

**NHS England South East
Personal Dental Services
Specialist-led Special Care and Paediatric Dentistry
Draft Service Specification**

Service Specification Number	
Service	Special Care and Paediatric Dentistry
Commissioner Lead	NHS England South-East
Period	April 2021 Anticipated contract term -10 years with option for further 2 years (to be confirmed)
Date of Issue	12 th June 2019
Version	V6, final draft for engagement

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Final draft for engagement

1. Introduction

When developing this specification, the working group considered a number of information sources. These included:

- The findings from the patient and public engagement which was conducted as part of the needs assessment
- The findings from the stocktake exercise of current special care/paediatric services
- The draft commissioning standards for vulnerable adults developed by the Office of the Chief Dental Office, published in June 2019
- Feedback from the South East Special Care Managed Clinical Networks on a draft specification
- Feedback from other stakeholders on a draft specification

The purpose of this draft specification is to outline the services to be commissioned for specialist-led special care and paediatric dental services. Stakeholders will be invited to comment on this draft specification as part of the stakeholder engagement process prior to procurement. Findings from the engagement will be considered in the development of the final specification.

2. Background

2.1 Description of the Speciality

Special Care Dentistry

The speciality of Special Care Dentistry is concerned with the improvement of the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors. The specialty focuses on adolescents and adults only and includes the important period of transition as the adolescent moves into adulthood. The speciality was formally recognised by the General Dental Council (GDC) in 2008.

It is important to recognise that Special Care Dentistry is not synonymous with the Community Dental Service (CDS). It is a specialty related largely to adults, whereas most CDS provide some Special Care Dentistry, but also provide other services such as Paediatric dentistry.

Paediatric Dentistry

The specialty of Paediatric Dentistry provides specialist oral healthcare for infants and children whose needs cannot be adequately managed by their General Dental Practitioner. This includes care for children with extensive oral disease, those whose

oral health care is complicated by intellectual, medical, physical, social, psychological and/or emotional disability, children with developmental disorders of the teeth and mouth, and children who are either too anxious or too young to accept routine dental treatment if required. The age range covered by the specialty is normally regarded as 0 -16 years, at which stage children transition to adult oral health services.

Transition from Paediatric to Special Care Dentistry

It is important that local transitional arrangements and age implications are understood and communicated to both service users and all dental clinicians. There can be some local variation in this transition stage due to local arrangements in the delivery of care for certain conditions and age limits for access to certain components of the service, such as in-patient Paediatric services.

For those with comorbidity, significant disability and/or complex health needs specialist care beyond 16 will be most appropriately met by the adult specialty, Special Care Dentistry. Transition to other adult specialties, such as restorative dentistry, oral surgery, oral and maxillofacial surgery and orthodontics may also occur during adolescence. Transition should have a carefully planned, co-ordinated and systematic approach which is prepared well in advance of the transition phase.

2.2 Service Delivery - National Picture

Special Care and Paediatric Dentistry are provided by General Dental Practitioners (GDPs), by Community Dental Services (CDS) and by Hospital Dental Services, including Dental Hospitals.

These services operate under various contractual arrangements and have different methods of data collection. Therefore, identification of the volume of Special Care and Paediatric Dentistry provided by each sector or by each provider is difficult.

A survey of NHS Area Teams was undertaken in September 2014 by NHS England in an attempt to describe how much Special Care and Paediatric Dentistry was being commissioned. Responses were received from 12 out of 27 Area Teams and covered 36 CDS. However, very little useful data was obtained to inform the national picture of current service provision and demand for special care dental services.

The services were very disparate in terms of size of population served (135,700 to 1,963,500 people) and the reported size of the adult special care population they served (0.33% to 27% of the population). All of the services operated under a Personal Dental Service agreement except one, which was provided under a standard NHS contract. The majority of contracts were due to finish in 2015 or 2016.

The main contracting currency used was UDAs and almost half had key performance indicators attached to the contract.

Special Care and Paediatric Dentistry provided under a GDS contract cannot be quantified; data collection (via the FP17 form) submitted to the BSA limits the ability to easily capture and identify this group of patients. Special Care Dentistry provided in the hospital sector does have a separate specialty code 451 that is not widely used. There are no separate or specific treatment function codes for Special Care Dentistry. Treatment is often recorded utilising restorative and/or oral surgery codes, which may not reflect the true cost of providing this service.

Development of Special Care Dentistry provision has usually been provider led and based on historical CDS provision and the clinical interests of committed clinicians. The introduction of the specialty in 2008, with transitional arrangements for admission to the specialist list has reinforced historical provision in existing areas.

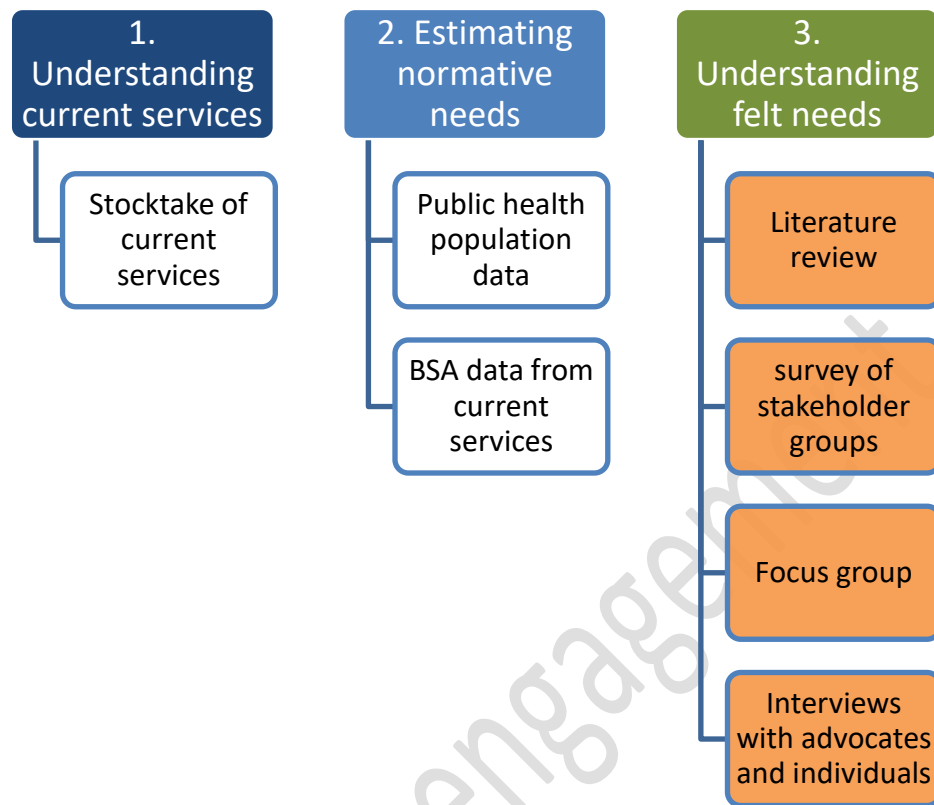
Referral protocols and acceptance criteria have developed locally, again often provider driven to manage demand. This has resulted in variability in provision between services.

Current contracting arrangements have led to variability in activity targets, contract monitoring and quality measurement. IT systems are different in each sector and there is no standard software system for recording and reporting Special Care Dentistry. The British Dental Association's CaseMix tool is used by many CDS's to measure patient complexity, but clinicians using the tool are not usually calibrated and this does contain a subjective element which makes comparison challenging.

2.3 Population Need in the south of England

As part of the preparation for procurement of special care and paediatric services Public Health England have been leading on an assessment of need. The Needs Assessment consists of three linked workstreams figure 1.

Figure 1. Oral Health Needs Assessment workstreams



The needs assessment has included a public engagement exercise. This exercise gathered the views of people likely to require special care dental services. This findings from the engagement have informed the development of this specification.

A summary of the findings is contained in the embedded presentation below



PPE special care
summary findings Ju

2.4 Workforce – National Picture

Special Care and Paediatric Dentistry, in common with other dental specialties, are provided by dentists and Dental Care Professionals (DCPs).

Special Care and Paediatric Dentistry can and does form part of routine care provided by primary care dentists on an 'informal' basis. Most Special Care and Paediatric Dentistry at a specialist level is delivered by Community Dental Services, Foundation Trusts, District General Hospitals and dental hospitals under a variety of contractual arrangements. There are 10 dental hospitals in England providing under graduate and post graduate training and delivery of NHS dental services. Traditional dental hospitals are usually hosted by secondary care trusts.

Care provided by secondary care providers is largely outpatient based. Much of this care could be delivered in primary care. However due to historic hosting arrangements, with the acute trusts, care is currently paid for at secondary care tariff.

