

# **Introductory guide to commissioning Dental Specialties**

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<b>Cross Reference</b>	This document should not be read in isolation and is part of suite of documents including; Guide for Commissioning Special Care, Guide for Commissioning Orthodontics, Guide for Commissioning Special Care Dentistry, Guide for Commissioning Oral Surgery/Oral Medicine, Equality & Health Inequalities supplement
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## 1 Foreword

NHS England produced the Five Year Forward View to set out a shared view of the challenges ahead and the choices about health and care services in the future; it applies to all services, including dentistry.

This consensus on the need for change and the shared ambition for the future is the context in which these Commissioning Guides for Dental specialties have been produced. Clinicians, commissioners and patients have contributed to this work to describe how dental care pathways should develop to deliver consistency and excellence in commissioning NHS dental services across the spectrum of providers to benefit patients.

In order to deliver this vision and implement the pathway's 'a coalition of the willing' NHS England partners, HEE and PHE, specialist societies and others who have contributed to their development will need to respond in the implementation phase by unlocking structural and cultural barriers to support transformational change in dental service delivery.

It's a future that will dissolve the artificial divide between primary dental care and hospital specialists; one that will free specialist expertise from outdated service delivery and training models so all providers can work together to focus on patients and their needs.

These guides set out a framework and the implementation and pace of change will vary across England. This will be an iterative process; therefore, it will be necessary to review and update these guides regularly. However, implementation will require energy, brave decisions and momentum, together with a willingness to share good practice, innovation and learning, as it emerges, to accelerate the speed and impact of change to improve patient care.

## 2 Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and,
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

### 3 Executive summary

It is now widely recognised that the NHS needs transformational change to services in order to deliver better outcomes for patients, promote health and ensure that we commission effectively.

Progress has been made in improving oral health and access to services in general. However, inequality in oral health experience and inequity in access to primary and specialist care exists. These guides focus on the commissioning and delivery of specialist care pathways; however, the gateway to specialist care relies on access to efficient and effective primary dental care services. Whilst there has been some improvement in general access over the past few years, commissioners need to ensure that they continue to meet their duties to commission primary care services appropriate to the needs of their populations. This means making effective use of available resources by challenging primary care providers to deliver care to those who need it most and by adopting appropriate recall intervals for those who can be seen less frequently, freeing capacity for access by new patients. Achieving improvements in access to primary care will widen access to specialist care for those who need it.

NHS England has developed these Guides for Commissioning Dental Specialties to be used by commissioners to offer a consistent and coherent approach. They describe the direction required to commission dental specialist services. This will reflect the need and complexity of patient care and the competency of the clinician required to deliver the clinical intervention rather than by the setting within which the care is delivered. Care will be delivered via a pathway approach which will provide clarity and consistency for patients, the profession and commissioners. There will be nationally agreed minimum specifications for each service, including how quality and outcomes are to be measured, which can be enhanced locally.

They are intended to ensure there is national consistency in the NHS commissioning offer for dental specialist services and service delivery. The pathway will also provide consistency across England in agreeing, at a national level, as much of the detail around commissioning, such as referral criteria, core data set required on referral, quality of environment and equipment, contractual frameworks etc. as well as consistent measures of quality and outcomes. The frameworks describe the concept of clinical engagement and leadership through Managed Clinical Networks (MCNs) which will work closely with commissioners, Dental Local Professional Networks (LPNs) and , describe and monitor the patient journey from primary care to specialist care.

The first phase of this work during 14/15 has included developing frameworks for the following specialties: Orthodontics, Special Care Dentistry, Oral Surgery/Oral Medicine and Restorative dentistry. Further work on restorative mono specialties, Paediatric Dentistry and Supporting Specialties (Oral Radiology, Oral Microbiology and Oral Pathology) will follow. This document is an overarching introductory guide to the individual commissioning guides. The concepts and principles herein highlight the common challenges and solutions for all dental specialties.

NHS England is committed to working and engaging with patients, carers and the

public in a wide range of ways. Throughout this process we have ensured that people's views are heard by having patient representatives on every group and convening a patient review group who have helped us develop the content. This is outlined in detail in the patient engagement and stakeholder engagement appendices.

Moreover, it must be understood that ultimately it is the patient who should make the decision about what treatment, if any, to undergo. The practitioner's role is to advise on treatments and options, and benefits and risks. This discussion between patient and practitioner should form the beginning of every patient journey and every specialist care pathway. That includes patient consent to the information sharing needed for their journey along a pathway.

The process of developing these patient involvement frameworks has also included engagement with Stakeholder groups that have an interest in dentistry, as outlined in the acknowledgments, stakeholder engagement appendix and governance model in the Appendices.

This is the beginning of a process. Locally, commissioners need to undertake work to understand the specialist services that are currently being provided, by who and where. The quality and quantity of these services, together with the impact and cost, also need to be identified before any change or procurement takes place. Many commissioners and clinicians have already made progress on aspects of this approach locally. However, they need to measure themselves against the enablers within each of the guides to understand next steps and agree local priorities. Commissioners will need support to identify current dental resources so decisions can be made; for example, in establishing MCNs that may require investment or flexibility in contracting such as the use of Commissioning for Quality and Innovation payments (CQUIN). The work of developing the commissioning guides has identified a number of examples of innovative solutions and exploiting flexibility in current contracting forms. Locally, commissioners will need to consider investment and contractual flexibility to support the implementation of new care pathways. The implementation of care pathways could deliver efficiency gains in some areas; however, there may be a need to consider the use of these savings as investment to pump prime change in other areas of dentistry. The next phase of this work could support the validation and sharing of solutions to harness and communicate examples of good practice and innovation. Some of the identified enablers will be more difficult to implement at a local level however, nationally NHS England could support identified enablers to become a reality. An example would be expanding the use of NHS number within dentistry.

