Lancashire and South Cumbria Integrated Care Board

ICB Primary Care Commissioning Committee

Date of meeting	8th February 2024
Title of paper	Primary Dental Care Prioritisation Framework
Presented by	Peter Tinson, Director of Primary Care
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Agenda item	5a
Confidential	No

Executive summary

The ICB Board and Primary Care Commissioning Committee have previously agreed to the delivery of the Dental Access and Oral Health Improvement Programme.

One of the key deliverables of the programme is to develop a set of objective measures to help support the prioritisation of resources allocated to improving dental access and reducing oral health inequalities.

This report details the engagement undertaken in the development of the framework and based on the feedback from stakeholders, makes the recommendation to adopt framework with immediate effect.

Advise, Assure or Alert

Assure the committee:

- of the development of the framework informed by stakeholder engagement

Recommendations

The Primary Care Commissioning Committee are asked to note and review the contents of this report and:

- Agreed to the implementation of the framework with immediate effect (subject to any further feedback from PCCC members by the 31 January 2024).

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	
4	Meet financial targets and deliver improved productivity	

5	Meet national and locally determined performance standards and targets	
6	To develop and implement ambitious, deliverable strategies	**X**

Implications				
	Yes	**No**	**N/A**	**Comments**
Associated risks			N/A	
Are associated risks detailed on the ICB Risk Register?			N/A	
Financial Implications			N/A	

Where paper has been discussed		
Meeting	**Date**	**Outcomes**
Various engagement forums		

Conflicts of interest associated with this report
N/A

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

Report authorised by:	Craig Harris, Chief Operating Officer

ICB Primary Care Commissioning Committee
8 February 2024

Primary Dental Care Prioritisation Framework

1 Introduction

1.1 The purpose of this report is to:

- Update the Committee on the progress of developing a resource prioritisation framework to support the distribution of primary care dental and oral health resources.
- To highlight some of the challenges and issues that exist in assembling the data to be used in the framework.
- Seek agreement to adopt the framework to support prioritising the allocation of primary care dental resources.

2 Background

2.1 Access to NHS dental services is a challenge nationally and locally across all sectors, with pressures in primary care services being well publicised. In response to these challenges the Lancashire & South Cumbria Integrated Care Board (ICB) held a Dental Access and Oral Health Improvement workshop in May 2023, where stakeholders were invited to share their views and a programme of work began to emerge.

2.2 The current provision of primary care dental services delegated from NHS England largely reflects the same position that Primary Care Trusts transferred to NHS England in 2013. This is due to the nature of the contracts and how provision was locked into contract agreements when the present dental services legislation was introduced in April 2006.

2.3 Prior to 2006 providers could set up and apply for a cost per item service wherever they wanted. Service delivery was not commissioned in the way we think of commissioning care today, and a demand driven model grew based on footfall and not clinical need. Introduction of the current General Dental Services contract in 2006 fixed the activity in the new UDA based model. Activity became ‘frozen’ based on previous year’s (2005) demand, with GDS contracts running in perpetuity.

2.4 The Dental Access and Oral Health Improvement Programme objective is to address the current challenges facing NHS dental services. One of the programme aims is to improve dental access to members of the population with the greatest oral health inequalities. This can be achieved by using objective measures to help prioritise the limited flexibilities available to the ICB to invest funds in the areas of Lancashire and South Cumbria with the greatest needs. It

must be acknowledged that prioritising resources to those areas of greatest need, may require funds to be diverted to different geographies within the ICB.

2.5 As one of the five projects within the programme, the prioritising resources project team is tasked with the development of a framework through which resources can be prioritised for specific geographies/patient groups based on objective measures or indicators. This project builds on the established Equident[1] toolkit that was developed by dental public health consultants within the North West to support equitable commissioning of dental care services. This approach was shared nationally and published in the British Dental Journal In Practice.(1) Thus, the preliminary stage of this project was to develop a set of indicators to populate the prioritisation framework.

3 Developing the indicators

3.1 The subject matter experts have led the development of the indicator set building on the foundations set out in the Equident toolkit.