Ideally Special Care and Paediatric services should have Consultant leadership, but this may not be possible in all cases and services may be led by a Specialist. Ideally the specialist would have links to a teaching hospital. Services usually deliver care using specialists and dentists with a specialist interest.

Services also utilise Dental Care Professionals (DCP). This group includes dental hygienists and dental therapists, as well as dental nurses many of whom will have completed post-basic qualifications in both sedation and Special Care Dentistry. Many Special Care and Paediatric providers employ dental therapists as they can provide the less complex dentistry as part of their overall treatment plan. Dental therapists and hygienists can provide treatment under inhalation sedation, following suitable training and competency assessment.

Dental Nurses with suitable training and competency assessment can provide a range of additional extended skills. These include taking radiographs, impression taking and application of fluoride varnish and provision of oral health advice. Prevention is vital for people requiring Special Care and Paediatric Dentistry.

Health Education England (HEE) and the deaneries are responsible for providing an adequate number of Special Care and Paediatric Dentistry specialist training posts nationally. Local Trusts and providers will work in conjunction with HEE to host and deliver training to dentists and DCP's. Training Programme Directors in Special Care and Paediatric Dentistry will oversee training locally. Funding for some trainee posts is available from deaneries.

2.5 Levels of Care

NHS England has published commissioning guides/standards for paediatric¹ and special dentistry². The Department of Health advanced care pathway working group defined procedures and modifying patient factors that describe the complexity of a case. The levels of complexity do not describe contracts, or practitioners or settings. Levels 1, 2 and 3 care descriptors reflect the competence required of a clinician to deliver care of that complexity.

Level 1 outlines what a dentist on completion of undergraduate and dental foundation training (or its equivalence) would be expected to deliver. Therefore,

¹ <https://www.england.nhs.uk/wp-content/uploads/2018/04/commissioning-standard-for-dental-specialties-paediatric-dentistry.pdf>

² <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-spec-care-dentistry.pdf>

Commissioners expect that level of competence as a minimum competency standard for performers on the NHS performer list.

The levels of care are described as:

Level 1 –needs that require a skill set and competence as covered by dental undergraduate training and dental foundation training, or its equivalent

Level 2 –procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register. This care may require additional equipment or environment standards but can usually be provided in primary care. Level 2 complexity maybe delivered as part of the continuing care of a patient or may require onward referral

Level 3a - needs that require management by a dentist recognised as a specialist as per the GDC-defined criteria

Level 3b – needs can only be managed by a dentist recognised as a specialist as per the GDC defined criteria and holding consultant status

Further detail on the treatment/patient types which fall into the different levels of care can be found in section 3.

3. Transforming Services

The points below set out NHS England South East’s approach to commissioning services from 1 April 2020:

- Services will be commissioned in line with the NHS Long Term Plan³. Services will need to deliver NHS care in a more joined up and coordinated way using health professionals from different disciplines working together, in networks focused on local communities and reducing reliance on hospital care
- Managed Clinical Networks (MCNs) will enable clinicians to shape and influence service redesign through working with commissioners and patients. In developing, redesigning, procuring and monitoring services, arrangements will be made to involve patients, carers and the public, and the organisations that advocate for them including Health Watch;
- Contracts will include key performance indicators (KPIs) and/or quality indicators which will incentivise quality;

³ <https://www.england.nhs.uk/long-term-plan/>

- GPs will require appropriate training to support valid referrals
- A single point of entry for referral to services underpinned by a referral management system;
- Referral management will be via electronic referrals
- Referrals will include an agreed minimum data set
- Agreed definitions and standards for waiting times both for review of referral, assessment, advice and treatment 'starts' from optimum treatment time.
- Patients and referring dentists will have access to waiting time data and will use this information when considering where to refer for treatment;
- Services will be specialist led and will use skill mix in care delivery;
- Maintenance of core skills and enhanced continuing professional development (CPD) for all members of the team

4. Service Definition

4.1 Aims and Objectives of Service

Aims

The service will:

- Ensure access to dental care for children and patients with additional needs unable to receive care or treatment in a primary care setting due to their enhanced management needs
- Provide care and treatment to children and those with additional needs in line with the evidence base and best practice to achieve clinically effective outcomes for patients
- Contribute to the improvement of oral and general health and reduction in health inequalities of the local population with a focus on prevention both via service delivery and partnership working with a range of health care providers and other key stakeholders.
- Work in partnership with the wider dental system to facilitate access to early intervention for treatment to prevent the need for treatment at more advanced stage of disease

Objectives

The service will achieve its aims by providing:

- A leadership role within local networks focusing on prevention, early intervention and access to Special Care and Paediatric services
- Specialist-led Special Care and Paediatric dental services to the required standards meeting the identified needs of the population
- Mandatory and additional (sedation, domiciliary care) dental services for patients who are unable to access care from general dental practice as described in the service specification
- Treatment under general anaesthesia for those patients who meet the criteria for referral to the service and who have a clinical need for treatment under GA, linking with secondary care services to achieve access to general anaesthetic services
- Care which complies with national commissioning guides
- Joint working arrangements with other specialised services to provide multi-disciplinary care for patients as appropriate
- Services that have suitably trained and skilled workforce to deliver the services and needed to provide Special Care and Paediatric dentistry in the local area, including Level 2 and Level 3 care
- Services from premises which meet the relevant legislative requirements and comply with the access requirements outlined in this specification
- Services which are fully integrated with the dental electronic referral service and are compliant with relevant IT and IG legislation and guidelines
- A contribution to the building of skills across the local dental workforce by participating in teaching and training and workforce development

4.2 Contract Type and Length

The contract is offered under the terms of the NHS (Personal Dental Services Agreements) Regulations 2005 effective from 1 April 2006 and any subsequent revisions.

It is anticipated that the agreement will be for 10 years in the first instance with the option available to both parties to extend for up to a further 2 years by mutual agreement. This is an indicative contract length and is subject to confirmation by NHS England.

4.3 Service Description

Population covered

The specialist-led special care and paediatric dental services described in this specification will cover people resident in the lot area or registered with a General Medical Practitioner in the specified area. It will also provide immediately necessary care and clinically-appropriate treatment to any individual temporarily residing in the area and meeting the eligibility criteria to access the service.

The final version of the specification will include, in this section, a description of the lots. The lots have yet to be determined but the development of them will consider the shared care and leadership role this service will provide. It is anticipated that the commissioned service will cover a population of 750,000 to 2 million. The size of the population covered will be influenced by local systems and geography and the estimated level of need in the population.

4.4 Service description/care pathway

Special Care Dentistry

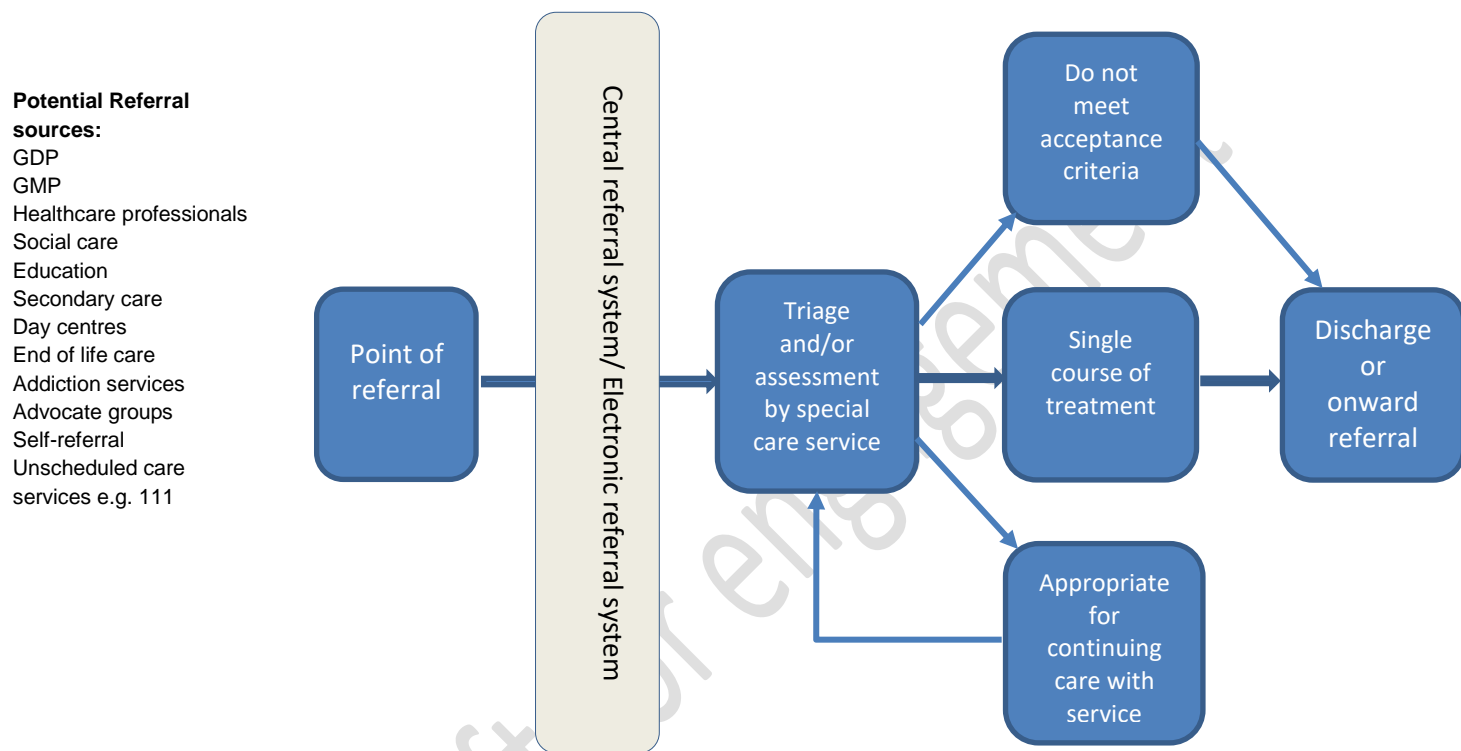
Adult patients (aged 16+ years) who meet the description of level 2/3 care (section 7) will be accepted for care with the special care services. Care may be provided completely by the specialised service or care may be shared with other services, including the referring dentist and the specialised provider.

