NHS England and NHS Improvement - South East

Specialist led Special Care and Paediatric Dentistry Service Specification

Service Specification Number	
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1. Introduction

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

- the findings from the public engagement which was conducted as part of the needs assessment
- the findings from the stocktake exercise of current Special Care and Paediatric Dentistry services
- the NHS England guide for commissioning dental specialties – Special Care Dentistry, published in 2015
- the NHS England guide for commissioning dental specialties – Paediatric Dentistry, published in 2018
- the commissioning standard for vulnerable adults developed by the Office of the Chief Dental Officer, published in June 2019
- feedback from the South East Special Care and Paediatric Dentistry Managed Clinical Networks (MCNs) on a draft specification
- feedback from other stakeholders on a draft specification.

The purpose of this specification is to outline the services to be commissioned for specialist led Special Care and Paediatric Dentistry services. Stakeholders have been invited to comment on the draft specification as part of the stakeholder engagement process prior to procurement. Findings from the engagement have informed the development of this final specification.

2. Background

2.1. Description of the specialty

Special Care Dentistry

The specialty 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, 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 specialty 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 CDSs 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 (GDP). 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 under 16 years of age, 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 service users, carers 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 inpatient 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.

This service will deliver both Special Care and Paediatric Dentistry and manage the transition between paediatric and adult dental specialties, where there is a continuing care need.

2.2. Service Delivery - National Picture

Special Care and Paediatric Dentistry are provided by 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 CDSs. 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 (PDS) 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 General Dental Services (GDS) contract cannot be quantified; data collection (via the FP17 form) submitted to the Business Services Authority (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.

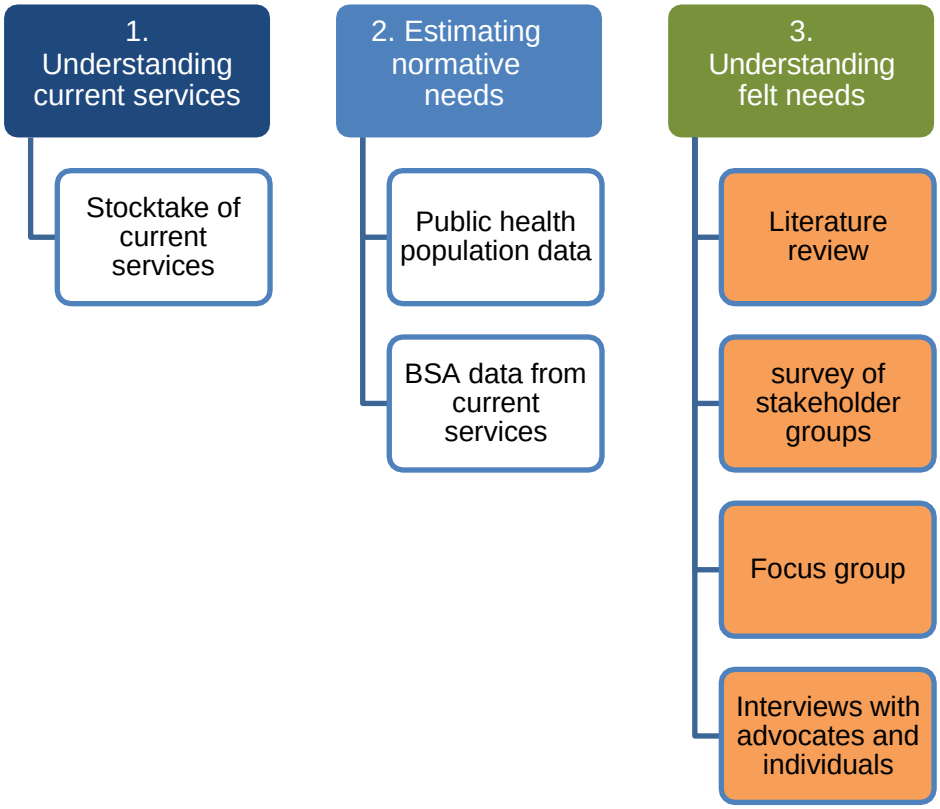
Referral protocols and acceptance criteria have developed locally, again often provider driven to manage demand. This has resulted in variability in provision between services.

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 BDAs case mix tool is used by many CDSs 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 Dentistry services, Public Health England (PHE) have been leading on an assessment of need. The needs assessment consists of three linked workstreams as shown in figure 1.

Figure 1. Oral health needs assessment workstreams



Findings from the three elements of the needs assessment have informed the development of this specification.

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 CDSs, foundation trusts, district general hospitals and dental hospitals under a variety of contractual arrangements. There are 10 dental hospitals in England providing undergraduate and postgraduate 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.

Services also utilise DCPs. 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 Dentistry providers employ dental therapists as they can provide the less complex dentistry as part of patients' overall treatment plans. 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, 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 NHS trusts and providers will work in conjunction with HEE to host and deliver training to dentists and DCPs.

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 Paediatric[1] and Special Care dentistry[2]. 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, 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 equivalent) would be expected to deliver. Therefore, commissioners expect that level of competence as a minimum competency standard for performers on the NHS Performers List.

The levels of care are described as:

Level 1 –needs that require a skillset 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 may be 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. These specialist dentists will usually be appointed as a consultant and working as part of a multidisciplinary team.

Further detail on the treatment/patient types which fall into the different levels of care can be found in section 7.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/04/commissioning-standard-for-dental-specialties-paediatric-dentristry.pdf
[2] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-specl-care-Fdentstry.pdf

3. Transforming Services

The points below set out NHS England and NHS Improvement South East's approach to commissioning services from 1 April 2021:

- Services will be commissioned in line with the NHS Long Term Plan[3]. Services will need to deliver NHS care in a more joined up and co-ordinated 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 Healthwatch.
- Contracts will include quality standards which will incentivise quality improvement.
- A single point of entry for referral to services underpinned by a referral management system.
- Referral management will be via electronic referrals (DERS) for all dentists.
- There will be an agreed method for non-dentists to refer into the service. This will include GPs, patients and carers (including self-referral).
- Referrals will include an agreed minimum data set.
- Agreed definitions and standards for waiting times 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.

[3] https://www.england.nhs.uk/long-term-plan/

4. Service definition

4.1. Name of service

This service will be known as ‘Dental services for people with additional needs’ This is the name of the service for external use. It is recognised that the distinct clinical specialities remain Special Care Dentistry and Paediatric Dentistry.

4.2. Aims and objectives of service

Aims

The service will:

- Ensure access to dental care for children and adults with additional needs unable to receive care or treatment from a level 1 provider due to their enhanced management and/or clinical needs.
- Provide prevention, care and treatment to children and adults with additional needs in line with the evidence base and best practice to achieve clinically effective outcomes for patients.
- Provide patient centred care which gives people choice and control over the way in which their care is planned and delivered; based on what matters to them and their individual needs.
- Work in partnership with the wider health and social care system to improve access to early intervention and treatment, reduce health inequalities and promote prevention of oral diseases across the whole of the Special Care and Paediatric Dentistry care pathway.

Objectives

The service will achieve its aims by delivering the following objectives:

- 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 have additional needs that require skills beyond those available in general dental practice, as described in the service specification.
- Treatment under general anaesthesia (GA) 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 GA services.

