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# 2U Dental

## 21<sup>st</sup> Century Mobile Dentistry in Care Homes

How Clinical Innovation and Team  
Logistics Elevate Quality of Care

 BANNING  
DENTAL GROUP

Flexident  
*Mobil Tandvård*

 dentify<sup>®</sup>



Initiating the  
launch of 2U Dental  
services in the UK



# 21<sup>st</sup> Century Mobile Dentistry in Care Homes:

## How Clinical Innovation and Team Logistics Elevate Quality of Care

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# Executive Summary

Oral health in UK care homes is undergoing a critical transition. Regulatory bodies, families, and care providers increasingly recognise that oral health is not peripheral, but a fundamental to safety, wellbeing, and quality of life. Yet despite clear expectations set out by CQC and NICE NG48, many care homes struggle to secure regular, high-quality dental provision. The result is a persistent gap between mandated standards and practical delivery.

A modern, 21st-century solution must go beyond sporadic dental visits. It must integrate clinical excellence, digital workflow, logistics optimisation, and multidisciplinary oversight into a single, coherent care model.

This report outlines how the 'BFD model' can be delivered through the combined strengths of:



**The Banning Dental Group**, offering specialist-led, digital-first clinical excellence rooted in modern, evidence-based, multi-specialty dentistry.



**Flexident AB** (Sweden), demonstrating over 15 years of operational success in scalable, systematised mobile dentistry across eldercare settings.



**Dentify**, providing the digital infrastructure necessary for scheduling, triage, record-keeping, compliance, and reporting at scale.

Together, these components form a 21st-Century Mobile Dentistry Architecture capable of meeting (i) regulatory requirements, (ii) improving clinical outcomes, (iii) reducing emergency admissions, (iv) supporting care-home staff, and (v) delivering transparent, inspection-ready documentation.

The BFD model is more than a service – it is a sustained clinical partnership model that aligns with the future of integrated, preventative healthcare.

The evidence is clear: early intervention, on-site access, and consistent clinical oversight reduce risk, enhance resident comfort, strengthen family confidence, and lead to better CQC outcomes.

This report sets out the rationale, international benchmarks, clinical framework, digital backbone, and operational model needed to transform oral healthcare for one of the UK's most vulnerable populations.

2U Dental with the integrated BFD model stands ready to deliver that transformation, combining innovation with clinical rigour and system-level thinking to redefine what mobile dentistry can achieve in the UK care-home sector.

# 1 | Introduction:

## Why a Modern Oral Care System in Care Homes Is Needed

Oral health is inseparable from general health, yet it remains one of the most overlooked dimensions of care-home medicine/care.

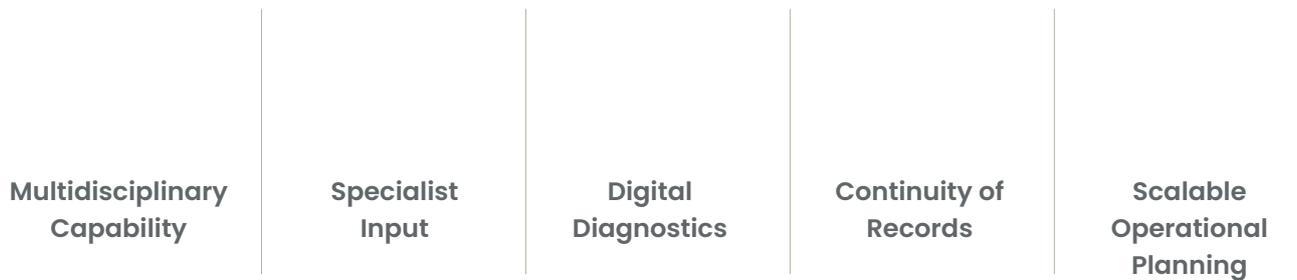
Residents face elevated risks of:

- Chronic oral infections
- Pain, discomfort, and malnutrition
- Reduced ability to communicate
- Increased risk of hospitalisation

- Poor quality of life

The UK’s care-home sector, currently caring for over 400,000 residents and on upwards trajectory, continues to struggle with a fragmented, low-capacity oral care infrastructure. Dentistry has historically been based on clinic attendance, yet frail, bedbound or cognitively impaired residents cannot simply be transported to a practice.

Traditional mobile dentistry, meanwhile, lacks:



The result is a persistent gap between what regulation mandates, what homes need, and what current providers deliver.

**A 21st-century mobile dental system must therefore achieve three outcomes simultaneously:**

1. Meet and evidence CQC and NICE NG48 compliance
2. Provide clinically excellent, specialist-supported care onsite
3. Operate with the logistics, digital infrastructure, and scalability of a modern healthcare service

This report outlines how an integrated care architecture, combining Banning Dental Group’s clinical excellence, Flexident’s proven mobile model, and Dentify’s digital-engine platform, can deliver the standard of dental care that residents deserve and regulators increasingly expect.





## 2 | The Regulatory Imperative

(CQC and NICE NG48)

The regulatory landscape is unambiguous: care homes must ensure that every resident receives appropriate oral health assessment, care planning, and access to treatment.

### 2.1 NICE NG48

(Oral Health for Adults in Care Homes)

- › NG48 mandates that care providers must:
- › Assess each resident's oral health at admission
- › Create an individualised oral health plan
- › Provide daily oral care, delivered by trained staff
- › Enable timely access to dental treatment
- › Manage urgent and emergency pathways appropriately
- › Maintain documentation and monitoring over time

Homes must evidence not only activity, but quality, consistency, and outcomes.

## 2.2 CQC's interpretation

CQC inspectors now routinely assess:

- ✔ Whether oral health plans are in place and followed
- ✔ Whether oral care training has been delivered and refreshed
- ✔ Whether there is escalation for pain, infection, broken teeth, or denture problems
- ✔ Whether oral health is included in multidisciplinary reviews
- ✔ Whether care homes maintain secure, auditable records
- ✔ Whether homes can demonstrate access to dental services

Where failings are found, CQC increasingly cites breaches under:

- Safe (*S1, S2*)
- Effective (*E1, E2*)
- Responsive (*R1*)
- Well-led (*W2*)

## 2.3 The CQC Single Assessment Framework (SAF 2023):

A New Regulatory Lens for Oral Health

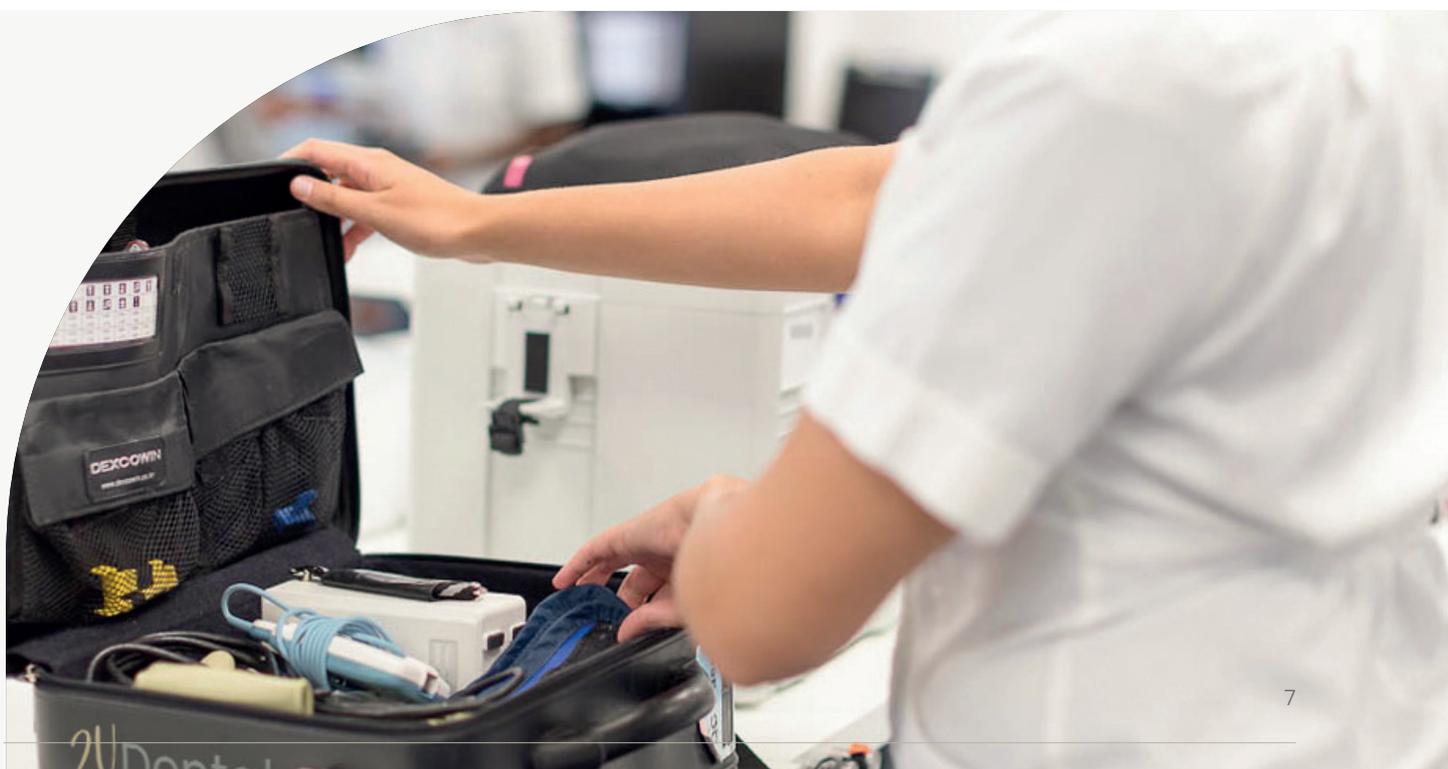
In November 2023, the Care Quality Commission introduced its Single Assessment Framework (SAF), replacing the previous Key Lines of

Enquiry (KLOEs) model with a more dynamic, experience-based approach to regulating health and social care services.