The provider will be required to deliver an advice and treatment planning service to local clinicians as part of the service.

There will be a cohort of special care patients who need to be seen in special care services for continuing care as their needs are too complex to be managed in the GDS.

The proposed adult referral pathway is shown in figure 2.

Figure 2. Proposed care pathway for adults



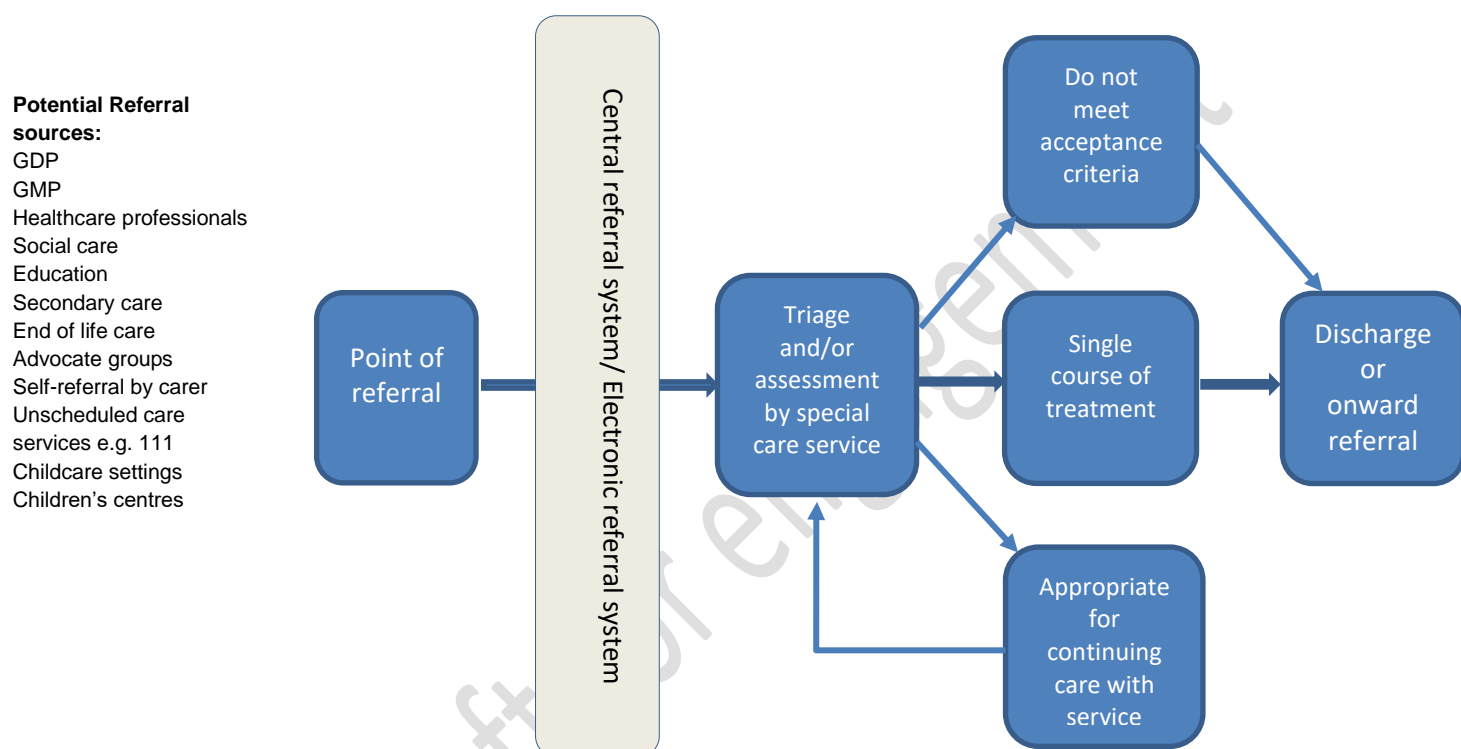
Paediatric Dentistry

Child patients (aged <16 years) who meet the description of level 2/3 care (section 7) will be accepted for care with the paediatric service. Care may be provided completely by the specialised service or care may be shared with other services, including the referring dentist and the specialised provider.

There will be a cohort of paediatric patients who need to be seen in the specialist-led service for continuing care as their needs are too complex to be managed in the GDS.

The proposed referral pathway for children is shown in figure 3.

Figure 3. proposed care pathway for children



General Anaesthetic (GA) services

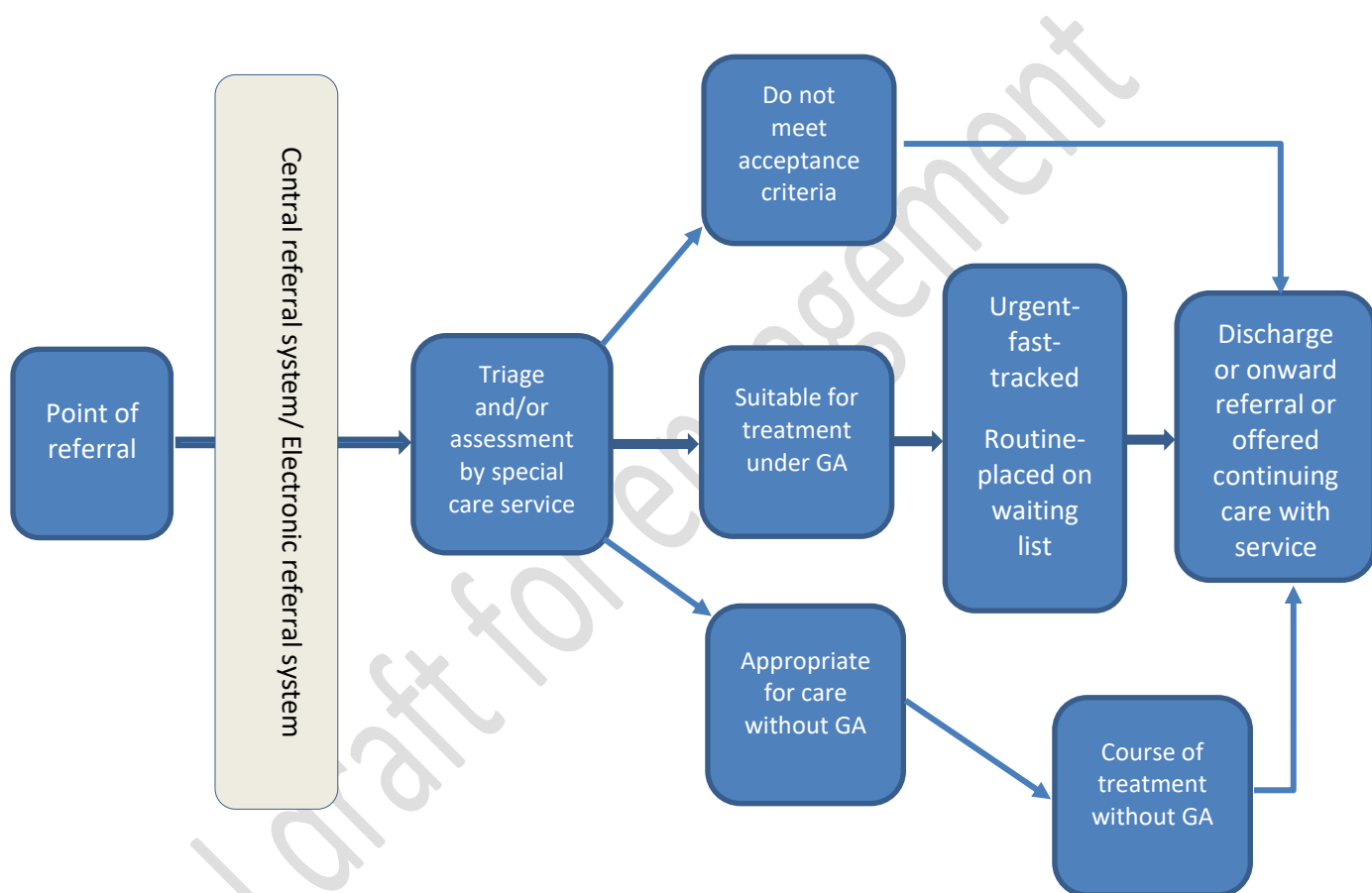
Adult special care and Paediatric patients who are unable to be treated by any other treatment modality such as local anaesthetic +/- sedation may require dental treatment under general anaesthetic. The service must ensure that it secures access to general anaesthetic facilities which comply with the relevant legislation and guidance. The service should provide exodontia and clinically relevant restorative treatment under general anaesthetic. Restorative treatment would normally only be available for patients with special needs.

