decay, was approximately £50.5 million among children aged 0 to 19 years, £7.8 million of which was attributable to the under 5s

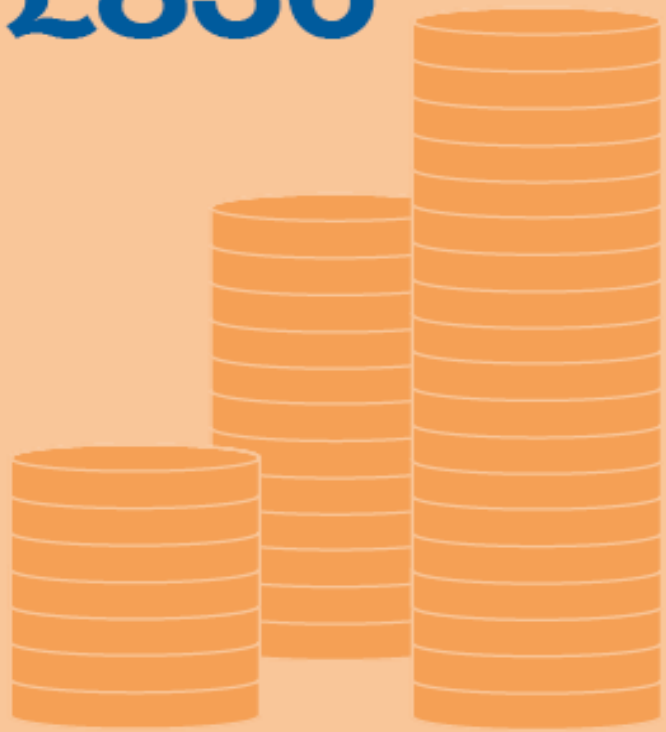
Dental Decay Affecting Incisors (front) Teeth



- This is an aggressive form of decay that affects upper incisors and can be rapid and extensive in attack
- It is associated with long term bottle use with sugar-sweetened drinks, especially when these are given overnight or for long periods of the day
- Children with incisor decay are likely to have more teeth affected than is the case for general decay, so tackling this problem may lead to relatively higher benefits

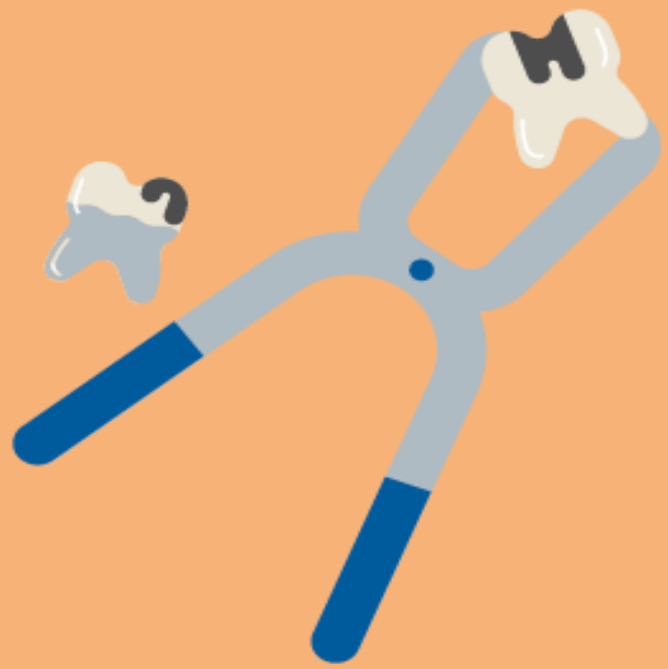
The average cost of a **tooth extraction** in hospital for a child aged 5 and under is

£836



£50.5m

was spent on tooth extractions among those under the age of 19 in 2015 to 2016



£7.8m

was spent on tooth extractions among the **under 5s**

Research about extractions in children in North West hospitals found that **26%** had missed days from school because of dental pain and infection

An average of **3 days** of school were missed due to dental problems

67% of parents reported their child had been in pain

38% of children had sleepless nights because of the pain

Many days of work were potentially lost as **41%** of parents/ carers were employed

What works?

Oral Health

- To prevent tooth decay, the evidence indicates:
  - Increasing exposure to fluoride by:
    - Regular tooth brushing with a fluoride toothpaste containing at least 1,000ppm fluoride, twice per day.
    - Fluoride Varnish Treatment at least twice a year.
    - Water fluoridation schemes.
  - Sugar reduction and healthy eating, incl breastfeeding, with support for behaviour change where required. Other population level measures can also have an impact e.g. restrictions on advertising and marketing, product formulation eg National Sugar Reduction Programme. Sugary drinks in baby bottles are particularly implicated in incisor caries.
  - Regular visits to the dentist, as often as recommended, and as soon as teeth erupt.
- Targeted supervised tooth brushing schemes in early years settings for those at greatest risk of poor oral health can help reduce oral health inequalities. PHE estimates that after 5 years, the return on investment (ROI) for targeted supervised tooth brushing is £3.06 for every £1 spent, increasing to £3.66 after 10 years. After 5 years, targeted supervised tooth brushing can result in an extra 2,666 school days gained per 5,000 children.
- Buddy Practice Schemes operate in a number of areas whereby primary care dentists link with early years settings with the aims of increasing access to dental care for young children and increasing the numbers receiving fluoride varnish. They also help allay any fears of the dentist which might be held by parent, child or both.