3.2 Stakeholders include Consultants in Dental Public Health, the Local Dental Network, the Local Representative Committee and ICB Primary and Integrated Neighbourhood Care Team members.

3.3 The indicators are grouped into broad domains:

- **Access** – Expressed as a percentage of the population who access care using the national access metric.
- **Access Availability** – The value and volume of primary care dental resources that are invested in an area to provide access to dental care**.**
- **Disease Prevalence** – A set of data which gives an indication of the disease burden in a particular geography.
- **Deprivation** – Poor oral health, like many aspects of health are linked to deprivation.
- **Public Health: wider determinants** – Aspects of health which impact on oral health

3.4 Aligned to the principles in Equident the indicators included in the framework had to meet certain specific criteria:

- **Meaningfulness -** the data had to be directly or indirectly relevant to the dimension they represent.
- **Comparability -** in order to allow comparisons between areas, it was essential to be able to arrange the selected indicators in ascending order, thereby enabling ranking.
- **Availability -** the data needed to be available at all levels of the geographical footprint used for benchmarking.

[1] EquiDent - Developing a toolkit to support equitable commissioning of dental care services | BDJ In Practice (nature.com)

3.5 A full list of the indicators and their description is provided in Appendix A.

4 South Cumbria Boundary Change

4.1 At the time of writing, there is an acknowledgement that the boundary changes in South Cumbria mean that dental access figures have not been possible to collate as the newly configured local authority also includes data relating to the north of Cumbria. NHS Business Services Authority (NHSBSA), who process the dental activity data, are keen to try and generate reports based on the legacy pre-April 2023 boundaries that only include South Cumbria geographies. This work is ongoing, and it is anticipated that the data issues will be resolved when NHSBSA have update their datasets.

5 Ranking

5.1 Delegates from the above-mentioned workshop were then invited to rank the indicators, based on priority. The delegates were drawn from across the ICB and external stakeholders, including representatives from:

- Population Health
- Local Authority Public Health Team
- Place based partnership leads
- Healthwatch
- Local Dental Network
- Local Dental Committee
- Urgent dental care providers
- Dental call handling service

5.2 Each delegate was asked to complete the following task:

There are several indicators and metrics that tell us about the populations' dental access rate, how existing resources are distributed, along with information about the population's oral health and demographic data for a range of indictors which impact on oral health.

Please rank the following indicators assigning each a number between 1 and 13, where:

***1** = the indicator that you would **most** like to influence the distribution of resources*

***13** = the indicator you would **least** like to influence the distribution of resource*

5.3 Each indicator rank would then be assigned a score, so that the cumulative score for each indicator would allow the indicators to be then ranked based on the feedback from stakeholders.

6 Engagement with stakeholders

6.1 Stakeholder engagement started on 7th December 2023, and continued up until 26th January 2024. A summary of the responses received is included in Appendix B below.

6.2 Engagement with stakeholders has prompted further interest in dental access and oral health, especially from Place based colleagues who have come into post between the commencement of the programme and this engagement exercise.

6.3 There has been no feedback about the data metrics/indicators used, or suggestions to widen the dataset.

7 Next Steps

7.1 Upon agreement with Primary Care Commissioning Committee, adoption of the framework to support prioritising the allocation of primary care dental resources. This will include feedback to stakeholders of the outcome of the engagement exercise and an annual review of indicators to consider any new data that may be made available to ICBs.

8 Conclusion

8.1 In conclusion the Dental Access and Oral Health Improvement Programme has completed the task of developing a set of objective measures and asked for feedback from a wide range of stakeholders from across the ICB to help support a ranking exercise of the indicators.

9 Recommendations

9.1 See recommendation in cover sheet. The PCCC are asked to note and review the contents of this report and:

- Agreed to the implementation of the framework with immediate effect (subject to any further feedback from PCCC members by the 31 January 2024).