The SAF retains the five familiar inspection domains: **Safe, Effective, Caring, Responsive, and Well-led** whilst also introducing two significant shifts:

- 1** A stronger focus on lived experience, articulated through 'I statements' that express what people should feel and expect from good care.
- 2** A new set of 'Quality Statements', which specify what providers must consistently demonstrate to deliver safe, person-centred, and well-led services.

This new framework has substantial implications for oral health provision in care homes.



### 2.3.1 Why the SAF Makes Oral Health More Visible Than Ever

The SAF embeds oral health expectations across all five domains rather than confining them to isolated criteria. Poor oral care – pain, infection, denture problems, lack of access to treatment, now has potential to affect a home’s rating under:

<b>Safe</b>	Are risks prevented, recognised, and managed? Are treatments safe? Are staff trained to deliver care properly?	Example: A resident’s untreated oral infection or unsafe denture use now impacts the ‘Safe’ judgment.
<b>Effective</b>	Is evidence-based practice delivered? Do services communicate well? Do people receive coordinated care?	Example: A resident’s untreated oral infection or unsafe denture use now impacts the ‘Safe’ judgment.
<b>Caring</b>	Are systems, governance, and partnerships effective?	Example: Leadership must demonstrate oversight of oral health pathways, training, incident management and partnership with dental services.
<b>Responsive</b>	Are services flexible, personalised, and able to meet changing needs?	Example: Homes must show that oral care needs are identified, responded to promptly, and reviewed over time.
<b>Well-Led</b>	Are systems, governance, and partnerships effective?	Example: Leadership must demonstrate oversight of oral health pathways, training, incident management and partnership with dental services.

In short, oral health is no longer a care sub-theme but a cross-cutting determinant of overall quality.

### 2.3.2 ‘I Statements’: What Residents Should Experience

Pages 6–15 of the SAF make clear what matters to people living in care homes. Residents should:

“Feel safe and understand their health problems.”

“Be involved in decisions about their treatment.”

“Receive care from skilled staff who know their needs.”

“Get help quickly when things go wrong.”

All of these experiences rely heavily on consistent oral care assessment, early intervention, clear communication, and rapid access to professional dental support.

**For example:**

A home without a dental partner cannot ‘provide skilled support for changing health needs’.

A resident with ill-fitting dentures struggling to eat cannot be receiving ‘person-centred, dignified care’.

A resident with dental pain who cannot express discomfort cannot ‘feel safe’.

The SAF therefore makes unmet oral health needs far more visible during inspections.

### 2.3.3 Quality Statements: What Providers Must Demonstrate

Each domain includes Quality Statements describing the behaviours, systems and evidence that services must demonstrate.

#### The SAF requires homes to

- Ensure safe equipment and clinical interventions (*e.g. denture hygiene, management of oral infections*). (Page 8)
- Have enough staff with the right skills to meet residents' health needs, including oral care. (Page 8)
- Use evidence-based practice and maintain clinical oversight. (Page 10)
- Provide accessible information and clear communication with other services, including dental providers. (Pages 9–10, 13–15)
- Learn from incidents and feedback and demonstrate continuous improvement. (Pages 7, 16)

#### These statements directly align with:

- Regular dental assessments
- Specialist-led care planning
- Documented oral hygiene support
- Digital reporting and escalation pathways
- Partnership frameworks with on-site dental services

A home cannot fully meet the Quality Statements if oral health is neglected or if dental access is sporadic or unavailable.





### 2.3.4 How the BDF Model Supports SAF Compliance Across All Domains

The SAF shifts expectations from episodic inspections to continuous evidence generation. This is precisely what the integrated Banning–Flexident–Identify (BFD) model provides:

- **Safe:** specialist-led risk management, digital documentation, infection control, equipment standards.
- **Effective:** evidence-based dentistry, multidisciplinary planning, clear communication with GP/pharmacy/clinical teams.
- **Caring:** pain reduction, respect for dignity, resident-centred planning, dementia-sensitive practice.
- **Responsive:** timely triage, consistent visit schedules, flexible escalation and follow-up.
- **Well-Led:** governance frameworks, audit trails, training logs, continuous improvement data.

## 2.4 The compliance-to-care gap

Most care homes want to comply but face real barriers:

- Local dentists unable or unwilling to visit
- Long NHS waiting lists
- No specialist capability for complex cases
- Poor continuity of care due to provider turnover
- Lack of digital systems
- Workforce shortages limiting daily oral care consistency

A compliant system must therefore provide:

- ✔ Regular onsite dentistry
- ✔ Clear audit trails
- ✔ Clinically led reporting
- ✔ Staff training
- ✔ Treatment pathways for all levels of complexity

Mobile dentistry, when properly architected, is uniquely positioned to fill this gap.

# 3 Clinical Evidence: Gaps, Risks & Outcomes

## 3.1 Clinical Risks

Care-home residents often live with multiple comorbidities, dependence on others for daily activities, and altered cognitive function. When oral disease progresses untreated, it results in chronic and sometimes severe pain and, pain that many residents cannot clearly articulate.

This discomfort leads to reduced willingness or ability to eat, contributing to weight loss, dehydration, and nutritional decline. Oral bacteria enter the respiratory tract more readily in frail residents, significantly increasing the risk of aspiration pneumonia, a leading cause of preventable mortality in care homes.

Furthermore, untreated caries and periodontal disease frequently escalate into acute infections, requiring hospital admissions, intravenous antibiotics, or emergency surgical intervention. Beyond these physical impacts, chronic oral pain can worsen behaviour, mood instability, or confusion in residents with dementia, compounding cognitive decline and increasing carer burden.

## 3.2 System Risks

In the absence of structured dental pathways, care homes face operational instability. Residents may wait months or even years for routine appointments, pushing dental issues into emergency territory. Homes must then rely on overstretched GP services, community dental services with long backlogs, or crisis-driven hospital referrals.

This reactive pattern increases 'safeguarding exposure', as unresolved oral pain or visible deterioration is increasingly treated by inspectors as neglect rather than an

unavoidable limitation of the NHS system. Complaints from families escalate when residents experience discomfort or repeated infections without clear plans for intervention.

Additionally, the lack of dental continuity undermines the home's ability to demonstrate safe, proactive care during CQC inspections. Documentation becomes inconsistent, fragmented, or absent-making with 'Well-led' and 'Effective' domains particularly vulnerable.

## 3.3 Workforce Pressures

Carers are essential to maintaining oral health, yet many report feeling under-equipped for this responsibility. Oral hygiene tasks can be challenging, especially when residents resist care or experience agitation.

Without proper training, staff may avoid these tasks or perform them inconsistently, leading to deterioration even in residents without active disease. Carers often struggle to judge when an oral problem warrants escalation, resulting either

in over-escalation (adding avoidable pressure on healthcare systems) or under-escalation (leading to preventable harm).

This workforce pressure is compounded by high turnover, meaning oral care competence can vary significantly across shifts or between one month and the next. Homes with no external dental partner often try to manage these challenges alone but lack the clinical oversight to guide and support staff effectively.

### 3.4 Outcomes from Structured Programmes

When care homes implement a structured mobile dental programme, combining regular onsite visits, digital documentation, specialist backup, and staff training, the improvements are notable. Residents experience better oral hygiene, fewer infections, and more stable dentition. Homes report fewer emergency hospital admissions and faster resolution of dental issues.

Staff confidence increases because they are supported by clear assessment pathways, escalation procedures,

and training refreshers. Families also respond positively when they see visible improvements in a resident's comfort, nutrition, and wellbeing. Importantly, homes achieve stronger CQC inspection outcomes because oral health becomes a clearly documented, auditable part of the care model rather than an afterthought.



## 4 | International case study: Flexident AB (Sweden)

### 4.1 Mobile Dental Care in Stockholm – Providing Accessible Oral Healthcare for Vulnerable Populations

Mobile dental care in Stockholm plays a crucial role in ensuring access to oral healthcare for some of society's most vulnerable individuals. Flexident's service is specifically designed to reach elderly, multi-morbid patients and individuals with physical and/or psychological disabilities who, due to their health status or functional limitations, have significant

difficulties attending a conventional dental clinic. By delivering dental care directly in patients' own homes or in residential care facilities, the aim is to provide continuity, safety, and high-quality oral healthcare to patients who would otherwise risk being excluded from regular dental services.

### Patient Population and Care Needs

The majority of patients are elderly and medically compromised, often suffering from multiple chronic conditions. Many have varying degrees of cognitive impairment, including dementia diagnoses ranging from mild memory deficits to severe dementia with pronounced personality changes, agitation, or aggressive behaviour. These conditions frequently complicate both communication and cooperation during dental examinations and treatments.