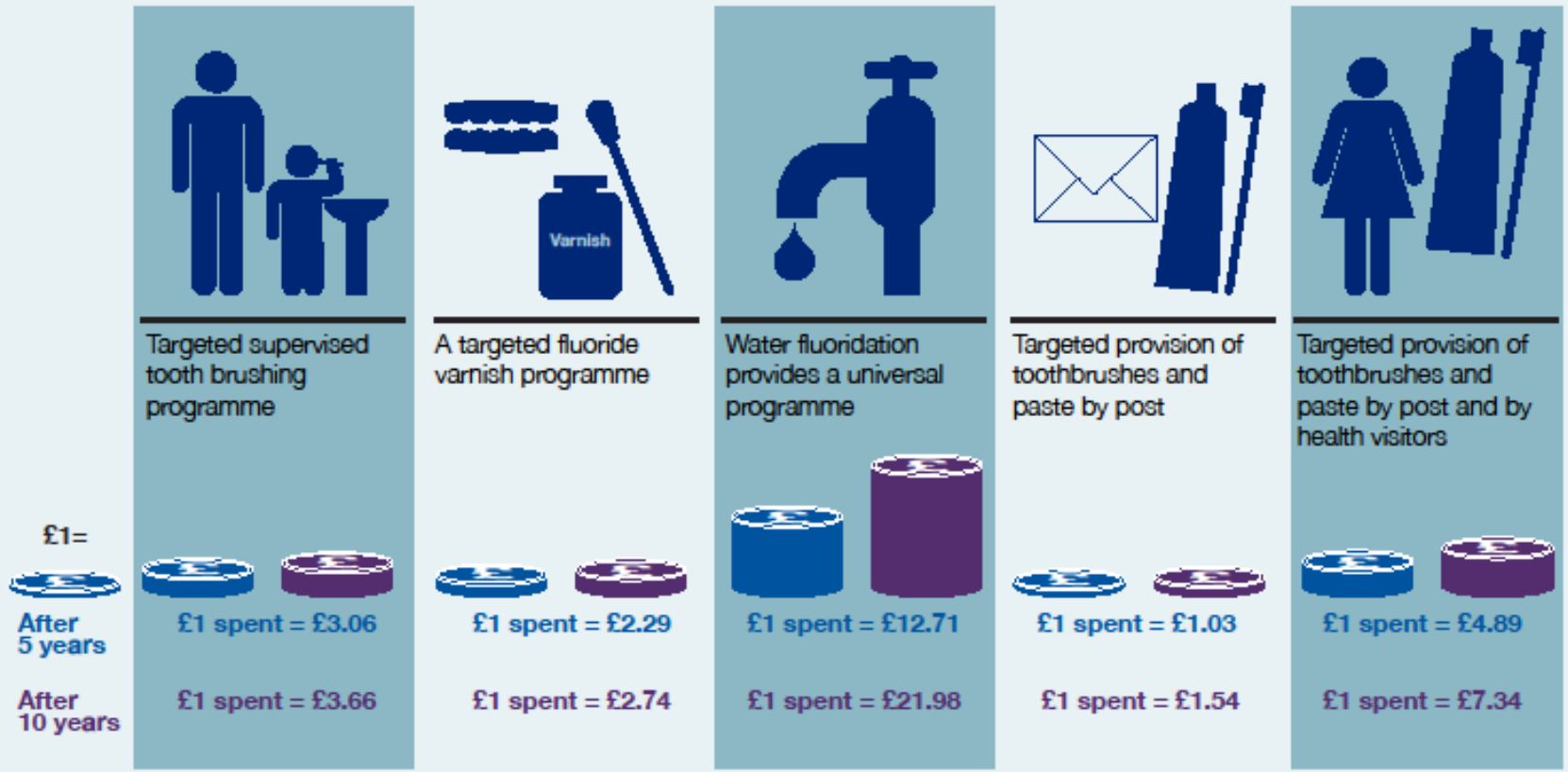
Find out More

- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf P27 onwards in particular sets out evidence for a range of specific interventions.
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605266/Delivering_better_oral_health.pdf
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/574835/PHE_supervised_toothbrushing_toolkit.pdf
- https://www.nice.org.uk/guidance/ph55
- https://www.nice.org.uk/guidance/ng30

Public Health England

Return on investment of oral health improvement programmes for 0-5 year olds*

Reviews of clinical effectiveness by NICE (PH55) and PHE (Commissioning Better Oral Health for Children and Young People, 2014) have found that the following programmes effectively reduced tooth decay in 5 year olds:



*All targeted programmes modelled on population decayed, missing or filled teeth (dmft) index of 2, and universal programme on dmft for England of 0.8. The modelling has used the PHE Return on Investment Tool for oral health interventions (PHE, 2016). The best available evidence has been used in this tool and where assumptions are made these have been clearly stated

PHE Publications gateway number: 2016321

Roles and Responsibilities –

The Health and Social Care Act 2012 redistributed responsibilities and resources previously held by Primary Care Trusts as follows:

Local Authorities

- Assessment and monitoring of oral health needs including via dental surveys of various population groups, as part of the PHE Dental Public Health Epidemiology Programme. This requires LAs to commission the fieldwork to undertake the local surveys, according to a national protocol.
- Improving oral health in the population
- Planning, commissioning and evaluation of actions and programmes to tackle poor oral health and reduce inequalities
- Commissioning Oral Health Promotion Services where relevant
- Power to make proposals regarding water fluoridation schemes, a duty to conduct public consultations in relation to such proposals, powers to make decisions about such proposals and duties to report and monitor such schemes.

NHS England

- Commissioning all primary, specialist and hospital preventive and clinical care for oral conditions. This covers general dental practices, access centres and community dental services for primary care, a range of providers for specialist care and dental and general hospitals for inpatient and outpatient care.

Public Health England

- Provide high level expertise and evidence regarding oral health on oral health to support and add value to LAs and NHSE teams.
- Access to Director of Dental Public Health, Consultants in Dental Public Health and others with dental public health specialists.
- Design, Co-ordination and Delivery of the Dental Public Health Intelligence Programme.
- Securing agreement with LAs on the dental survey so that oral health information is collected on population groups that are of interest to them and to the NHS

Dental Epidemiological Surveys – Role of LAs

- The local authority shall participate in any oral health survey conducted or commissioned by the Secretary of State under paragraph 13(1) of Schedule 1 to the 2006 Act (powers in relation to research etc.)(49) so far as that survey is conducted within the authority's area.
- Maximise co-operation with the surveys by institutions, for example by communicating their support to schools and optimising consent returns
- Monitor contract compliance and support fieldwork teams where there are difficulties accessing survey populations and gaining consent.
- Ensure results are submitted to the centre
- Receive results and share them with relevant colleagues within the LA
- Access to more detailed analysis or to raw anonymised data via Dental Epidemiology Co-ordinators

Five year programme for national dental epidemiological surveys 2017/18 to 2022/23

Survey year	Population group under scrutiny	Comments
2017/18	Adults encountered in general dental practices	Provides baseline and comparative data on oral health and service use by adults at LA level
2018/19	Caries levels among 5 year old children in primary schools with a locally decided option to include special support schools in addition	Requirement for Official Statistics - PHOF
2019/20	Caries levels among 3 year old children attending child care settings- caries	Responds to LA top priority request for information about young children. Allows comparison with 2013 survey
2020/21	Caries levels among 5 year old children in primary schools with a locally decided option to include special support schools in addition	Requirement for Official Statistics – PHOF and Water Act
2021/22 To be decided when 2017/18 adults in practices survey has been evaluated	Either mainstream adults encountered in general dental practices Or one or two defined sub-groups of adults for LAs to choose from – a core protocol to be provided and data to be pooled nationally where it has been collected in comparable fashion. Or - 12 year-old children – caries, orthodontic need, impact of poor oral health	Responds to LA priority requests for data about adults, allows comparison with 2018 survey, provides comparator data for local surveys of sub-groups. Responds to LA request for information about a variety of sub-groups of adults Responds to LA request for information about children. Allows comparison with 2009 survey.
2022/23	Caries levels among 5 year old children in primary schools with a locally decided option to include special support schools in addition	Requirement for Official Statistics - PHOF