There is a particular emphasis on helping commissioners understand the financial impact of implementing the commissioning guides, to provide an estimate for the associated upfront costs along with any expected financial savings to the NHS. The initial work will involve needs assessment, understanding current provision, enabling consistent data collection and coding. Implementation support will also include the development of a commissioning pack to encourage effective and consistent commissioning to benefit patients. Work on an additional set of guides will also take place during this phase, focusing on Paediatrics, the Supporting Specialties

(Radiology, Oral Microbiology, Oral Pathology) and further detail on Restorative mono-specialties (Endodontics, Periodontics, Prosthodontics).

An implementation phase will include supporting commissioners to identify what could and should be undertaken nationally or regionally; and what should be supported by Commissioning Support Units locally. However, the first steps for commissioners on these first four strategic specialist commissioning guides will be to review current local progress against the frameworks and pathways, to assess local priorities, and agree what enablers need to be put in place, such as establishing clinical networks and referral processes.

Commissioners need to be aware that the effective implementation of needs-led dental specialist care pathways relies on maintaining and ensuring access to effective primary dental care services; particularly for those groups in the population who do not access care routinely or have additional needs. Publishing these guides is the first step in what is intended to be an iterative process. Those commissioners who need to procure services in this transition can use the guides to complete needs assessment, set minimum standards and service direction and ensure that proposed outcomes and quality measures are included in service specifications. The guides, including this overarching introductory framework, can be made available to potential bidders. Tendering providers will need to include a statement in their submissions on how they will work with commissioners to comply with the requirements of the guides.

Commissioning the new pathways is intended to ensure improved access, quality of care and patient outcomes.

## 4 Why do NHS dental specialties need to change?

The NHS Five Year Forward View<sup>1</sup> was published in October 2014 during the development of these commissioning and care pathway guides for dental specialties. The forward view is not about structures and institutions but describes a broad consensus on why the NHS needs to change and sets the direction for the future. It builds on the principles of prevention, achieving better value and outcomes, meeting need and delivering patient centred care within a supportive system. It recognizes that England is too diverse for a 'one size fits all' care model to apply everywhere, but suggests national leadership act coherently to describe care delivery model options that allow meaningful flexibility to meet local need and circumstances.

The statement “Increasingly we need to manage systems – Networks of Care – not just organisations” represents a strong commitment to the direction and content of these strategic dental specialty commissioning guides. It confirms that services need to be integrated around the need of patients not organisations or training programmes. NHS England, now the commissioner of all dental services in England, will take decisive steps to break down barriers in how care is provided between primary care and hospitals. The Five Year Forward view is particularly relevant for dental specialist care and these emerging national care pathway frameworks will meet one of the most important changes it heralds – to expand and strengthen primary and 'out of hospital care', it also aims to focus on creating and protecting health not just treating ill health and providing isolated episodes of care.

NHS England commissions all NHS dental services. The benefit of a single commissioner for dentistry is the ability to plan and produce more consistent standards of delivery and better health outcomes for patients across the whole of England. The promotion of a consistent, more efficient and effective approach to commissioning dental specialty services, using existing investment and specialists, is the intention of the guides.

The guides have been produced to address deep-rooted inequalities, inequity, and variable quality of care; they are intended to promote consistent value and quality of specialist dental care provided to patients. Methods to describe population need and current services, working jointly with Public Health England (PHE), are modelled and shared for commissioners and clinicians to inform local need assessment and the impact of existing services in meeting identified need. Current inefficiencies in the system are raised, but the commissioning guides are not about just reducing costs but to release resource from one part of the dental system and use it more effectively in another. They are intended to support a change in culture. Clinicians in dentistry need to understand that there is a clinical cost to working in an outdated way. One patient's abandoned or failed treatment is potentially another patient's delay or lack of treatment that could have improved oral health. Using these guides is about supporting commissioners and clinicians to work together to ensure that resources invested by the NHS in dental specialist care are used in the most effective way to provide the best possible quality and quantity of care for patients; to meet need rather than serve demand.

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<sup>1</sup> [www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf)

As responsible clinical stewards, specialists in dentistry can assist in leading change and provide a more effective use of constrained resources by broadening their influence with primary care clinicians. A cultural shift is required which calls upon dental specialists to ask, not if a treatment or procedure is possible, but whether it provides real value to the patient and genuinely improves the quality of life. They should also consider if some of their specialist time and knowledge would be better spent supporting primary care to benefit many more patients than they can treat working in isolation in an acute setting.

Whatever a clinician's role in dentistry they need to be willing to demonstrate leadership in managing and using resources effectively by working with dental public health, commissioners and other stakeholders e.g. local authorities, Healthwatch and patient groups. This means being prepared to contribute to discussions and decisions about allocating resources, setting priorities and having some awareness of population need, in addition to understanding the needs of patients referred to their particular specialty and service.

The Independent Review of NHS Dental Services published in June 2009, (Steele Review) suggested a pathway approach to dental care provision should be adopted. Following this, the Department of Health established advanced care pathway groups for a number of specialties which defined case and procedural complexity at three levels.

