Lancashire and South Cumbria Integrated Care Board

ICB Primary Care Commissioning Committee

Date of meeting	18th January 2024
Title of paper	Dental Commissioning Plan
Presented by	Peter Tinson, Director of Primary Care David Armstrong, Senior Delivery Assurance Manager
Author	David Armstrong, Senior Delivery Assurance Manager
Agenda item	5c
Confidential	Yes

Executive summary

The purpose of this report is to seek approval for the costed dental commissioning plan for 2024/25.

The plan is primarily based on the dental access and oral health improvement programme which was previously received and agreed by the Committee at its meeting in September 2023 and ICB Board at its meeting in November 2023.

The plan is affordable within the ICB dental budget allocations.

Advise, Assure or Alert

Advise the committee**:**

- Of the costed dental commissioning plan for 2024-25.

Assure the committee**:**

- That the plan is fully funded and affordable with the current dental budget allocations.

Recommendations

The Committee is asked to approve the dental commissioning plan.

Which Strategic Objective/s does the report contribute to		Tick
1	Improve quality, including safety, clinical outcomes, and patient experience	**x**
2	To equalise opportunities and clinical outcomes across the area	**x**
3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	**x**
4	Meet financial targets and deliver improved productivity	**x**
5	Meet national and locally determined performance standards and targets	**x**
6	To develop and implement ambitious, deliverable strategies	**x**

Implications

	Yes	No	N/A	Comments
Associated risks	x			Included within a separate risk section of the paper

Are associated risks detailed on the ICB Risk Register?	x			Dental access is currently captured on the corporate risk register
Financial Implications		x		None fully within budget allocations

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
Dental Services Group	30-November-2023	Support for the proposed plan

Conflicts of interest associated with this report

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Data privacy impact assessment completed			x	

Report authorised by:	Craig Harris, Chief Operating Officer

ICB Primary Care Commissioning Committee
18th January 2024

Dental Commissioning Plan

1. Introduction

1.1 This paper is to provide detail of and seeks approval from the committee to the following:

- The dental commissioning plan for 2024/25.
- The timing of implementation to allow for a full year investment into the programmes.

2. Background

2.1 When dental services were delegated to the ICB it included all aspects of NHS dental healthcare, including primary care, secondary acute dental care and community and special needs dental care. The financial information section below provides more detail, but a large proportion of the delegated funding is committed to services based on inherited contractual commitments. This is detailed in table below:

Dental Service	Number of Contracts
Primary care dental	202 Dental Practices
Secondary care dental	10 NHS Trusts
Community & special care dental	2 Providers

2.2 The primary care dental services are based on contracts held by high street dental providers, in perpetuity, and based upon activity and values arising from the introduction of the general dental services (GDS) contract in 2006. The ICB are therefore contractually bound to these historically based and located contracts.

2.3 Opportunities to target investments in specific patient cohorts or geographies arise when dental providers choose to hand back all or a proportion of their contract.

3. The Dental Access and Oral Health Improvement Programme

3.1 The Dental Access and Oral Health Improvement Programme (DAOHIP) is a clinically led programme to identify and develop new and innovative programmes and to promote and propose investments to improve two critical aspects of the dental system – access and oral health.

3.2 The main objective of the DAOHIP is to improve access to dental services alongside improving oral health and aims to:

- Use objective measures to help prioritise which areas of Lancashire and South Cumbria are in most need of dental access and oral health support.
- Reduce access and oral health inequalities across the ICB by developing evidence-based care pathways.

3.3 The DAOHIP has already identified three areas for immediate investment:

- Paediatric Services- children's oral health in LSC is very poor, with the prevalence of decay in some areas double that to the England average.
- Elderly Services- improved services are required to support our elderly population in Care Homes
- Urgent Care- the universal coverage across the ICB delivering access to any patient in need of urgent care arising from dental pain or bleeding, or patients from a priority group is still identified as a need.

4. Dental Commissioning Plan

4.1 The proposed dental commissioning plan is a full annual plan for 2024/25 and seeks to invest recurrently available funding in a non-recurrent manner whilst longer term investment decision are considered.