Suspended via NHS Directive due to Covid

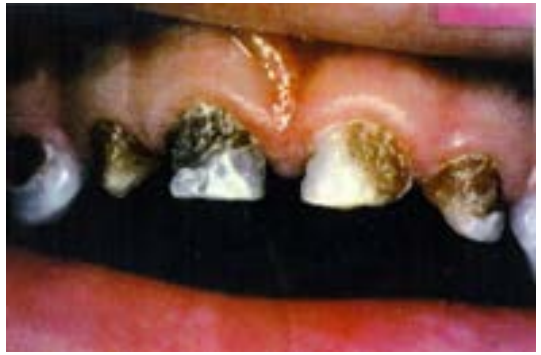
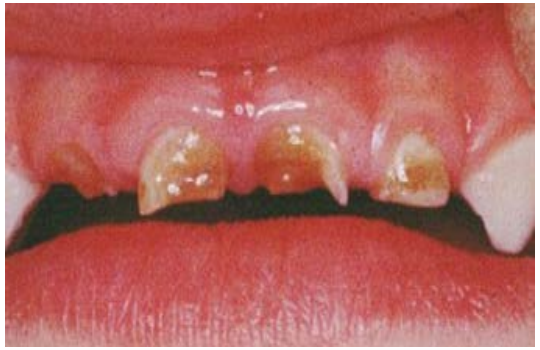
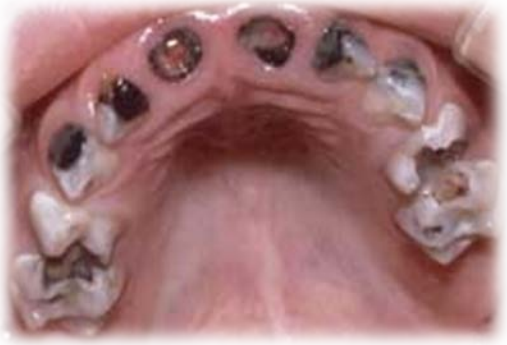
Commissioning Arrangements for Dental Epidemiological Surveys

- Co-commissioned with NHSE as a specific LOT within Community Dental Services
- Value is £10k
- NLaG current provider
- Contract monitoring arrangements are built into contract monitoring meeting for oral health promotion services as currently same provider
- Dental Public Health Consultant in PHE Regional Centre who acts as Epidemiology Programme Co-ordinator is a member of Oral Health Strategy Group.

Measurement of Dental Disease

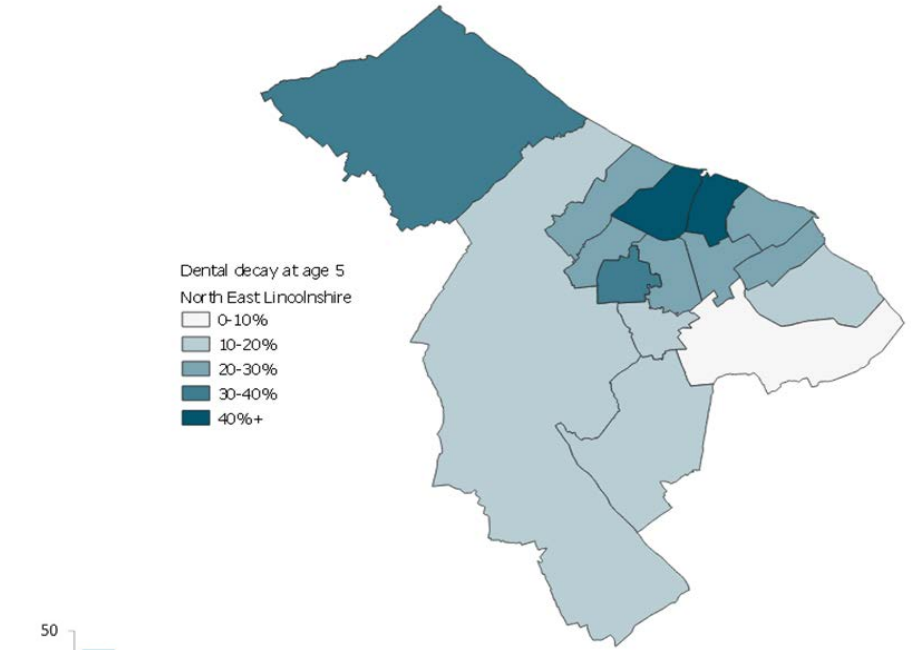
D = number of decayed teeth
M = number of missing teeth
F = number of filled teeth

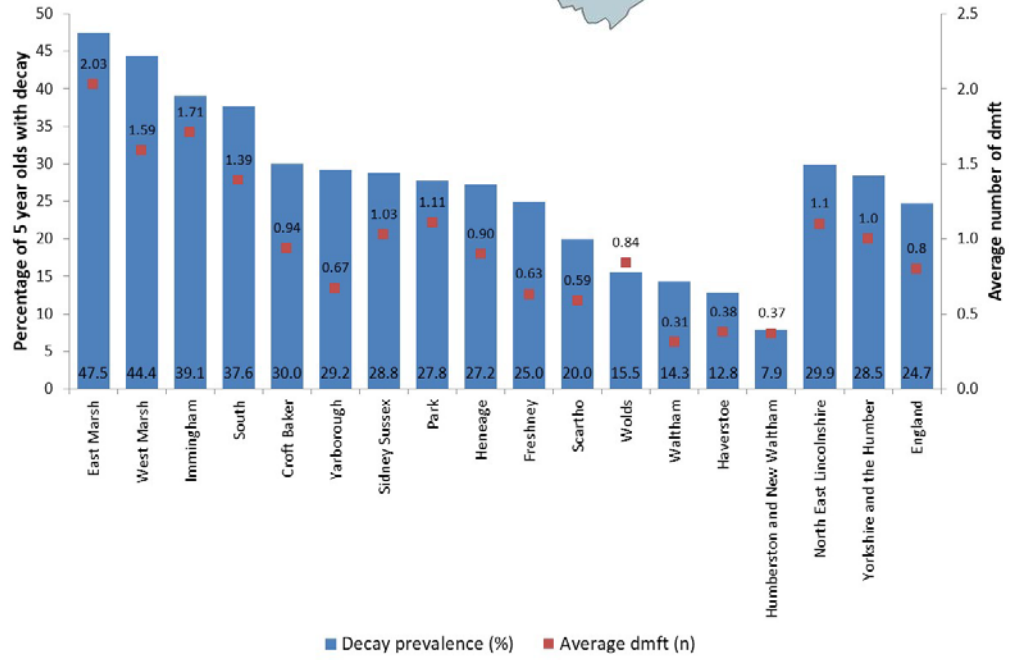
= d3mft/DMFT

Oral Health in Children and Young People in NEL

- Based on the 2016/17 dental survey, 22.9% of 5 year olds in NEL had dental decay. This is higher than the England figure but lower than regional levels. There is an ongoing reducing trend.
- The mean number of teeth decayed, missing or filled was 0.87, lower than the 1.07 figure in 2014/15.
- The most recent granular level data we have is for 2014/15. This shows considerable differences in dental decay across NEL, with East Marsh and West Marsh having higher prevalence than the least deprived wards.
- Nearly half of children in East Marsh had some level of decay. Those children also have over twice as many decayed, missing or filled teeth (dmft) compared to the NEL average.



