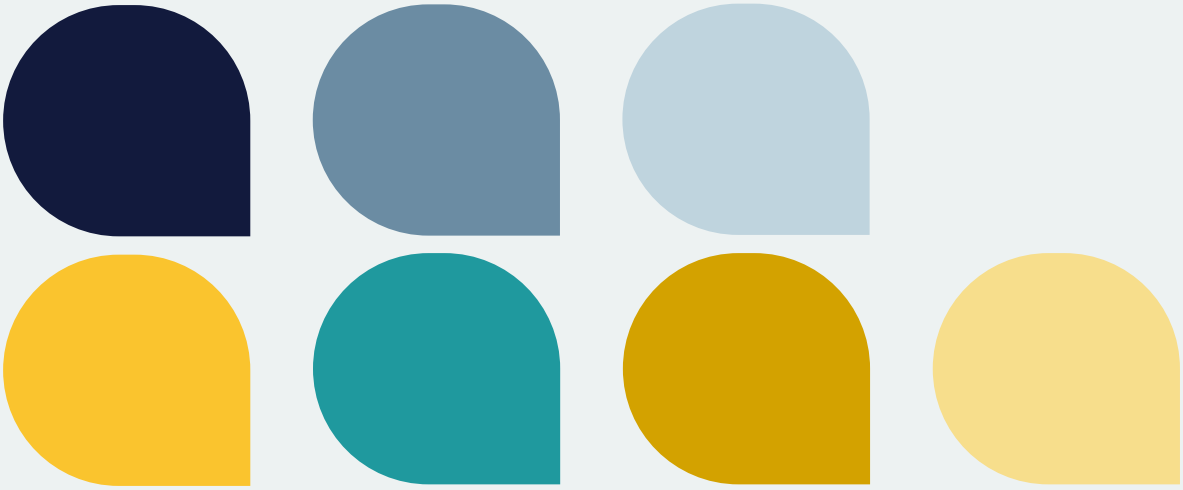
Primary Care Network
NHS Confederation

A new front door: reimagining primary care for the next decade

A collection of essays from leaders in optometry, community pharmacy and dentistry



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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. For more information visit www.nhsconfed.org

The Primary Care Network is part of the NHS Confederation. It supports, connects and empowers primary care members to maximise the impact they have on patient care and drive change. For more information visit www.nhsconfed.org/primary-care

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Foreword

Ninety per cent of all NHS contacts happen in primary care – not just general practice, but community pharmacy, optometry, dentistry and audiology. Yet too often, primary care is mistakenly equated with general practice alone, leaving these vital sectors as an afterthought, despite the fact that over 10,000 pharmacies, 5,000 high-street opticians and 20,000 dental professionals are delivering NHS care, day in day out, in communities across England.

Primary care is frequently called the 'jewel in the NHS crown', and rightly so. Like a true jewel, it is complex, resilient and multifaceted. Each component – whether it's a pharmacist managing long-term conditions, an optometrist preventing avoidable sight loss, or a dentist safeguarding oral health – adds brilliance to the whole. Its fissures are not flaws, but the very features that give it strength, diversity and depth.

As NHS Confederation chief executive Matthew Taylor said at NHS ConfedExpo 2025: "The NHS is fighting for life." In that case, primary care is not just the frontline, it is the lifeblood. The opportunity within this sector is immense. It is already doing so much and it should be in prime position to lead the next era of NHS reform. Not as an adjunct to hospitals, but as the central engine of a health service rooted in prevention, integration and neighbourhood-based care.

Publication of the ten-year health plan is imminent. National leaders have provided high-level insights into its strategic intentions but, as is always the case, the devil is in the detail.

This latest set of essays in our reimagining primary care series features our members from community pharmacy, dentistry and optometry. Like the earlier contributions from general practice, they do not aim to provide a

definitive roadmap. Rather, they offer a vision of what could be possible if structural barriers were removed and current constraints lifted. They imagine a future where the full breadth of primary care is recognised and respected – not as separate services, but as an integrated part of a neighbourhood health service, working together to support people to live well, at home and in their communities.