4.2 The first three schemes, identified as the highest priority, are led and developed directly from the DAOHIP. The specific locations where investments will be made will be determine by the investment framework due to be ratified by the Committee in February 2024.

4.3 The other proposed schemes have been developed to increase capacity, improve service delivery, and enhance the dental system in order to manage and mitigate risks and service problems arising across the ICB dental system in totality.

4.4 The below provides a summary of the proposals for 2024/25.

Description	Priority	Investment 2024-25
Child Access & Oral Health Improvement	1	£981,200
Care Homes	2	£338,000
Pathways 1, 2 & 3	3	£908,400
Managed Clinical Network (Restorative Dentistry)	4	£31,000
Expansion of Orthodontic Services	5	£200,000
Intra Oral Scanners	6	£60,000
Surgical Exposure Service for Paediatrics	7	£20,000
Tier 1 services – General Dentist with Special Interests	8	£12,500
Sedation Services	9	£105,000
Advice & Guidance	10	£40,000
M&LCSU Management Support	11	£210,000
Total		£2,906,100

4.5 The schemes have been developed and prioritised in conjunction with the local dental network and local dental committee to ensure that they are clinically led, prioritise the most pressing health inequalities and are attractive to the dental profession locally. Additional support has been provided from a wider group of stakeholders including consultants within local provider trusts, the regional consultant in dental public health, the ICB dental clinical fellow and the dental clinical advisor.

4.6 The primary care dental team proposed dental commissioning plan is aligned with the ICB planning processes, with all content reflected in the planning assumptions.

4.7 Further details of the schemes are included within appendix one, including a summary of the expected benefits.

5. Financial Information

5.1 The ICB receive allocations specifically identified for dental services, the allocations cover all aspects of dental services. The allocation is utilised to set the budgets across these three areas based on existing commitments, historic spend and to develop and enhance the services offered to the patients across the ICB.

5.2 The primary care dental and orthodontic contracts are defined as in perpetuity they are rolled forward on an annual basis unless specifically amended. The contracts are based upon targeted Units of Dental Activity (UDAs) or Units of Orthodontic Activity (UOA's) which roll forward on a recurrent basis, with costs uplifted for the annual Doctors and Dental Renumeration Board (DDRB) inflationary uplifts, all of which is full funded and budgeted for as part of the annual financial planning processes.

5.3 The majority of the primary care budget could be described as fixed as it is based upon the existing contracts in place, however a number of providers have handed back their contracts, it is the resources arising from these hand backs which allow for changes and new innovative investment programmes, as described and included in the commissioning plan, to be funded.

5.4 The secondary care dental contracts will be aligned to the overarching acute contracting terms and conditions applicable to all ICB acute contracts. The ICB acute contracts are developed using the payment by results system and paid for using national tariffs. The contractual terms and conditions for 2024/25 will need to reflect the systemic changes encountered in 2023/24 with providers struggling to sustain services, with some local providers having to suspend or reduce some services such as orthodontics and restorative dentistry, both services being officially identified as being fragile services. The secondary dental budget will be based upon the activity demanded and capacity delivered by acute providers, with contracts reflecting the expected level of service delivery in 2024/25. All additional resources to fund the investments in the dental commissioning plan will be fully funded from within the overall allocation.

5.5 The community and special care dental contracts are based upon existing contractual terms and conditions, all be it on time limited contracts held with the Lancashire Collaborative and North Cumbria Partnerships. The only currently forecasted changes in 2024/25 will be the implementation of the DDRB inflationary uplifts for 2024/25, these are historically funded by NHS England when negotiations are concluded, and adjustments implemented.

5.6 All aspects of the ICB dental financial planning are reconciled to the dental allocations, budgets will be set as described above.

5.7 The investments in the commissioning plan are fully restricted to the values available and arising from the contractual handbacks, this is designed to ensure that the investment can be made from resources that are fully funded but not fully committed, therefore removing as far as possible any financial risks.

5.8 The total value of the recurrent handed back contracts is more than £4m therefore the proposals are substantially less than the resource available. This process is not expecting to permanently reinvest resources from primary care dental, if for example resources become available from the existing secondary dental budgets these will be utilised for the non-recurrent investment in those investments into the acute sector.