A large proportion of patients are dependent on caregivers or healthcare staff for activities of daily living (ADL), particularly for maintaining adequate oral hygiene. As a result, oral health is often neglected over time, especially during periods of declining general health or hospitalisation. Many patients have experienced long interruptions in dental care, which significantly increases the risk of advanced oral disease.

### Scope and Organisation of the Mobile Dental Unit

Flexident's mobile dental unit consists of a team of 12 dentists working closely with dental hygienists and support staff. Each year, the team performs approximately 8,000 basic dental examinations within the mobile service, in addition to more extensive diagnostic assessments and urgent examinations due to acute dental problems.

These examinations include both returning patients with an established dental history and a substantial number of newly registered patients. For every examination, radiographic diagnostics are performed as needed, with the extent determined by the patient's dental and medical status. Approximately 70% of patients require complementary radiographic examinations beyond those included in a standard basic examination. Overall, around 65–70% of patients are assessed as being in need of extensive dental treatment, infection control measures, or follow-up radiographic evaluations after major interventions.

### Common Diagnoses

**The most frequently observed diagnoses during examinations include:**

- Dental caries
- Periodontitis and peri-implantitis
- Gingivitis and peri-implant mucositis
- Extensive crown and root fractures
- Retained root fragments
- Teeth with apical pathology and/or fistulas

These conditions are particularly prevalent among newly registered patients who have lacked regular dental care for extended periods, often coinciding with rapid deterioration in general health.



### Treatment Philosophy and Clinical Approach

The primary objective of treatment is to address acute and symptomatic conditions and to perform care that cannot be postponed. A secondary, equally important goal is to eliminate or reduce sources of infection and discomfort, thereby maintaining patients in a stable, infection-free state and minimising future risks.

Due to medical fragility, limited cooperation, or cognitive impairment, many patients are unable to undergo comprehensive dental rehabilitation in a single course of treatment. Instead, treatment is often divided into

multiple phases. For example, during the first year, the most severely compromised teeth may be extracted, while remaining teeth are either temporarily restored or monitored to preserve chewing function for as long as possible. Further extractions or definitive treatments may then be performed during subsequent treatment periods.

Among newly enrolled patients, extensive dental sanitation is common, whereas only a small minority require no treatment beyond regular visits with a dental hygienist.

#### Clinical Activity and Treatment Volume (2025)

During 2025, the mobile dental unit performed approximately:

**5,500** basic dental examinations | **6,000** permanent restorative treatments (excluding temporary restorations)

**530** treatments involving new full or partial dentures | **1,500** non-surgical tooth extractions | **880** repairs or adjustments of existing dentures

Approximately **40** root canal treatments | Approximately **11,000** dental hygienist procedures for prophylaxis or mechanical cleaning

**3,300** complementary radiographic examinations, of which **around 2,900** were extensive radiographic assessments

These figures reflect only treatments performed within the mobile dental unit and do not include patients referred to fixed clinics for more advanced or complex procedures.

### **Long-Term Impact and Importance of Continuity**

Although it is not always possible to completely halt the progression of caries or periodontal disease, long-term experience has clearly demonstrated that regular and recurring visits significantly improve oral health outcomes. Many patients are able to retain their natural teeth and chewing function for substantially longer periods through continuous monitoring, preventive care, and early intervention.

The importance of continuity became particularly evident during the COVID-19 pandemic, when home visits were suspended for extended periods. During this time, numerous patients deteriorated rapidly, in some cases transitioning from being fully dentate to having only root remnants. This resulted in the need for additional sanitation procedures and the provision of removable dentures.

By maintaining regular dental contact, oral problems can be detected and treated at an early stage, before they escalate in severity and complexity. Most patients typically require one or two major sanitation phases before transitioning into a maintenance phase, characterised by preventive care and minor operative interventions. This approach allows many patients to avoid extensive dental treatment in the future, except in cases of acute need.

### **Conclusion**

Mobile dental care in Stockholm is an essential component of equitable healthcare delivery. By adapting dental services to the needs and limitations of vulnerable populations, Flexident is able to preserve oral function, reduce pain and infection, and improve quality of life for patients who would otherwise face significant barriers to dental care. Continuous, patient-centered, and flexible care remains the cornerstone of Flexident's work.

## 4.2 Case Summary/Observations

### Patient Population and Care Needs

Sweden's elder oral-health infrastructure is built on the premise that dental care is not optional but a core component of healthcare for older adults. Local authorities partner with a dental provider like Flexident to deliver preventative examinations, hygiene support, and treatment directly within care settings.

This approach embeds dentistry into the wider health and social-care system, enabling early detection of deterioration and ensuring consistent oversight. Homes do not rely on sporadic external visits; instead, dental professionals are integrated into the resident's ongoing healthcare journey, which results in better continuity, faster intervention, and more reliable long-term outcomes.

### Operational Efficiency

Flexident has refined the operational mechanics of mobile dentistry over more than a decade. Their model incorporates sophisticated route planning, allowing clinicians to serve multiple care homes efficiently in a single day while maintaining adequate time at each site for high-quality assessments and treatments. Standardised transportable equipment ensures predictable workflows, minimising delays caused by variable home environments.

By aligning visit frequency with clinical need and regulatory expectations, Flexident achieves a balance between cost efficiency and clinical reliability - something the UK currently lacks. Their operational discipline demonstrates that mobile dentistry can be delivered at scale without compromising care quality.

### Workforce Innovation

Flexident's workforce model reflects an understanding that oral health cannot rest solely on occasional clinician visits. Hygienists, dental nurses, and trained carers all play defined roles within the system. Hygienists manage much of the preventative work and routine reviews, freeing dentists to focus on complex or specialist-led interventions.

Meanwhile, carers receive structured training to support daily oral hygiene tasks and recognise early signs of disease or discomfort.

By distributing responsibility across multiple roles, Sweden reduces clinical risk, avoids bottlenecks, and ensures that oral care is maintained between professional visits - a model particularly relevant to high-dependency UK residents.

### Lessons for the UK

The Swedish experience demonstrates that mobile dentistry only becomes effective when supported by a system, not merely a service. The UK can adopt these principles without large-scale restructuring: integrating digital pathways, building specialist-led oversight, and deploying consistent visit schedules. A shift from 'call us when there's a problem' to 'we proactively manage oral health' would align with CQC expectations while improving resident outcomes.

The Flexident case study also shows that sustainability requires predictable workflows, specialist collaboration, and training integration - elements at the heart of the BFD architecture.

# 5 | The 21<sup>st</sup> – Century Care Delivery Architecture

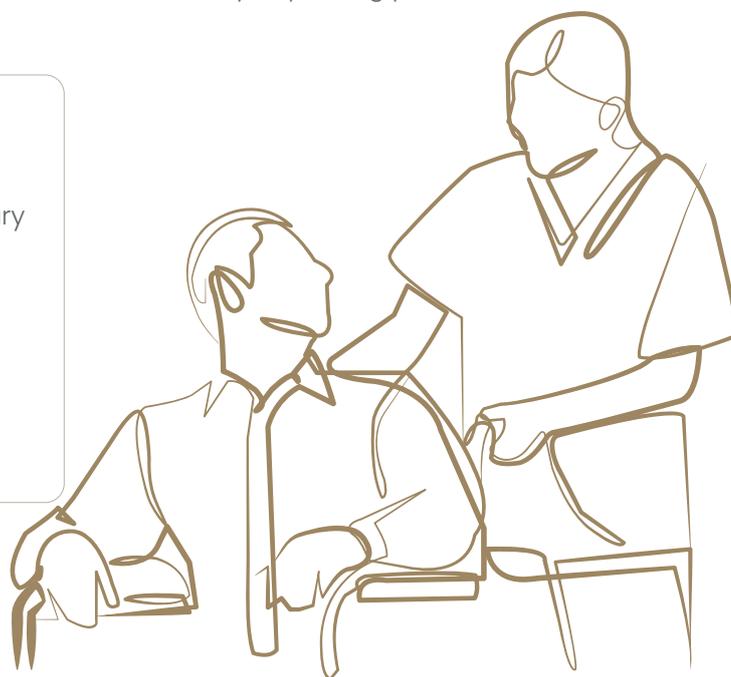
## An Integrated Innovation Stack

Modern mobile dentistry in care homes requires more than a visiting clinician; it requires a co-ordinated clinical, digital and logistical architecture. The 21st-Century model emerging through the collaboration of Banning Dental Group, Flexident, and Dentify represents a significant step-change from historical 'in-out' mobile dental visits.

What makes this architecture modern is not merely that it brings dentistry to the care home, it is the alignment of standards, technology, and operational discipline, designed to meet the regulatory expectations set by CQC and NICE NG48 while materially improving patient outcomes.

### At its core, this BFD architecture combines:

- ▶ Clinical excellence and multidisciplinary capability (*Banning*)
- ▶ A proven mobile delivery model at scale (*Flexident Sweden*)
- ▶ A digital workflow and logistics engine optimised for care-home environments (*Dentify*)



## 5.1 Clinical leadership as the foundation

Banning Dental Group has redefined the expectations of what a modern dental provider can deliver. Their model is 'Scandinavian in style', emphasising space, comfort, digital workflows, affordability,

and multidisciplinary excellence. This is not cosmetic branding; it is a clinical operating philosophy that directly supports the level of care required in complex environments like care homes.