In 2035, this vision is reality. The expertise and capabilities of primary care are fully realised. The traditional concept of hospital outpatients is a thing of the past. Instead, resources follow patients, who receive equitable, accessible and preventative care, delivered seamlessly by services collaborating for the person, not the provider.

To secure the future of the NHS, we must unlock the full potential of all primary care disciplines – placing them at the heart of a system designed around people, not pathways.

The essays that follow are grounded in today's realities, but they also challenge us to be bolder: to invest, to integrate and to imagine a health service where care is not only closer to home, but shaped by the needs and strengths of the communities it serves. If we are serious about building a sustainable, equitable NHS, the full power of primary care must not only be recognised, but unleashed.

Ruth Rankine
Director
Primary Care Network

Chapter 1 – From vision checks to vital care: embedding optometry in the NHS neighbourhood model

Dharmesh Patel
Optometrist and Chief Executive, Primary Eyecare Services

Introduction

In 2025, eyes are the most common reason for outpatient attendances in England. Hospital ophthalmology services account for over 8 million appointments every year, yet a significant proportion do not require consultant-led care. Instead, they could be managed within one of the 5,000 optometry practices across England located on our high streets and in shopping centres, rooted in communities. These are not just places for vision checks, they are a vital, yet underused, frontline of healthcare. In the next decade, they will become the beating heart of a new model of eye care: accessible, preventative, personalised and digitally connected.

A vision for 2035

We envision a future where most eye care is no longer hospital-based but delivered in neighbourhoods by trusted local clinicians equipped with advanced tools, seamlessly integrated into the broader health system. No longer peripheral, optometry is fully embedded within multidisciplinary teams, co-managing patients alongside GPs, pharmacists and social care professionals in a unified ‘one team’ approach.

By 2035, this ambition has become a reality; a reimagined model of care will have resulted in a better patient experience, improved health outcomes and sustained efficiencies for the NHS and wider economy.

In 2035:

- Primary care optometry is an integrated and essential component of neighbourhood health and care teams within a 'one team' model.
- Eye care is delivered close to home as standard by local practices as the first point of contact, empowered and enabled to provide urgent care, long-term condition management with AI supported diagnostics.
- Seamless patient experience supported by fully interoperable digital systems, with shared access to patient records, imaging and real-time care plans via the NHS App.
- Every patient has visibility and agency over their eye health, with personalised care pathways and preventative interventions triggered from the optometry setting.
- Workforce capability and scope have expanded, with clinicians working to the top of their license, and new roles supporting clinical decision-making and community coordination. This includes expanded prescribing capabilities and use of independent prescribers.
- A focus on prevention, health equity and multimorbidity ensures optometry contributes to wider population health goals.

This vision is ambitious, but not unrealistic. It ensures we are harnessing the capacity, expertise and capability that already sits within community optometry, facilitating the shift of care closer to home.

How do I know it's not unrealistic? Because it builds on much of the work we are already doing in Primary Eyecare Services, a not-for-profit primary care provider at scale. In 2024, we delivered care to more than 800,000 people through over 3,000 optometry practices across 30 integrated care systems.

These community-based services prevented more than 515,000 avoidable hospital appointments and saved 250,000 GP appointments in the last 12 months alone.

What we're doing today is proof of what's possible. By scaling, connecting and empowering this existing infrastructure, we can reimagine eye care and transform the health system from the ground up.

Meeting patients where they are

By 2035, primary care optometry is a fully integrated, indispensable pillar within the local NHS infrastructure. No longer viewed as an ancillary or retail-led service, it is embedded within at-scale delivery models, from primary care networks to primary care provider collaboratives. Optometry practices operate as essential nodes within this system, delivering accessible, high-quality care in collaboration with general practice, community pharmacy, social care and mental health services.

This transformation has been driven by an unwavering commitment to Right Care, Right Person, Right Time, a vision enabled by advanced technology, underpinned by health equity, and focused on holistic, person-centred wellbeing.

What will it feel like for people?

Michael: trust and prevention

Michael is 45 years old and lives in an area of deprivation. He represents a patient cohort previously underserved by traditional healthcare models. He rarely sees his GP but has begun attending his local optometry practice due to changing eyesight needs at this age. The practice is now recognised as a trusted health access point in his community.