The levels of complexity do not describe contracts, or practitioners or settings. Levels 1, 2 and 3 care descriptors reflect a case in terms of procedural difficulty, patient modifying factors and competence required of a clinician to deliver care of that level of complexity.

Level 1 complexity outlines the skillsets and competencies covered by dentists completing undergraduate and dental foundation training (or its equivalence). Commissioners would expect this level of competence as a minimum standard within NHS mandatory contract delivery. Providers of NHS primary care would be expected to ensure care of this level is delivered without referral to specialist services. Most practitioners develop interests, skills and competence with experience; therefore the majority of general dental practitioners currently operate above level one in a number of specialist areas and this is expected to continue.

This introductory guide outlines the strategic framework for delivery of *specialist dental* patient care pathways. Many practitioners in primary care who are not on the specialist list deliver care at Level 2 care complexity. Commissioners will expect the same standards of quality and outcome regardless of the provider or setting. Every practitioner delivering Level 2 care on referral will be expected to have a formal link with a consultant-led MCN and to take part in benchmarking and audit as a minimum requirement to maintain and assure competence.

The three levels of care have been defined:

- Level 1 complexity outlines the skillsets and competencies that are covered by teaching and training in the dental undergraduate and Dental Foundation (FD) programme. Such skills are enhanced and improved with experience so the

development of these skills is a career-long process. The provider is responsible for the delivery and quality of mandatory services. Treatments that are not specifically defined in Levels 2 or 3 are de facto Level 1.

- Level 2 care is defined as 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 case complexity maybe delivered as part of the continuing care of a patient or may require onward referral. Providers of Level 2 care on referral will need a formal link to a specialist, to quality assure the outcome of pathway delivery.
- Level 3a and Level 3b care is that which requires specialist practitioner or consultant led care due to complex clinical or patient factors. This care can be provided in a primary care, dental hospital or in a secondary care setting depending on the needs of the patient and/or local arrangements which may include current training commitments.

Each of the guides will describe what is expected of providers of dental services at each level of care complexity in terms of clinical competence, procedural complexity, modifying patient factors, and equipment or environment requirements. It sets out the factors which would escalate a patient's journey to specialist care and what preparation primary care and the patient need to commit to.

A 'care pathway' approach was proposed for all dental services in *Securing Excellence in Commissioning NHS Dental Services*<sup>2</sup> (SEICD). The focus is on commissioning the entire dental pathway as a single, consistent, integrated model of service delivery. This reflects the fact that, as a general principle, the NHS should be offering the same high standard in terms of quality, value and outcome of care, regardless of where in the country it is delivered. Changes in the population have resulted in a requirement for specialist services to adapt accordingly. Research and increasing evidence regarding effectiveness of dental treatments can inform the delivery of specialist care. Clinical care pathways are now in widespread use in other areas of NHS delivery and dental specialist care can benefit from adopting the approach. All the specialist commissioning guides in this series will include a care pathway with an illustrative patient journey. This will describe a consistent national framework for specialty dental care delivery, regardless of setting, to ensure a focus on value, patient outcomes and greater consistency in delivery of services, both in the sequencing, effectiveness and quality of clinical care and the patient 'journey'.

These guides are intended to inform and support local dental LPNs and commissioners to work with clinicians and PHE Consultants in Dental Public Health to understand local need, impact of current investment and what would enable them to transform services in their area: to build on work already undertaken with local partners, including patients. There will be a need to establish, strengthen or formalise clinical networks and specialist groups to take joint responsibility with commissioners to implement system change which can take account of local needs and circumstances, including reviewing progress to date and required pace of change.

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<sup>2</sup> <http://www.england.nhs.uk/2013/02/13/dental/>

Examples and case studies are included in the individual guides so that commissioners can identify and share best practice.

Locally, delivery is often based on models 'inherited' from Primary Care Trusts (PCTs); however, with commissioners and clinicians working together with patients, commissioners can begin to implement national pathways as they emerge, promoting innovation, testing and validating best practice, and sharing expertise to get the best 'local fit'. This should help to overcome local 'turf wars' and organisational interests to benefit patients and the population.

## 4.1 Getting serious about prevention

A preventive care pathway approach in primary care is currently being piloted in a number of areas across England. Professor Steele's 2009 review recommended a pathway approach to care focussed on prevention. This drew on a number of local pilot pathways that had been developed to test a more preventative approach to care. Since 2011 the national dental pilots, testing elements of a new contractual system, have been using a preventative pathway developed for the contract reform programme.

The concept of needs-led, evidenced-based, prevention-focused care pathways is central to contract reform to support change in dental service delivery. Specialist dental services can dovetail this approach as advocated in these strategic framework commissioning guides. However, this relies on maintaining and continuing to improve access to primary care dentistry and investing in primary care.

The aim of adopting a care pathway approach is to shift dental service delivery from an interventional to a preventive focus with care based on individual need and risk; with the main emphasis on outcomes and effectiveness of clinical care. Additionally, the pathway model aims to encourage patients to take responsibility for protecting and maintaining their own oral health, and committing to the demands of receiving specialist or advanced care, as part of a long-term continuing care relationship between themselves and their dental teams.