All other treatment options should have been considered by the service where appropriate prior to accepting these individuals for dental treatment under general anaesthetic,

The service must ensure that any activity carried out under a general anaesthetic is reported under the Hospital Episodes Statistics (HES) reporting system, so that it is included in national reporting of GS data.

The local pathway for care under general anaesthetic is shown in figure 4.

Figure 4. Care pathway for treatment under general anaesthetic



As part of the GA pathway the services must ensure that it has access to timely orthodontic assessments for patients being considered for extractions of first permanent molars.

Sedation

Due to the complex needs of Special Care and Paediatric patients it is necessary for the service to provide dental treatment using a range of treatment modalities, including both psychological such as behaviour management and pharmacological such as sedation (inhalation, intra-nasal, intra-venous). Sedation is used as an adjunct to behaviour management and local anaesthetic. The service must offer care

under inhalation, intra-venous and intra-nasal sedation, where it is clinically appropriate to do so.

For Adult Special Care and Paediatric patients to receive care under sedation their needs must meet the criteria for level 2/3 special care or paediatric care as described in section 7. The criteria take into the account both demand and the limitations of being able to provide certain dental treatments to a high standard under sedation such as molar endodontics.

The main reason for the use of sedation is because of limited co-operation, this may be due to anxiety, learning disability, young age etc.

Sedation services must be delivered in line with service standards outlined in 'Commissioning Dental Services: service standards for Conscious Sedation in a Primary Care setting' (NHS England, June 2017)

Domiciliary care

Adult Special Care and Paediatric patients who are unable to access dental clinics due to, for example, mobility issues, dementia must be offered access to domiciliary care. This service must provide care for patients with urgent and routine dental problems.

Domiciliary care must be provided for patients for whom it is clinically appropriate and where it is unrealistic for the patient to travel to the clinic. It is recognised that for clinical and logistical reasons it may not be possible for a full range of mandatory treatments to be provided in a domiciliary setting. Treatment plans may have to be modified to take account of this. Treatment under sedation and general anaesthetic are excluded from being provided in a domiciliary setting.

Feedback from the public engagement exercise has shown a need for clarity about when domiciliary care may be offered and appropriate. The aim is to eliminate the geographic variation that currently exists about who can access domiciliary care and the treatment offered. The intention is to develop an agreed set of criteria for domiciliary care which will be used across the South East of England. These will be developed by the MCNs and the service will be expected to abide by them.

Case Mix Index

The service should use the case mix index for all patients. The latest version of the tool should be used. The 2019 version of the tool is available from <https://bda.org/casemix>

Case Mix Index for adults

The Case Mix Index is a tool to assess the degree of difficulty in carrying out dental treatment, based on the individual's impairment or disability and the impact this has

on providing a responsive service. It assesses Communication, Cooperation, Medical problems, Oral risk factors, Access to Oral care and Legal and ethical barriers to care. It does not assess the degree of dental complexity. It is completed at the end of each course of treatment as it is impossible to assess these factors prior to or at the beginning of a course of treatment.

Case Mix Index for children

The Case Mix Index has been adapted for paediatric patients to reflect the fact that the parents and/or guardians play a large role in the dental care of their child. So, if the parent's communication skills are poor this reflects on the difficulty in treating the child. Similarly, if the parent does not bring the child to appointments, the child is subject to a care order or is on a child protection plan this can impact on the ability to provide care and the additional time needed.

The case mix tool is intended to be one of several indicators which can be used to monitor and ensure adequate provision of dental services for disabled children and adults.

Referral forms

Referral forms for the service will be developed with the provider and appropriate MCN to ensure that they capture the essential information required for accurate triaging and assessment. Where an electronic referrals system is in place the referral algorithm will be developed with the provider and the appropriate MCN.

4.5 Service Requirements (Provider)

Clinical services

The provider will:

- Ensure that service provision conforms to all relevant guidance and standards;
- Provide a clinical service in line with 'Level 2 and 3' provision as described in the Guides for Commissioning Specialist Services
- Ensure that where referrals are deemed inappropriate, or where additional information is required to establish appropriateness, they respond to the referring dentist within 10 working days, to request clarification, confirm reason for rejection or arrange onward referral to appropriate providers;
- Liaise with the referring practitioner and provide a written report containing the treatment plan; reports to be sent within 2 weeks of the completion of the assessment – for referrals triaged as routine,
- Provide high-quality, timely and appropriate care;
- Maintain good working relationships with colleagues in and outside the NHS who contribute to the overall care of any patients to ensure that this is conducted in the most appropriate, efficient and effective manner;

- Follow the local referral pathways;
- Deliver care within a defined timescale recognising the provider's contracted activity level; patients assessed as eligible for treatment should be scheduled for treatment in a timely manner based on clinical need/age; 95% of patients should start treatment within 18 weeks of referral being received.
- Where possible the patient should receive care from the same clinical team so that they are able to build a trusting relationship with them.
- Where appropriate patients should be offered an introductory visit so that they are able to familiarise themselves with the service in advance of any dental care being provided
- Ensure that they have good links to secondary care and other clinical services so that care can be provided in a co-ordinated way for the benefit of the patient e.g. out-patients under the care of the secondary care multi-disciplinary team.

Strategic leadership

The provider will:

- Have a key role in providing clinical strategic leadership to the wider dental system within the area. The service (through the strategic lead) will be responsible for bringing together local stakeholders, both dental and non-dental, to improve and develop local pathways and care for children and patients with additional needs. This will involve working with established and emerging local networks
- Ensure that a senior representative (or deputy) from the service attends the appropriate MCN. 100% of MCN meetings must be attended.
- Ensure that the service is able to cascade information from MCNs, commissioners, other networks etc. to staff within the service
- Ensure that the service has processes in place which ensure that it adopts practise and service developments agreed by the MCN
- Facilitate patients to access care from other services including other level 2/3 dental services

Governance

The provider will:

- Monitor and seek to improve service satisfaction rates
- Implement a programme to ensure that feedback from service users is sought and acted upon;
- Implement a feedback exercise which asks patients *"have your needs been met by the service? If not, what could we do differently"*. The service must

demonstrate that it reflects on this feedback and implements changes as a result, as part of a robust audit cycle.

- Ensure that robust procedures are in place to address issues arising from the patient pathway e.g. validation of patient data, management of patient complaints and incidents, management of clinical information/data security
- Provide a person who has the responsibility for overall clinical leadership of the service. This person should be a Consultant or specialist in special care or paediatric dentistry.
- Provide service leads for the following areas:
 - Special care dentistry
 - Paediatric dentistry
 - Training and workforce development
 - Governance
 - Strategic leadership (with an external focus)
 - Domiciliary care
 - Sedation
 - GA
- The service leads and overall clinical lead must have protected time to carry out their leadership duties. All the leads should have up to date level 3 safeguarding training.

The role of the service leads will not be as clinical experts but as strategic leaders. They will have a role in building relationships with other parts of the healthcare system e.g. emerging healthcare networks (ICS, PCN) with the aim of ensuring that patients across the system are able to access appropriate care.

Communication

The provider will:

- Ensure the service provides information to patients/carers/public about the services including waiting time
- Ask all patients at their first assessment appointment
 - Whether they have any additional needs e.g. ground floor surgery, hearing loop, quiet waiting space. These needs should be clearly recorded on the patient notes so that any member of staff is made aware of these needs.
 - For their preferred method of communication. This method should then be used by the service. To meet the varied needs of the patients the service must offer a variety of communication methods including text, e-mail, letter.
- Ensure that the patient's additional needs and communication preferences are updated at each assessment appointment.