His sight test is more than a vision check. Connected to the NHS App, his health record outlines his lack of previous medical history interactions.

This, associated with retinal signs during his examination, triggers an opportunistic cardiovascular disease screening within the practice. With raised blood pressure identified, the practice is able to provide lifestyle advice and digital coordination with community pharmacy and general practice to ensure Michael can get the diagnosis and treatment he requires before escalation of his condition.

Michael's optimum sight correction to read supports his ability to remain in employment and supports him in his caring duties for elderly family. As Michael spends time in the optometry practice, the team can support him to connect to wider services in the local community as required through the local neighbourhood arrangements.

This is proactive care in action: preventative, personalised and made possible by trust at local access points and full interoperability of clinical records.

Susan: living with glaucoma

Susan is 58 years old and has managed glaucoma for 12 years. Until recently, she attended hospital eye services every six months. Now, routine glaucoma care is delivered in her local optometry setting. Her practice, equipped with high-resolution ocular coherence tomography (OCT) diagnostic scanning, remote intra-ocular pressure monitoring and AI-assisted clinical tools, tracks her condition precisely.

Her data, including imaging, medications and adherence tracking, feeds directly into a shared care portal accessed by her ophthalmologist. When Susan's intraocular pressure increases slightly, her optometrist consults the hospital's digital advice and guidance system, receiving a response within two hours.

The decision? No re-referral needed. Instead, her drops are adjusted using extended prescribing powers granted to the optometrist, who is part of the network of independent prescriber qualified professionals.

Susan stays local. Her care remains safe and the system avoids unnecessary hospital demand.

Priya: Urgent care, seamlessly delivered

Priya is 35 years old, lives in a busy commuter town and works full time in a digital marketing agency. One morning, she wakes with a painful red eye and sensitivity to light. Concerned but aware of the community urgent eyecare service (CUES) through the NHS App, she accesses it immediately from her phone.

The system triages her in real-time. A teleconsultation is arranged that morning with a local optometrist, who, following a structured remote assessment, identifies the need for an in-person examination. Priya is offered a face-to-face appointment within hours, conveniently near her office and outside core working hours. The optometrist, equipped with slit-lamp biomicroscopy and diagnostic dyes, confirms a corneal abrasion.

Treatment is initiated immediately. Medication is requested digitally and sent directly to her local community pharmacy, where she picks it up later that evening. Her care is logged in her NHS health record, including red-flag checks, and a message is shared with her GP for continuity, although no GP appointment is needed.

By accessing care digitally and locally, Priya avoids unnecessary time off work, an A&E attendance, or long waits for a GP appointment. Her recovery is swift, and she reports feeling reassured by the expert, accessible care. Her experience reflects how optometry-led urgent care can be seamlessly blended with technology and human expertise to deliver timely, convenient and effective treatment.

Digital integration and intelligent infrastructure

This future has been enabled by radical improvements in digital infrastructure. Optometry practices are fully interoperable with the NHS ecosystem. All sight tests, urgent care episodes and imaging are logged into the patient's NHS care record.

- **NHS App integration**: NHS sight test dates, prescription history, appointment booking and medication requests are available at the patient's fingertips.

- **Decision-support tools**: AI flags abnormalities in retinal images supporting early identification of Alzheimer's, diabetic retinopathy and macular degeneration.

- **Video and in-person care**: Urgent eye care triage is streamlined through a digital-first model, blending virtual consultations with in-practice assessments, and linked to community pharmacy for immediate access to medications.

- **Data-driven prevention**: National data sets monitor access, diagnosis rates and clinical outcomes across localities flagging inequalities and guiding resource allocation.

Evolving the workforce: skills, scope and leadership

2035's optometry workforce is broader, more skilled, with everyone working to the top of their license and fully embedded in multidisciplinary teams.

- All optometrists with access to extended formulary for prescribing and independent prescriber optometrists are more commonplace, with at least one in each neighbourhood.

- Clinical imaging technicians and health and wellbeing coaches in optometry practices support extended diagnostics and brief interventions.