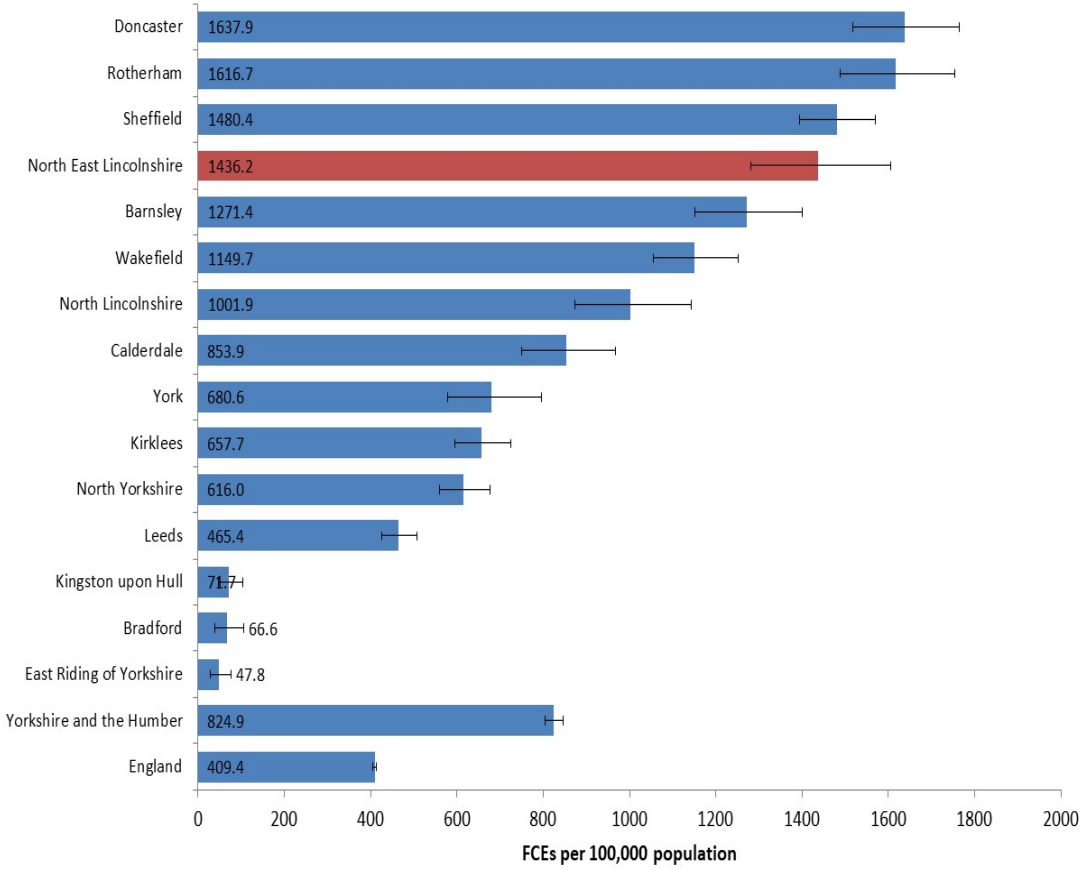


Source: 2014/15 Dental Survey of 5 year olds

Hospital Admissions

- The most common primary reason for hospital admissions of children and young people was for diseases of the oral cavity, salivary glands and jaws, the majority of which (91%) were for dental caries. This suggests variously that some CYP may not be accessing/have access to primary dental care and/or have extensive dental decay. As dental decay is considered to be largely preventable, many of these admissions are potentially avoidable.
- There were 310 FCEs for children aged 10 years and under with a primary diagnosis of dental caries (tooth decay) in North East Lincolnshire during 2018/19. This equates to a rate of 1436.2 FCEs per 100,000 population, which is the fourth highest rate in the Yorkshire and the Humber, and is significantly higher than both the England and regional rates. The majority of extractions are done under general anaesthetic.
- Dental caries were the main reason for admission by far for children ages 5-14, all of whom will have missed at least 1 day of education.

Rate of Finished Consultant Episodes (FCEs) per 100,000 population for children aged 10 years and under with a primary diagnosis of dental caries, England and Yorkshire and the Humber local authorities, 2018/19



Source: NHS Digital

Northern Lincolnshire Joint Oral Health Improvement Strategy 2019-2023

Aim: to improve oral health and reduce oral health inequalities, with an emphasis on giving every child the best start in life and adopting the principle of proportionate universalism.

Objectives:

- To optimise exposure to fluoride through toothpaste and other vehicles
- To improve access to reliable and consistent information, advice and guidance around oral health improvement and risks to oral health
- To address the drivers of poor oral health and oral health inequalities, through appropriately scaled, upstream, evidence-informed actions
- To improve access to primary dental care
- To ensure oral health promotion and preventative care is embedded within relevant contracts and delivery of services (e.g. making every contact count)

Objectives:

- To improve knowledge and skills of key workforces to maximise good oral health for their service users
- To drive a settings-based approach to oral health improvement for key target groups, e.g. schools, early years settings and residential care homes
- To identify and assess needs and assets in relation to oral health, in order to inform programme development
- To embed oral health within relevant policies and strategies
- To take forward the recommendations from the review of the oral health promotion service