## 5.2 Multidisciplinary treatment capability

### Care-home residents often present with:

- Polymorbid health conditions
- Polypharmacy interactions affecting oral health
- Increased prevalence of periodontal disease, caries, oral infections
- Cognitive impairment affecting communication and consent

These cases require multiple specialisms. Banning's system is explicitly built around GDC-registered specialists across all major domains: periodontics, oral surgery, prosthodontics, orthodontics, and endodontics. This is precisely the level of capability needed to meet NG48 guidance on prevention, urgent care pathways, and treatment planning

### 5.3 Digital-first workflow

Modern mobile dentistry requires digital workflow to function effectively and safely. Banning's practices are fully digital, equipped with the advanced technologies needed to:

- Capture high-resolution diagnostics through intraoral imaging
- Enable remote specialist input
- Operate cloud-based treatment planning
- Support multi-practice coordination

The philosophy emphasises the heavy investment in advanced digital equipment and the challenges of importing EU-standard technology into UK clinical settings. These are not generic capabilities - they are critical for:

- Reducing clinical error
- Improving transparency with care staff
- Maintaining continuous patient records
- Ensuring continuity between mobile visits

### 5.4 Logistics and workflow optimisation (Dentify)

Dentify's platform introduces:



Digital scheduling



Real-time reporting



Workflows for consent, triage and record-keeping



Audit trails aligned to CQC expectations



Integration with GP/Pharmacy/Carer workflows

**This is the missing layer in the UK:** the ability to turn clinical capability into a reliable, scalable delivery system across hundreds of care homes.

### 5.5 Flexident's operational blueprint

Flexident AB Sweden provides between 15 and 20 years of operational evidence that mobile dentistry can operate at scale, sustainably, and with high regulatory compliance.

The Swedish model demonstrates:



Cost-effective delivery



Optimised routing and time-per-patient



Integration with social care teams



Data-driven quality metrics

This model underpins the operational design of the BFD Model.

# 6 | A New Clinical Excellence Model

Mobile dentistry for care homes cannot rely on traditional general dentistry. The needs are more complex, the risks are higher, and the regulatory environment more demanding. The Banning–Flexident–Dentify (BFD) architecture provides a blueprint for a clinical excellence model that elevates standards across the entire mobile pathway.

## 6.1 A philosophy of modern, patient-centred dentistry

Banning describes itself as aiming to ‘change the face of modern dentistry,’ providing an experience that is comfortable, spacious, digital, and affordable.

**This same philosophy sits at the core of 2U Dental’s mobile proposition for vulnerable residents who historically have been:**

- Under-served
- Over-looked
- Left in reactive rather than preventative care pathways

The clinical excellence model takes this philosophy and adapts it to the constraints and realities of the care-home environment.

## 6.2 Multidisciplinary clinical planning

A standout feature of the BFD clinical excellence model is its multidisciplinary approach, where specialists collaboratively plan treatment. The interview highlights:

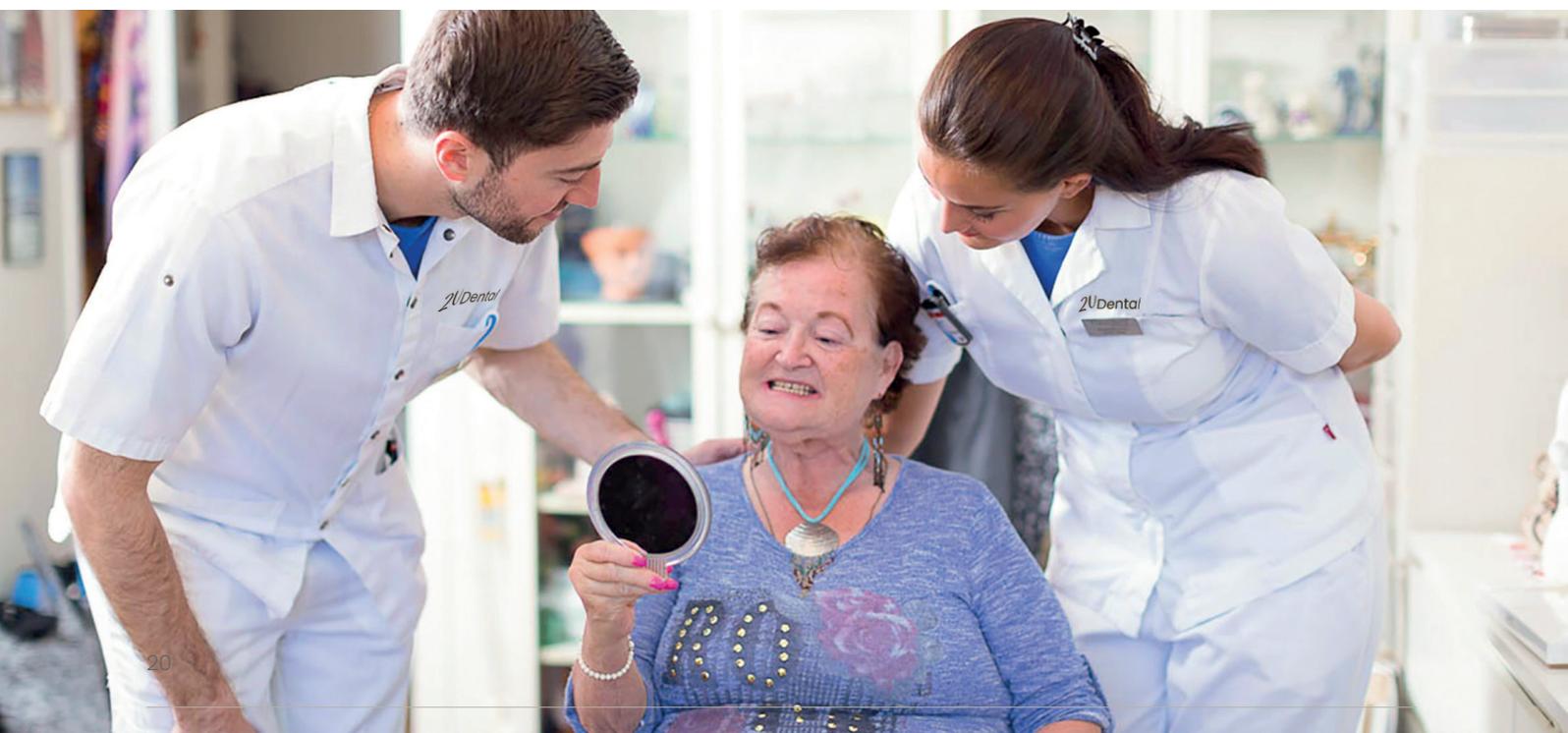
‘We have GDC registered specialists involved in all advanced treatment planning as well as providing onsite treatment.’

**For care homes, this is transformative. Most mobile services rely on:**

- Single dentists
- Limited diagnostics
- Fragmented referral pathways

**In contrast, an excellence model requires:**

- Integrated specialist input
- Complex-case triage
- Specialist-led planning for oral surgery, prosthetics, periodontal disease, and restorative dentistry



### 6.3 Digital clinical communication

The interview emphasises how intraoral cameras are among their most valuable tools because they allow patients to see what is going on in their mouth. In care homes, this is equally vital for:

- Communicating with carers
- Training staff
- Documenting risk
- Enabling remote clinical discussion
- Providing visual evidence for safeguarding and clinical escalation

This aligns directly with CQC expectations for transparency, documentation, and shared decision-making.

### 6.4 Technology-enabled quality

Banning invested heavily in digital equipment 'not standard in the UK'. Imported technology challenges aside, such equipment is essential for consistent, safe care in an environment where:

- Residents cannot easily attend a clinic
- Clinicians must often work without traditional surgery setups
- Treatment plans must be executed in varying spaces with varying staff support

### 6.5 Continuous professional standards

Because Banning clinicians attend conferences, adopt new technologies, and actively collaborate with colleagues, their model naturally incorporates:

- Continuous learning
- Modern minimally invasive techniques
- Up-to-date clinical protocols

These standards are exactly what CQC expects under 'safe', 'effective', and 'responsive' care domains.

### 6.6 A model aligned to future dentistry

The clinical excellence model for mobile care homes positions 2U Dental as delivering future-standard dentistry to the most vulnerable population group in the UK.



# 7 | Digital Workflow & Logistics Innovation

## 7.1 Scheduling & Capacity Management

Effective dental provision across multiple care homes requires precision scheduling, something traditional manual systems cannot reliably achieve. Dentify's platform creates a digital 'command centre' where clinicians, managers, and care homes see upcoming visits, capacity allocations, and real-time changes. The system automatically optimises routing to minimise travel time while maintaining clinically appropriate visit durations.

This allows the service to expand without losing reliability: as new care homes join the programme, routing and scheduling dynamically adjust to maintain consistency of care.

## 7.2 Standardised Record-Keeping

Documentation sits at the heart of CQC compliance, and Dentify ensures that every action – from assessments to treatments to training is recorded consistently. Digital periodontal charts, intraoral images, and structured treatment plans create a detailed clinical record accessible during future visits or specialist reviews.

These records also feed into care-home documentation, providing carers and managers with clear summaries of findings, risks, recommended care, and follow-up actions. The digital nature of the system eliminates the fragmented, paper-based records that frequently undermine homes during inspections.

## 7.3 Triage & Escalation Pathways

Dentify incorporates structured triage frameworks built around red/amber/green risk-coding. High-risk residents can be flagged for priority review; moderate-risk individuals receive scheduled attention;

low-risk residents enter routine monitoring cycles. When urgent concerns arise, such as swelling, bleeding, suspected infection, or trauma, the platform triggers escalation pathways that guide homes on appropriate next steps, including referral to specialists or emergency support.