- Care which complies with national commissioning standards/guides.
- Joint working arrangements with other specialised services to provide multi- disciplinary care for patients, as appropriate.
- Shared care arrangements with level 1 providers, as appropriate.
- Services that have suitably trained and skilled workforce to deliver the services 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/system (DERS) and are compliant with relevant IT and Information Governance (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 across the dental system and to support the whole patient pathway. We would expect providers to maintain commitment to specialist training and teaching. Outside this, the commitment would be worked up with the commissioner and HEE.
- Ensure that every patient receiving care from the service has a prevention plan as part of their overall treatment plan, in line with Delivering Better Oral Health and Making Every Contact Count (MECC). This should include professional prevention interventions and advice to patients and carers on how to improve oral and general health.

The service will develop a leadership role within local networks (within and beyond dentistry) focusing on reduction in inequalities, prevention, early intervention and access to care for those with additional needs. This will include:

  - Ensuring that oral health improvement is integrated into other care pathways for people with complex needs
  - Working with partners, such as Primary Care Networks (PCNs), to ensure that people with complex needs have a streamlined experience when accessing dental care
  - Increase awareness of dental care services for people with additional needs across the health and social care system (including specialist and enhanced services)

- Working with commissioners to support development of the whole patient pathway for Special Care and Paediatric Dentistry, e.g. support level 1 care services through supporting training.
- In the event of access to and experience of care being impacted by significant events outside the control of the service, work with commissioners and key partners to ensure needs of Special Care and Paediatric patients and their carers are recognised and addressed in ways that maintain the principles of equal access and treatment.

4.3. 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. Care provided under a general anaesthetic will be contracted for using an NHS standard contract. Both contract lengths will be 10 years with the possibility of extension for a further two years.

It is required that all aspects of this specification will be in place by commencement of the service unless otherwise stated.

4.4. Geography covered

The specialist led Special Care and Paediatric Dentistry services described in this specification will cover people resident, or registered with a GP, in the geography covered by NHS England and NHS Improvement South East. It will also provide urgent care and clinically appropriate treatment to any individual temporarily residing in the area and meeting the eligibility criteria to access the service.

As part of engagement with current providers and category analysis of the Special Care and Paediatric Dentistry pathway, it was determined that lots should cover a minimum population size of 750,000 due to the economies of scale that result, easing recruitment and ensuring quality. Lot sizes have taken account of the need for both Special Care and Paediatric Dentistry to be specialist led and have appropriate skill mix. The lots will utilise county boundaries for delineation where possible.

4.5. Care pathway

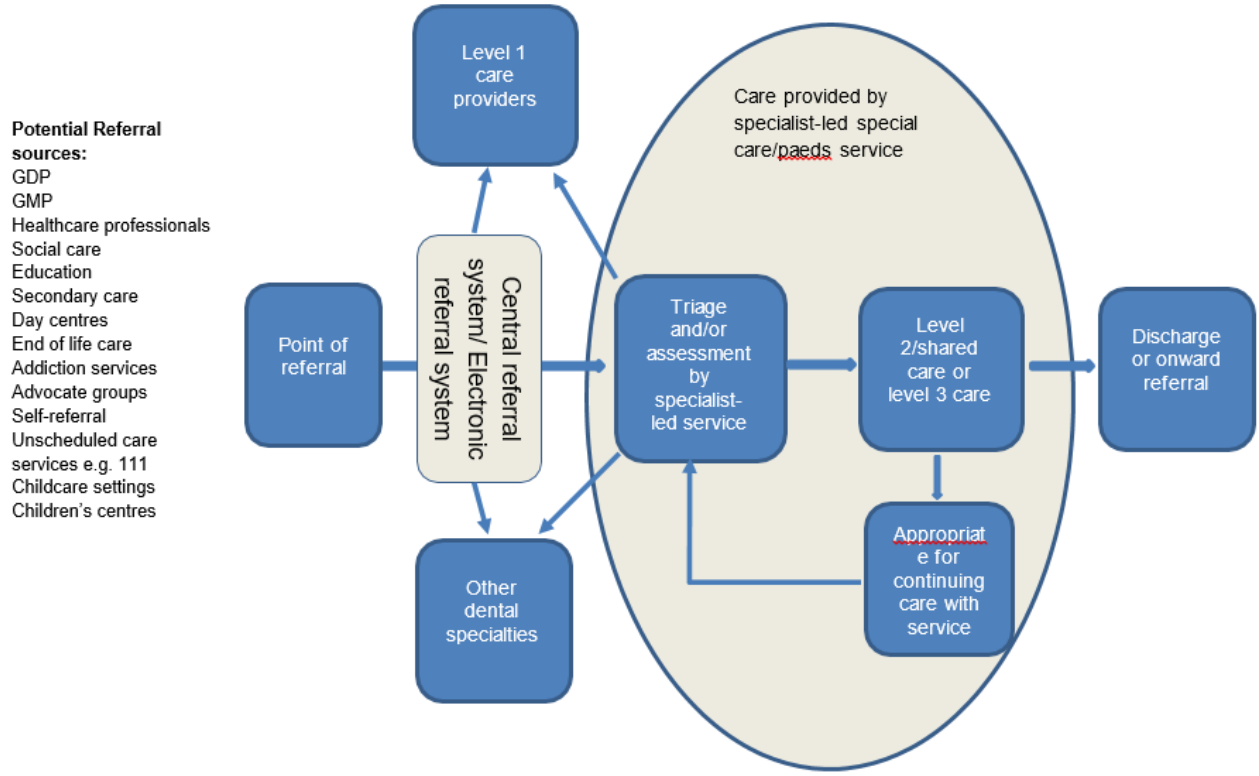
The specialist led Special Care and Paediatric Dentistry services will be part of a wider pathway delivering care to patients across the South East. The proposed pathway is summarised diagrammatically in figure 2.

Patients will move between the different levels of care in a bi-directional way, depending on their specific needs at points in time.

This pathway will enable much of the care to be delivered in primary care by GDPs as level 1 providers. The specialist led service will have a role in working with networks (e.g. MCNs, care home networks, pharmacy networks etc) to develop the local workforce, provide shared care and specialist expertise into the pathway development.

The specialist led Special Care and Paediatric Dentistry service will be an integral part of the whole system care pathway. Referrals will be accepted from several sources and the service will work with other providers to ensure that patients receive the right care in the right setting. The proposed referral pathway is shown in figure 2.

Figure 2. Proposed referral 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 Special Care provider or care may be shared with other services, including the referring dentist.

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 by level 1 general dental services.

Paediatric Dentistry

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

There will be a cohort of paediatric patients who will require a single course of treatment. In contrast, 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 by level 1 general dental services.

General Anaesthetic (GA) services

Adult Special Care and Paediatric Dentistry patients who are unable to be treated by any other treatment modality such as local anaesthetic, with or without sedation, may require dental treatment under GA. The service must ensure that it secures access to GA facilities which comply with the relevant legislation and guidance. The service should provide all clinically appropriate treatment under GA for patients who fall into the categories outlined in this document.