Action Plan

No.	Action	Life course focus
1. To optimise exposure to fluoride through toothpaste and other vehicles		
1.3	Implement supervised tooth brushing programmes	Early years
1.5	Promotion of importance of baby teeth, adult teeth and raise awareness of 6 year molars and fluoride varnish	Early Years
2. To improve access to reliable and consistent information, advice and guidance around risks to oral health and improving own oral health		
2.1	Ensure provision of oral health information and signposting to all pregnant women by midwives	Pregnancy
2.3	Ensure up to date NHS dental access information available to midwifery teams to support signposting to other services	Pregnancy
2.6	Promote completion of red book oral health sections by health visiting teams, parents and dentists.	Early years
3. To address the drivers of poor oral health and oral health inequalities, through appropriately scaled, upstream, evidence-informed actions		
3.2	Collaboration with Looked after children/foster care services and children's homes ensuring staff receive oral health training	V. groups
3.3	Oral Health promotion, support and tooth brushes to those schools in targeted areas and special schools	V. groups
4. To improve access to primary dental care		
4.1	Encourage promotion of dental check by 1 campaign and importance of access to dental services and early interventions to prevent tooth decay/poor oral health	Early years
4.2	Improve parental culture of dental phobias, issues around children receiving treatment passing on own phobias/issues	Early years
5. To ensure oral health promotion and preventative care is embedded within relevant contracts and delivery of services		
5.1	Ensure that all contract specifications for maternity services include a requirement to promote oral health and inclusion of staff training in oral health promotion.	Pregnancy
5.2	Provide/develop/support educational oral health programmes for inclusion into existing parent and child sessions.	Early years
5.3	To embed oral within early help assessments/interventions and safeguarding pathways Caries Risk Assessment Tool – to be discussed.	Early years
5.4	Ensure that all contracts specifications for early year's services include a requirement to promote oral health and train staff in oral health promotion.	Early years
6. To improve knowledge and skills of key workforces to maximise good oral health for their service users		
6.1	Ensure that oral health included in healthy child programme pathway visits and staff all staff involved receives oral health training and receive regular updates.	Early years
6.4	Incorporate oral health into all early years, midwifery and school nurse annual training programmes.	0-18 years
7. To drive a settings-based approach to oral health improvement for key target groups, e.g. schools, early years settings and residential care homes		
7.3	Ensure promotion of maintaining good oral health and healthy eating policies in place in all childcare settings	Early years
7.4	Resources provided to early years setting to promote good oral health, to include further support with updating policies, resources, workforce development and toothbrushes provided in targeted areas as needed.	Early years
9.	**To embed oral health within relevant policies and strategies**	
9.1	Ensure oral health input into infant feeding guidelines/policies.	Early Years

Building Capacity for Oral Health Improvement

- Workforces and settings – whole school approaches, early years settings, vulnerable adults settings, workforces in children's social care
- Commissioning levers – policies, practices, assessments,
- Policy – settings-based food policies, oral health policies
- IAG - Change4Life campaigns, Be Food Smart App, Eatwell Guide, Digital local offer
- Healthy Child Programme – oral health embedded within that and within service specification for health visiting and school nursing services.

Optimising exposure to fluoride

- Two community water fluoridation schemes in NEL covering Barnoldby-le-Beck and serving parts of Immingham. Performance monitoring and liaison meeting with Anglian Water facilitated by PHE

- Based on available evidence PHE suggests fluoridation is a cost effective intervention with a good return on investment. A total of 1611 school days are gained per 10,000 children after 5 years

- Targeted supervised tooth-brushing schemes (suspended due to Covid but now being recovered)

- Fluoride varnish applications in dental practices

Water fluoridation prevents tooth decay

Fluoridation schemes in England cover some 6 million people

5-year-olds **in fluoridated areas** are

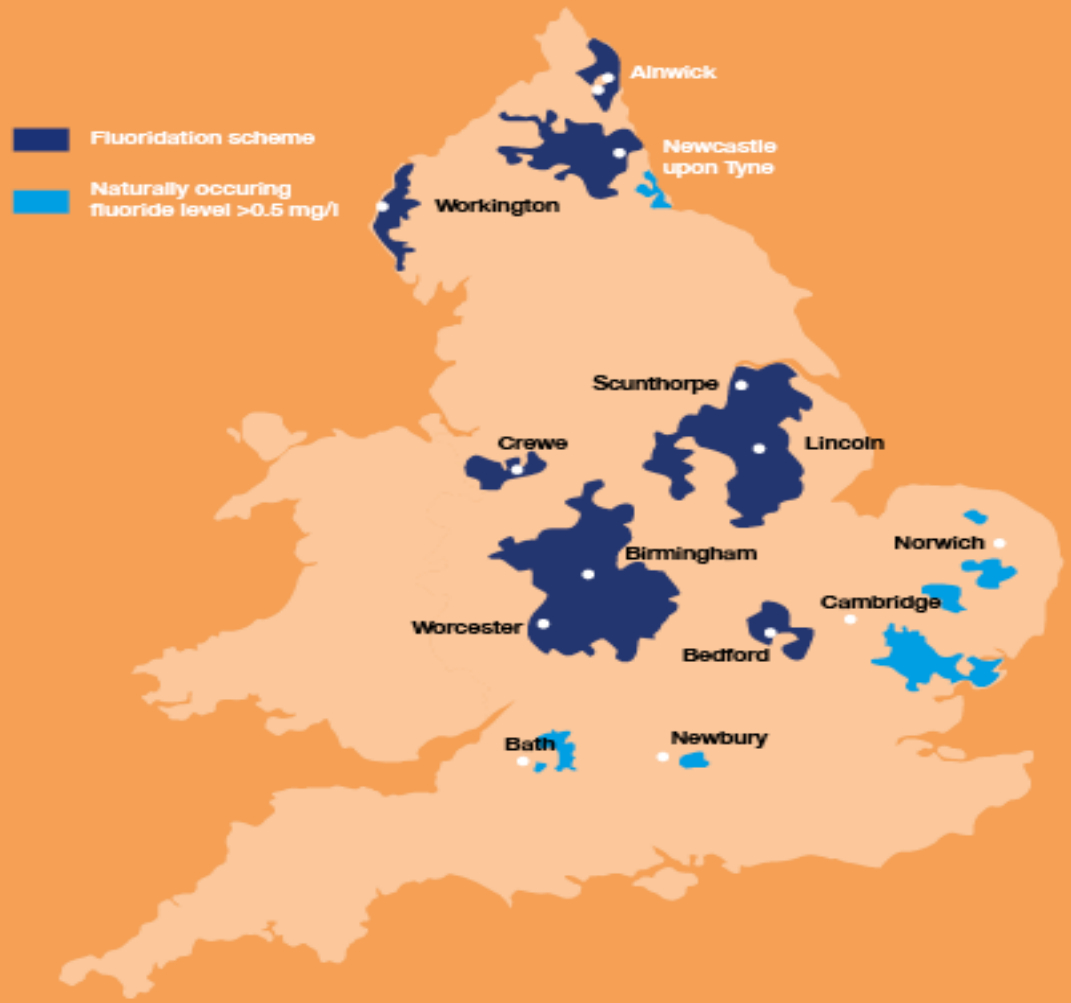
28% **less likely** to have had **tooth decay** than those in non-fluoridated ones

In **fluoridated areas** there are

55% **fewer hospital admissions** of very young children for tooth extractions than in non-fluoridated areas

On average, **fluoridation schemes** in England **cost less than 50 pence per person** per year (operating costs)

Water fluoridation has operated effectively for **50 years in England and 70 years worldwide**



Oral Health Promotion Service - Scope

- **Aims** to improve the oral health of the resident populations of North and North East Lincolnshire, and those in targeted settings, and contribute to reducing inequalities in oral health across the two authorities adopting the principles of proportionate universalism.