This dramatically improves clinical safety by ensuring that decisions are guided by clear, evidence-based protocols rather than subjective judgement.

## 7.4 Compliance Alignment

The platform ensures that consent is properly documented, audits are timestamped, and treatment notes adhere to regulatory requirements. Training attendance, carer competencies, and oral care logs can all be stored within the system, providing a robust paper trail that supports the 'Safe', 'Effective', and 'Well-led' CQC domains.

Homes benefit from inspection-ready documentation without needing to manually piece together evidence across emails, folders, or paper files.

## 7.5 Logistics Optimisation

(Influenced by Flexident AB)

Drawing on the operational discipline demonstrated in Sweden, the model includes standardised portable kits, calibration of equipment for multi-site use, and efficient restocking processes. Data is used to forecast demand by home size, resident acuity, and historical patterns, allowing faster response times and better resource allocation.

This ensures the service remains reliable and sustainable even as scale increases.

# 8 | A Proven Scalable Model

## 8.1 Evidence of Scalability

Flexident's long history demonstrates that mobile dentistry can operate at regional and national scale when underpinned by structured workflows. The Swedish model manages thousands of residents annually, with repeat visits ensuring ongoing care continuity. Through standard operating procedures, clinicians deliver predictable outcomes regardless of which practitioner attends, demonstrating that a mobile service can behave like a mature healthcare system rather than an ad-hoc visiting service.

## 8.2 Clinical Scalability

Scalable mobile dentistry requires repeatable clinical frameworks: standardised assessments, consistent use of digital diagnostics, and clearly defined treatment pathways. Flexident maintains clinical quality by ensuring that each clinician works within a shared methodology, supported by specialist oversight.

This prevents variation across different homes or clinicians, one of the major risks in the UK's fragmented dental landscape.

## 8.3 Operational Scalability

Operational scalability depends on forecasting, resource planning, and quality assurance. The Flexident model uses digital reporting to monitor key performance indicators such as visit adherence, clinical outcomes, escalation rates, and time-per-resident metrics. This allows continuous refinement of processes and early identification of bottlenecks.

The model also demonstrates the value of predictable visit cycles, enabling seamless integration with care homes' routines and workforce patterns.

## 8.4 Relevance to the UK

The UK care-home sector has similar needs but currently lacks a coordinated delivery model. Adopting the Flexident principles, enhanced by Banning's specialist-led clinical approach and Dentify's digital backbone – positions the BFD Model to offer a future-proof, scalable service that directly addresses gaps in the UK market.

This combination creates a unique competitive advantage: clinical excellence plus operational discipline plus digital integration, delivered through a mobile format capable of supporting thousands of residents.

# 9 | Why UK Care Homes Need Integrated On-Site Solutions

The UK's care-home sector operates within a uniquely challenging environment. Homes support residents with high levels of dependency, complex medical conditions, and significant oral health needs.

Yet despite these pressures, access to consistent dental care remains fragmented and difficult to secure. Integrated on-site solutions are no longer a luxury; they are a structural necessity for safe, effective, modern care.

## 9.1 Rising Dependency Levels

Residents entering care homes today are older, frailer, and more medically complex than previous generations. Many retain natural teeth, often with restorations, crowns, bridges, or implants that require ongoing professional maintenance. Polypharmacy, dry mouth, impaired dexterity, and dementia all accelerate oral deterioration.

Traditional community dental services are not designed to meet this level of need, and conventional 'clinic attendance' models are unworkable for residents who cannot travel safely or comfortably. A service that brings clinical capability to the resident, rather than the other way around, is essential for managing this demographic reality.

## 9.2 Increasing Regulatory Scrutiny

The Care Quality Commission (CQC) has made oral health a visible indicator of overall care quality. Inspectors now expect homes to demonstrate structured assessment, well-documented plans, and timely access to professional intervention. Oral health is increasingly cited in inspection reports, with deficiencies reflected in lower ratings, particularly under 'Safe', 'Effective', and 'Responsive'.

Homes that cannot secure consistent dental support find themselves unable to meet core expectations, even when the broader care provided is competent and compassionate.

An integrated on-site dental pathway supports regulatory compliance by ensuring that oral care is embedded into everyday care routines and is demonstrably monitored over time.



### 9.3 Workforce Challenges and Support Needs

Care staff face mounting pressures, including tight staffing ratios, the complexity of residents' needs, and high turnover. Oral care tasks, often time-consuming, uncomfortable for residents, and technically challenging, are among the first to suffer when workloads increase.

Integrated onsite dentistry does more than treat residents; it supports the workforce. Clinicians can train staff directly, demonstrate techniques, highlight early warning signs, and provide the reassurance that professional support is readily available.

This partnership improves both competence and confidence, creating a more stable and consistent oral care culture within the home.

### 9.4 Expectations from Families and Stakeholders

Families are increasingly informed and vocal about the quality of care their relatives receive. Oral health issues – visible decay, swollen gums, bad breath, weight loss due to eating difficulties – are emotionally charged and often interpreted as signs of neglect.

Homes that partner with integrated mobile dental services are able to demonstrate proactive oversight, regular assessments, and prompt interventions. Families see a clear commitment to wellbeing, which

strengthens trust, reduces complaints, and enhances the overall reputation of the home.

### 9.5 Clinical and Operational Risk Reduction

Poor oral health is closely linked to avoidable hospital admissions, including infections, dental abscesses, trauma, or aspiration pneumonia. These events disrupt residents' stability and expose homes to clinical and safeguarding risks.

A consistent on-site programme reduces these risks by identifying issues early, treating them promptly, and monitoring residents at appropriate intervals. Homes gain a reliable escalation pathway and a documented audit trail, all essentials for defensibility, governance, and risk mitigation.

### 9.6 A Future-Focused Model of Care

As the UK healthcare landscape shifts toward integrated care systems (ICS) and multidisciplinary collaboration, care homes are expected to align with modern models of preventative, joined-up healthcare. On-site dentistry positions homes at the forefront of this evolution, offering a service model that mirrors wider policy direction.

Integrating clinical excellence, logistics efficiency, and digital transparency transforms dentistry from an ad-hoc service into a predictable, system-level component of resident care.



# 10 | The 2U Dental Perspective: Partnership, Not Provision

2U Dental's offering is grounded in a simple but powerful proposition: care homes don't just need a visiting dentist, they need a clinical partner. The distinction shapes every feature of the 2U Dental offering and sets it apart from transactional or ad-hoc services.

## 10.1 Co-Designing Oral Health Pathways

2U Dental begins by working closely with home managers, nurses, and care teams to understand the home's population, routines, risk factors, and current oral care challenges. Together, the home and the clinical team build an oral health pathway aligned with NICE NG48, ensuring that assessments, daily care, and interventions are structurally embedded into the home's processes.

This collaborative design ensures the service integrates seamlessly into daily workflows rather than acting as a bolt-on or an interruption.

## 10.2 Training and Empowering Care Staff

A core principle of partnership is knowledge transfer. 2U Dental clinicians do not simply carry out treatments; they equip care staff with the skills and confidence to deliver excellent daily oral care. This includes hands-on demonstrations, practical coaching, competency checks, and refreshers.

By investing in the workforce, 2U Dental helps homes achieve consistency across shifts and reduces reliance on external crisis intervention.

## 10.3 Building Clinical Continuity and Familiarity

Partnership means sending the same clinicians to each home, establishing trust with residents and staff, and developing an understanding of the home's culture, residents' needs, and communication preferences. Familiarity reduces anxiety for residents, particularly those with dementia, and ensures that every visit builds on a clear awareness of past assessments and treatments.

This continuity mirrors the multidisciplinary relationship residents would experience in a fixed-location clinic, adapted thoughtfully for the care-home environment.



## 10.4 Transparent Reporting and Digital Integration

2U Dental's reporting model goes beyond providing generic summaries. Homes receive structured digital reports that outline clinical findings, risk assessments, completed treatments, follow-up needs, and recommendations for daily care. These reports are formatted to align with CQC expectations and integrate with the home's governance and auditing processes.

This transparency supports strong inspection outcomes, enhances communication with families, and strengthens accountability.

## 10.5 Accessibility and Responsiveness

Being a partner means being present beyond scheduled visits. 2U Dental maintains responsive communication channels for queries, advice, and urgent concerns.

When staff identify a potential problem, they can seek guidance quickly, preventing escalation and ensuring resident comfort.

This responsiveness creates a sense of shared responsibility and makes the oral care pathway feel supported, not isolated.

## 10.6 Shared Goals and Long-Term Alignment

The partnership is built around shared objectives: improving oral health outcomes, reducing emergency incidents, enhancing quality of life, and strengthening regulatory compliance. 2U Dental's success is tied to the home's wellbeing, creating a joint commitment to resident-centred care.

This long-term alignment differentiates 2U Dental's model from conventional transactional providers and establishes the foundation for measurable, sustainable improvements in oral care.



# 11 Conclusion

**2U Dental's offering is grounded in a simple but powerful proposition: care homes don't just need a visiting dentist, they need a clinical partner. The distinction shapes every feature of the 2U Dental offering and sets it apart from transactional or ad-hoc services.**

The landscape of oral healthcare in UK care homes is shifting. Regulatory expectations have sharpened, clinical risks are better understood, and families increasingly demand transparency, consistency, and demonstrable quality. Within this environment, a fragmented or reactive approach to dentistry is no longer viable. What is required is a structural, proactive, integrated model capable of delivering high-quality care within the home – reliably, safely, and at scale.