All other modalities of treatment should have been considered by the service where appropriate prior to accepting these individuals for dental treatment under GA.

Provision of Endodontic treatment should usually be limited to incisors and canines which have a good long-term prognosis and where there is no other practical option for treatment. Provision of Prosthodontics should also be limited and carefully risk assessed prior to treatment being considered due to the risks associated with GA and repeat GAs. For these reasons it may not be clinically appropriate to offer the full range of mandatory treatment options for patients requiring care under a GA.

When carrying out treatment under GA the service should liaise with other services responsible for patients to ensure that any other treatments, for example, blood tests, are completed at the same time to minimise repeat GAs.

When carrying out care under GA reference should be made to:

- Guidelines for the management of children referred for dental extractions under General Anaesthesia 2011, revised 2016[4] and any subsequent revisions or new guidance.

[4] https://www.rcoa.ac.uk/document-store/guidelines-the-management-of-children-referred-dental-extractions-under-general

- Provision of Oral Care under General Anaesthetic in Special Care Dentistry – A Professional Consensus Statement 2009[5] and any subsequent revisions or new guidance.

As part of the GA pathway the service should ensure that it has access to timely Orthodontic assessments for patients being considered for extractions of first permanent molars. The service should have a formal arrangement with local Orthodontic services to ensure that they are able to achieve this. This must be developed via the relevant MCNs (Orthodontic, Special Care/Paediatrics).

Sedation

Due to the complex needs of Special Care and Paediatric Dentistry 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 (oral, inhalation, intra-nasal, intra-venous). Sedation is used as an adjunct to behaviour management and local anaesthetic. The service must be able to offer care under oral, inhalation, intra-venous and intra-nasal sedation, where it is clinically appropriate to do so.

For Special Care and Paediatric Dentistry patients to receive care under sedation, their needs must meet the criteria for level 2/3 Special Care or Paediatric Dentistry care as described in section 7. The criteria take into 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 best practice service standards currently outlined in ‘Commissioning Dental Services: service standards for Conscious Sedation in a Primary Care setting’ (NHS England, June 2017), or any document which supersedes this.

Domiciliary care

Adult Special Care and Paediatric Dentistry patients who meet the criteria for the service as described in Section 7 of this specification and where domiciliary care is appropriate because they are unable to access dental clinics due to, for example, mobility issues or dementia, must be offered access to domiciliary care.

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

[5] https://www.bsdh.org/index.php/bsdh-guidelines

plans may have to be modified to take account of this. Treatment under sedation and GA 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.

Other specialist dental services

The service will not deliver other specialist dental services directly but will have a role in facilitating access to these services for Paediatric and Special Care patients. The service may refer patients directly (via DERS for all dental specialties) to other specialist services and may need to carry out joint treatment planning or care delivery with other specialist services.

This includes supporting orthodontic treatment plans and orthodontic assessments prior to extraction of permanent molars under GA.

Emergency Planning

The service will have robust business continuity and emergency plans that they will implement as required. The service will work with the commissioner to deliver care as agreed during national and regional incidents. These incidents may impact on the ability of the provider to deliver the service in line with the requirements laid out in this specification. In such times the service and the contract will follow national guidance in relation to adjustments during a period of emergency planning and delivery.

It is recognised that during restoration and recovery from an emergency situation, services will initially remain under national direction, but later in the phase it is likely arrangements will revert Regional leadership which will mean local review and possible negotiation of contractual matters.

4.6. Service requirements (provider)

Specialist clinical leadership

The service is required to be specialist led. The service must employ Special Care and Paediatric Dentistry specialists to ensure that the overall clinical leadership and governance of the service is provided by specialists.

The role of the specialists will be to provide skills and expertise into the development and/or implementation of:

- Clinical policies

- Clinical guidelines
- Clinical governance frameworks
- Staff training
- Clinical audit
- Performance management processes
- Peer review programmes.

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.
- Follow the local referral pathways through the NHS commissioned electronic referral system.
- 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.
- Where the referrals are deemed to be appropriate, accept on the electronic referral system; the system will communicate acceptance to the referring practitioner. Liaise with the referring practitioner about any information requirements you or they may have, for example waiting times for assessment or treatment.
- On completion of treatment discharge letters to uploaded on to the electronic referral system within 2 weeks
- 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.
- Deliver care within an agreed timescale for patients assessed as eligible for treatment should be scheduled for treatment in a timely manner based on clinical need/age;
- Ensure that, where possible, the patient should receive care from the same clinical team so that they are able to build a trusting relationship with them.

- Ensure that, where appropriate (for example, patients with severe learning disabilities) patients are 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, where possible, the approach taken is personalised to the needs and preferences of the individual, for example, patients and/or carers are given a choice on care received, days and times of appointments and communication methods.
- 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. outpatients under the care of the secondary care multidisciplinary team.
- 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 practice and service developments agreed by the MCN.
- Facilitate patients to access care from other services including other level 2/3 dental services.

Strategic leadership

The service will provide strategic leadership to the local health system in line with the NHS Long Term Plan, as the NHS continues to move from reactive care towards a model embodying active population health management. The provider will collaborate with partners across the care system to support delivery of the NHS Long Term Plan. This will involve, for example, working in partnership with PCNs to promote prevention of oral diseases and early intervention for at risk groups. It may also involve working with PCNs and local communities to co-design improvements to better meet population needs. Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) are expected to lead on the local implementation of the NHS Long Term Plan ambitions for individuals with learning disabilities, autism or both, which presents opportunities for Special Care and Paediatric Dentistry Services to ensure that oral health is included in the plan.

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 adults with additional needs. This will involve working with established and emerging local networks.

- Be an advocate for oral health promotion at a community level, such as training for care home staff, with other system leaders particularly local authorities (community level oral health improvement programmes will continue to be commissioned by local government).
- Ensure that a senior clinician (or deputy) from the service attends the Special Care and Paediatric MCN. 100% of MCN meetings must be attended by the service.
- Work with MCNs and other partners across the local health care system to manage unmet need for oral health care for people with additional needs.
- 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.

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 provider will provide evidence as part on the on-going contract monitoring to 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, for example, 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.

- All the service leads should have up to date level 3 safeguarding training.
- The role of the service leads will not only be as clinical experts but as strategic leaders. They will have a role in building relationships with other parts of the healthcare system, for example, emerging healthcare networks (Integrated Care System and PCNs) with the aim of ensuring that patients across the system are able to access appropriate care.

Communication

The provider will:

- Have an annual communication strategy that includes communication with the public, dental services and the wider health and social care system. Services should decide locally what their annual communication strategy should involve but it should support the strategic leadership role of the service.
- Ensure the service provides information to patients/carers/public about the services, including waiting times and accessibility.
- Ensure before the first appointment that any additional needs for accessing the service are known to the whole team, for example, ground floor surgery, hearing loop, quiet waiting space/time.
- Ensure that by the end of their first appointment:

Any additional needs are known and that these are clearly recorded on the patient notes so that any member of staff is made aware of them, for example, when a receptionist is making an appointment.