- **Service Objectives**
- To enable oral health improvement across the life course by giving every child the best start in life and laying solid foundations for good oral health throughout the life course.
- To reduce the prevalence of dental caries in children and young people by increasing exposure to fluoride and improving diet and feeding habits
- To undertake activity to ensure the habits of long-term bottle use, night-time bottle use and the use of sugared drinks are challenged and alternative habits adopted by families in communities where incisor caries is known to be high
- To build knowledge of oral health improvement, and skills for its application in practice, of key workforces across health, social care, educations and the VCSE sector, maximizing digital opportunities where appropriate.
- To work with Authority on commissioned or managed work streams to ensure oral health messages are included alongside other health, welfare and parenting advice. E.g. troubled families, HCP, safeguarding, CLA, wellbeing.

- **Service Objectives**
- To develop the capacity for oral health improvement in key settings, such as, early year's settings, schools, residential care or nursing home, creating environments where policies and practices support improvements in oral health.
- To work with schools and support the means for teachers to deliver oral health components of Personal, Social and Health Education and the new curriculum around Health Education.
- To offer expert advice around oral health in the development of policies and commissioning
- To offer information, expert advice and guidance around oral health and dental services to communities and professionals, and into the development, delivery and evaluation of an oral health action plan.
- To embed oral health improvement in relevant community capacity initiatives

Recommissioning of Oral Health Promotion Services

- A joint procurement exercise with North Lincolnshire was planned for March 2020 to maximise resource and increase commercial attractiveness.
- We will review procurement arrangements once the second Covid peak has sufficiently tailed off
- Contract Term 3+1+1
- NEL contribution is £52620 +2.42%
- Quarterly Contract Monitoring will be in place commencing with delivery plan

Oral Health Promotion Service Specification

- Intelligence-led
- Evidence-based
- Outcome focused:
  - A reduction in the prevalence of decay experience (d3mft) to the national average or below where possible and an ongoing downward trend
  - A reduction in the average d3mft score
  - A reduction in hospital admissions relating to dental health
- Service Description:
  - Delivery of oral health programmes in early years settings
  - Development of partnerships, training and workforce development
  - Supporting community capacity building and oral health campaigns
  - Contributing to relevant multi-agency groups to ensure that oral health is represented in all relevant settings and policies
  - Support for schools around oral health to deliver forthcoming requirements around PSHE and health education

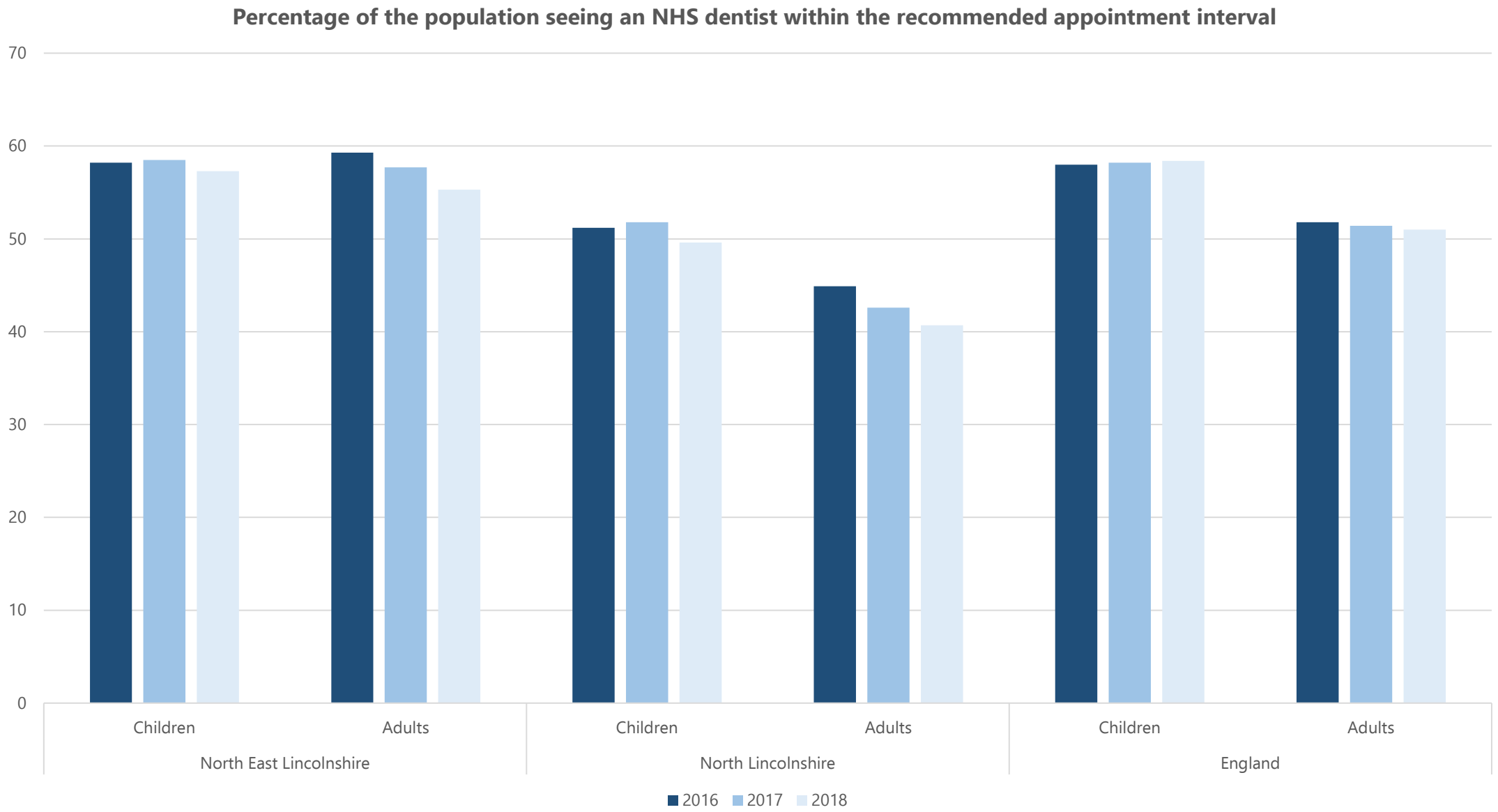
Access to Dental Services (commissioned by NHSE)