- Neighbourhood eye health coordinators via primary eye care providers at scale focus on population health – working with community link workers, housing officers and educators to support preventative eye care. Using eye health data to target population health interventions and address inequality.

Workforce development has been underpinned by NHS investment in education and training, supported by national service frameworks and local delivery models.

Public health and population vision

In 2035, primary care optometry plays a frontline role in tackling some of the biggest public health challenges of the decade:

- **Cardiovascular disease and diabetes**: Early signs in retinal vessels trigger care escalations for people not accessing routine check-ups. Opportunistic screening for at-risk groups is the standard of care in optometry practices.

- **Dementia pathways**: Emerging AI-supported Ocular coherence tomography diagnostic scans support early screening and onward referral.

- **Hearing pathways**: many practices using audiology teams and the wider optometry practice workforce as well as modern technology to support optimisation of hearing.

- **Health inequality**: Targeted interventions with neighbourhood teams for at-risk groups – people experiencing homelessness, refugees, care-experienced young people, and low-income families, ensure no community is left behind.

- **Employment and independence**: Timely access to sight tests and low vision support where required prevents avoidable sight loss from derailing careers, education or housing security.

Optometry is no longer just about sight – it is a gateway to wellbeing, equity and social participation.

Joined-up, right-sized referrals

The reimagined referral pathway is digital, smart and proportionate:

- All referrals include imaging and structured history, eliminating unnecessary duplication.
- Digital advice and guidance is embedded, providing real-time specialist input.
- Subspecialty triage supported by clinical expertise and AI ensures the right clinician receives each referral, based on need not geography alone.
- Preventing avoidable referrals: For long-term conditions like glaucoma, robust shared care protocols support primary-led management, with escalation only when clinical thresholds are met.

This delivers the holy grail of system design: patients are referred when needed, not ‘just in case’ or due to lack of diagnostics, and local care is the default, not the exception.

What needs to change

For optometry to be reimagined in this way, eight core characteristics need to change over the next decade:

Optometry: current state vs future vision (2035)

Characteristic	Current state	Future vision (2035)
Public perception	Retail focused	Core NHS provider
Data sharing	Fragmented	Fully interoperable
Patient journey visibility	Low	NHS App integration
Prescribing powers	Limited	Expanded capabilities
Prevention role	Underutilised	Proactive identification
Service models	Inconsistent	National frameworks embedded
Funding	Limited	Moves with patient
Contracting	Lack of/complex	Primary care providers at scale

Conclusion: from the periphery to the front line

If we are serious about reimagining primary care, we must fully integrate the professions that already serve our communities every day. Optometry has the infrastructure, workforce and public trust to deliver more but requires national support, strategic commissioning, system-wide recognition and local integration.

The potential is at least 1.9 million saved NHS appointments and net savings of £98 million, as outlined by PA Consulting's 2024 report: Key Interventions to Transform Eye Care and Eye Health.

By embedding optometry into the heart of neighbourhood teams, harnessing intelligent technology, and investing in skills and equity, we can ensure that every patient, from Michael to Susan, receives the right care, from the right person, at the right time.

By 2035, we can make eye care in optometry a true front door to health proactive, equitable and embedded in every neighbourhood.

Chapter 2 – From dispensaries to indispensable: community pharmacy as the true front door to the NHS

Amit Patel
Chief Executive, Community Pharmacy South West London

Conor Price
Chief Executive, Community Pharmacy London

Introduction

With over 11,000 locations and 1.6 million daily visits, community pharmacy is arguably the most accessible health service in the NHS. However, its potential to act as proactive clinical partner remains constrained by outdated perceptions, digital isolation and structural fragmentation.

The traditional view of community pharmacy has been overly transactional, focused primarily on dispensing medication. While this function is critical, it is only one facet of pharmacy's wider capability. Pharmacists possess deep clinical knowledge, particularly in medicines optimisation, safety and adherence, and are increasingly trained in independent prescribing, health promotion and the management of long-term conditions. As the NHS moves toward a neighbourhood-based, integrated care model, the time has come to position pharmacy not as a peripheral contractor, but as a core member of a reimagined, multidisciplinary primary care team.

The outdated image of pharmacy as a medication supply function still defines how it is commissioned, regulated and funded. It's time to leave that model behind.