As set out in the Five Year Forward View, action is needed on three fronts; *demand, efficiency and funding*. Assuming there will be no increase in *funding* of dental specialist care, compensating action is required on *efficiency and demand*. Other system change is needed and these guides will suggest steps commissioners can take to incentivise and support reform happening as intended. Examples include:

- The overarching vision is the adoption of patient-centred care with a population health outlook for dentistry, underpinned by the design and delivery of all services. Specialist clinical services viewed as one aspect of the broader spectrum of dental service delivery and having formal and managed links to primary care;
- The offer of longer-term and outcome-measured contracts in primary care specialist delivery to sustain and stimulate investment could facilitate change.

Some of the specialist guides contain suggested incentives for commissioners to consider which can support change locally;

- Flexibility within acute organisations to agree job plan alterations and/or local contractual arrangements with consultant and specialist staff to allow them to release time to take part and lead MCNs with primary care providers will also be required. This can be part of contract negotiations within annual commissioning intention notifications or rewarded through CQUINs;
- Whole system adoption of patient-centred care that engages patients as equal partners in their care, supported by contractual change and measures of quality and outcome rather than an over-reliance on activity reporting performance management is needed;
- Primary care services working formally at scale, bringing clinicians together, possibly through federation. Federated practices could employ consultants and specialists to reflect the central role of primary dental care. These systems of working can be developed to meet local needs; such models are to be tested in primary medical care and could support innovation in dentistry.

## 4.2 Emerging models

NHS England commissioners each have LPNs for dentistry. The LPN Chairs together with PHE Consultants in Dental Public Health (CsDePH) are the clinical voices to dental commissioners. They need to engage consultants in dental specialties to take leadership roles within MCNs to strengthen clinical leadership where it already exists and to establish this way of working where it has not developed by altering job plans and arrangements to stimulate it to happen.

## 4.3 Managed clinical networks (MCN)

MCNs have been defined as *'linked groups of health professionals and organisations from primary, secondary and tertiary care working in a coordinated manner, unconstrained by existing professional and organisational boundaries to ensure equitable provision of high quality, clinically effective services'*.

A MCN is a way of working where clinicians from all settings across a clinical pathway can focus on patients and services rather than being constrained by organisational boundaries. MCNs use only aggregate data in order to shine a light on trends such as outcomes, appropriateness of referrals, etc, to drive up quality. Leading and managing MCNs should be part of the role of an NHS Consultant team in all dental specialties. Taking part in MCNs should be agreed as part of a consultant's job plan and a mechanism to fund the programmed activities (PAs) agreed. This has to be achieved within existing resources and is a matter for commissioners to facilitate using negotiations with secondary care providers during contract discussions and/or through efficiency savings. Clinicians, taking an active

role in the MCN, need to be recognised and this work supported within the contractual framework.

All information used by MCNs should be contribute to ensure a patient-centred focus to clinician's work and must involve all specialists working in a particular geographical area and specialty so that peer review, audit and supervision is mainstreamed across organisational boundaries and settings .

MCNs will be accountable to commissioners and will work closely with PHE CsDePH and LPN Chairs but how they develop and operate, to improve services locally by involving clinicians and patients locally, is a matter for local determination and flexibility.

Fair processing/privacy notices should be checked to ensure they state that confidential patient information may be anonymised for audit or research purposes.

## 5 How to use the guides

### 5.1 Ethos

England is too diverse for a ‘one size fits all’ care model to apply everywhere. These specialist commissioning guides are intended to assist commissioners by providing a national framework for new care delivery models at local level. There is a need to act coherently so clinicians and commissioners will be expected to review the enablers outlined in these guides, to first assess local progress, gaps and resource, in order to plan change to meet local need and circumstances. All providers, commissioners and clinicians will be expected to adhere to core principles such as consistency in e.g. coding, costing, quality measures, minimum specifications etc. Local teams will have flexibility over pace and scale of change to reflect local circumstances and needs, but will be expected to adhere to standards, measures and vision.

The commissioning guides are intended to stimulate debate and action locally. However, transformational and transactional change is required in the delivery of dental specialist services and commissioners are encouraged to review population need, investment and impact of existing local services in meeting that need, using the enablers set out in the patient journeys within these guides as a benchmark. An NHS England-led implementation phase will follow.

### 5.2 Context

An emphasis on improving outcomes and effectiveness, consistency and clarity, regardless of setting, is needed in a number of areas and the individual specialist guides offer a framework and some detail for commissioners and clinicians to achieve that by offering:

- Clarity of what is expected as a minimum by primary care providers treating patients with Level 1 complexity, dentists with enhanced skills and experience or specialists treating patients with Level 2 complexities on referral and specialist- and consultant-led care treating patients with Level 3 complexity;
- Description of patient complexity and procedures across all levels of care, building on advanced care pathway work led by the Department of Health;
- Expected clinical competencies and outcomes at each level of care;
- Consistent environment and equipment standards within outline model specifications;
- Generic and specialty specific clinical outcomes, quality standards and patient reported outcome and experience measures (PROMS) (PREMS) for England;
- Consistent referral core data set, coding and tariff expectations for care pathways;
- Access to services across each pathway to ensure that people with disabilities and all other “hard to hear” groups of people have equitable access to specialist dental care when required.

These guides have been developed to support NHS England’s single operating framework for commissioning dental services in England. They have been developed with commissioners, specialist and generalist clinicians working with PHE

CsDePH, Health Education England (HEE) postgraduate dental Deans/ Directors, the British Dental Association, patient and public representatives and representatives of the Royal Colleges, specialist societies and organisations.