This report has set out the architecture and evidence underpinning such a model. The clinical excellence and multidisciplinary capability provided by Banning Dental Group, combined with the long-proven operational methods of Flexident, show that mobile dentistry can be both sophisticated and scalable when built on strong foundations. Dentify's digital workflow ensures the reliability, auditability, and coordination necessary for modern healthcare delivery.

2U Dental brings these components together into a coherent UK-ready system designed specifically for care-home realities.

The benefits of this transformation extend beyond oral health. Residents experience greater comfort, better nutrition, reduced infection risk, and improved quality of life. Families gain confidence in the care their relatives receive. Care staff feel supported, trained, and connected to a responsive clinical partner. Homes strengthen their regulatory standing, reduce risk exposure, and enhance their overall care reputation.

As the UK moves toward more integrated, preventative models of health and social care, mobile dentistry – delivered with clinical rigour, system-level thinking, and digital transparency – will form a core component of high-quality residential care. 2U Dental, using the BFD Model is positioned to lead this evolution, offering a model that is not only compliant and clinically robust but genuinely transformative.

The future of oral healthcare in UK care homes will not be defined by the limitations of the past. It will be defined by the integration of specialist clinical capability, digital innovation, logistical efficiency, and long-term partnership.

This is the standard that residents deserve, that regulators expect, and that 2U Dental is ready to deliver.

**Fundamentally, this approach reframes what oral healthcare in care homes can be. It shifts the sector from:**

- Reactive crisis management to planned, preventative care
- Ad-hoc access to consistent professional oversight
- Documentation gaps to transparent, inspection-ready reporting
- Isolated clinician visits to a true clinical partnership

# 12A Appendix I:

## Expanded CQC Oral Health Compliance Checklist

### 12.1 Admission Procedures

Upon admission, every resident should undergo a structured oral health assessment that captures the condition of natural teeth, gums, soft tissues, dentures, and any implants or restorations. This assessment must consider medical history, cognitive status, dietary habits, and any factors that increase oral health risk. Findings should be recorded clearly, forming the baseline for future care planning.

A personalised oral health plan must then be created, detailing daily hygiene requirements, known risks, required support levels, and any immediate need for clinical intervention.

### 12.2 Daily Oral Care Delivery

Residents should receive oral care at least twice daily, including brushing with fluoride toothpaste, denture cleaning where applicable, hydration support, and gentle assessment for signs of discomfort, ulceration, or changes in oral hygiene tolerance.

To ensure consistency, homes must have practical routines embedded into shift structures, supported by visual prompts, documented protocols, and accessible oral care equipment.

### 12.3 Training and Competency

All care staff should receive oral care training at induction, followed by periodic refreshers to maintain competency. Training should cover techniques for resistant residents, recognition of oral disease, escalation criteria, denture management, and infection control. Competency assessments should be documented and included in the home's governance records. High-quality training ensures alignment with NICE NG48 expectations and demonstrates a proactive approach to oral health management.

### 12.4 Record Keeping and Documentation

Oral care must be documented daily, including whether care was delivered, the resident's response, observed concerns, and any deviations from routine (e.g. refusal). Records should be easily accessible to staff and contribute to risk monitoring and care reviews.

Any escalation, such as suspected infection, pain, trauma, or behavioural changes linked to oral discomfort – should be clearly recorded, with evidence of follow-up actions.

### 12.5 Access to Dental Services

Homes must show that residents have timely access to professional dental care. This includes scheduled routine visits, urgent response pathways, and a clear schedule for reassessment. Contracts or partnership agreements should be available for inspection, demonstrating that dental access is structured and reliable rather than ad-hoc.

A consistent provider improves continuity of care and provides a predictable support framework for the home.

### 12.6 Governance and Quality Assurance

Homes should conduct regular audits of oral care documentation, review incidents involving oral health, and track training compliance. Leadership should oversee trends, identify gaps, and ensure corrective actions are implemented.

An effective governance structure not only strengthens inspection outcomes but also ensures that oral health becomes a sustained, embedded priority within the home.

# 12B Appendix II:

## Research and Industry Papers' Summaries

- I. A preventive care approach for oral health in nursing homes: a qualitative study of healthcare workers' experiences (Bellander et al BMC Geriatrics 2024)
- II. Adult social care workforce survey report (DHSC/Gov UK 2025)
- III. Care home managers' perspectives on domiciliary dental care: a qualitative study (Janssens et al BMC Geriatrics 2025)
- IV. Care Homes Market Report (CMA 2017)
- V. Crisis in care homes: the dentists don't come (Patel et al BDJ Open 2021)
- VI. Improving the oral health of older people in care homes (TOPIC): a protocol for a feasibility study (Tsakos et al. Pilot and Feasibility Studies 2021)
- VII. Oral health for adults in care homes (NICE Guideline NG48 2016)
- VIII. Smiling Matters (CQC 2019)
- IX. Smiling Matters: Oral health in care homes - progress report (CQC 2023)
- X. Supporting better oral care in care homes: what quality looks like (Care Inspectorate 2021)
- XI. Telehealth technologies in care home: a gap for dentistry? (Bhamra et al Journal of Public Health 2023)
- XII. What CQC is checking at all health and social care services (CQC 2023)

### I A preventive care approach for oral health in nursing homes: a qualitative study of healthcare workers' experiences (*Bellander et al BMC Geriatrics 2024*)

This qualitative study explores how Swedish healthcare workers experience assessing oral health using the ROAG-J tool within the national Senior Alert (SA) quality-register system, revealing both strong facilitators and persistent structural barriers to delivering preventive oral care in nursing homes. Workers described that a structured assessment framework increased awareness, improved communication, and helped prioritise oral health as part of holistic care, with ROAG-J enabling earlier detection of problems often hidden from view in frail or cognitively impaired residents. However, they also reported significant challenges: residents, especially those with dementia, frequently resisted oral care, triggering ethical dilemmas around autonomy, distress, and the need to provide essential hygiene. Staff described technical difficulties with natural dentitions and complex dental work, concerns about safety (e.g. biting, choking), and frustration

when oral care was deprioritised due to high workload or inadequate managerial support. Organisational issues, including unclear roles, inconsistent routines, insufficient equipment, duplicate documentation systems, and lack of integration between nursing and dental services, further compromised care. Competency varied widely across staff groups, with high turnover and limited training undermining reliable use of ROAG-J; many workers lacked confidence in their assessments and called for more hands-on education from dental professionals. Overall, the study concludes that structured tools like ROAG-J and team-based processes can meaningfully strengthen preventive oral health work, but sustainable improvement requires clearer organisational responsibilities, regular dental involvement, and continuous training to support staff delivering oral care to increasingly complex, dentate older adults.

## II Adult social care workforce survey report (DHSC/Gov UK 2025)

This national workforce survey highlights the sustained and severe recruitment and retention pressures facing adult social care providers in England, with 71% reporting recruitment as challenging and 57% reporting difficulties retaining staff. Workforce instability is driven largely by better pay outside the sector, cited as the top barrier to both recruitment (27.8%) and retention (35.2%), alongside issues such as childcare costs, long DBS processes, and transport barriers. Domiciliary care settings reported consistently greater challenges than residential care homes across recruitment, retention, and staff morale, reflecting higher job demands and weaker structural support. Although some providers noted small improvements in staff morale and agency access, around 37% expressed concern about sustaining service delivery over the next six months, especially given a sharp fall

in overseas care worker visa grants following 2024 immigration changes. Providers also reported declining application numbers and reduced applicant quality, further straining capacity. The findings underscore that many homes operate with fragile staffing levels, limited resilience, and rising workforce burnout – all of which directly impact their ability to deliver consistent personal care, including oral health support. The report concludes with caution that the results, though not weighted to the entire sector, reflect a clear and widespread sentiment: workforce shortages remain the most significant operational risk for adult social care, with downstream effects on regulatory compliance, care quality, and the feasibility of implementing preventive health practices such as structured oral care and continuous training to support staff delivering oral care to increasingly complex, dentate older adults.

## III Care home managers' perspectives on Domiciliary Dental Care: A Qualitative Study (Janssens et al., BMC Geriatrics (2025))

This qualitative study explores the perspectives of care home managers on domiciliary dental care (DDC) in settings where such services have been fully implemented and embedded over a prolonged period. Unlike earlier studies that focused on access barriers or theoretical preferences, this research examines lived operational experience in care homes that have worked with structured DDC provision for between eight and twelve years. The aim was to understand how managers perceive the value, limitations, and sustainability of domiciliary dental services once they are no longer novel or pilot interventions. Care home managers expressed a strong preference for domiciliary dental care over conventional external dental services. Transporting residents to dental practices was consistently described as costly, time-intensive, and stressful for both residents and staff, particularly for those with mobility limitations or cognitive impairment. On-site dental provision was viewed as significantly more humane and operationally efficient, reducing disruption to daily routines and minimising

the need for staff to be diverted from core care duties. Managers also highlighted that without on-site services, dental care was often deferred or abandoned altogether due to practical constraints.