A vision for 2035

Imagine walking into your local pharmacy in 2035. It's bright, welcoming, clinically advanced – and central to your health journey. Whether you need urgent advice, routine monitoring, mental health support, or help managing a long-term condition, your pharmacy team are your first point of care. And behind the scenes, they're fully connected to your GP, your care plan and your health record.

This is not a fantasy. It is the logical next step in the evolution of the NHS. As the pressures on general practice intensify, and hospital systems become ever more stretched, a more distributed, neighbourhood-based model of care is not just desirable – it is essential.

And at the heart of this model sits a reimagined, empowered community pharmacy.

Importantly, the opportunity does not stop at pharmacy alone. There is untapped capacity across dentistry and optometry too. If every provider delivering NHS services, including pharmacists, dentists and optometrists, were supported to deliver routine vaccinations, the NHS would gain a network of more than 40,000 locations offering preventive care – a dramatic expansion beyond the current 6,500 GP practices. This has profound implications for public health resilience, particularly in managing future vaccination campaigns and outbreaks.

Everyday care transformed

In 2035, community pharmacy is the primary, proactive engine of neighbourhood care. Now fully digitised and interoperable, pharmacies offer:

- **Point-of-care diagnostics and prescribing** across minor illness, chronic disease, contraception and more.
- **Shared care delivery** with GPs, dentists, optometrists, mental health teams and social care partners.
- **Population health analytics**, identifying unmet needs and informing system-wide resource planning.
- **Preventive care**, including vaccinations, health checks and lifestyle interventions – delivered at scale.
- **Frontline surveillance**, contributing real-time insights to system-wide health intelligence, monitoring trends that serve as early indicators of emerging public health issues.

What will it feel like for people?

Aisha, now 42, hasn't seen a GP for a urinary tract infection in a decade. She walks into her local pharmacy and speaks to an advanced pharmacist practitioner. Using AI-supported diagnostics and access to her full shared care record, the pharmacist diagnoses, prescribes and updates her longitudinal health plan, automatically notifying her GP and care team. The visit takes 15 minutes, start to finish.

John, 68, no longer juggles GP visits for his hypertension. His pharmacy provides wearable-enabled remote monitoring, real-time medication adjustments, and integrated behaviour change support. The pharmacist – part of a digitally connected neighbourhood care team – reviews John's dashboard weekly, proactively intervening when readings shift. His blood pressure has been stable for years.

David, managing type 2 diabetes, is part of his pharmacy's chronic care cohort. Every month, he checks in through a mix of in-person services and virtual support. His pharmacy-led care plan includes foot checks, HbA1c tracking and dietary coaching. Only when complexity increases is his care escalated to his GP or specialist. Hospitalisations are rare.

Ella, now 77, still cares for her husband, who lives with dementia. But when she experienced caregiver fatigue, it was her pharmacist who spotted the signs early. Within days, she was connected to peer support, counselling and flexible respite options – seamlessly accessed through the pharmacy's neighbourhood care navigator.

Building the future we need

Real change will require decisive structural reform, which includes:

- **Formation of collaborative, at-scale provider vehicles**. These could take the form of community pharmacy collaboratives or corporate entities developed through local pharmaceutical committees. Such structures would provide the governance, operational maturity and contractual authority necessary to engage with PCNs, integrated care systems and neighbourhoods. Embedding dedicated community pharmacy clinical directors within each collaborative would ensure that pharmacy has a credible voice in local planning and delivery.

- **From fragmented to integrated**. We must shift from a siloed model of care to one where pharmacy is fully embedded within integrated primary care teams which include GPs, nurses, dentists, optometrists, allied health professionals and, critically, community and voluntary sector organisations. Local place-based teams will increasingly operate as multidisciplinary teams across health and social care, including services such as welfare advice, housing support and mental health. Pharmacy needs to be structurally connected to these partnerships and empowered to contribute meaningfully to wider determinants of health.