Nick Barkworth

Amy Lepiorz

February 2024

Prioritisation Framework

	Access					Disease							
	Access			Access Availability		Disease Prevelance			Deprivation			Public Health - wider determinants	
	mmm/yy	mmm/yy	mmm/yy	22/23 £s invested per head of population	UDAs per head of population	Child (DMFT)	Urgent Care Calls (% of population)	FP17s for B1 Urgent as precentage of pop (by service/practice)	IMD	Children living in poverty	Older people in poverty	Older adults with a limiting long term health problem (over 65)	Need assistance with at least one self care activity (over 65)
Area	Children	Adult	Over 65										
Barrow-in-Furness													
South Lakeland													
Blackburn with Darwen													
Blackpool													
Burnley													
Chorley													
Fylde													
Hyndburn													
Lancaster													
Pendle													
Preston													
Ribble Valley													
Rossendale													
South Ribble													
West Lancashire													
Wyre													

Indicator Descriptions

Dental Access

The national measure for dental access is the number of patients resident in a geography who have attended a dental practice in the previous 24 months for adults or 12 months children. The figure is a unique count, which means that patients who have attended multiple times will only count once in the given time frame.

Child (0-18yrs)

The percentage of children who have attended a dental practice in the previous 12 months.

Adult (18+yrs)

The percentage of adults (18 years of age and over) who have attended a dental practice in the previous 24 months.

Adult (Over 65yrs)

The percentage of adults (65 years of age and over) who have attended a dental practice in the previous 24 months.

Access Availability

These two availability indicators are calculated by using the information that relates to ICB commissioned primary care dental services in each of localities. This is for routine dental care, and not any of the specialist commissioned pathways. Primary care dental service providers are commissioned to deliver a volume of activity measured in ‘Units of Dental Activity’ or ‘UDAs’ for a fixed contract value.

2022/2023 £s invested in routine dental services per head of resident population

The amount of funding in routine dental service contracts expressed as a £'s per head of population.

UDAs per head of resident population

The number of units of dental activity (UDAs) per head of resident population.

Disease Prevalence

Each of these indicators provide an indication of the level of disease present in each of the geographies.

Prevalence of dental decay in 5-year-olds (dmft)

The dmft (decayed, missing and filled primary teeth) and DMFT (decayed, missing, and filled permanent teeth) are commonly used and valuable indices for determining and monitoring the oral health status of a population. The proportion of a population affected by dental decay as measured by the dmft/DMFT index is used as a standard to compare dental health in many age groups, but is most used for children aged 5, 12, or 15yrs.

The prevalence of dental decay measured by the dmft for 5-year-olds is used within the prioritisation matrix, with data accessed from the sixth National Dental Epidemiology Programme survey of 5-year-old children in England, 2022.

Dental caries is the most common non-communicable disease worldwide, and these indices provide an indication of the levels of poor oral health in a specific area or population. Higher dmft indicates children with more experience of tooth decay and poorer oral health. The dmft index is also linked to levels of deprivation, with children in deprived areas experiencing three times the level of decay, than those in the least deprived areas.

Further details can be found at https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2022/national-dental-epidemiology-programme-ndep-for-england-oral-health-survey-of-5-year-old-children-2022

Urgent Care

Urgent dental care is defined as patients who are in immediate need of support for dental trauma, swelling, bleeding or pain relief. The majority of calls to the ICB

urgent dental care phone line are patients who are symptomatic and in pain. Toothache comes in two main forms, a tooth problem relating to dental decay which can cause severe pain and/or swelling, or a gum problem causing infection pain and swelling. Both are an indicator that there is an incidence of disease in the callers mouth.

Urgent care calls (per 1,000 residents of population)

The ICB commissions a call handling service the books patients into appointments for urgent dental care. The service is available to patients who have an urgent need and cannot current access a dental practice of their own. Many of the callers do not have an ongoing relationship with a dental practice. The service interfaces with '111' and the calls are triaged and mapped to specific geographies.

Urgent courses of dental care (as percentage of population)

When a dental practice treats a patient for an urgent intervention, unless there is follow up care required, they will normally submit a claim for the UDAs associated with a 'Band 1 Urgent' treatment. This data is made available to the ICB from NHSBSA and can be mapped to the patients post code.