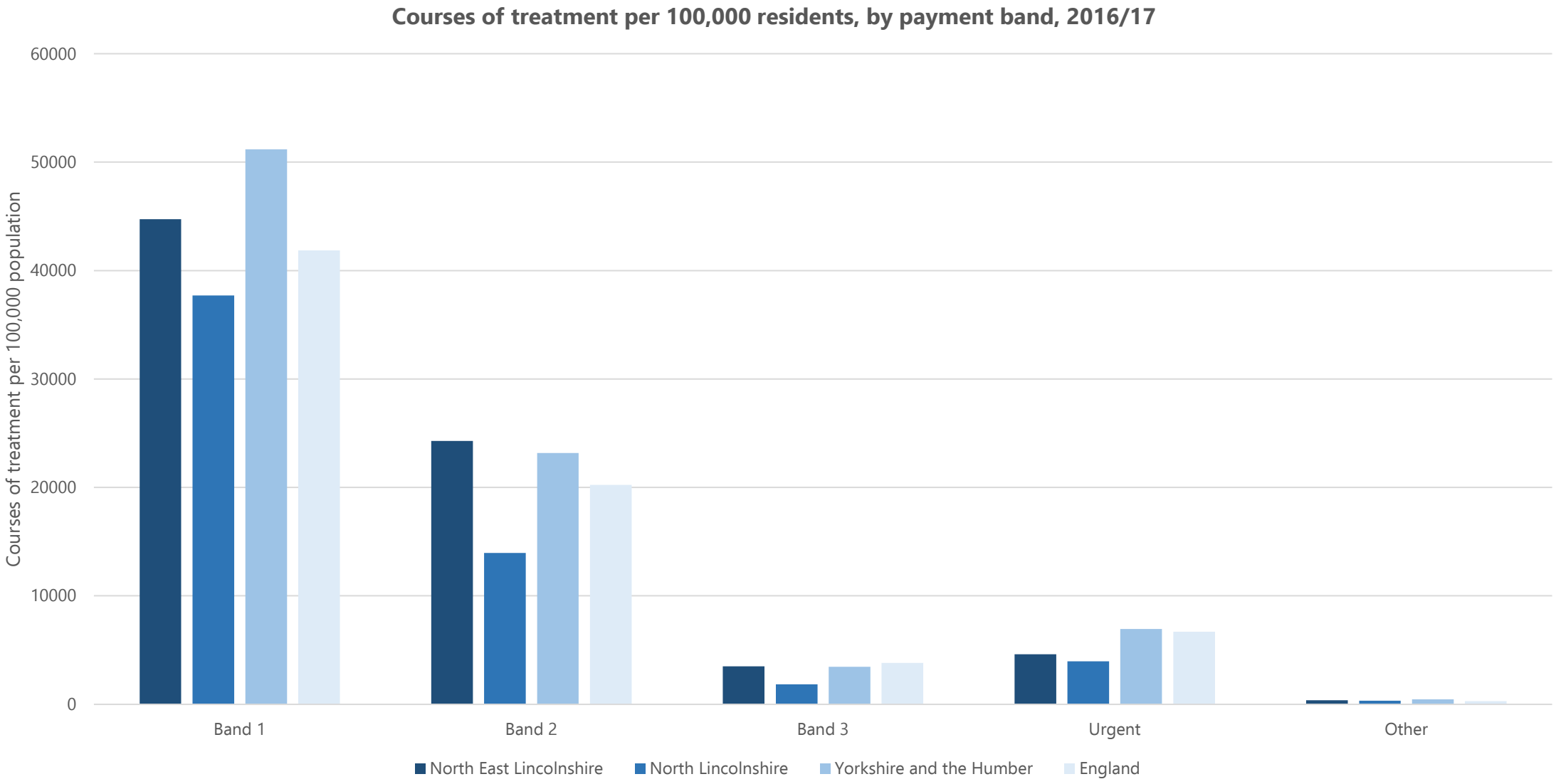
Across Northern Lincolnshire:

- Secondary care services mainly include oral and maxilla-facial surgery and orthodontics
- Primary care based orthodontic services
- Two primary care based oral surgery services
- Community Dental Services (CDS) provided by NLaG.

In NEL:

- There are now 17 primary care dental practices
- Under the current General Dental Service contract (2006) there is no formal registration with an NHS dental practice. Patients who have received a course of NHS treatment have a 12-month guarantee period and most practices follow a recall system for check ups, in line with NICE guidance.
- There are approximately 232k Units of Dental Activity (UDAs across Bands 1-3) commissioned each year, totalling £8.2m pa.
- At the year ended 31 March 2019, 88% of the contracted UDAs were delivered. This was skewed by four practices, who delivered very low numbers of UDAs and with whom NHSE are liaising to support them to turn around their delivery model.


Percentage of the population seeing an NHS dentist within the recommended appointment interval
70
60
50
40
30
20
10
0
Children
Adults
Children
Adults
Children
Adults
North East Lincolnshire
North Lincolnshire
England
2016
2017
2018


Courses of treatment per 100,000 residents, by payment band, 2016/17
60000
50000
40000
30000
20000
10000
0
Courses of treatment per 100,000 population
Band 1
Band 2
Band 3
Urgent
Other
North East Lincolnshire
North Lincolnshire
Yorkshire and the Humber
England

Actionable insight from the Adolescent Lifestyle Survey (ALS) Data 2019 –

- Of all respondents:
  83% had been to the dentist in the last year.
  12% had not been to the dentist in the last year but do have a dentist
  5% had not been to a dentist and don't have one.