For each specialist commissioning guide a common format has been used. The individual guides include the following:

- Description of the speciality;
- Description of the current national workforce and training capacity;
- Population need and delivery at a national and regional level, (where data exist) giving commissioners a methodology to collate and understand local need and to assess the impact of current services in meeting that need;
- Quality standards and metrics for competency of clinicians, environment including equipment;
- Generic and specialty-specific PROMs and PREMs. Commissioners, clinicians and service leads can add additional measures, if capacity to measure and report on more exists. All commissioners will be expected to collect and report on the core set to allow comparison

Enablers to transformation have been identified for each specialist area. Some of these are drawn from current best practices and some are aspirational to stimulate innovation. The guides also prescribe a minimum specification which commissioners will be expected to use when transforming or procuring new services. The pace and scale of implementation and change is a matter for local consideration, flexibility and management. The guides contain an illustrative patient journey which sets out minimum standards and metrics that commissioners would be expected to adopt to allow for benchmarking and service quality improvements over time. Assessing progress against the enablers described within the patient journeys would be the first task for commissioners, together with establishing or strengthening clinical networks (LPNs and MCNs). Investing in change is a matter for local implementation and by and large will be met from within existing resources by identifying where efficiencies across the whole pathway should be made. This accepts that, on occasion, investment needs to be made to support longer-term efficiencies from service and training programme redesign.

### **5.3 Dental specialities**

There are 13 dental specialities recognised by the General Dental Council the regulatory body for dentistry. The four specialties covered in this initial commissioning guide development work are:

- Oral Surgery and Oral Medicine
- Orthodontics
- Special Care dentistry
- Restorative dentistry

Other specialist commissioning guides will follow in this series with priority for paediatric dentistry, further detail on restorative mono specialties and supporting services including, radiology, oral microbiology and oral pathology.

## **5.4 Current arrangements**

The majority of dental care in England is provided by primary care practitioners working in high street practices, community and specialist clinics under contracts for General Dental Services (GDS) and agreements for Personal Dental Services (PDS) contracts. The majority of specialist dental services are delivered in secondary care settings, in acute hospitals, foundation trusts, district general hospitals and dental hospitals under national and local tariff arrangements. There are 10 dental hospitals in England providing undergraduate and postgraduate training and delivery of NHS dental services. Traditional dental hospitals are generally hosted by secondary care trusts. Care is largely outpatient-based and could be suitable for standard or advanced mandatory primary care contracting. Due to historic arrangements, with the acute trusts, care is currently paid for at secondary care tariff; including the level one complexity of care cases, which are required for teaching purposes.

NHS commissioners have responsibility for ensuring that they commission appropriate services to meet the needs of their populations. However, unlike medical care, there is a significant private sector element to dental service primary and specialist provision and commissioners need to take this in to account when assessing needs and planning services.

Although dental specialist services are currently provided mainly within the NHS secondary care sector and/or in dental hospitals, referrals are accepted from both NHS and private practitioners. Therefore consideration needs to be given to ensure that any clinician (NHS or private) referring a patient to an NHS-commissioned dental specialist service adheres to acceptance criteria and requirements.

## **5.5 Training**

It takes time to train skilled, specialist staff so NHS dentistry risks confining progress due to some outdated models of training delivery that no longer matches changing patient need, and flows, or workforce requirements.

When redesigning specialist dental care pathways, training needs of both the current and future workforce need to be considered and secured. Dental clinical training requires direct patient care under supervision. Dental service contracts should clarify that trainees can be involved in service delivery wherever possible and training posts approved by Postgraduate Dental Dean/ Directors would specify requirements.

HEE and its constituent Local Education and Training Boards (LETBs) are responsible for workforce development and commissioning of education and training for the healthcare workforce. Commissioners should ensure they have formal arrangements to share population need and related dental service commissioning plans with their LETB dental lead (usually the Postgraduate Dental Dean or Director)

in order to align system leadership so that workforce and training delivery planning reflects service requirements to meet changing population need.

Undergraduate training mostly takes place in dental hospitals, although many dental students, dental therapy students and dental hygienist students carry out some supervised clinical practice in approved NHS training clinics or practices in primary care. Training and education costs are funded by a combination of HEFCE, HEE (SIFT) and by NHS England through commissioned services to training providers.

Completion of dental foundation training in primary dental care is compulsory to enable UK dentists to join the NHS Performers List without conditions. This allows practitioners to deliver primary care dental services to Level 1 complexity, as a minimum competency. Dentists will develop interest and additional competence with experience and CPD.

There are approximately 900 foundation dental training places in England funded by HEE. Foundation dentists deliver NHS services and the costs of this are funded by HEE. LETBs and commissioners need to work coherently in the planning, location and delivery of training services.

Dental core training is a programme lasting between one and three years and is undertaken after dental foundation training and its purpose is to enable dentists to acquire additional skills and experience in particular areas of dentistry. HEE funds part of the costs of this training (mostly salaries) and employers fund the remainder. There are approximately 550 dental core training posts in England, and these posts are currently mostly in dental teaching hospitals and district general hospitals, with some in primary care. Strategic decisions based on the numbers and locations should be influenced by NHS England.