6. Risk

6.1 Financial risks have been mitigated as far as possible, only resources that were historically committed through contracts and, therefore, fully and recurrently funded have been identified to finance the proposed investments. The proposed investments are also predominantly non recurrent, many are one-off investments, those that are service based are initial pilot programmes that can if proven to be unsuccessful and not delivering the intended benefits, or if financial conditions change in an adverse manner, be terminated.

6.2 Clinical risks have been mitigated as far as possible, the DAOHIP is a clinically led programme, and the highest priority investments arise directly from this programme. Other investments arise directly to mitigate service delivery issues that have arisen within the current financial year.

6.3 The highest priority investments are to be implemented in the areas identified as having the greatest clinical need, this is to directly react to the issues of oral health inequity identified in the DAOHIP.

6.4 The contracts for pathways one, two and three terminate on the 31 March 2023. Providers require sufficient notice to manage their appointment books, around two months, to ensure that there is no interruption in provision.

7. Recommendations

7.1 The committee is asked to:

- Approve the dental commissioning plan for 2024/25.

David Armstrong

Senior Delivery Assurance Manager

Appendix 1 – Detailed Dental Commissioning Intentions 2024-25

Worksheet%20in%20C%20%20Users%20

Pathway	Priority		Q1 Apr - Jun 24	Q2 Jul - Sep 24	Q3 Oct - Dec 24	Q4 Jan - Mar 25	Total (000s)
Child Access and Oral Health Improvement	1		£264,800	£234,800	£240,800	£240,800	£981,200
Care Homes	2		£84,500	£84,500	£84,500	£84,500	£338,000
Pathways 1, 2 & 3	3		£304,200	£304,200	£150,000	£150,000	£908,400
Managed Clinical Network (Restorative)	4		£7,750	£7,750	£7,750	£7,750	£31,000
Expansion of Orthodontic Services	5		£50,000	£50,000	£50,000	£50,000	£200,000
Intra Oral Scanners	6		£60,000	£0	£0	£0	£60,000
Surgical Exposure Service for Paediatrics	7		£5,000	£5,000	£5,000	£5,000	£20,000
Expansion of Primary Tier 1 service - General Dentist with Special Interests	8		£0	£2,500	£5,000	£5,000	£12,500
Sedation Service	9		£26,250	£26,250	£26,250	£26,250	£105,000
Advice & Guidance	10		£10,000	£10,000	£10,000	£10,000	£40,000
MB&CSU Management Support	11		£52,500	£52,500	£52,500	£52,500	£210,000
			£865,000	**£777,500**	**£631,800**	**£631,800**	**£2,906,100**