Deprivation

Index of Multiple Deprivation (IMD)

This is the main Index of Multiple Deprivation (IMD) summary measure. It is presented as a score and is a weighted average of the seven IMD domains: Income Deprivation, Employment Deprivation, Health Deprivation and Disability, Education Skills and Training Deprivation, Barriers to Housing and Services, Living Environment Deprivation, and Crime. The more deprived an area, the higher the IMD score.

This data is from the Department of Levelling Up, Housing & Communities. Further detail on IMD can be found at the following link: https://www.gov.uk/government/collections/english-indices-of-deprivation

This indicator is included as there is clear evidence of the link between levels of deprivation and poor oral health in both adults and children. Those from deprived areas are disproportionately more affected by dental disease, have higher rates of hospital admissions for tooth decay in children aged 6-10, and poorer uptake of general dental services than those from less deprived areas.

Children in Poverty: Income Deprivation Affecting Children Index (IDACI)

This indicator is a measure of children living in poverty. The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0-15years living in income deprived families.

This data was published in 2019 and is sourced from the Ministry of Housing, Communities and Local Government. Further information regarding the IDACI can be found at: https://www.gov.uk/government/collections/english-indices-of-deprivation-2019

Growing up in poverty is harmful to children's health and well-being, adversely affecting their future health and life chances. A considerable body of evidence links deprivation during childhood to both poor child oral health outcomes and future poor adult oral health.

Older people in poverty: Income deprivation affecting older people Index (IDAOPI)

This indicator is a measure of older people living in poverty. The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation. It is a subset of the Income Deprivation Domain which measures the proportion of the population in an area experiencing deprivation relating to low income.

This data was published in 2019 and is sourced from the Ministry of Housing, Communities and Local Government.

Although there are no national targets the Government aims to tackle poverty and promote greater independence and well-being in later life. People living in more deprived areas have a greater need for health services, with evidence identifying poorer oral health in areas of higher deprivation.

Public Health - wider determinants

Older adults with a limiting long-term health condition

This indicator is a measure of all older adults over the age of 65 years, with a limiting long-term health condition, which limits day to day activities. This is expressed as a proportion of the entire over 65 years population.

This data is from 2023 and is extracted from the POPPI database (Projecting Older People Population Information). Figures are taken from the Office for National Statistics (ONS) 2011 Census, with projections calculated by applying percentages of people with a limiting long-

term illness in 2011 to projected population figures. More information can be found at: https://www.poppi.org.uk/

There is evidence to suggest a link between long-term health conditions in older adults and poorer levels of oral health. Furthermore, having a long-term health condition can also lead to limitations and barriers in accessing dental care services, in terms of mobility and the ability to attend dental appointments.

Older adults: need assistance with at least one self-care activity

This indicator is a proportional measure of the total population aged 65 and over who need help with at least one self-care activity. These include activities such as: dressing; washing hands and face; eating, including cutting up food; taking medicine; getting in and out of bed. Whilst toothbrushing is not specifically listed as one of the activities, it can be inferred that this population would likely demonstrate difficulties with oral self-care.

This data is from the POPPI database (Projecting Older People Population Information). Figures are taken from the Health Survey for England 2016: Social care for older adults (2017) NHS Digital. More information can be found at: https://www.poppi.org.uk/

Reduced ability to manage self-care tasks is linked to poorer oral health in older adults. This may be due to limited manual dexterity and mobility affecting toothbrushing activities leading to increased risk of tooth decay and gum disease, and/or a poorer diet, which predisposes to dental decay

Outcome of Engagement

Of the 55 stakeholders from across the ICB who were invited to rank the indicators, 18 stakeholders responded. The responses were received from Local Authority representatives, colleagues in Population Health, Healthwatch, Primary Care GP, Dentists/Therapist, ICB dental commissioning team.

The results of the ranking exercise are below, with any comments received from stakeholders detailed.