Service delivery by dental core trainees contributes to the total activity delivered by their employing provider and these costs are not funded by HEE. Cases currently required by secondary care training providers to meet training programme needs, for which the additional costs of providing this care is met by NHS England through tariff, should be factored into any service redesign. Training programmes will need to adapt to changing patient needs and flow and opportunities exist to enrich training experience.

Dental specialty training lasts between 3 and 5 years and is undertaken by dentists who will join a GDC specialist list on completion of the programme. There are approximately 500 dental specialty trainees in England. Programmes are usually based in dental teaching hospitals and district general hospitals with placements in primary care increasingly included. These are partly funded by HEE (salaries, study leave and a contribution to costs of providing clinical educational support) and other costs are funded by employers.

Dental professionals in all spheres of dentistry are currently able to access Postgraduate training through Postgraduate Medical Education, currently funded by HEE. These training opportunities are aimed at the entire dental team and thus, through collaborative work between NHS England and HEE, it is anticipated that the skills required to enhance the workforce can be accurately identified and training met

through education tailored specifically at these areas. This could enhance care for patients, particularly those with Levels 1 and 2 care complexity.

Funding streams for training and education are complex. HEE has a gross budget and allocates to Regions and LETBs. In a nutshell the costs incurred in teaching dentists in training are met through these allocations.

The additional cost of providing training within NHS service delivery attracts funds and is paid directly to acute trusts so it can be difficult to identify and direct to support dental service delivery. HEE is taking forward the implementation of Shape of Training Review for the Medical Profession. There is a need to review the principles and direction of this with regard to dentistry.

HEE Workforce plan for England 2015/16<sup>3</sup> confirms that they will look at the commissioning of dental specialty training, in order to align training with the changing oral health needs of the population and the requirements of NHS England.

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<sup>3</sup> HEE Investing in people for health and healthcare Workforce plan for England Proposed Education and Training Commissions 2015/16.

## 6 Population health needs

### 6.1 Introduction

This section of each of the strategic guides will describe how the need for oral healthcare services for a defined population for a given specialist area can be assessed using readily available information. It will describe need at a population level and service data. However, there are limitations in existing service data as it is not consistently collected, rarely captures need at the point of referral nor does it report outcome on delivery.

Within this overarching document this section will outline a summary of generic oral health needs for England. It takes into account a variety of population characteristics that have the potential to impact on the need for services and considers how statistics relating to service provision may be used to estimate current and future need. This helps by making best use of available funding and enhancing patients' journeys through delivery of care, aligned to best practice. It outlines the wider demographic picture for England that is common to all specialties.

The UK population is increasing, ageing and becoming more diverse; all of these changes have implications for commissioning dental specialist healthcare services. Appendix 1 describes what needs assessment is and the steps needed to complete. PHE Specialists and CsDePH are aligned to NHS Regions and can lead this process locally. PHE is intending to produce a more detailed needs assessment toolkit to accompany the implementation phase.

Oral health needs assessment (OHNA) relevant to a particular specialty, where it exists and examples of good practice are covered within the individual guides to assist commissioners address inequalities in disease experience and/or access to services. Limitations of existing aggregate data sources are discussed and tips and hints on how to triangulate data or use synthetic analysis to support decision making are shared as needs assessment is not an exact science.

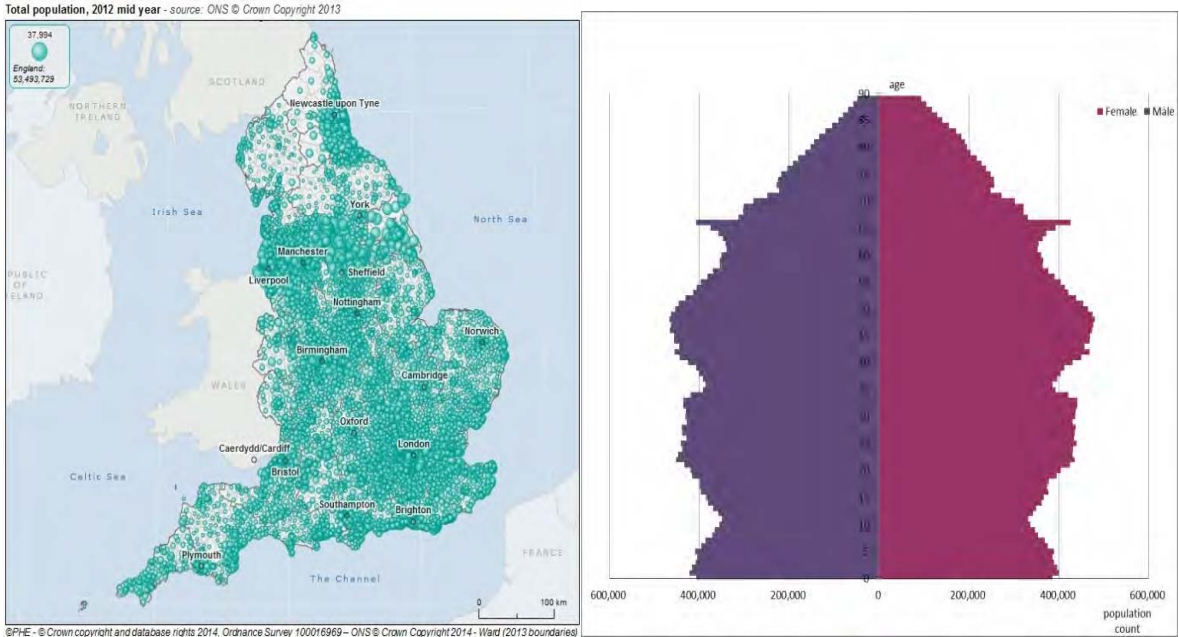
# 7 Population information for England

There are some essential features of England’s population that commissioners need to consider, along with some modifying features that, either alone or in combination, are likely to increase the need for specialist dental services. National data for England and/or examples of local data are shown, followed by a link to local sources to facilitate the creation of bespoke local needs assessments by commissioners.