Recurrent Handbacks £4,000,000

Pathway	Scheme Details	Comments/Costings	Benefits and Outcomes	Priority	Area	Q1 Apr - Jun 24	Q2 Jul - Sep 24	Q3 Oct - Dec 24	Q4 Jan - Mar 25	2024-25 Total (000s)	Risks	Mitigations
Child Access and Oral Health Improvement	Lancashire and South Cumbria has some of the worse child oral health in England (Pendle and Blackburn with Darwen are ranks 4th and 5th worse in the country. Elective care recovery is taking longer for children, including those who require an extraction of teeth in a hospital setting with some waiting for treatment for over 50% of their life in pain. This pathway aims to integrate primary care dental teams with local authority and population health colleagues in providing an integrated approach to prevention through a nurse led behaviour change programme while offering clinical care for sympomatic children in pain referred into care via the urgent care pathway. The scheme will also integrate practice teams with specialist paediatric dentists to offer enhanced clinical care stabilising and temporising oral health while children wait in pain for extractions (sometimes negating the need for an extraction all together).	Child Access 7 areas and 2 towns (Barrow, South Lakeland, Blackburn, Burnley, Blackpool, Hyndburn,Preston, and the towns of Fleetwood and Skelmersdale are the priority areas). Also includes enhanced care aligned to paeds GA pathway and CDS. **Costings:** Max of 1 clinical session per week per practice = 13 sessions per quarter. Bigger geographies have 2 practices (Preston, Blackpool and Blackburn). to cover the clinical care in the chair. (£650) Max of 2 sessions per week per practice for nurse led behaviour change (£300) Network meetings per month £300 - if required Note: Enhanced care additional cost per patient (to be decided) also nurse led behaviour change to be decided - will impact on costs for Q3 - Q6. Clinical Network payment too . **Maximum** Per practice per quarter / month: Clinical Session per quarter = 13 x £650 = £8,450 Prevention and Behaviour Change per quarter = 2 x (13 x £300) = £7,800 Consumables - per week £250 - assume x8 = £12,000 per quarter Meetings - per week £300 - assume x 4 = £1,200 per quarter Total Per quarter = £18,400 **Total for 12 practices per Qtr = £220,800** **Notes** Late start will mean Q1 costs will be minimal. Not all practices will deliver the maximum offer	**Outcomes:** 2,500 treatment patient appointments for children in pain. Behaviour change clinics for 9,000 families, parents or carers of children A reduction in caries in under 5 year olds. Reduction in family members having to take off work to look aftetc hidlren in pain who can't attend school due to pain from tooth decay. Transformed primary care workforce with more experience in managing symptomatic children, using enhanced care techniques which will in turn lead to less reliance of secondary care services. Support the recruitment and retention of dental team, by providing a more diverse job role and portfolio for the whole dental team. A better understanding of demand, efficacy and cost consequences of the pathway for future 'Flexible Commissioning' opportunities. Integration of dental team in social care, GP teams and secondary care providers.	1	Primary Care	£220,800	£220,800	£220,800	£220,800	£883,200	1) The Expression of Interest exercise conducted in December 2023 led to **51** practice stating they would wish to be part of this programme, the risk highlighted is the commissioning capapity is insufficient to accept all EoI offers - prioritised allocation. 2) Nurse training can't start until Nov, enhanced care in Dec. 3) Risk of capacity in PFNC to deliver some schemes in a timely manner.	1) Provider have already made positive noises about the scheme. 2) Q1 & Q2 delivery will be for routine activity while the behaviour change and enhanced care training is delivered. 3) Phasing the implementation and working with clinicians as the scheme progresses will ensure pathways are more readily accepted by the profession reducing repetition EOIs at a later date.
		Evaluation of the clinical pathways, and additional support for clinical leadership				£6,000	£6,000	£12,000	£12,000	£36,000		
		Expansion of the Call Handling service to accommodate the increased number of calls arising from the implementation of the Child Access and Oral Health Improvement and the Care Homes investments (Priority 1 and 3)				£8,000	£8,000	£8,000	£8,000	£32,000	1) pressures arising on the call handling service due to the high priority investment in Paediatric Access and Care Homes	
		Funding to support the Dental Access & Oral Health Improvement Programme with additional resources for communications and public relations. Communication is identified as a key pillar of the programme as a whole, without providing sufficient resources to socialise and publise the programmes outcomes, proposals and investments the programme will not be as successful.				£30,000	£0	£0	£0	£30,000	1) One of the key work streams in the Dental Access and Oral Health Improvement programme is communications, this is an intergral part of this particular programme but the resources are expected to benefit other programmes	1) The resources will be used to communicate the outcomes and proposals from the DA&OHIP.
		Total				£264,800	£234,800	£240,800	£240,800	£981,200		