- **Levelling up digital infrastructure**. Pharmacy should not be left behind simply because its IT systems are not centrally funded. A place-based funding mechanism, possibly underpinned by risk-sharing agreements, must be developed to support digital integration. Pharmacies should have full access to shared care records, interoperable prescribing systems, and scheduling tools linked to the NHS App. Without this, pharmacy's clinical potential will remain unrealised. Integration of records is not simply about efficiency: it is fundamental to delivering effective, patient-centred care tailored to individuals' needs.

- **Impactful strategic commissioning**. Rather than commissioning services at an organisational level, we need population outcome commissioning at neighbourhood level. This allows for pooled resources and shared delivery responsibility across general practice, pharmacy, dentistry and optometry. It reduces siloed competition and instead promotes collaborative working based on defined, measurable outcomes. Existing funding pots, including the underspent Pharmacy First allocation, should be repurposed to catalyse this shift, starting with demonstrator sites in willing systems.

- **Effective use of data and population health management (PHM)**. Community pharmacies generate vast amounts of data daily – from dispensing records to service usage and clinical consultations. When connected to wider PHM platforms, this data becomes a powerful tool for identifying unmet need, targeting high-risk cohorts and supporting proactive intervention. For example, pharmacies could use prescribing trends to flag patients with poorly controlled hypertension or irregular medication adherence. By integrating this intelligence into neighbourhood health dashboards, commissioners can make better-informed decisions and allocate resources more effectively. This is not just about sharing information; it is about transforming data into action.

- **Investment in leadership and workforce development**. Pharmacists must be trained and empowered as system leaders, capable of co-designing pathways and contributing to multidisciplinary neighbourhood teams. This needs to begin from the ground up. The frontline workforce must be supported to think differently, engage with other sectors, and take an active role in collaboration and transformation. Leadership development must go beyond traditional CPD and focus on system leadership, strategic thinking and collaborative problem-solving.

Conclusion

Community pharmacies operate at the heart of their communities – physically embedded, trusted and walked into millions of times each day. By 2035, with the right digital, clinical and organisational infrastructure, they have become a cornerstone of community-based, integrated care. Not an optional extra, but an essential foundation.

If we are serious about transforming primary care, we must bring community pharmacy in from the margins. The ambition is not merely to protect pharmacy services, but to reposition them as proactive, integrated and indispensable elements of local care delivery. By embracing digital innovation, new governance models and outcome-based commissioning, we can unlock the full value of pharmacy for patients and systems alike.

A neighbourhood model of care built on mutual respect and shared outcomes across pharmacy, general practice, dentistry and optometry can radically improve access, equity, and sustainability. Patients will be seen faster, closer to home, by professionals best suited to meet their needs. Capacity will be freed up in general practice. Prevention will become the norm, not the exception.

This is the NHS we must build – one where community pharmacy is no longer a transactional service, but an indispensable health partner. The profession is ready. The infrastructure is emerging. The need is urgent.

It is time for community pharmacy to step up, and for the system to step forward and meet it.

Chapter 3 – From ‘dental deserts’ to neighbourhood dentistry: rethinking dental health provision for the next decade

Lorraine Mattis
Chief Executive, University of Suffolk Dental CIC

Introduction

Access to NHS dentistry in England has reached a critical state, with far-reaching consequences for individuals, communities and the wider healthcare system. Moreover, satisfaction with NHS dentistry has fallen to a record low.

Years of chronic underfunding, growing workforce shortages and a flawed contractual model have left millions without access to even the most basic dental services. More than 13 million adults – over one in four – are struggling to find NHS dental care, while entire areas of the country have become ‘dental deserts’. Areas of high deprivation are disproportionately affected by shortages, which deepens already widening health inequalities. Indeed, children living in the most deprived areas of England are more than twice as likely to have experienced dental decay than those in the least deprived.

But 2035 tells a different story. By 2035, England’s dental care system stands as one of the most transformed pillars of the NHS – a service once teetering on the edge of collapse, now renewed through innovation, integration and bold reforms to its funding model. Central to this transformation is the

adoption of new care models that see dentistry not just as a service to be accessed in an emergency, but with oral health professionals fully integrated within a neighbourhood health model, and where oral health and education is everyone’s business, embedded in public health, education and community life.