## 7.1 Describing the resident population

Mid-year population estimates for 2013 suggest that there are approximately 54 million residents in England. The area, age and gender distribution of the population of England are shown below (Figure 2).

**Figure 2 Area, age and gender distribution in England, 2012**



Source: Public Health England Knowledge Gateway

Source: Office for National Statistics

Local detail can be sourced from: [http://www.apho.org.uk/default.aspx?QN=HP\\_LOCALHEALTH2012](http://www.apho.org.uk/default.aspx?QN=HP_LOCALHEALTH2012)

Information describing population estimates and population trends can be sourced from:

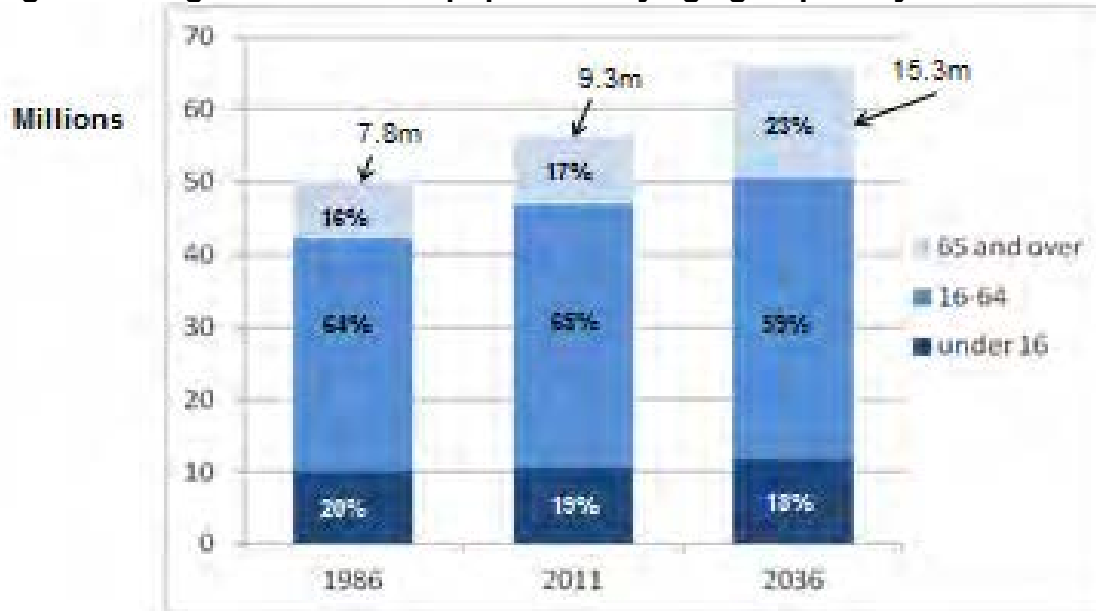
<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates+by+Age+and+Sex#tab-data-tables>

It is important for commissioners to consider population growth when planning future commissioning. Mid-year population estimates for 2013 demonstrate a growth in the population of England, with the largest growth in London, the East and South East. This growth has largely been due to natural change (births and deaths) and net international migration. The population of England is expected to continue to grow. Population growth estimates at local authority level can be found at:

<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Projections#tab-data-tables>

The UK population is ageing. This change is predicted to continue over the next two decades with the largest increase seen in those aged 85 years and over (Figure 3).