Despite their satisfaction with domiciliary services, managers expressed a clear desire for reliable, locally embedded dental partnerships, ideally involving dentists or dental facilities closely connected to the care home or surrounding community. However, this aspiration was widely regarded as unrealistic. Managers reported persistent difficulties in engaging local dentists, citing limited willingness to treat care home residents, inadequate compensation, and a lack of suitable portable equipment. As a result, many managers had become resigned to the fact that domiciliary dental care may be the only feasible route to professional oral healthcare for their residents. Domiciliary dental care was perceived as providing tangible organisational value. Managers described the service as well integrated into

their operational routines and appreciated its role in delivering essential curative care, particularly for new residents who often arrived without an existing relationship with a dentist. DDC was also seen as relieving families of responsibility and reinforcing oral health awareness among care staff. However, important unmet needs remained. Managers expressed concern about the limited frequency of visits, typically restricted to twice per year, which left care homes struggling to manage acute dental issues between appointments. They also noted a lack of sufficient training and education for care staff, particularly in preventive oral care and early problem identification. Financial sustainability emerged as the most significant threat to the long-term viability of domiciliary dental care. While managers broadly accepted the principle of paying for DDC and recognised its value, rising annual fees were increasingly difficult to justify within constrained care home budgets. Managers reported frustration over limited transparency around cost increases and diminishing flexibility as programmes expanded. There was strong consensus that without additional structural funding or reimbursement reform, domiciliary dental services would remain financially fragile, regardless of their clinical or operational benefits.

#### **IV Care Homes Market Report (CMA 2017)**

This report by The Competition and Markets Authority (CMA) provides a detailed assessment of the structural, financial and operational challenges within the UK care-home sector. The report highlights significant pressures affecting both providers and residents, including rising care needs, persistent funding gaps in publicly funded placements, and inconsistencies in the quality and transparency of care. It identifies systemic difficulties for residents and families in accessing clear information, comparing services, and exercising choice, particularly during crises. The CMA also raises concerns about sustainability, noting that many

The study also highlighted the importance of local context and managerial leadership in determining the effectiveness of domiciliary dental care. Successful implementation depended heavily on stable internal oral-care coordinators and active managerial ownership of the process. However, high staff turnover in long-term care frequently undermined continuity, creating logistical challenges and increasing the burden on already stretched teams. Managers described a sense of powerlessness in addressing these issues due to wider workforce shortages and limited recruitment options.

Overall, the study concludes that domiciliary dental care is widely accepted, operationally effective, and strongly preferred by care home managers when compared with traditional dental access routes. However, its sustainability is constrained by rising costs, workforce instability, and limited capacity for emergency or preventive coverage. The findings reinforce the need for redesigned funding models, greater use of mid-level oral health professionals such as oral hygienists, and policy-level intervention to ensure that domiciliary dental care can be delivered at scale as the population of care-dependent older adults continues to grow.

providers face financial fragility, constrained investment, and rising workforce costs. Importantly for health partners, the study emphasises that unmet healthcare needs, including oral health, can be exacerbated by fragmented coordination between care homes and external clinical services. The report concludes that improving market functioning requires greater transparency, stronger consumer protections, clearer accountability structures, and better integration of health and social care inputs to support residents' wellbeing.

### V Crisis in Care Homes: The Dentists Don't Come (*Patel et al BDJ Open 2021*)

This paper reports qualitative findings from the Fluoride Interventions in Care Homes (FlInCH) Trial, focusing specifically on the challenges of accessing dental care for older people living in care homes in England. The study situates its findings within the context of an ageing population, increasing levels of frailty and dependency at the point of care home admission, and structural changes to both social care and NHS dental service provision. The authors argue that these factors have combined to produce a reactive and fragmented dental care system that is fundamentally misaligned with the needs of care home residents. Findings demonstrate that dental care within care homes is overwhelmingly reactive, with access typically sought only when residents experience acute pain or visible problems. Oral health was widely described as a low priority for residents, families and, at times, care staff, a situation compounded by assumptions about ageing and tooth loss. These attitudes were reinforced by the practical challenges of delivering daily mouth care to residents with dementia or behavioural difficulties, where cooperation and consent could not be assumed. Participants consistently emphasised that continuity and familiarity—such as regular visits from the same dental professionals—would significantly improve resident acceptance and outcomes, particularly for those living with cognitive impairment.

A central theme was the widespread inability to secure dental practitioners willing or able to attend care homes. Managers reported persistent difficulties accessing both NHS and private dentists, despite policy guidance emphasising the importance of oral health in care settings. Although domiciliary care was strongly preferred, it was also recognised as clinically limited, with dentists constrained by portable equipment and time pressures. Attempts to establish local relationships with dental practices were frequently unsuccessful, leading some care homes to rely on general practitioners or emergency services when residents experienced dental pain. Even when services were theoretically

available, access was obstructed by complex and burdensome referral processes. Managers described lengthy online referral forms requiring nursing input, long waiting times for appointments, and repeated cancellations due to transport failures or resident ill health. In several cases, residents never received treatment despite repeated referrals, highlighting a lack of coordinated, end-to-end care pathways. The absence of a clear point of contact for urgent dental issues was described as a significant source of distress for both staff and residents.

Physical accessibility and transport were identified as major barriers to off-site dental care. Many dental practices were not wheelchair accessible, and suitable transport for residents with mobility impairments was scarce, expensive, or unreliable. These challenges were compounded by the cost of transport, particularly for residents with limited financial means, creating stark inequalities between those able to self-fund care and those dependent on family or local authority support. Affordability and exemption processes emerged as some of the most intractable barriers. Care home managers frequently lacked information about residents' eligibility for free dental care and were unable to verify exemption status due to misalignment between dental charging systems and social care funding arrangements. Fear of financial penalties for incorrect declarations discouraged staff from completing exemption forms, leading to delays or avoidance of care. Managers described ethical discomfort in asking families to fund treatment and frustration at a system in which dental care was treated differently from other routine healthcare services such as optometry or pharmacy.

Across the findings, a strong sense of responsibility without corresponding power was evident. Care home managers and staff felt accountable for the wellbeing of highly vulnerable residents but lacked the authority, resources or system support to secure timely dental care. This imbalance was illustrated by a detailed clinical case

study within the paper, documenting how systemic barriers resulted in prolonged poor oral function, nutritional compromise and diminished quality of life for a resident who never received definitive dental treatment before his death. The authors conclude that the current dental care system for care home residents is not fit for purpose and has resulted in widespread dental neglect among older people living in institutional care. They argue that urgent commissioning reform is required to ensure adequate provision of both routine and urgent dental services delivered by appropriately skilled

clinicians. At a minimum, free routine dental examinations for all care home residents are proposed, aligned with other preventive health services, to enable early intervention, advice and prevention. The paper also highlights opportunities to explore technology-enabled solutions such as teledentistry as an adjunct to face-to-face care, while emphasising that sustainable improvement will require coordinated reform across funding, workforce development and service design in partnership with the social care sector.

### **VI Improving the oral health of older people in care homes (TOPIC): a protocol for a feasibility study (Tsakos et al. Pilot and Feasibility Studies 2021)**

This feasibility-study protocol outlines a planned cluster randomised controlled trial (RCT) designed to test whether a complex oral health intervention, built directly from NICE NG48 and co-designed with residents and care home staff, can be realistically delivered and evaluated in care homes across London and Northern Ireland. The authors highlight the scale of unmet need: older adults in care homes experience significantly higher levels of caries, periodontal disease, pain, malnutrition, and hospital admissions than their community-dwelling peers, with poor daily oral hygiene, cognitive impairment, polypharmacy-related dry mouth, and sugar-rich diets compounding risk. Evidence for effective interventions is currently weak, and no robust trials exist, prompting the need for structured evaluation. The proposed intervention includes three components: (1) formal staff training in oral health promotion using video-based and printed materials; (2) routine use of the Oral Health Assessment Tool (OHAT) with personalised care plans;

and (3) a “support worker assisted” twice-daily toothbrushing regime using 1500 ppm fluoride toothpaste, supported by laminated tip cards and weekly hygiene logs. The feasibility trial aims to test recruitment, retention, fidelity, acceptability, and data completeness, alongside a parallel process evaluation exploring practical barriers and contextual factors. Outcomes will include clinical indicators (caries, plaque, bleeding), oral symptoms, urgent dental episodes, quality of life measures, and adherence to intervention components. The authors emphasise that the co-design process is intended to enhance realism and sustainability, and that findings will guide the development of a definitive large-scale RCT. Overall, the protocol highlights the persistent systemic gap between guideline aspiration and frontline practice, the need for structured, measurable oral health pathways in care homes, and the growing urgency for scalable, evidence-based preventive interventions.