In 2035, no one is talking about oral health – because it’s no longer a crisis, no longer siloed, and no longer neglected. It has become so seamlessly integrated into everyday health and wellbeing that it simply is. This should be our ultimate measure of success.

From fragmentation to integration

At the heart of the transformation is the neighbourhood oral health team: a model that can flex to suit local contexts, and that has matured into a globally respected standard. These teams include dental therapists, dental nurses, oral health educators and dentists, working in partnership with GPs, pharmacists, health visitors, social care workers and voluntary, community and social enterprise (VCSE) sector colleagues. Together, they manage shared patient lists and coordinated digital health records, offering holistic, preventative care across entire communities.

Routine check-ups, restorative treatment (within their scope of practice), and oral hygiene support are delivered by dental therapists who now form the backbone of NHS dental provision, supported by a wider team of oral healthcare professionals. Their training – once limited by a bottleneck of placements and financial disincentives – has been scaled nationally through government investment in dental therapy education hubs and community-based placements. Changes to how dentistry is commissioned enables a mixed-model approach that can see dental therapists holding contracts, as well as dentists. As a result, areas previously deemed ‘dental deserts’ can now provide equitable access to treatment and oral health.

Dentists, too, have found renewed purpose. No longer pressured to deliver high volumes of procedures, they are now the clinical leads for complex care, mentors for dental therapists and supervision of dental teams through a distributed leadership model. Their work is outcome-driven, measured by

reductions in disease prevalence and patient transitions from high to low risk – not the number of extractions or restorations performed.

Dentists and dental therapists are not only providers of patient care, but also clinical leaders shaping strategic decisions at the system level. They play a pivotal role in primary care provider collaboratives, helping to transform services and deliver care through a neighbourhood model. By adopting a ‘one workforce’ approach, they contribute to optimising productivity, shifting care out of hospital settings, and prioritising prevention – from oral health to broader areas such as screening and vaccination.

A digital, decentralised system

Digital innovation and greater use of technology has ensured safe, scalable care. In 2035, a seven-year-old child in a former ‘dental desert’ can receive a digital scan at their local neighbourhood hub or community diagnostic centre, which is analysed remotely by AI and verified by a central NHS diagnostic hub. If treatment is needed, they’re referred to a nearby health centre where a dental therapist already familiar with their medical and social history can begin care within days.

This ‘distributed dentistry’ model is particularly powerful in underserved and rural areas. Mobile dental units staffed by dental therapists and dental nurses now visit farming villages and care homes on a rotating schedule. For vulnerable adults or those with mobility challenges, care is no longer a battle, it’s a basic entitlement.

After decades of being a ‘digital desert’, dental practices are fully integrated into NHS systems, and paper prescriptions consigned to history. Digital interoperability and electronic prescribing have become the norm, allowing oral health professionals to work in tandem with wider health partners, and provide seamless care to patients.

Prevention as the first line of care

Most importantly, 2035 is the year prevention eclipsed intervention – oral health and oral education is everyone’s business. Not just delivered by dental care professionals, teams across health, social care and education are trained as oral health educators. Inspired by models in Finland and Japan, oral health education begins at nursery and continues through every school year. Sugar awareness campaigns are embedded into local authority wellbeing strategies and all medicines for children, including antibiotics, are sugar-free.

Crucially, dental nurses have emerged as community oral health champions. From parenting classes to food banks, they teach parents how to brush their children’s teeth, interpret food labels, and access free dental packs. In 2035, the rate of hospital admissions for dental decay in children dropped below 5,000 for the first time in over 40 years – a tenth of what it was a decade earlier.

Conclusion

The vision for 2035 is clear – and achievable. But to achieve it, we must start delivering on it today. Through bold reform, smarter commissioning, investment in a diverse oral health workforce, and full integration into the wider health and care system, we can move dentistry from the margins to the mainstream of NHS care.

This is not about tinkering around the edges but requires a reimagining of purpose and a shared commitment to prevention. Oral health can no longer be a neglected afterthought – prevention must become the first line of defence. And how will we know if we’ve succeeded? When oral health is no longer a public health emergency. When it is so deeply embedded in everyday life, systems and behaviours that it no longer requires a separate conversation.

That is the future we must create – starting now.

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