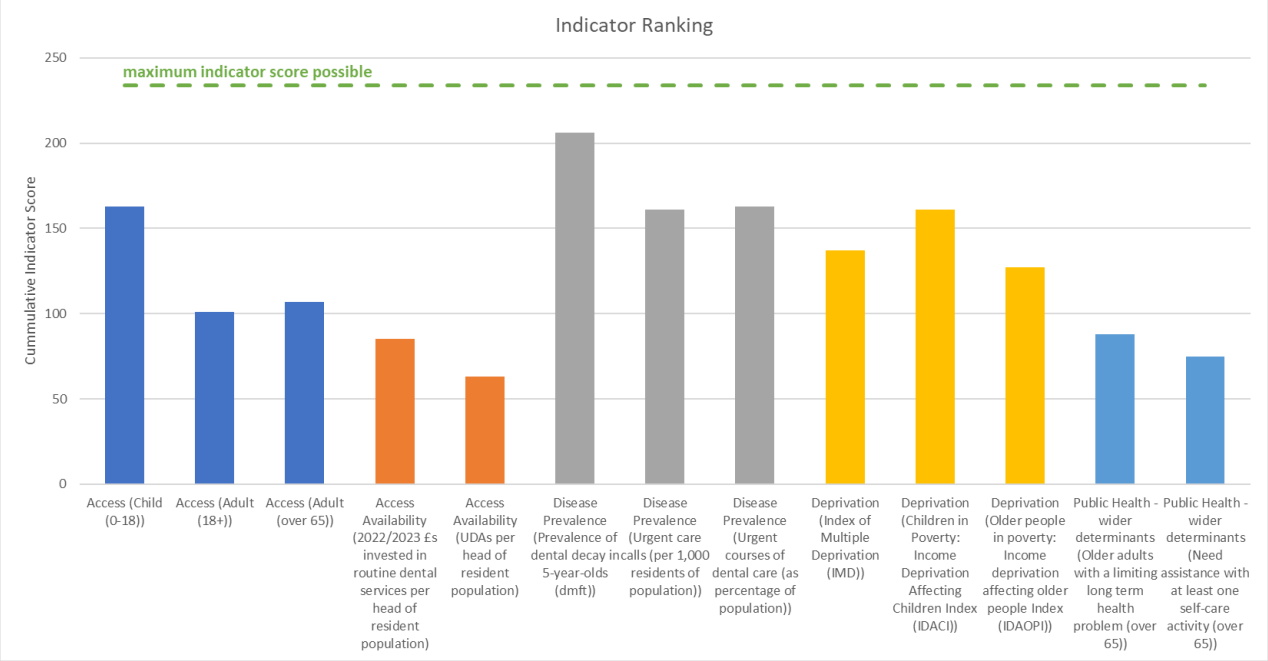

Chart 1: Indicator scores

Indicator	Score
Access (Child (0-18))	163
Access (Adult (18+))	101
Access (Adult (over 65))	107
Access Availability (2022/2023 £s invested in routine dental services per head of resident population)	85
Access Availability (UDAs per head of resident population)	63
Disease Prevalence (Prevalence of dental decay in 5-year-olds (dmft))	206
Disease Prevalence (Urgent care calls (per 1,000 residents of population))	161
Disease Prevalence (Urgent courses of dental care (as percentage of population))	163
Deprivation (Index of Multiple Deprivation (IMD))	137
Deprivation (Children in Poverty: Income Deprivation Affecting Children Index (IDACI))	161
Deprivation (Older people in poverty: Income deprivation affecting older people Index (IDAOPI))	127
Public Health - wider determinants (Older adults with a limiting long term health problem (over 65))	88
Public Health - wider determinants (Need assistance with at least one self-care activity (over 65))	75

Table 1: Indicator scores

As evident from the responses received, stakeholders felt strongly that disease prevalence and deprivation should be considered ahead of access availability, access rates and wider determinants of health, except for child access rates which also scored highly.