Care Homes	In recent years there has been increasing focus on improving the quality of care for residents in care homes and in ensuring that care homes are supported by appropriate health services. In response to national reports from both the CQC and the NHS, the Enhanced Health in Care Homes was updated to include a more comprehensive section on oral health care. The intention is to integrate dental teams to support Primary Care Networks deliver and oral health framework with two key focuses: - Supporting the care home with their obligations under NICE Guidance NG48 - Providing face to face care for residents in care homes The scheme has a preventative focus ensuring that the residents of care homes have oral health assessments and ongoing reviews with access to face to face care as and when needed. In turn this will reduce pressure on urgent dental care services, Medical Practices and Emergency Services as highlighted in the CQC report 'Smiling matters: oral health care in care homes': *"All too often, treatment would only be sought when people were in pain, but issues with accessing emergency NHS dental care meant care homes would call a GP or NHS 111, or even take the person to A&E – putting added burden on services that are already under pressure."* Having good oral health reduces frailty in the elderly by improving nutrition through being able to eat, to be better able to communicate, take medication and a reduction in the exacerbation of respiratory illness that is linked to poor oral health, such as aspiration pneumonia.	10 providers to work with Las/PCNs to deliver the pathway 1 session per week Max of £650 per session (includes clinical delivery), however a nurse led training/engagement session with a care home would be £200. Max would be (10 x £650) x (52/4) = £84,500 per quarter	**Outcomes** The outcomes of the pilot relate to both service delivery (support for care home teams and clinical support for residents) and a greater understanding of demand from care homes enabling a more permanent solution to be commissioned in the future. **Care Home Support:** •The development a policy on oral health. •Initial oral health assessments for new residents and their appropriate review. •The development of mouth care plans for individual patients. •The development of knowledge and skills for care staff. **Clinical Support for residents:** •The dental practice will provide clinical advice, care and services to residents of their named care homes. •Support care home staff with advice about individual patient's conditions through telephone, video or in person consultations •For residents who already have a regular dentist, liaise with the patient's regular dentist and facilitate care. •For residents who do not have a dentist, and where there is no current domiciliary care provider, the practice may provide appropriate clinical care either at the care home or at the practice as appropriate. •Undertake an oral health examination in line with NICE recall guidance and Delivering Better Oral Health, either within the care home or the dental practice that is supporting the care home. **Service Demand and Workforce Utilisation** •The level of demand for care from the care homes involved in the pilot (both from supporting care home staff and clinical support for the residents). •How dental practices will utilise skill mix to deliver the pilot, engaging with the whole dental team as well as clinical dental technicians from outside of the practice. •What workforce transformation is required to support dental practices with delivery of a permanent solution.	2	Primary Care	£84,500	£84,500	£84,500	£84,500	£338,000	1) Quarter 2 delivery will be minimal while the service mobilises. 2) Uncertainty of the number of providers 3) Uncertainty of the demand from care homes	EOI resulted in 27 practices responding
Pathways 1, 2 & 3	**Pathway 1: Urgent Dental Care** This pathway provides services to that either do not have a regular dentist or are unable to access their current dentist and have an urgent dental need which includes (trauma, swelling, bleeding and dental pain). **Pathway 2: Care required following an urgent intervention** This pathway provides services to patients who have accessed services under Pathway 1 but need further treatment to manage or stabilise their immediate treatment need. Often the patient requires ongoing treatment to cure or prevent the issue from occurring again. Treatments provided under Pathway 2 should leave patients orally healthy and free from the immediate and ongoing need to access services under Pathway 1. **Pathway 3: Routine care where the patient is part of a nationally recognised priority group** This pathway provides services to a specific group of patients who currently do not have a dentist and fall into a priority group such as:- •Undergoing pre-cancer treatment. •Due to have heart surgery. •Medical conditions where oral health is particularly important for systemic health. •Vulnerable groups and those who have a high risk of deterioration of their oral health if not treated. • (STATUTORY REQUIREMENT) Looked after Children- those who require a statutory dental assessment as part of OFSTED and LA returns and were unable to find access at a local practice.	Support for Urgent Care and Follow Up Care (Pathway 1 is offset, pathways 2/3 offset and funded)	**Pathway 1** Approximately 10,000 urgent care appointments for patients in pain. **Pathway 2** Approximately 6,000 follow up appointments for patients requiring treatment having already had an urgent need addressed **Pathway 3** Approximately 3,000 courses of treatment to make patients orally fit.	3	Primary Care	£304,200	£304,200	£150,000	£150,000	£908,400	1) The pathway contracts end on the 31/03/24, without a thorough review of the benefits to patients and services this create a major risk to any proposed ongoing commissioning intentions, therefore a 6 month extention is proposed. The direct cost is included, the offset value is already included within the baseline contracts	1) Resources have already been identified to fully fund the Pathway 1, 2 & 3 development, utilising the existing allocated resources form the contract handbacks. 2) Additional mitigations have been idnetified to provide resources for investment in subsequent services once the 6 month extension elapses, based on 50% reduction
Managed Clinical Network (Restorative)	Restorative dental services are recognised as a fragile service by the ICB and at present there is no funded clinical leadership, unlike Orthodontics, Oral Surgery, Special Care and Paediatric Dentistry. The proposal is to fund a Restorative managed clinical network (MCN) in line with national commissioning guidance to ensure sustainable support the ICB, Provider Collaborative and the Local Dental Network in the commissioning, quality improvement and service transformation of specialist restorative dental services that operate across both secondary care and primary care.	Creation and support for a Restorative Dentistry managed clincial networks	The funding will secure 3 sessions per month for a Restorative MCN Chair to provide clinical leadership in the transformation of restorative services across the ICB.	4	System wide	£7,750	£7,750	£7,750	£7,750	£31,000	1) The approval to suspend external resources into the UHMB Restorative Svs was that an MCN was formed to develop the service collaboratively across the ICB providers	1) The MCN can be implemented and developed. 2) This was a part of the agreement relating to the suspension of referrals to UHMB Restorative.