- Ensure that each member of staff uses the patient's additional needs and preferred method of communication to customise the care and approach for the individual patient. This includes non-clinical staff such as receptionists who have a crucial role in ensuring that the patient's needs are met.
- Ensure that they provide a service website which contains information which can help patients and carers prepare for their visit. An example which patients have found useful in the past has been a video or downloadable document summarising the patient journey in simple language appropriate to people with a variety of with additional needs. Ideally any document could be customised by carers for individual patients. photographs and information on staff in the service should also be available.
- The website should also include information on how the service is delivering against the quality framework with the aim that the public is able to see how the service is performing against the quality measures
- Ensure that interpreting services (including British Sign Language) are available for patient who need them
- Provide information on who is eligible and exempt from dental charges and facilitate patients in accessing support for completion of forms for claiming exemptions

Access

The provider will:

- Ensure that the service provides good access to care. When addressing access the service must demonstrate that it has addressed all five aspects of access:
 - Acceptability
 - Affordability
 - Availability
 - Accommodation
 - Accessibility

The provider must take steps to ensure that relevant stakeholders (e.g. care home managers, social workers, day centre staff) are aware of the service, what it provides and how to access it. The provider must use a variety of communication methods to disseminate this information e.g. website, social media, written information.

4.6 Excluded from the Service

The service is limited to Special Care and Paediatric mandatory services and specified additional services within complexity level 2 and 3 and therefore excludes all advanced mandatory services. The service will not provide care to patient groups such as in-patients as part of this contract, although the provider may contract directly with other providers e.g. secondary care, haemophilia centres to provide care for patient groups excluded from this specification if it wishes.

The following services are excluded from this service:

- Care to secondary care in-patients
- Unscheduled care for patients who are not under a course of treatment with the service OR who are not appropriate for care with the service (do not meet criteria)
- Sedation and domiciliary care for patients who do not meet the level 2/3 criteria in section 7 e.g. patients with dental anxiety alone
- Care to other in-patients e.g. forensic mental health units, health and justice secure units

4.7 Service Requirements (Performer)

Performers will ensure that for each new course of treatment:

- The patient and/or carer understands that the patient will need to attend the appointments on time and on the correct day. If the patient is late, the performer may be unable to see the patient since his/her treatment session might subsequently run late and thus inconvenience all other patients scheduled to attend after the failed appointment. If the patient misses their appointment or cancels without giving 24 hours' notice, the patient will be offered the next available appointment (usually maximum of six weeks after the date of the failed/late cancelled appointment). The service should have a process in place for managing patients who repeatedly fail to attend appointments. This may include referring to safeguarding policies and liaison with carers and other agencies.
- they deliver safe and appropriate care
- offer a choice of appointment times including evening and weekend appointments
- where patient's needs are outside the scope of the service they are referred to a more appropriate provider of care.

4.8 Referral Acceptance and Data Collection/Submission

Providers must comply with the requirements listed below:

- the service will only use the referral management process as identified by the relevant Local Office and the service must have systems which are compatible with the current and future local referral management services, including web-based electronic referrals
- the service will only use electronic data interchange (EDI) to submit claims to the Business Services Authority
- providers will review the referral for appropriateness within 10 working days of the referral being received, returning any that are incomplete or inappropriate

- all referrals will not automatically warrant an assessment appointment to be offered.
- Where the referral suggests that a routine assessment is appropriate this should be offered within 12 weeks from date of receipt of the referral
- If a referral is clinically triaged as being urgent then the appointment should be offered within 2 weeks from date of receipt of the referral. Until the patient is assessed by the service pain management remains the responsibility of the GDP. Where the patient does not have a GDP, the service will need to ensure the patient's pain is managed.
- following assessment where a patient meets NHS criteria and is ready to commence treatment they should be placed on a treatment waiting list if it is not possible to start treatment immediately. The placement on the waiting list is to be prioritised in date order of referrals being received recognising some patients need to be treated more quickly due to clinical need;
- providers will communicate the outcome of the assessment with the referring practice either confirming acceptance of the patient for treatment and outlining the treatment plan or provide an explanation why treatment has not been offered.
- Any correspondence about the patient must be copied (via their preferred method of communication) to the patient or, where appropriate, their representative
- 95% of patients should be treated within 18 weeks of the referral being received
- the submission of FP17s for completed courses of treatment is required within 62 days

4.9 Service Delivery

The model of service delivery is that of a specialist led service. The service must employ sufficient special care and paediatric specialists (on GDC specialist list) to provide clinical leadership and governance of the service. Clinicians, dental care professionals and other staff working for the service must be adequately trained, skilled and experienced to deliver a high quality and safe service. It is up to the service to determine the correct level of skill mix.

It is not proposed that the commissioners undertake a process of level 2 accreditation for non-specialist clinicians working in the service. The service will hold the responsibility for ensuring that all dentists providing level 2 care have the appropriate skills, knowledge, training and experience to provide the care. The provider can choose to follow an assurance model similar to that of accreditation or they can opt for an alternative method. If, during the course of the contract the commissioners implement an accreditations process then the service must comply with that process.

All staff must have annual appraisals and personal development plans and there must be a system for clinical supervision within the service.

4.10 Training

Training must be supported and encouraged within the service for clinicians, DCPs and other staff.

Suggested topics for staff (including non-clinicians) training include:

- Disability equality training
- Equality and diversity training
- Excellent customer service/communication
- Equality Act
- Mental Capacity Act
- Informed consent
- Dementia
- Brief advice for alcohol, tobacco, diet

The service must be part of the system to develop the skills of the wider workforce within the geography they are working. This will include supporting the skills and development of the primary care workforce. The plan for this will be developed by the Managed Clinical Network.

Health Education England (HEE) and the deaneries are responsible for providing an adequate number of Special Care and Paediatric Dentistry training posts nationally. Service providers will work in conjunction with the HEE to host and deliver training to dentists and DCP's.

5. Outcomes

5.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	X
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

Quality and outcome measures

Definitions

Key performance indicators include a mix of Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMs) and Clinical Outcome Measures.

The service must report against the quality framework described in section 5.2 but can also collect and report other PROMs and PREMs if it wishes.

Any measures used need to be clear and meaningful with regard to these different audiences using the data; for example, it should be possible for non-clinical audiences to understand clinical outcome measures. Measures should also take account of what a good service looks like for these different groups and should be patient centred. There is a need to reduce inequalities between patients with respect to both their ability to access services and the outcomes achieved for them. The quality measures used need to reflect this and the care should be as seamless as possible.

Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMs)

PROMS

Generic PROMs can include simple patient reported clinical outcome measures used elsewhere in dentistry.

Examples of PROMS -

Were you given appointments at a time that was convenient to you?

Was your appointment at a convenient location?

Did the clinic facilities meet your needs?

It must be emphasised that given the nature of some special care and paediatric service users' disabilities, the functions of eating and speaking comfortably, should be presented as separate questions, rather than as the single generic question that may be appropriate elsewhere. In addition, the responses to such questions may not be truly indicative of the quality of care received.

PREMS

With regard to additional specialty specific PREMs, these could include disabled access, having adequate time to understand the proposed treatment and what it will entail for delivery of their care, feeling valued as a service user and the particular attitude and approach of staff members.

Examples of PREMS -

Were you treated with dignity and respect?

Was your dental treatment explained to you in a way that you could understand?

Would you recommend the service to your friends and family?

Were you satisfied with the treatment you received?

As a more qualitative measure it may also be helpful for services to show how they have evaluated, reflected upon, responded to, and acted upon feedback and how services are being developed to improve patient experience as a result of the feedback received.

Clinical Outcome Measures

The National Commissioning Guide outlines the following as examples of evidence which could be used to demonstrate that appropriate processes and protocols are in place:

- Key performance indicators e.g. actual waiting times, DNA rates, CaseMix, Repeat GAs, band 2 to urgent courses treatment
- SIRIs and Never events.
- Formal complaints
- Accolades
- Reference to CQC inspection reports and CQC Outcomes
- Audits

5.2 Locally defined outcomes

It is proposed that the service will be measured using a quality framework which will focus on five key areas:

- Access
- Communication
- Value for Money
- Clinical Care
- Patient Experience

The draft quality framework is shown in the table below. The final quality framework will be co-developed with the provider.