Indicator	Score
Disease Prevalence (Prevalence of dental decay in 5-year-olds (dmft))	206
Access (Child (0-18))	163
Disease Prevalence (Urgent courses of dental care (as percentage of population))	163
Disease Prevalence (Urgent care calls (per 1,000 residents of population))	161
Deprivation (Children in Poverty: Income Deprivation Affecting Children Index (IDACI))	161
Deprivation (Index of Multiple Deprivation (IMD))	137
Deprivation (Older people in poverty: Income deprivation affecting older people Index (IDAOPI))	127
Access (Adult (over 65))	107
Access (Adult (18+))	101
Access Availability (2022/2023 £s invested in routine dental services per head of resident population)	88
Public Health - wider determinants (Older adults with a limiting long term health problem (over 65))	88
Public Health - wider determinants (Need assistance with at least one self-care activity (over 65))	75
Access Availability (UDAs per head of resident population)	63

Table 2 : Indicator scores sorted from highest to lowest

Comments from stakeholders

Stakeholder 1

I have put prevalence of dental disease in 5 yr olds as my number 1. We have been seeing increased amounts of caries in young children which are requiring extractions as the teeth are not restorable. My feeling is that we need to make sure that there is unlimited access for children so that we can deliver a sound preventative message and provide evidence based preventative measures such as fluoride varnish.

We do need to get to these children and their parents and that would include having enough resources to get the message into the population outside of the dental practice. Obviously good access to the dental practice is needed. If we can reduce the number of children with dental disease then the war can be won to bring those children into adulthood with reduced needs for treatment.

We do need to improve general access to dental care, however it will always be a challenge due to the level of funding. The workforce is the key to access and we need more health professionals in dental practice. Unless funding is available to make working in the NHS more attractive then we will continue to lose to the private sector. I mean by attractive that the working conditions are better, not just the income, which needs more people at the coal face.

Stakeholder 2

Ranked below from a pop health perspective. The logic being:

- *Understand prevalence first.*
- *Then understand current access.*
- *Then allocation of resource (UDAs etc.)*
- *Then wider factors*

Seeing regular data on all 13 would be good.

Stakeholder 3

Please note that the ranking was considered based on patient experience examples from the Blackpool Community.

With regards to the UDA ranking, it must be noted that this is something that we strongly support in terms of a reform.

Stakeholder 4

Thank you for your paper. What I would like to see is some context about the efficacy of dental intervention and an evidence base to illustrate what the most effective method of intervention might be. Also there does not appear to be any separation of the discussion between prevention and treatment which will be a determining factor in the allocation of resources.

Finally I do not see any reference to environmental interventions such as fluoridation of water in preventing tooth decay particularly in younger persons.

Response to Stakeholder 4

Many thanks for the reply, which touches on some of the national conversations happening at present. I'm going to try and answer the best I can, however some of the areas you have highlighted are outside of the primary care remit and lie with Directors of Public Health in our local authorities. I have consulted with our NW Consultant in Dental Public Health in drafting this response too.

The paper was intended to detail the additional steps that the primary care dental team are taking to collaborate with colleagues from in the ICB and wider in developing an evidence base through which objective measures are used to inform commissioning decisions.

The paper is based on the current published Equident tool which was developed by NW NHSE Consultants in dental public health. It is the first national tool available to support dental commissioners to review their commissioning of General Dental Services through a health inequalities lens . There are specific commissioning guides available for commissioning of specialist dental services, which sit outside General Dental Services contracts.

This paper has taken the principles in Equident and used a collaborative "virtual approach" with stakeholders from the original dental access workshop to gain insight into their views regarding prioritising the measures that should be used for reviewing provision of General Dental Services.

General Dental Services all include prevention at an individual level, usually delivered while the patient is in the chair. With the exception of water fluoridation, prevention at community level is a statuary responsibility of Local Authority colleagues. However we are keen to enable dental practice teams deliver care in a more integrated fashion.

There are defined evidence bases for oral health community prevention programmes, based upon PHE 'Return Of Investment tool 2015'. A priority matrix planning tool 'IDEA' has recently been developed to enable them to plan their programmes too.

Going forward, one could consider using both Equident and IDEA , to engage on a future joint initiative between dental services commissioning and wider partner for funding and implementing of at scale system wide prevention programme. This process has occurred in neighbouring ICSs via the Population Health Team, Consultant in Dental Public Health and leads for dental commissioning.

I hope this response provides you with additional information to clarify the approach taken in the paper.