- Their preferred method of communication is known, 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 SMS, email, telephone and letter.
- Ensure that the patient's additional needs and communication preferences are updated at each assessment appointment.
- Ensure that the patient's additional needs and preferences are used to inform all interactions with the patient, e.g. when booking appointments at reception.
- 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 additional needs. Ideally, any document could be customised by carers for individual patients. Photographs and information about staff in the service should also be available.
- The website should also include information on how the service is delivering against its 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 patients who need them.
- Provide information, as simply as possible, on who is eligible and exempt from dental charges and facilitate patients accessing support for the 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:

1. **Acceptability** -Public expectations about how services should look. This can vary substantially for different population groups
2. **Affordability** - Location, e.g. travelling distance
3. **Availability** - How well services are distributed, e.g. ratio of dentists to population
4. **Accommodation** - How care is provided, e.g. opening hours, urgent care slots, waiting times, ease of booking an appointment
5. **Accessibility** - Location, e.g. travelling distance as well as physical accessibility within the practice itself, e.g. for disabled access.

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

Scope of service

The service will provide dental services to children and adults with additional needs and to children who have complex treatment needs as defined by this service specification. Children are defined as being under 16. Some patients will have an ongoing continuing care relationship with the service; others will receive episodes of treatment following referral.

The service is limited to mandatory and advanced mandatory services for adults who fit the criteria for Special Care Dentistry and children who fit criteria for Paediatric Dentistry.

The service will also provide the following additional services:

- Sedation
- Domiciliary
- Dental Public Health Services

The service will provide hospital based dental treatment for adults and children (as defined above) under GA.

Exclusions

The following services are excluded from this service:

- Advanced mandatory services for adults who have complex treatment needs (although the service will support treatment planning and other providers in the delivery of treatment)
- 3b complexity for Special Care or Paediatrics; however services will need to work in partnership to deliver multi-disciplinary care for the most complex cases which may involve secondary care
- Care to secondary care inpatients not admitted for the purposes of treatment by this service
- Care to other inpatients, for example, forensic mental health units or health and justice secure units, unless they meet the criteria for the service and can receive care as outpatients
- Unscheduled care for patients who are not appropriate for care with the service (do not meet criteria)
- Sedation for patients who do not meet the criteria in section 7, for example, patients with dental anxiety alone
- Domiciliary care for patients who do not meet the criteria in section 7
- Orthodontic treatment; although the service will support Orthodontic treatment planning for patients that meet criteria in section 7
- Care to any other patients who do not meet the criteria in section 7.

4.7. Managing missed appointments

The provider will ensure that 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 the 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 a 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 are not brought to appointments. This process should recognise the unique needs of these patients and their health conditions. This may include referring to safeguarding policies and liaison with carers and other agencies. The service should have processes in place to ensure that 'was not brought' (WNBs) are less likely to occur, for example email or web access for short-notice cancellation of appointments.

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 NHS England and NHS Improvement South East commissioner. The service must have systems which are compatible with the current and future local referral management services, including web-based electronic referrals. Non dental referrers will be able to continue with paper-based 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 is incomplete or inappropriate.
- 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 by the service as being urgent then the appointment should be offered no more than two weeks from date of receipt of the referral, or sooner when clinically appropriate, for instance, if uncontrolled pain. Until the patient is assessed by the service any 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 an assessment where a patient meets NHS criteria and is ready to commence treatment, the patient 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 referrer either confirming acceptance of the patient for treatment or provide an explanation of 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 start treatment within 18 weeks of the referral being received.
- the submission of FP17s for completed courses of treatment is required within 62 days.
- The service will endeavour to report any activity carried out under a GA under the Hospital Episodes Statistics (HES) reporting system, so that it is included in national reporting of GA data. As there are limitations to HES data the service must also maintain internal records of patients and treatment carried out under GA. This dataset must be released to the commissioners on request.

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

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 children and adults with additional needs

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, co-operation, 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 start 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, for example, 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.

Referrals

Referral information 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. Electronic referral systems will be in place for referrals from dental providers. The referral algorithm has been developed with the provider and the appropriate MCN. Paper referral forms must be available and accepted only from non-dental sources. A standardised South East form (to be developed) must be used. The service must ensure that it collects and collates the data for referrals not made through the electronic process.

4.9. Service delivery

The model of service delivery is that of a specialist led service. The service must employ Special Care and Paediatric Dentistry specialists (on the GDC specialist list) to provide clinical leadership and governance of the service. Clinicians, DCPs and other staff working for the service must be adequately trained, skilled and experienced to deliver a high quality and safe service. It is for the service to determine the correct level of skill mix.

The commissioners plan to implement an accreditation process for all performers not on the Special Care or Paediatric specialist lists, in line with national guidance. The service must comply with this process. All providers need to ensure that all non-specialist performers are working towards level 2 accreditation from contract commencement. All non-specialist performers must be accredited which we would expect to be within the first three years of the contract unless an alternate timeframe is advised by the commissioner.

Feedback has been given by NHS England and NHS Improvement South-East about the use of the current accreditation process. Changes may be made in future whereby the service seeks assurance that clinicians are competent in line with accreditation requirements rather than this function being performed by a regional panel.

Further information about accreditation can be found through the link below: https://www.england.nhs.uk/wp-content/uploads/2018/09/guidance-for-the-accreditation-of-performers-of-level-2-v24.pdf

All staff must have annual appraisals and personal development plans. There must be a governance system in place so that the provider can ensure that all performers and DCPs maintain and develop their skills and knowledge appropriate to their scope of practice.

4.10. Training

4.10.1. Training and development for provider staff

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

4.10.2. Training of the wider workforce

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 dental workforce, for example, training GDPs to deliver domiciliary care. The plan for this training will be developed by the MCN.

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 HEE to host and deliver specialist training to dentists as well as support training of DCPs.

5. Outcomes

5.1. NHS Outcomes Framework Domains

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

5.1.1. 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 the 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.

5.1.2. 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? Did the service meet your needs overall?

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 – (taken from the national commissioning guide)

- 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?

The commissioner expects 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.

5.1.3. Clinical outcome measures

The commissioner expects the provider to maintain records about the following and provide a summary annually

- Key performance indicators, for example actual waiting times, Was Not Brought (WNB) rates, case mix, repeat GAs, band 2 to urgent courses of treatment
- Serious Incidents and Never Events
- Formal complaints
- Accolades
- 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 quality framework is shown in Appendix F. This will be reviewed during the life of the contract.

6. Premises

6.1. Premises and equipment requirements

The provider is expected to secure facilities suitable for service delivery in the locations 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, for example, HTM01-05 best practice.