Draft Quality Framework

Category	Description
Effective Care	Proportion of all patients who receive care who are categorised as case mix level 2 or above
	Proportion of patients where application of fluoride is recorded as part of the treatment provided
	Adults (over 16 years)
	Children (under 16 years)
	Proportion of appointments which are not attended by patients
Waiting times	Proportion of discharge letters sent within 2 weeks
	Proportion of patients accepted for care who are seen for an assessment within 12 weeks
	Proportion of patients who start treatment within 18 weeks
Patient experience	Proportion of patients reporting satisfaction with care provided - using question <i>"have your needs been met by the service?"</i>
	Patients' additional needs are recorded at assessment
Governance	Service leads have received level 3 safeguarding training

6. Premises

6.1 Premises and Equipment Requirements

The provider is expected to secure facilities suitable for service delivery the location of which are detailed in the lot specifications. The premises must meet the needs of the patients and their carers. The nature of the patient group means that the service should have facilities and equipment to treat patients with additional needs. The service does not have to offer services from a mobile unit but can choose to use mobile units. If a mobile unit is used it must comply with the relevant guidelines and legislation e.g. HTM0105.

Examples of non-standard equipment which must be provided are:

- Hoist
- Wheelchair tipper
- Dental chair and equipment for people weighing over 23 stone

The provider must indicate potential premises and number of surgeries planned for the provision of the service, this may include the development of outreach clinics (as a hub and spoke arrangement), plans to work with other practices or other innovations. Services should not be provided from single surgery sites (with the exception of mobile units). The provider should ensure that performers work with other performers for the majority of their clinical time i.e. lone working should be avoided. Where it is not possible to avoid lone working e.g. domiciliary care this should not represent more than 20% of the clinical time of the performer.

The provider will be responsible for the funding of all premises and service delivery costs including but not limited to consumables, equipment, laboratory services, appliances and IT operational infrastructure (including Electronic Data Interchange [EDI]).

The provider shall ensure that the premises used for the provision of Special Care and Paediatric Dentistry:

- Are suitable for the delivery of these services
- Are equipped to meet the reasonable needs of the patients
- Are EDA compliant
- Are registered with the Care Quality Commission (CQC)
- Has appropriate and with sufficient waiting-room accommodation for patients and carers
- Has equipment and facilities that conform to relevant standards / regulations and are maintained regularly in line with guidelines and manufacturers protocols

- Is responsible for the funding of all consumables, equipment, laboratory services and appliances
- That any laboratory services are registered with the Medical Devices Agency and these work within the relevant legislation
- Has robust governance and quality assurance programmes in place to ensure a safe environment for all service users.
- Have in contract access to appropriate radiographic facilities and the arrangements for the facilities covers all the legal requirements relating to the use of radiographic equipment
- That the telephone number to be used by patients and or professionals in connection with the delivery of the Special Care and Paediatric service is a local personal number, unless the service is provided free to the caller.
- Meets HTM01-05 best practice
- Uses agreed local checklists highlighting aspects of the service and facilities of relevance such as signage and accessible information

6.2 Location of Services

Providers will need to demonstrate that the premises proposed for the delivery of the service are in a convenient location (e.g. close to schools, places of work, good transport links or homes) within the defined location(s) advised as part of the procurement process. The locations should be easily accessible to patients arriving by foot, public transport or car.

6.3 Additional Requirements

In addition to the requirements detailed in 5.1, the provider must ensure that:

- they have robust governance and quality assurance programmes in place to ensure a safe environment for all service users;
- they have safe processes and working environment in place, that will include ensuring that there are up to date policies and processes, that staff are familiar with these and have the relevant training;
- legal requirements relating to radiological legislation and guidance are met;
- dental laboratory services used meet with GDC guidance, EU legislation, are registered with the Medical Devices Agency and work within the relevant legislation;
- dental services are in accordance with best practice as set out in the following guidance
 - High Quality Care for All – next stage review 2008
 - NHS Constitution, 2009
 - Implementing Care Closer to Home, 2007
 - Modernising Medical Careers
 - NHS Personal Services Agreements
 - Ionising Radiation (Medical Exposure) Regulations
 - AIDS/HIC infected Healthcare worker Guidelines

- Equalities Act, 2010
- Human rights Act, 1998
- Dental Practitioners' Formulary
- GDC Standards for the Dental Team
- GDC Standards
- Caldicott Principles
- The Hazardous Waste Regulations, 2005
- The Health and Safety at Work Act (1974) Statement of Policy with Respect to the Health and Safety at Work of All Employees
- Disability Discrimination Act (1995) and Disability Equality Duty (DED) 2005
- Decontamination of Dental Instruments: Health Technical Memorandum (HTM) 01-05, Parts 1 and 2, 2013
- Health Protection Agency Guidance on Infection Control, Communicable Diseases for Primary and Community Care within the Local Area
- Securing Excellence in Dental Commissioning, NHS Commissioning Board 2013
- Guide for Commissioning Dental Specialities – Special Care, 2015
- Guide for Commissioning Dental Specialities – Paediatrics, 2018
- Royal College of Surgeons of England, National Clinical Guideline for the Extraction of First Permanent Molars in Children (2014)
- Five Year Forward View, NHS England 2014 (aspects relevant to dentistry)
- BSDH Guidelines and Policy Documents for Oral Care of People with Disabilities (<https://www.bsdh.org/index.php/bsdh-guidelines>)
- BSPD guidelines (<https://www.bspd.co.uk/Resources/BSPD-Guidelines>)
- Draft Commissioning Standard for Dental Services for Vulnerable Adults

7. Clinical Competencies

7.1 Description of the Complexity Levels

The table below describes the different levels of care and where it should be provided. This service will provide level 2 and 3 care only.

Adults (aged 16+ years)

Special care (adults)	Tier		
	Level 1 Primary care	Level 2 Shared care (joint specialist-led and primary care)	Level 3 Specialist-led special care service
Adults with moderate to severe learning disabilities	Patient with LD and able to accept all forms of treatment in GDS. Able to have a full mouth exam including charting, radiographs, BPE. Pt co-operative enough to have treatment. May need to be referred to for more complex care.	Patient with LD. Able to have full mouth exam, BPE, simple scaling, simple fills but will not tolerate radiographs. The patient is able to accept some elements of care in primary care but may need treatment planning or specific types of treatment carried out in a specialist-led service	Patient is unable to accept care in primary care e.g severe/profound LD. 24/7 support - residential, full time care at home. Best interest. Lack capacity. Inability to have a straightforward examination (not able to have full mouth exam, BPE, radiographs). Severe behavioural issues. Combined with complex medical conditions that make them too complex to manage in GDS. Domiciliary care. Sedation or general anaesthetic required for treatment. Mental health issues/personality disorders. Risk of harm to healthcare workers.
Adults with physical disability and/or communication impairment	Patient disability does not significantly impact on the ability to transfer to the dental chair. Being in a wheelchair does not preclude them being treated in primary care. Interpreter services are available. Those with language difficulties in isolation should be seen in primary care.	Patient able to have full examination in primary care dental surgery. If require treatment may require access to hoist or wheelchair tipper. .	Patient requiring assisted transfer. Pts who cannot have treatment delivered safely in dental chair. May require domiciliary care or specialist equipment e.g hoist, wheelchair tipper. Sedation or general anaesthetic required for treatment.

Adults with progressive degenerative diseases resulting in neurological conditions such as MS, MND, Huntington's Disease	Patient able to have a full examination, BPE, radiographs, scaling, simple fillings. Treatment able to be delivered safely within pts co-operation and behavioural limits.	Second opinions or joint treatment planning. Able to co-operate for full mouth exams, BPE but unable to tolerate radiographs and treatment. Pts may have capacity issues or fluctuating capacity.	Patient is not able to access regular dental care. Lack of capacity. Best interest decisions. Unable to co-operative for dental treatment safely. May require dental treatment with sedation or general anaesthesia. May require domiciliary care.
Adults with mental health issues	Patient able to have a full examination, BPE, radiographs, scaling, simple fillings. Treatment able to be delivered safely within pts co-operation and behavioural limits.	Able to have full examination in primary care dental surgery. Limited co-operation for certain treatments such as fillings, extractions etc. If patient is supported by CPN or support worker. Pts may have capacity issues or fluctuating capacity. Pts with fluctuating periods of uncontrolled mental health and behavioural issues.	Patient who are unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings, case conferences etc. Sedation or general anaesthetic required for treatment.
Adults with dementia	Patient able to have a full examination, BPE, radiographs, scaling, simple fillings. Treatment able to be delivered safely within pts co-operation and behavioural limits.	Second opinions or joint treatment planning required. . Able to co-operate for full mouth exams, BPE but unable to tolerate radiographs and treatment. Pts may have capacity issues or fluctuating capacity.	Patient is not able to access regular dental care. Lack of capacity. Best interest decisions. Unable to co-operative for dental treatment safely. May require dental treatment with sedation or general anaesthesia. May require domiciliary care.
Adults with complex medical conditions	ASA 1 and 2	ASA 3.	ASA 4 and above Sedation or general anaesthetic required for treatment.
Adults with severe dental anxiety	Care should be provided in primary care for patient with anxiety who is able to accept an examination including radiographs, BPE, simple scaling. ASA I/ASA II patients requiring treatment under IHS/IV sedation.	Medically compromised patient able to have examinations/continuing care in primary care but require IHS/IV sedation or GA for treatment.	Medically compromised patient who is unable to have examinations/continuing care in GDP and require IHS/IV sedation or GA for treatment. These patients are ASA III/ASA IV and their medical problems/complex needs fulfil the acceptance criteria of the service in addition to their anxiety.
Patients requiring specialist equipment e.g. specialist dental chairs for people weighing over 23 stone.	Patient who is mobile and have no co-morbidities. If exceeding the weight of the chair examination and simple treatment may be provided without reclining the chair.	Patient who is usually cared for in primary care but need treatment using a bariatric chair or wheelchair tipper.	Patient who is severely obese and have medical problems which are too complex to manage in primary care. Patient who is unable to access general dental services due to limited mobility, large wheelchairs, transfer to dental chairs. Housebound patients who may need, due to their problem, treatment using a bariatric chair or