### **VII Oral health for adults in care homes (NICE Guideline NG48 2016)**

NICE NG48 sets out the national evidence-based standard for oral health in care homes and remains the cornerstone for regulatory expectations under both CQC’s former KLOE framework and the 2023 Single Assessment Framework. The guideline emphasises that oral health is fundamental to residents’ dignity, nutrition, comfort, communication

and overall wellbeing, and must be treated as a core component of personal care rather than an optional or cosmetic activity. NG48 requires every resident to receive a structured oral health assessment on admission – ideally using a validated tool such as the Oral Health Assessment Tool – with findings integrated into personalised

care plans and regularly reviewed as needs change. The guideline mandates twice-daily mouth care with fluoride toothpaste, daily denture care, clear escalation pathways, and access to dental services for both routine and urgent needs. It stresses the need for trained staff, noting that care workers must understand the impact of untreated oral disease, including infection, aspiration pneumonia, behavioural changes, and reduced quality of life; especially for people with dementia or communication difficulties. NG48 also highlights commissioners'

### VIII Smiling Matters (CQC 2019)

The CQC's Smiling Matters report provides a landmark national review of oral health provision in 100 care homes and exposes widespread systemic failings that place residents at avoidable clinical risk. The review found low awareness and weak implementation of NICE guideline NG48, with only 28% of managers having read it and fewer having embedded it into daily practice. Oral health assessments were inconsistent, care plans lacked detail, and daily mouth care was frequently deprioritised, especially for people with dementia or complex needs. Many homes lacked oral health policies, formal training, or competence frameworks for staff; 47% of homes provided no specific oral health training at all. Access to dental services was a significant barrier: routine check-ups were rare, waiting times long, domiciliary care severely limited, and emergency

### IX Smiling Matters: Oral health in care homes – progress report (CQC 2023)

The CQC's 2023 progress report shows meaningful but uneven improvements in oral health provision within care homes since the original Smiling Matters review in 2019. Awareness of NICE NG48 has risen sharply, with only 9% of managers unaware of the guidance (down from 39%), and over half of homes now having dedicated oral health policies. Oral health assessments on admission increased to 83%, and the proportion of care plans fully covering oral health needs more than doubled (60% vs 27% in 2019). Staff training has improved substantially, with 60% of homes reporting

responsibilities to ensure accessible dental provision, addressing gaps in domiciliary and community dental services. The committee underscores that organisational policies, consistent documentation, and collaborative working with dental teams are essential to sustaining high-quality practice. NG48's underpinning principle is clear: good oral health is a basic human right, and care homes must have the systems, skills and partnerships required to meet this duty of care.

pathways unclear – leading to inappropriate GP and A&E attendances. Care records were often incomplete, making it difficult to track needs, interventions or follow-up. The report highlights serious consequences of poor oral care, including malnutrition, aspiration pneumonia, unmanaged pain, behavioural distress, and loss of dignity. CQC concludes that oral health has not been treated with the same priority as other personal care domains and calls for urgent cross-sector action: mandatory training, improved commissioning of dental services, embedding NG48 in regulatory frameworks, better staff guidance, and stronger public and family awareness. The findings establish a compelling case for integrated, structured dental support within care homes and reinforce the clinical and regulatory rationale for modern mobile dentistry models.

regular oral health training, supported by pandemic-driven online learning opportunities. However, major systemic gaps persist: only 28% of homes had an oral health champion, daily care quality remained inconsistent, and record-keeping often lacked detail, especially around NHS dental charge exemptions. Most critically, access to NHS dentistry has worsened dramatically with the percentage of homes reporting they can 'never' obtain NHS dental care has quadrupled (6% to 25%), driven by shortages in domiciliary dental provision, low contractual incentives, and

workforce constraints. Care homes described significant delays, cancellations, and the inability to secure visits for frail or bedbound residents. The report reinforces that poor oral health directly affects nutrition, weight, dignity, mood, and infection risk, and that progress requires better commissioning, clearer guidance for dental professionals, stronger integration with ICS structures, and

embedding oral health within regulatory processes under the new Single Assessment Framework. Overall, while awareness and policy adoption have improved, the core barrier – access to timely, appropriate dental care – has worsened, underscoring the need for coordinated, system-level solutions and modern mobile dentistry models.

### **X Supporting better oral care in care homes: what quality looks like** (*Care Inspectorate 2021*)

This Care Inspectorate quality framework provides a detailed, practice-focused illustration of what good oral care looks like in Scottish care homes, offering one of the clearest operational standards available for frontline providers. It emphasises that oral health is a basic human right and directly linked to dignity, nutrition, communication, comfort and broader health risks, including heart disease, pneumonia, malnutrition and dementia-related decline. The guide outlines what inspectors and providers should expect to see in high-quality care: structured oral health risk assessments on admission and reviewed at least every six months; clear personal oral care plans reflecting residents' preferences; twice-daily toothbrushing, proper denture hygiene, and regular soft tissue checks; and sensitive, person-centred support for residents who resist care, particularly those with dementia. It highlights common failings such as infrequent assessments, inadequate documentation,

unmarked or poorly maintained dentures, unsafe storage of disinfectants, and the inability to recognise pain or distress linked to oral problems. The document stresses multi-professional collaboration, requiring routine dental registration, timely referrals for pain, infections or denture issues, and regular input from dental services and NHS Caring for Smiles/Open Wide teams. Extensive improvement resources are provided, including training pathways, infection control guidance, dementia care standards, dysphagia support, and end-of-life oral care frameworks; under-scoring the need for continuous staff development and organisational policies. Overall, this framework presents a comprehensive, operationally grounded model for delivering safe, person-centred oral care and serves as a practical benchmark for care homes seeking to meet modern regulatory and clinical standards.

### **XI Telehealth Technologies in Care Homes: A Gap for Dentistry?**

(*Bhamra, Gallagher & Patel, Journal of Public Health 2023*)

This paper presents a rapid evidence review examining the use of telehealth technologies in care homes, with a specific focus on the relative absence and underdevelopment of teledentistry within this broader landscape. While telehealth has expanded significantly across medical and allied health disciplines—particularly following the COVID-19 pandemic—the authors identify dentistry as a notable gap in both research and implementation. The review aims to assess what is currently known about telehealth use in care homes, the extent to which findings from other clinical disciplines may be transferable to dentistry, and the implications

for future oral healthcare delivery models.

The review demonstrates that telehealth has been widely used across care homes for disciplines such as geriatrics, psychiatry, neurology, dermatology and palliative care. Across these domains, teleconsultations were generally found to be acceptable to residents, staff and clinicians, particularly when used to improve access to specialist input, reduce hospital admissions, shorten waiting times and minimise unnecessary travel. Many studies reported cost savings associated with reduced hospitalisation and more efficient use of clinical resources.

Diagnostic accuracy was shown to be high in certain disciplines, particularly when assessments relied on visual data or structured scoring systems, although in-person consultations remained the preferred option where physical examination was critical.

In contrast, the evidence base for teledentistry was found to be extremely limited. Only four studies directly examined teledentistry in care home settings, all of which focused on the use of intra-oral cameras operated by trained staff to support remote assessment by dental professionals. Despite the small number of studies, findings were broadly positive. Teledentistry was shown to be technically feasible, with high diagnostic accuracy when compared to face-to-face dental examinations, particularly using asynchronous “store-and-forward” models. Reported sensitivity and specificity for diagnosing dental pathology were high, and intra-examiner agreement between remote and in-person assessments was described as excellent. Resident acceptability of teledentistry was generally favourable, though outcomes varied according to cognitive status and dependency level. Most residents tolerated the use of intra-oral cameras well, with non-psychotic and more autonomous residents showing higher acceptance. More dependent or cognitively impaired residents experienced greater difficulty, particularly with keeping their mouths open or cooperating with the procedure, indicating that teledentistry may not be universally applicable across all care home populations. Importantly, teledentistry was found to reduce the need for resident transport to external dental facilities, with a significant proportion of residents managed entirely through remote assessment and

follow-up.

Economic evidence specific to dentistry was limited but suggestive. Where cost analysis was undertaken, asynchronous teledentistry models were consistently found to be the lowest-cost option, outperforming both real-time video consultations and conventional face-to-face examinations. The majority of teledentistry costs were associated with oral examination and treatment planning rather than technology itself, suggesting potential efficiencies if integrated into structured service models using trained non-dentist staff. The authors conclude that while telehealth is now well established across many areas of care home healthcare, dentistry has not kept pace. Nevertheless, findings from the wider telehealth literature are largely transferable, indicating that teledentistry has the potential to improve access, reduce system pressures and support care planning and follow-up. Crucially, teledentistry is positioned not as a replacement for face-to-face dental care, but as a complementary tool that can support triage, screening, preventive oversight and continuity between in-person visits. The paper highlights the need for further research into acceptability, digital literacy, infrastructure requirements and workforce models, particularly in relation to the UK care home sector.

Overall, this review reinforces the case for integrating tele-enabled dental assessment into modern care home dentistry models. It provides evidence that remote dental technologies can play a valuable supporting role within a blended delivery approach, particularly when combined with on-site clinical services, trained care staff and structured oral health programmes.

## XII What CQC is checking at all health and social care services (CQC 2023)

This easy-read version of the CQC's Single Assessment Framework (SAF) explains the updated approach the regulator now uses to assess all health and social care services in England. While retaining the familiar five Key Questions: Safe, Effective, Caring, Responsive, and Well-Led, the SAF introduces two important elements: "I statements", which describe what people should experience when receiving good care (e.g. feeling safe, respected, informed), and "Quality Statements", which define what providers must demonstrate in practice to deliver those experiences. Across the SAF, CQC emphasises safety, clear communication, well-trained staff, personalised care, good transitions between services, timely

responses to needs, inclusion, and strong leadership supported by reliable systems and continuous improvement. The framework signals a shift from task-based compliance to experience-based, evidence-driven regulation, requiring services to show not only that processes exist but that they result in positive, consistent outcomes for people. For oral health in care homes, the SAF strengthens expectations around risk management, staff competence, person-centred care, timely access to clinical support, effective documentation, and integrated working - making oral healthcare a cross-cutting factor influencing all five domains of quality.