Expansion of Orthodontic Services	Secondary Care orthodontics is recognised as a fragile service by the ICB. Nationally there is a shortage of consultant orthodontists wanting to work in secondary care, which is contributes to the ICB challenges of being able to provide a resiliant and responsive service. This not only impacts on patient care but also the ICB compliance with RTT guidance. East Lancashire Teaching Hospitals is in a the unique position of being able to expand the secondary care service by employing an additional consultant for 0.7 WTE per week, which would greatly improve the resiliance of the ICB secondary care service offer.	Expansion of Orthodontic Services in ELHT to support the additional consultants activity. Acute Orthodontics has been identified as a fragile services across the ICB - with the workforce recruitment and retention cited as the major cojntributory factor	The job plan for the consultant would be split between Burnley and Blackburn with the consultant providing a full range of secondary care services. The ICB would be in a much better position to progress with its transformation or secondary care orthodontics into a pan ICS service, reducing patient impact felt by long wait times, contributing to support for other trusts where there are significant challenges with gaps in provision and unwarrented longer patient wait times.	5	Acute	£50,000	£50,000	£50,000	£50,000	£200,000	1) The orthondontic service is recognised as being a fragiule service, at risk primarily from workforce capacity	1) Permitting the employment of a further consultant at East Lancashire Hospitals NHSFT will provide further assurance of the services sustainability and resilience into the future.
Non Reccurent Funding for Infrastructure	Modernising the Orthodontic care pathway is key to attracting new clinical talent into the ICB as well as providing a more resiliant service. Integrating primary and secondary care services, allowing consultant patient treatment plans to be delivered primary care by a specialist is an important aspect of reducing pressure in secondary care. Presently patient moulds are taken using a compound that results in a physical model of the patients mouth. Storage and transportation of the models, proves costly and cumbersome when trying to move patient treatment between hospital sites and also primary care. Using intra oral scanners to make a 3D digital image of the patients oral cavity provides instant access to the clinical model of the mouth, that can also be manipulated to formulate rapid treatment plans. Use of this technology is also desirable for consultants chosing clinical posts in secondary care.	Intra oral scanners - One for each hospital department. Supports the modernisation of the orthodontic pathway.	Clinical teams in Trusts will be able to instantly share clinical models of patients mouths to provide rapid decision making between consultants and specialists across Trusts and primary care. It will enable clinicians to work remotely and support orthodontic therapists on sites where there may be gaps in consultant or specialist cover. Space currently used for the storage of physical models will start to be utilised for patient treatment and consultantion. LSC Orthodontic service will be seen by clinicians considering a position in secondary care and working in LSC, will see the LSC seoncdary care services and forward facing when it comes to utilising the latest technology.	6	Acute	£60,000				£60,000		
Surgical Exposure Service for Paediatrics	Presently the only option for children to have cannine exposed prior to orthodontic treatment is by undergong the procedure in secondary care. Lengthy delays in wait times, mean that children are waiting over 12 months before they can start their orthodontic treatment plan. By delivering the exposure in Primary Care, the wait time is greatly reduced and care often delivered closer to home.	Creation of a Tier 2 Paediatric Service to reduce Acute Admissions Values currently estimated - awaiting ELHT notification of the numbers of patients, and a cost per review	This pathway would provider care for approximately 80 children per year. It would reduce the number of children requiring hospital treatment for care, and in turn speed up the orthodontic treatment pathway. Reduction in risk to patients from root resorption and less damaged to roots for children who are waiting many months for treatment, in certain circumstances.	7	Primary Care & Acute	£5,000	£5,000	£5,000	£5,000	£20,000	1) Uncertainty over the net impact on acute activities	1) Implement assuming no net reductions in acute activity, the service being of a higher quality for patients by avoiding hospital attendances where possible
Expansion of Primary Tier 1 service - General Dentist with Special Interests	Restorative dental services are recognised as fragile by the ICB. This investment will support the development of primary care providers to develop closer working relationships with secondary care providers testing the feasibility of restorative patients being fully or partially treated in secondary care under a consultant developed treatment plan.	Expand the numbers of GDP's with Special Interests in Endodontics, Periodontics and Prosthodontics (Quarterly running cost £5k)	Developing a network of GDPs to support secondary care restorative services Enhancing the skills of primary care dental teams Part of the development work will lead to some treatment being delivered in Primary Care Support the recuitment and retention of workforce Better utilisation of skills that exist in Primary Care	8	Primary Care	£0	£2,500	£5,000	£5,000	£12,500	1) Uncertainty of the number of providers 2) Risk of capacity in PFNC to deliver some schemes in a timely manner.	1) Delivery Assurance will seek expressions of interests from across the ICB primary care providers. 2) Replicate existing models implemented for similar programmes.