			<p>wheelchair tipper, wider door access, accessible toilets.</p> <p>Patient who may require specialised transport to get to a clinic.</p> <p>Patient who is unable to leave home and need domiciliary care.</p>
<p>- Homeless people and rough sleepers</p>	<p>Can be treated in primary care where there are no issues of capacity or complex medical needs</p>	<p>Limited co-operation for certain treatments such as fillings, extractions etc. Pts may have capacity issues or fluctuating capacity. Pts with fluctuating periods of uncontrolled mental health and behavioural issues. Pt with medical problems or complex needs that require more specialised management/treatment.</p>	<p>Patient who is unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings required, case conferences etc. Sedation or general anaesthetic required for treatment.</p>
<p>- Migrants, asylum seekers, refugees and sex workers (excludes people detained/housed within the health and justice system)</p> <p>People with substance misuse</p>	<p>Can be treated in primary care if there are no problems which mean more specialist care is required Language barriers in isolation are not a reason for referral to specialist services</p>	<p>Able to have full examination in GDS dental surgery. Limited co-operation for certain treatments such as fillings, extractions etc. Patient may have capacity issues or fluctuating capacity. Patient with fluctuating periods of uncontrolled mental health and behavioural issues. Patient with medical problems or complex needs that require more specialised management and treatment.</p>	<p>Patient with medical problems or complex needs that require more specialised management and treatment. Patient who is unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings, case conferences etc. Sedation or general anaesthetic required for treatment.</p>
<p>People in secure forensic psychiatric units</p>			<p>Treatment may be provided in the clinics or on a domiciliary basis. Patient with medical problems or complex needs that require more specialised management and treatment. Patient who is unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings, case conferences etc. Sedation or general anaesthetic required for treatment.</p>

Paediatric care (children aged 16 years and under)

	Tier		
Paediatric care	Level 1 Primary care	Level 2 Shared care (joint specialist-led and primary care)	Level 3 Specialist-led paediatric service
Children with moderate/severe and profound multiple learning disabilities	Patient with LD and able to accept all forms of treatment in GDS. Able to have a full mouth exam including charting, radiographs, BPE. Pt co-operative enough to have treatment. May need to be referred to for more complex care.	Patient with LD. Able to have full mouth exam, BPE, simple scaling, simple fills but will not tolerate radiographs. The patient is able to accept some elements of care in primary care but may need treatment planning or specific types of treatment carried out in a specialist-led service	Patient is unable to accept care in primary care e.g. severe/profound LD. 24/7 support - residential, full time care at home. Best interest. Lack capacity. Inability to have a straightforward examination (not able to have full mouth exam, BPE, radiographs). Severe behavioural issues. Combined with complex medical conditions that make them too complex to manage in GDS. Domiciliary care. Sedation or general anaesthetic required for treatment. Mental health issues/personality disorders. Risk of harm to healthcare workers.
Children with physical and/or communication impairment	Patient disability does not significantly impact on the ability to transfer to the dental chair. Being in a wheelchair does not preclude them being treated in primary care. Interpreter services are available. those with language difficulties in isolation should be seen in primary care.	Able to have full examination in primary care dental surgery. If require treatment may require access to hoist or wheelchair tipper. .	Patient requiring assisted transfer. Patient who cannot have treatment delivered safely in dental chair. May require domiciliary care or specialist equipment e.g. hoist, wheelchair tipper. Sedation or general anaesthetic required for treatment.
Children with moderate/severe chronic mental health conditions including ADHD, Eating disorders and substance abuse or Under the care of PCAMHS	Child able to have a full examination, or and straightforward treatment i.e. Treatment able to be delivered safely within pts co-operation and behavioural limits.	Able to have full examination in primary care dental surgery. Limited co-operation for certain treatments such as fillings, extractions etc. Pts may have capacity issues Pts with fluctuating periods of uncontrolled mental	Child who is unable to have treatment delivered safely due to complex behavioural and psychiatric problems. Uncontrolled, unstable mental health issues. Risk of harm to healthcare workers. Lack or fluctuating capacity, best interest meetings, case conferences etc. Sedation or general anaesthetic required for treatment.

		health and behavioural issues.	
Children with complex medical conditions as classified by The American Society of Anaesthesiologists	ASA 1 and 2	ASA 3	ASA 4 and above Sedation or general anaesthetic required for treatment.
Children with dental anxiety	ASA I or II where HIS only is required	Sedation required for more complex treatment e.g. multiple extractions	Child under PCAMHS Acclimatisation for severe anxiety requiring multiple appointments Treatment under GA or sedation other than HIS required
Children with behavioural problems	Child is able to co-operate with treatment in primary care	Some treatment is possible in primary care. Joint treatment planning required	Child with severe Learning disabilities and behavioural issues who are unable to accept care in primary care or where involvement with multiple agencies is required
Children with cleft lip or palate or dental abnormalities including genetic diseases or dental trauma	Treatment required is routine and within the scope of primary care	Dental Trauma where the patient requires support for ongoing treatment after initial injury or joint care for initial injury	Specialist care required e.g. endodontics in complex trauma cases where there is open apex and /or displacement, Dental abnormalities and cleft palate patients. MDT care
Children under the care of social services or with complex social problems	Social issues do not impact on ability of child to receive care in primary care	Social issues may require joint treatment planning or liaison with external agencies	Complex social issues requiring contact with multiple external issues e.g. safeguarding

7.2 Governance and Information

The provider will have an Information Governance (IG) policy in place in accordance with the NHS Information Governance Toolkit. The following must be included in the policy:

- the provider must assign responsibility for IG to an appropriate member of staff;
- the policy must address the overall requirements of information quality, security and confidentiality;
- all contracts, staff, contractor, third party, contain clauses that clearly identify responsibilities for confidentiality, data protection and security;
- all staff members are provided with awareness and training across the IG agenda;
- the provider must implement IG Information Security management arrangements to ensure the NHS CFH Statement of Compliance is satisfied;
- the provider must ensure that all staff and all those working for or on behalf of the provider where applicable comply with the terms and conditions set out in the RA01 form;
- the provider must ensure that all correspondence, fax, email, telephone messages, transfer of patient records and other communications are conducted in a secure and confidential manner;
- the provider must ensure patients/carers are asked before using their personal information that is not directly contributing to their care and that patients'/carers' decisions to restrict the disclosure of their personal information is appropriately respected;
- the provider must be fully computerised, for examples, but not limited to, electronic patient records, ability to submit electronic FP17 claims by EDI transfer, access Compass to update contractual information including annual superannuation reconciliation returns and access schedules, submit Friends and Family Test data, submit annual complaints returns, work with any electronic referral management system in place (or be able to work with future systems);
- the provider must only use nhs.net email account/s when transferring patient identifiable information and other confidential or sensitive information.

7.3 General Principles

- Treatment should only be undertaken in situations where it is believed to be in the patient's best interests in terms of their oral health and/or psychosocial wellbeing.
- In all situations the clinical advantages and long-term benefits of treatment must justify such treatment and outweigh any detrimental effects

7.4 General Patient Factors

The clinician should ensure that the cooperation, motivation, aspirations and general health of the patient are consistent with the provision of treatment.

7.5 General Dental Practitioners

Providers will return any incomplete or inappropriate referrals.

Any referrals that require additional clinical information to explain the need for advice or where there is no indicator that the patient would warrant an assessment should be returned to the referring GDP with an explanation as to why the patient has not been offered an assessment.

Providers will work with GDPs to improve their referrals with the aim of ensuring that referrals are appropriate.

Providers will communicate the outcome of the assessment with the referring practice either accepting the patient for treatment or provide an explanation why treatment has not been offered.

Providers will inform the referring practice when treatment is complete or has been discontinued or abandoned.