- It is recommended children start attending a dentist once first teeth start to erupt. That around 17% of CYP have not been to a dentist in the last year is concerning as the opportunities for preventative advice and early identification and treatment of dental issues are being missed.
- We will explore with NHS England options to improve access to primary dental care for school children (and early years settings where possible) through, for example, dental buddy schemes.
- We will ensure oral health and access to dental care is included within assessments undertaken by children's services (e.g. early help, CIN, CP, SEND) and public health nursing

Flexible Commissioning

- NHS England, (NHSE) in Yorkshire and the Humber, has developed ‘flexible commissioning’. Further information is here:

Adobe Acrobat Document

- Seeks to address areas of inequality in terms of access and oral health promotion.
- The scheme uses already committed resources, and seeks a mutually agreed reduction in the (annual) units of dental activity (UDA) for primary care providers and a ‘twist’ from UDAs into a financial allocation. This will then allow providers to focus on alternative forms of treatment or intervention to patients, or areas, deemed most in need of **improved access or oral health prevention** initiatives
- There is a dental access and prevention framework which providers can draw from to determine provision: https://www.england.nhs.uk/wp-content/uploads/2019/09/starting-well-core-0-2s-dental-access-and-prevention-framework-v1.0.pdf
- Eligible providers are those who delivered 90% of their UDA activity at end of last financial year
- Flexible Commissioning and the provision it enables must be:
  - deliverable within contractual and budgetary constraints and is in line with procurement regulations and standing financial instructions
  - meets the recommendations made at a stakeholder consultation event, held in December 2018
  - not overly onerous on either providers or commissioners, in terms of monitoring.

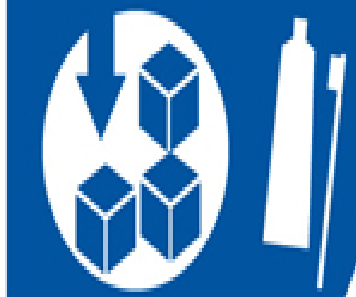
Flexible Commissioning

- Phase 1 will focus on in-practice interventions and treatment. With targeted prevention to 0- 19 and 65+ (both lifestyle and oral health).
- Three practices in NEL have been signed up to the scheme in Phase 1 to twist up to 10% of their contract value into a resource envelope.
- Phase 2 of the flexible commissioning strategy will require additional funding, as those providers deemed to be in areas of most need will be approached, with the offer of increasing their annual contracted value to 104%, to flex their approach to incorporate a skill mix model to patient cohorts
- Patient cohorts will be identified for phase 2 and are likely to include older people, including residents in care homes, children and the homeless. Delivery will include outreach and improved accessibility to treatment and prevention messages for the cohort the provider is commissioned to target.

What Will Success Look Like?

This will mean more children have fluoride protection on their teeth and consume less sugar in their food and drinks.

This will lead too:



Fewer general anaesthetics for tooth decay

Fewer sleepless nights

Fewer missed school days and days off work for parents

Less pain from tooth decay

Reductions in the numbers of children with tooth decay

A reduction in the oral health gap for disadvantaged familes

NHS England
Dental Pathway - Yorkshire and the Humber

North East Lincolnshire Scrutiny Committee

Background

Covid-19 has impacted, and continues to impact, on NHS dental services and there have been a number of changes, since March 2020, to manage services safely through the COVID-19 outbreak for patients and clinicians alike.

At the end of March 2020, following advice from the Chief Dental Officer, dentists were asked to stop routine treatment and provide remote consultations and triage. An urgent dental care system was set up to ensure that patients, who were in pain, could access (face to face) treatment where it was clinically necessary and appropriate, and following the remote triage.

Since 8 June 2020, dental practices have been able to re-open, to resume NHS dental services in accordance with advice set out by the Chief Dental Officer and Public Health England. However, to ensure that clinicians and patients are safe, all practices must follow the stringent infection prevention and control measures published by the Chief Dental Officer and Public Health England. This is impacting on the level of service that can be delivered by dentists and is as low as one-fifth of the activity that was being delivered prior to Covid at some practices.

All dental practices are expected to follow the guidance outlined in Standard Operating Procedures, including:

- Being open for face to face care unless there are specific circumstances which prevent this.
- To prioritise patients with urgent care needs. NHS England advice is that the sequencing and scheduling of patients should take into account the urgency of needs; the particular unmet needs of vulnerable groups and practices' available capacity to undertake activity.
- Patients requiring an urgent appointment should be offered an appointment, whether or not they have been treated on the NHS previously at the practice
- There is an expectation that priority must be given to patients in pain, irrespective of whether they are new patients or not to a practice over the provision of routine dental

Impact on patients

Practices are prioritising urgent dental care for those patients who require immediate attention. In addition, they are also prioritising the health and safety of both patients and staff. The nature of the treatments involved means adhering to strict infection control procedures between appointments, this reduces the number of patients that are able to be treated on a daily basis.

The other impact is on those patients wishing to resume their routine dental check-ups and treatments. Practices have been asked to prioritise those patients in urgent or emergency dental need. Therefore, patients requiring routine dental care such as check-ups and scale and polish will inevitably experience longer waiting times.

Current advice on accessing urgent dental advice/treatment

- Anyone with an urgent dental issue should telephone their dental practice (or any NHS practice if they don't have a regular dentist) for advice on what to do next.
- They will be triaged first over the telephone. If they need face to face care, they will be given an appointment and encouraged to attend as long as they do not have any COVID-19 symptoms.
- Anyone requiring treatment will be given clear instructions by the dental practice on what they need to do prior to their face-to-face appointment and once they get to the practice.
- If after telephone triage the clinician decides the issue is not deemed urgent, the patient may be given advice on how to self-manage their dental problem. They will be advised to make contact again if their situation changes

Communicating with the public

NHS England has been posting messages on social media platforms. Examples of these (local) posts are shown below.

Tweet: Please be aware that dentists are currently prioritising those patients with urgent dental needs; it is therefore unlikely that routine dental care such as dental check-ups will be available at this time. #helpushelpyou

Resumption – General Overview

The focus of NHS England's dental commissioning team - at this time - is to support providers to resume services, in line with Standard Operating Procedures and IPC guidance.

Primary Care

- All primary care providers are open and providing services outlined in the SOPs (aerosol generating and non-aerosol generating procedures). The minimum delivery requirement for primary care dentists is currently 20% of previous contracted activity levels.
- As of week commencing 26 October, fallow time between AGP appointments has reduced from 90 minutes to 30 minutes, which will result in practices being able to see more patients.
- A procurement will be undertaken in 2021, to commission a new primary care practice for Grimsby, following the closure of two practices, in the town, in 2019 and 2020.

Community Dental Services – NLAG's CDS provided a number of urgent dental care treatment centres and continued to provide face to face treatments, to support the local dental system, following the Department of Health and Social Care taking the decision to suspend all non-urgent dental activity between 24 March and 8 June. NLAGs CDS expects to be at 50% of previous contracted levels at the end of 20/21.

Urgent Care – Urgent care is the priority for all dental clinical activity at this time. The nearest contracted urgent dental care centres to NEL are Grimsby, Scunthorpe and Hull.

Secondary Care – NLAG's dental specialties (oral surgery, max fax) are currently providing approximately 42% of the comparable period in 2019/20. This is above the Y&H average of 36%. The trust has reported that services have recommenced and they are accepting new referrals, with a prioritisation model in place.

Debbie Pattinson
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