Examples of non-standard equipment which must be provided (although not all these need to be provided in all clinics, patients must be able to access these at a reasonable travel distance within the geography of the lot) are:

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

All sites should be compliant with HTM01-05 best practice within no more than three years of the commencement of this contract. NHS England and NHS Improvement would not expect care to be provided from single surgery sites unless agreed with the commissioner. The provider should ensure that performers do not work in clinical isolation for most of their clinical time. Where it is not possible to avoid clinical isolation, for example, in domiciliary care, this should be carefully planned and managed. The provider will be responsible for the funding of all premises and service delivery costs including but not limited to, consumables, equipment (capital and non-capital), laboratory services, appliances and IT operational infrastructure (including 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 Equality Act compliant
- Are registered with the Care Quality Commission (CQC)
- Have appropriate and sufficient waiting room accommodation for patients and carers
- Have equipment and facilities that conform to relevant standards/regulations and are maintained regularly in line with guidelines and manufacturers' protocols

- The provider is responsible for the funding of all consumables, equipment, laboratory services and appliances
- Have robust governance and quality assurance programmes in place to ensure a safe environment for all service users and staff
- Have in-contract access to appropriate radiographic facilities and the arrangements for the facilities covers all of the legal requirements relating to the use of radiographic equipment
- Appropriate radiography equipment, including intra-oral in all clinics and access to suitable OPG facilities (not in all clinics) to meet the needs of patients with a range of disabilities
- Where digital radiography is not immediately available there should be a plan in place to move to this as part of digital replacement programmes
- The telephone number to be used by patients and or professionals in connection with the delivery of the Special Care and Paediatric Dentistry service is a local personal number, unless the service is provided free to the caller
- Meets HTM01-05 best practice within three years of the start of contract
- Uses agreed local checklists highlighting aspects of the service and facilities of relevance such as signage and accessible information
- Have clinics available within the service with quiet spaces/times to offer patients for waiting and recovery, particularly for those with sensory issues.

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 (for example, close to schools, places of work or homes with good transport links) 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. Each location should at a minimum have disabled car parking on site.

6.3. Additional Requirements

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

- They have safe processes and working environments 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 (or their successor if superseded):
    - High Quality Care for All – next stage review 2008
    - Implementing Care Closer to Home, 2007
    - Modernising Medical Careers
    - NHS Personal Services Agreements
    - Ionising Radiation (Medical Exposure) Regulations (2017)
    - AIDS/HIC infected Healthcare worker Guidelines
    - Equalities Act, 2010
    - Human rights Act, 1998
    - Dental Practitioners' Formulary
    - GDC Standards for the Dental Team 2013
    - 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 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
- Delivering Better Oral Health – PHE latest edition
- Guide for Commissioning Dental Specialties – Special Care, 2015
- Guide for Commissioning Dental Specialties – Paediatrics, 2018
- Commissioning standard for urgent dental care – NHS England and NHS Improvement 2019
- 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)
- British Society of Gerodontology (BSG) guidelines (https://www.gerodontology.com)
- Commissioning Standard for Dental Services for Vulnerable Adults 2019
- ‘You’re welcome’ standards for young people friendly health services – Department of Health, 2011
- Making Every Contact Count Implementation Guide - Public Health England and Health Education England, 2018
- NHS Constitution, 2015
- Commissioning Dental Services: Service standards for Conscious Sedation in a primary care setting – NHS England 2017
- Guidance for Commissioners on the Accreditation of Performers of Level 2 Complexity Care – NHS England 2018.

7. Levels of clinical care

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 3a care only.

Adults (aged 16+ years)

	Tier		
Special care (adults)	**Level 1**	**Level 2**	**Level 3**
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 a specialist led service 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 from level 1 providers but may need treatment planning or specific types of treatment carried out in a specialist-led service	Patient is unable to accept care level 1 providers 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 by level 1 providers. Interpreter services are available. Those with language difficulties in isolation should be seen by level 1 providers	Patient able to have full examination in general 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 by level 1 providers 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	Patient's physical health is not significantly impacted by their condition and therefore can receive treatment in primary care	Patient's physical health is significantly impacted by their condition, but treatment can be managed on a shared care basis between primary and Special Care services	Patient's physical health is significantly impacted by their condition necessitating treatment in a Special Care setting
Adults with severe dental anxiety	Care should be provided by level 1 providers 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 from level 1 providers but require IHS/IV sedation or GA for treatment.	Medically compromised patient who is unable to have examinations/continuing care from level providers 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. Patient can receive some care without the need for specialist equipment	Patient who is usually cared for by level 1 providers 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 level 1care. 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 wheelchair tipper, wider door access, accessible toilets. Patient who may require specialised transport to get to a

			clinic. Patient who is unable to leave home and need domiciliary care.
-Homeless people and rough sleepers	Can be treated by level 1 providers where there are no issues of capacity or complex medical needs	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.	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.
- Migrants, asylum seekers, refugees and sex workers (excludes people detained/housed within the health and justice system) **People with substance misuse**	Can be treated by level 1 providers 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	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.	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.

Paediatric care (children under 16)

	Tier		
Paediatric care	**Level 1**	**Level 2**	**Level 3**
Children with extensive dental disease	Child is able to co-operate with treatment from level 1 providers	Require additional support and interventions and anxiety management programmes e.g. inhalation sedation or GA	Require additional support and interventions and anxiety management programmes which may include general anaesthetic

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 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 from level 1 providers but may need treatment planning or specific types of treatment carried out in a specialist-led service	Patient is unable to accept care from level 1 providers 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 by level 1 providers. Interpreter services are available. those with language difficulties in isolation should be seen in primary care.	Able to have full examination by level 1 providers. But may need referral if further treatment requires access to hoist or wheelchair tipper.	Patient with more complex physical or communication issues 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 level 1 providers. Limited co-operation for certain treatments such as fillings, extractions etc. Pts may have capacity issues Pts with fluctuating periods of uncontrolled mental health and behavioural Issues which may require additional management skills	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 often required for treatment.
Children with complex medical conditions	Child's physical health is not significantly impacted by their condition and therefore can receive treatment in primary care	Child's physical health is significantly impacted by their condition but their treatment can be managed on a shared care basis between primary and Special Care services	Child's physical health is significantly impacted by their condition necessitating treatment in a Special Care setting

Children with dental anxiety	Child is able to co-operate with treatment from level 1 providers	Significant anxiety increases the complexity of care and may require the use of conscious sedation or other management programmes	Significant anxiety increases the complexity of care and may require the use of conscious sedation or other management programmes Treatment under conscious sedation or GA may be required e.g. multiple deciduous extractions in young children, multiple permanent extractions in older children
Children with behavioural problems	Child is able to co-operate with treatment from level 1 providers	Behaviour problems increase the complexity of care and may require the use of conscious sedation or other management programmes	Child with severe Learning disabilities and behavioural issues increase the complexity of care and may require the use of conscious sedation or other management programmes or GA and where involvement with multiple agencies is required
Children with Dentoalveolar Trauma	Treatment required is routine and within the scope of level 1 providers i.e. able to provide emergency treatment including re-implanting of avulsed teeth. Uncomplicated crown fractures and mild subluxation	Dental trauma where the patient requires support for ongoing treatment after initial injury or joint care for initial injury e.g. crown fracture, injuries to primary teeth, multiple teeth involved, post initial treatment of avulsion and significant luxation.	Dental trauma where the patient requires support for ongoing treatment after initial injury or joint care for initial injury e.g. crown fracture, injuries to primary teeth, multiple teeth involved, post initial treatment of avulsion and significant luxation. And injuries to immature permanent incisors where endodontic management is required etc
Children with dental and oral abnormalities including genetic diseases and cleft lip/palate	Treatment required is routine and within the scope of level 1 providers	Where the defects are more complex - Hard tissues dental defects and disturbances of developing dentition requiring simple restorations	More complex abnormalities of dental and facial development e.g. moderate/severe molar hypomineralisation, amelogenesis and dentinogenesis imperfecta and hypodontia, Cleft Lip /palate. Will usually need multidisciplinary care with other dental services. Mild to moderate tooth surface loss and aggressive periodontal disease
Children under the care of social services or with complex social problems	Social issues do not impact on ability of child to receive care from level 1 providers	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 GDPR Regulations 2018 (Data Protection Act 2018). All practices must complete the NHS Data Protection Security Toolkit. The following must be included in the policy:

- The provider must assign responsibility for Data Protection to an appropriate member of staff - a Data Protection Officer who has been trained.
- The policy must address the overall requirements of information quality, security and confidentiality.
- All contracts - staff, contractor and third party - contain clauses that clearly identify responsibilities for confidentiality, data protection and security.
- All staff members are provided with awareness and mandatory training across the IG agenda.
- The provider must implement IG Information Security management arrangements to ensure the NHS Connecting For Health 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, 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 example 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, general and psychological health and wellbeing.
- In all situations the clinical advantages and long-term benefits of treatment must justify such treatment and outweigh any detrimental effects.

7.4. Improving quality of referrals

Providers will return any incomplete or inappropriate referrals to the referrer.

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 referrer either accepting the patient for treatment or provide an explanation of why treatment has not been offered.

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

7.5. Interdependencies

The provider will need to demonstrate effective working relationships with secondary care colleagues, and others across health and social care, to ensure appropriate management of complex cases and appropriate management of complications outside the scope of the service in accordance with the agreed pathways, for example, through best interest meetings and multidisciplinary working

All providers are required to ensure their performers become proactive members of their Special Care and Paediatric Dentistry MCN. Service providers and performers will work closely with the MCN to implement and improve patient pathways and ensure that patients receive a high quality service.

Relevant networks include, but are not limited to:

- NHS England and NHS Improvement
- Oral Surgery and Orthodontic MCNs
- 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 and PCNs
- Safeguarding boards.

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, to include evenings and weekends as well as weekday daytime access. The range of appointments offered should recognise that carers may be 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 who fit the acceptance criteria where this is assessed as being clinically appropriate. This will include patients referred from other services such as NHS 111.

Unscheduled access (urgent appointments) must be available during core hours. 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, for example, website, text and 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 be flexible and responsive to individual patient need (which includes the needs of their carers) in accordance with the Equality Act 2010 and the Health and Social Care Act 2008.

Bookable appointments will be provided during contracted opening hours. Core opening hours are defined as Monday to Friday, 9.00am to 5.00pm. The service should provide extended hours on a minimum of two evenings, and/or one early morning, and/or one Saturday morning session. Early mornings must have appointments commencing at 8.00am at the latest; evenings must have bookable appointments until 7.00pm; Saturdays must include three hours of bookable appointments.

The expectation is that the service provides two hours of extended appointments per whole time equivalent Dentist per week. How each service chooses to deliver extended hours is a local decision based on patient need and it would not be expected that all services will deliver early mornings, late evenings and Saturdays; it could be a combination of these. This does not mean that all Dentists will deliver care outside of core opening hours and it will be a decision for the service to determine the hours to be delivered for each clinic. Where Dentists do deliver care outside core hours the expectation is that they would finish earlier than their current time if they are doing an early morning, start later than their current time if they are working into the evening, or have a morning or afternoon off in the week if they are working a Saturday morning; the intention that staff work their same contracted hours but deliver these more flexibly to meet the needs of their patients and carers.

The sites offering extended hours should be chosen based on good access and close proximity to large population centres.

The contract does not require availability on bank holidays.

The practice must keep information on the nhs.uk website up to date, including opening hours for each clinic.

8.1. Patient Information

The service must ensure that patients are provided with relevant verbal and written information in a variety of formats (including easy-read version), 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, for example, 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.

- Information on the website including who they will meet and what will happen (including staff profiles where staff consent). This should be available as a downloadable and editable document that carers can adapt to support people with severe learning disabilities to prepare for their first visit
- An offer to have an introductory visit where that will help ease them into having treatment at a second visit.

Providers will be required to:

- tailor how information is provided to the preferences of the individual
- 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
- The provider should evidence that all patient information and consent processes have involved patients/carers in their development and that these are regularly reviewed and updated.

8.2. Safeguarding

Providers must ensure that:

- Valid consent is gained from all patients (who have the capacity) 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 people/vulnerable adults.
- Actions are in line with policies and recommendations of the local safeguarding boards.
- Recruitment procedures are in line with safeguarding best practice.
- Processes must be in place for patients who lack the capacity to consent, for example, working with partners from across health and social care to agree the best course of action for patients unable to give consent through 'best interest' meetings and using the support of Independent Mental Capacity Advocates (IMCAs) where there is no other suitable person to support the individual.

8.3. 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.

- Review/triage of referral – 10 working days (from date of receipt of referral)
- Information back to referrer – two 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.

If a referral is clinically triaged by the service as being urgent then the appointment should be offered no more than two weeks from the date of receipt of the referral, or sooner when clinically appropriate, for example, if uncontrolled pain. Until the patient is assessed by the service, any 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;

8.4. 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 general medical practitioners (where this is appropriate) may need to be sent via standard mail.

This does not account for the following situations –

- Patient electively discontinues treatment
- A change in treatment plan requires the patient to be reassessed by the referrer.

8.5. 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 ongoing care
- Contain a summary of the treatment provided and/or the reasons for discharge

- Contain information for patients/carers in a suitable language and format (according to patient preferences) that advises them on how to prevent disease and keep their mouth healthy between appointments
- Contain details of the continued treatment to be given by the service
- The referrer and patient will receive a discharge summary including the URN and/or NHS number within two weeks of completion of treatment.

Consideration should be given to providing a discharge summary to the patient's GP if clinically appropriate.

Patients whose treatment is not complete:

- Patients referred for a single course of treatment who were not brought for appointments (WNB) will be discharged back to their referring dentist, according to the provider's WNB 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 there is a WNB.
- 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. Baseline performance targets – Quality, Performance and Productivity

Performance Indicator	Indicator	Threshold	Method of Measurement
Control of infection	Premises to conform to HTM01-05 best practice and other relevant standards	100% within stated timescales	CQC report/other national quality assurance reports IPS six monthly audit tool
Premises and equipment compliance	Premises to conform to relevant national standards	100%	CQC report/other national quality assurance reports

Appendix A: Provider specification

	Requirement
Clinical skills and competencies: Performers	1. Registered with General Dental Council. 2. Currently on national Performers List (England) 2. Specialist in Special Care Dentistry and/or Paediatric Dentistry on the register held by the GDC or accredited as level 2 performer. Service must be specialist led by dentists who are on the GDC specialist list for Special Care and/or Paediatric Dentistry. Other performers delivering the service must be accredited or working towards accreditation as level 2 performers or on a HEE recognised training programme.
Clinical skills and competencies: Chairside Dental Care Professionals	**GDC Registered Therapist** Current skills outlined in the GDC Scope of Practice 2013 **GDC Registered dental nurse** Current skills in chairside dental nursing for Special Care and Paediatric procedures (where provided) and expanded duties subject to suitable training.
Facilities	Accessible, appropriately equipped and CQC registered clinical setting for the provision of Special Care and Paediatric Dentistry services. In-contract access to appropriate radiographic facilities and equipment.
Record keeping	Evidence of adequate clinical record keeping, document management/data governance as well as compliance with relevant legislation/standards. Use of contemporary and secure practice/records management software.
Medical emergencies	Evidence of training within last 12 months for all clinical staff. Staff undertaking/supporting treatment under sedation/GA should be trained in intermediate life support.