Sedation Training	Presently there are few providers delivering sedation in Primary Care for anxious patients. The only referral route is into secondary care for extraction under a general anaesthetic (GA). This proposal will develop a network of primary care practices to delivery a full range of mandatory dental services under sedation, for both anxious patients and children, negating the need for secondary care admissions and reducing the present GA wait list in hospital.	Support the expansion of sedation trained dental practice to deliver sedation for anxious patients and paediatrics - reduces the need for GA extractions Annually - 10 practices at £10,500 per practice	Development of the dental team for two dental nurses and one dentist in each practice training for both Inhalation and Intravenous sedation **Benefits** Support the elective care recovery, reducing the admissions for sedation Reduction in secondary care admissions for extractions Recruitment and retention of teams by developing the dental workforce. Faster access to care for patients who are in pain but do not meet the P1 or P2 critera for secondary care.	9	Primary Care	£26,250	£26,250	£26,250	£26,250	£105,000		
Non Reccurent Infrastructure	As part of the elective care recovery program the Managed Clinical Networks (MCNs) for Oral Surgery, Special Care, Paediatrics and Orthodontics have been developing initiatives that reduce the need for patients to attend an acute setting for care. Managing patients in a primary care setting not only frees up capacity in secondary care, thereby reducing the number of patients waiting overall, it also provides a more diverse job role for clinicians in Primary. Linked to this range of initiatives, is the opportunity to utilise a digital advice and guidance module the plugs into the FDS referral system (also developed by FDS). This module has an added benefit as it allows a 'shared care' record to be developed between the dental practice and secondary care provider which further enhanced the ability to reduce the need to visits to secondary care.	Advice and guidance	An outcome of this investment is a foundation that builds on the existing electronic referral platform and will allow: Shared records between Primary and Secondary Care Joint decision making and treatment planning Clinical opinion and guidance for patients who would have previously been referred into secondary care	10		£10,000	£10,000	£10,000	£10,000	£40,000		
MLCSU Programme & Project Management of Secondary Dental Transformation	MLCSU has provided a proposal for supporting the transformation of secondary dental services. The proposal includes detailed support to the Delivery Assurance team with Programme Management and Project Management support to lead on the Transformation of Secondary Dental Services across the ICB.	Progamme and project management support	Programme and project management support to deliver the transformation of fragile secondary care dental services (Orthodontic and Restorative).	11		£52,500	£52,500	£52,500	£52,500	£210,000		1) The proposal has been extended into 2024-25 to mitigate the risk the resources end in March24 and the transformation is not completed.
						£865,000	**£777,500**	**£631,800**	**£631,800**	**£2,906,100**		