7.6 Interdependencies

All providers are required to ensure their performers become pro-active members of the Special Care and Paediatric Managed Clinical Network (MCN). Service providers and performers will work closely with the MCN to implement and improve the patient pathways and ensure that patients receive a high-quality service.

The provider will need to demonstrate effective working relationships with secondary care colleagues to ensure appropriate management of complex cases and appropriate management of complications outside the scope of the service in accordance with the agreed pathways.

Relevant networks include, but are not limited to:

- NHS England;
- Oral Surgery MCN;
- Local Dental Network (LDN);
- Clinical Commissioning Groups (CCGs);
- Sustainability and Transformation Partnerships (STPs);
- British Dental Association (BDA);
- Local Dental Committees (LDC);
- Other relevant clinical networks;
- Local Authority Health and Wellbeing Boards and Scrutiny Committees;
- Health Education England (HEE) and Postgraduate Deanery;
- Healthwatch
- Local system networks e.g. ICS, PCN

8. Accessibility and Opening Hours

The service will be flexible and responsive to individual patient need in accordance with the Equality Act 2010 and the Health and Social Care Act 2008.

The service must offer a choice of appointments, e.g. evenings and weekends as well as weekday daytime access. The range of appointments offered should recognise that carers maybe unable to take time off work. It is not essential for the service to offer extended opening hours at every clinic, but extended hours must be available at a range of sites to maximise access.

The service must provide unscheduled care for patients in a course of treatment with the service where this is assessed as being clinically appropriate. The service must also provide unscheduled care for patients not currently undergoing a course of treatment with the service but who meet the level 2/3 criteria in section 7. This will include patients referred from other services such as 111.

Unscheduled access must be available during working hours (including weekends and evenings). The service should ensure that patients can access unscheduled care in a timely way. To deliver this the service may have to set aside specific time each day to manage this care.

The provider must ensure that patients are able to book and cancel appointments using a variety of methods e.g. website, text, telephone, recognising that due to their additional needs patients may not be able to give a long notice period if they are not able to attend an appointment.

The service will monitor patient satisfaction to include accessibility and implement change where reasonable and appropriate following discussion and agreement with the Commissioner.

8.1 Management of Failed Appointments

Providers are expected to demonstrate effective methods of monitoring and reducing failures to attend to improve service utilisation and improve treatment outcomes.

8.2 Patient Information

The service must ensure that patients are provided with relevant verbal and written information in a variety of formats, where necessary utilising a translator service.

The service must also provide information concerning the outcome of any assessment, a written treatment plan and an explanation of the different treatment options.

Prior to the start of treatment, the patient and/ or carer should be provided with the following information verbally and in writing

- treatment plan including length of treatment and frequency of visits;
- what to expect during treatment;
- what is expected of them and under what circumstances treatment will be terminated e.gg poor attendance, poor oral hygiene, abusive behaviour;
- the information should be given in such a way that it supports the patient's ability to give informed consent to initiate treatment.

Providers will be required to:

- ensure the patient and/or carer has a clear understanding in advance of what will happen to them during the treatment, who will be responsible for delivering each element of care
- ensure informed consent is gained for all patients prior to initiating assessment and / or treatment;
- have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults.
- have in place a policy that meets the commissioner's and CQC requirements for safeguarding children/young persons. The provider should evidence that all patient information and consent processes have involved patients/carers in its development and that it is regularly reviewed and updated.

8.3 Safeguarding

Providers must ensure that:

- valid consent is gained from all patients prior to initiating assessment and/ or treatment;
- they have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults. All staff must receive regular safeguarding training;
- they have in place a policy that meets the commissioner's and CQC requirements for safeguarding children/young persons.

8.4 Waiting Times

The definition of a treatment waiting list is the period of time when the patient is assessed and judged to meet NHS criteria, accepts the offer of NHS treatment and is ready to commence treatment.

There will be separate waiting lists for assessment and treatment that are to be managed as follows: NB times are maximum times

- Review/triage of referral – 10 working days (from date of receipt of referral)

- Information back to referrer – 2 weeks (from completion of triage/assessment/completion of treatment)
- Referral to assessment appointment – 12 weeks (from receipt of referral)
- Assessment to treatment start– 18 weeks

8.5 Discharge Criteria and Planning

A patient will be discharged only when the treatment for which they were appropriately referred is complete or when the patient's treatment is not appropriate for this service. Discharge will be via an agreed method. Discharge information to patients and doctors may need to be sent via standard mail.

8.6 Discharge Information Standards

Discharge information will:

- include the unique reference number (URN) (where referral management arrangements are in operation) and the NHS Number (where known)
- contain clear instructions for the patient's GDP for any on-going care
- contain a summary of the treatment provided and/or the reasons for discharge
- contain details of the continued treatment to be given by the service
- be sent to the referring GDP, patient and GMP within 2 weeks of treatment completion date

Standards for discharge letters:

- the referring GDP and patient will receive a discharge summary including the URN and/or NHS number within 2 weeks of completion of treatment
- the patient's General Medical Practitioner (GMP) should also receive the discharge summary. The GMP copy should include all relevant medical information including, but not limited to:
 - smoking status
 - alcohol consumption
 - blood pressure (if known e.g. for sedation/GA patients)
 - details of any brief advice, signposting or referrals e.g. to smoking cessation services
- where appropriate, other agencies will be informed;
- an FP17 completion form must be submitted within 62 days of the completion of active treatment

Patients whose treatment is not complete:

- patients who do not attend for appointments (DNA) will be discharged according to the provider’s DNA protocol following suitable efforts to contact the patient/carer to complete treatment. The provider must be able to demonstrate they have made reasonable efforts to contact the patient/carer and inform them what will happen if they DNA
- where appropriate, other agencies will be informed
- an FP17 completion form must be submitted within 62 days of the decision to discontinue treatment
- discharge letters must follow the above standards

9. Currency and Pricing

TBC

10. Baseline Performance Targets – Quality, Performance and Productivity

Performance	Indicator	Threshold	Method of
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Indicator			Measurement
Control of Infection	Premises to confirm to HTM01-05 best practice and other relevant standards	100%	CQC report/other national quality assurance reports IPS 6 monthly audit tool
Premises and Equipment Compliance	Premises to conform to relevant national standards	100%	CQC report/other national quality assurance reports

Final draft for engagement

Appendix A: Provider Specification

	Requirement
Clinical skills and competencies: performer(s)	<ol style="list-style-type: none"> 1. Registered with General Dental Council. 2. Currently on, or eligible for inclusion, on Performer List. 3. Specialist in Special Care Dentistry and Paediatric Dentistry on the register held by the General Dental Council <p>Service must be specialist led by dentists who are specialists in Special Care and Paediatric Dentistry or by one or more dentists who have completed additional training and hold Consultant in Special Care and Paediatric Dentistry or are on the GDC specialist list for Special Care and Paediatric Dentistry.</p> <p>Other performers delivering the service do not need to be on a specialist list but must have required skills to provide level 2 care as assessed and verified by the provider.</p>
Clinical skills and competencies: Chairside Dental Care Professionals	<p><i>GDC Registered Therapist</i> Current skills outlined in the GDC Scope of Practice 2013 and work under the supervision of GDC registered dental practitioner as outlined in the</p> <p><i>GDC Registered dental nurse</i> Current skills in chairside dental nursing for Special Care and Paediatric procedures (where provided) and expanded duties subject to suitable training.</p>
Facilities	<p>Accessible, appropriately equipped and CQC registered clinical setting for the provision of Special Care and Paediatric services.</p> <p>In-contract access to:</p> <ul style="list-style-type: none"> • appropriate radiographic facilities and equipment.
Record keeping	<p>Evidence of adequate clinical records keeping and a document management/data governance as well as compliance with relevant legislation/standards. Use of contemporary and secure practice/records management software.</p>

Medical emergencies	Evidence of training within last 12 months for all clinical staff.
Management of service: (interface with other clinical service providers and RMS)	<p>Appropriate IT to receive patient referrals safely and compliance with information governance standards.</p> <p>All providers will have an nhs.net email account.</p> <p>Able to communicate effectively (written and verbal) with primary and secondary care clinicians with primary and secondary care clinicians.</p>
Management of service: interface with patients	<p>Systems in place for receiving patient feedback and management of complaints/incidents.</p> <p>Robust appointment and reminder systems.</p> <p>Appropriate verbal and written information for patients in a variety of formats/media.</p> <p>Policy for minimising wasted appointment times due to failed appointments and cancellations.</p> <p>Flexible and responsive service able to adapt to patients' needs including those with physical or learning disabilities and different cultural needs, ethnicity, language.</p>
Management of service: interface with commissioners	Able to demonstrate systems in place for reporting on performance, activity and quality of service.

Appendix B: Location of Services

TBC

Final draft for engagement

Appendix C: Units of Dental Activity (UDAs) to be commissioned

TBC

Final draft for engagement