Management of service: (interface with other clinical service providers and RMS) **Management of service:** interface with patients	Appropriate IT to receive patient referrals safely and compliance with information governance standards. System in place to receive referrals from patient/carer directly (either through DERS or other method).
	All providers will have an nhs.net email account.
	Able to communicate effectively (written and verbal) with clinicians and teams providing level 2 and 3 care.
	Systems in place for receiving patient feedback and management of complaints/incidents.
	Robust appointment and reminder systems.
	Appropriate verbal and written information for patients in a variety of formats/media.
	Policy for minimising wasted appointment times due to failed appointments and cancellations with consideration for the specific needs of the patients
	Flexible and responsive service able to adapt to patients' needs including those with physical or learning disabilities and different cultural needs, ethnicity and language.
Management of service: interface with commissioners	Able to demonstrate systems in place for reporting on performance, activity and quality of service.

Appendix B: Lots

Lot number	Lot Name
1	Kent
2	Sussex
3	Surrey
4	Hampshire and the Isle of Wight
5	Berkshire, Oxfordshire and Buckinghamshire

Appendix C: Locations where premises will be required

Section 4.6 Service Requirements (Provider) Access (page 21) outlines issues to be taken into consideration with regards to the location of clinics. This appendix describes the locations within which clinics should be available as a minimum requirement for the life of the contract. The sites should be in areas of greatest population density and easily accessible to patients in terms of good transport links.

Lot number	Lot name	Required locations
1	Kent	**Planning Area** **Swale** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links; one to be on the Isle of Sheppey and the other off the island. **Medway** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links; the locations should give a good geographical spread across the Medway towns but should not be located in the Hoo peninsular. **Dartford, Gravesham and Swanley** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links. **West Kent** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links; the locations should give a good geographical spread with one of the sites located in the Weald of Kent.

Lot number	Lot name	Required locations
1 (cont.)		**Canterbury and Coastal** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links; the locations should give a good geographical spread. **Thanet** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links. **South Kent Coast** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links; the locations should give a good geographical spread. **Ashford** A minimum of 1 site located in a central area of greatest population density and easily accessible to patients in terms of road and transport links.

Lot number	Lot name	Required locations
2	Sussex	**Planning Area** **Eastbourne, Hailsham and Seaford** A minimum of 1 site located in areas of greatest population density and easily accessible to patients in terms of road and transport links. **Hastings and Rother** A minimum of 1 site located in areas of greatest population density and easily accessible to patients in terms of road and transport links. **High Weald, Lewes and Havens** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links. **Horsham and Mid Sussex and Crawley** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links. **Coastal West Sussex** A minimum of 1 site located in area of greatest population density and easily accessible to patients in terms of road and transport links. **Brighton and Hove** A minimum of 1 site located in area of greatest population density and easily accessible to patients in terms of road and transport links.

Lot number	Lot name	Required locations
3	Surrey	**Planning Area** **East Surrey** A minimum of 1 site located in area of greatest population density and easily accessible to patients in terms of road and transport links. **Guildford and Waverley** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links. **North West Surrey** A minimum of 2 sites located in areas of greatest population density and easily accessible to patients in terms of road and transport links. **Surrey Downs** A minimum of 1 site located in areas of greatest population density and easily accessible to patients in terms of road and transport links. **Surrey Heath** No sites are proposed for this area due to the small geographical area covered and close proximity to neighbouring planning areas; where a bidder feels a site in this location would enhance service delivery for the whole lot this will be taken into consideration during evaluation.

Lot number	Lot name	Required locations
3 (cont.)		**Farnham (South)** A minimum of 1 site located in or South of Farnham, in area of greatest population density and easily accessible to patients in terms of road and transport links will form part of the Surrey lot.

Lot number	Lot name	Required locations
4	Hampshire and the Isle of Wight	**Planning Area** **Southampton City** Minimum of 2 sites across the geography of Southampton City. The sites should be in areas of greatest population density and easily accessible to patients in terms of good transport links. **Portsmouth City** Minimum of 1 site across the geography of Portsmouth City. The site should be in area of greatest population density and easily accessible to patients in terms of good transport links. **South East Hampshire** Minimum of 2 sites across the geography of South East Hampshire which cover areas such as Petersfield, Havant, Waterlooville and Bordon. The sites should be in areas of greatest population density and easily accessible to patients in terms of good transport links. **Fareham and Gosport** Minimum of 1 site across the geography of Fareham and Gosport. The site should be in area of greatest population density and easily accessible to patients in terms of good transport links.

Lot number	Lot name	Required locations
4 (cont.)		**West Hampshire** • **New Forest** – Hythe. This is a mandated site • **Eastleigh** - minimum of 1 site in the Eastleigh area. The site should be in area of greatest population density and easily accessible to patients in terms of good transport links. • **Winchester** - minimum of 1 site in the Winchester area. The site should be within 3 miles of the city centre. • **Andover** – this is a mandated site. **North Hampshire** Minimum of 1 site across the geography of North Hampshire which cover areas such as Basingstoke and Alton. The site should be in area of greatest population density and easily accessible to patients in terms of good transport links. **North East Hampshire** A minimum of 1 site for the north of the planning area which covers areas such as Farnborough, Aldershot, Fleet and Yateley should be located in area of greatest population density and easily accessible to patients in terms of road and transport links.

Lot number	Lot name	Required locations
4 (cont.)		**Isle of Wight** Minimum of 1 site, preferably to be located in a central location on the island and easily accessible from all areas.

Lot number	Lot name	Required locations
5	Berkshire, Oxfordshire and Buckinghamshire	**Planning areas** **East Berkshire** Minimum of 3 sites with at least 1 site to be located within Slough Borough Council and 1 site to be located within Bracknell Forest District Council. **West Berkshire** Minimum of 3 sites with at least 1 site to be located within Reading Borough Council and 1 site to be located in the town of Newbury or Thatcham. **Buckinghamshire** Minimum of 5 sites with: At least 2 sites to be within Aylesbury Vale District Council, at least 1 of which should be within the town of Aylesbury Vale District Council. 1 site within Chiltern District Council. At least 2 sites in the south of the county with a minimum of 1 site in the town of High Wycombe. **Oxfordshire** Minimum of 6 sites with: At least 2 sites in Cherwell District Council with at least 1 site in Banbury and 1 in Bicester or Kidlington. At least 1 site in each of the following: • Oxford City Council • South Oxfordshire District Council • Vale of White Horse District Council • West Oxfordshire District Council.

Appendix D: Total Annual Contract Value

The Total Annual Contract Value includes the cost of the clinic (primary care) based services delivered under NHS (General Dental Services/Personal Dental Services) Regulations 2005 and the cost of hospital-based services for the treatment of patients under General Anaesthetic under the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

The primary care services will be commissioned via Personal Dental Services (PDS) agreements and hospital-based General Anaesthetic services will be commissioned via NHS standard contracts.

Each provider will be issued with two contracts for the provision of services, with each to have a Total Annual Contract Value (TACV). The PDS contract will have a range of activity (UDA) and performance measures (Key Performance Indicators) which will be notional for the first three years to understand activity levels and to account for the requirements of accreditation, during which time the contracts will be a 'block' basis.

Payments will be made in twelve monthly instalments via the national dental payments system (Compass). The payment will relate to a gross allocation to the provider with deductions to be made in relation to Patient Charges collected by the provider in line with the NHS Patient Charges Regulations 2005.

In the first 3 years of the contract the commissioners will monitor:

- Dentist Vacancy rate
- Number of cancelled clinics per annum

From year four, payment will relate to activity and performance achieved in each financial year. The payment will be based on planned activity for the year with the assumption that at least 96% of activity is delivered with an aspiration payment for Key Performance Indicators (KPIs) with Band A to be achieved for each of the KPIs. Failure to deliver 96% of planned activity or achieve Band A for each of the KPIs will result in financial recoveries.

The KPI will account for 3% of the TACV of the PDS contract.

The NHS standard contract will be on a block basis for the life of the contract.

The TACV for the PDS agreement will be based on a weighted capitation allocation (described below). The NHS standard contract will be based on identified historical allocation.

Annual Doctors' Dentists' Review Body (DDRB) uplifts will be applied to both contracts. This is in line with the NHS (PDS/GDS) Regulations 2005.

Capitation funding

The TACV for the PDS agreement is based on the population in each lot as identified by the Special Care and Paediatric service needs assessment with 70% of the value to be on an unweighted population basis and 30% on a weighted need basis.

The information on the weighted population has been derived on a CCG basis from the Public Health England Local Knowledge and Intelligence Service (LKIS) which informed the 'Special Care and Paediatric Dentistry South-East Needs Assessment Summary Report' (September 2019).

The unweighted element is based on total resident population 2016.

The allocations for deprivation are based on the IMD deprivation rating of the lots compared to the South-East total with each lot achieving a percentage of the South-East total.

The weighted allocations are based on the proportion of people falling into the weighted categories within the lot when compared to the proportion for NHS England South-East.

The table below describes how the weighted element of the allocation monies are identified with 50% identified for deprivation and 50% for care groups identified as likely to be high users of the service.

Category	% weighting
Deprivation prevalence	50%
Number of People with Learning Disabilities	10%
Number of People with long Term Conditions	10%
Number of people aged 85+	10%
Number of Children in Low Income families	10%
Care home beds per 100 people 75+ (Persons, 75+ yrs).	10%

This information informs the allocations for PDS contracts.

The allocations for the NHS standard contracts for GA services are based on historic spend in each of the lots

Total Annual Contract Value (2020-21)

LOT	PDS Activity	PDS KPI (3%)	PDS TACV	Allocation per head	NHS Standard Contract (GA)	Total Allocation
Kent	£6,852,540	£211,934	£7,064,474	£3.89	£1,217,271	£8,281,746
Sussex	£6,328,697	£195,733	£6,524,430	£3.88	£1,192,398	£7,716,828
Surrey	£3,932,149	£121,613	£4,053,762	£3.43	£781,195	£4,834,957
Hampshire and the Isle of Wight	£7,208,994	£222,959	£7,431,953	£3.77	£1,637,763	£9,069,716
Berkshire, Oxfordshire and Buckinghamshire	£7,059,859	£218,346	£7,278,205	£3.44	£1,427,198	£8,705,403

Appendix E: Activity

PDS contract - Units of Dental Activity

The UDA 'target' will be notional for the first 3 years of the contract and used for payment purposes only. At the end of year 2 there will be a review of levels of activity delivered with discussions during year 3 about the actual target to be applied from year 4.

Lot number	Lot Name	UDAs per annum
1	Kent	41,634
2	Sussex	38,451
3	Surrey	23,891
4	Hampshire and the Isle of Wight	43,800
5	Berkshire, Oxfordshire and Buckinghamshire	42,893

UDA price = £169.68 (2020/21) with the activity target based on the PDS TACV. The UDA price based on Special Care and Paediatric service in the South-East which has been subject to market testing.

NHS Standard contract – General Anaesthetic services

This will be paid on a block basis for the life of the contract but will be reviewed at the end of year two to assess number of sessions provided and patients treated. This will be used on an indicative basis for the life of the contract.

Appendix F: Key Performance Indicators (KPIs)

These are proposed Key Performance Indicators (KPIS) which will be monitored, reviewed and developed with the Special Care and Paediatric Managed Clinical Networks over the life of the contract.

They will account for 3% of the TACV for the PDS contract and will be applied to activity delivered in the PDS contract only.

Performance over a 12-month period from 1st April to 31st March each year will be reported with an annual submission to the commissioners. The submission will be made within 2 months of year-end.

The KPIs will act as a notional 'target' for years 1 – 3. From year 4, payment in relation to delivery of the above quality indicators. Failure to achieve Band A for each of the KPIs will result in financial recoveries in the following financial year.

Where following an end of year reconciliation, delivery of the UDAs falls below 96% of the contracted activity then the maximum payment in relation to the KPIs will be adjusted accordingly.

For instance, if the provider delivered 90% of contracted activity for the year then the maximum payment that could be made in relation to KPIs would be 90% of the contracted sum (3%) identified for KPIs.

Key Performance Indicators

Category	Description		Standards	Weighting	Band A	Band B	Band C	Payment Band A	Payment Band B	Payment Band C
Access to care	Proportion of discharge letters sent within 2 weeks		**95%**	**10%**	**>95%**	**90-95%**	**<90%**	**100%**	**75%**	**0%**
	Proportion of patients accepted for care who are seen for an assessment within 12 weeks		**95%**	**10%**	**>95%**	**90-95%**	**<90%**	**100%**	**75%**	**0%**
	Proportion of patients who start treatment within 18 weeks		**90%**	**10%**	**>90%**	**80-90%**	**<80%**	**100%**	**75%**	**0%**
	Proportion of all patients who receive care who are categorised as case mix level 2 or above		**70%**	**15%**	**>70%**	**60-70%**	**<60%**	**100%**	**75%**	**0%**
Personalised care	Proportion of patients or carers reporting satisfaction with care provided - using question *"have your needs been met by the service?"*		**90%**	**20%**	**>90%**	**80-90%**	**<80%**	**100%**	**75%**	**0%**
Evidence-based care	Proportion of patients who are in a continuing care relationship with the service where application of fluoride varnish/high fluoride toothpaste is recorded as part of the treatment provided	Adults (over 16 years)	**45%**	**10%**	**>45%**	**30-45%**	**<30%**	**100%**	**75%**	**0%**
		Children < 16 years	**45%**	**10%**	**>45%**	**30-45%**	**<30%**	**100%**	**75%**	**0%**
	Proportion of appointments which are not attended by patients		**11%**	**15%**	**<11%**	**11-15%**	**>15%**	**100%**	**75%**	**0%**