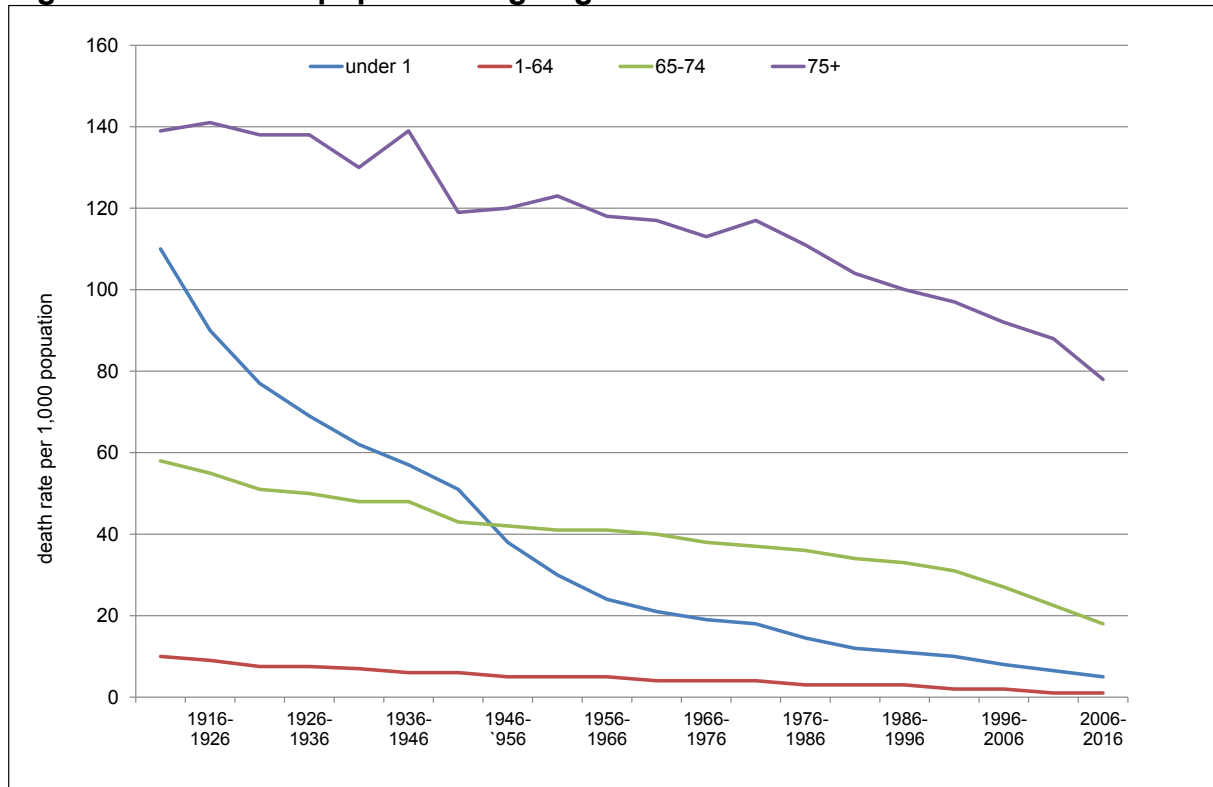
**Figure 3. England and Wales population by age group and year**



Source: ONS, 2013

Ageing of the population refers to both the increase in the average (median) age of the population and the increase in the number and proportion of older people in the population. This demographic change is largely attributed to past improvements in mortality rates across all age groups and continuing improvements in mortality rates at the oldest ages (Figure 4). In England, the proportion of the population aged 65 years and over is expected to increase from 17% in 2010 to 23% in 2035 (ONS, 2013). This older population is also increasing in diversity.

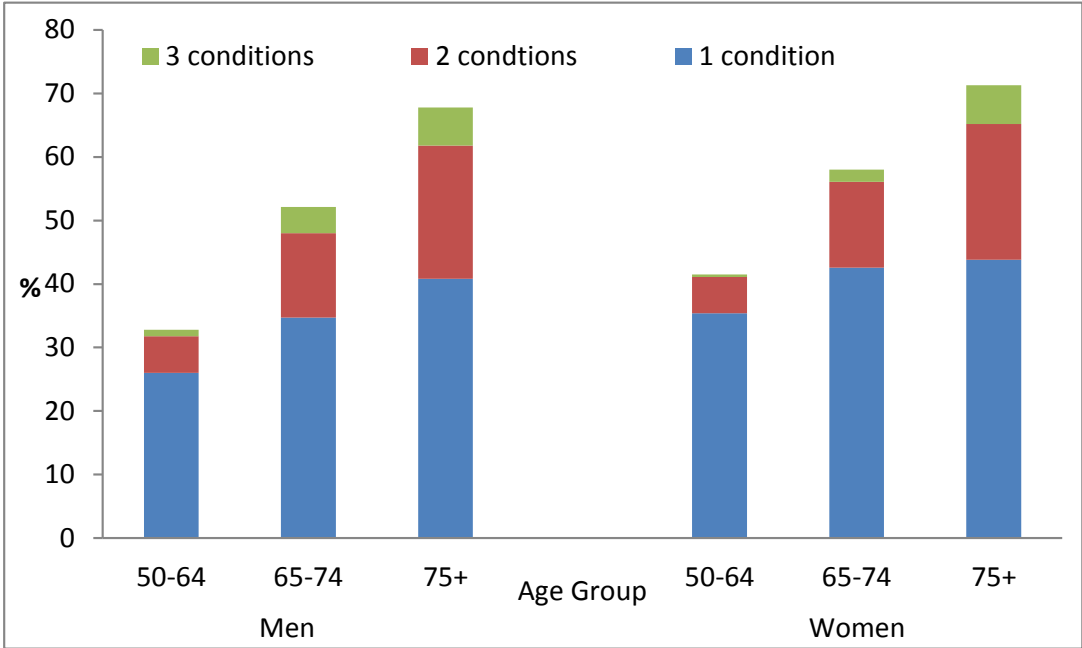
**Figure 4. Drivers of population ageing**



Source: ONS, 2013

Older people are more likely to have limiting long term medical conditions and the likelihood of having more than one condition increases with age (ELSA, 2009) (Figure 5). Such conditions can increase complexity of patients and impact on the need for Level 2 or 3 care. With increasing age and frailty, older people become more likely to live in residential or nursing homes. Information describing the number of older people living in nursing homes based upon GP registration data may be accessed via the Health and Social Care Information Centre and the Projecting Older People Population Information System (POPPI).

**Figure 5. Proportion of the older population with one or more medical conditions by age group and gender**



Source: ELSA, 2009

**Ethnicity**

The prevalence of most acquired oral diseases and conditions varies between various ethnic groups. It is therefore important to understand the composition of the population with regards to ethnicity. Population estimates by ethnic group for local authority districts and higher administrative areas in England can be found at: <http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates+by+Ethnic+Group#tab-data-tables>

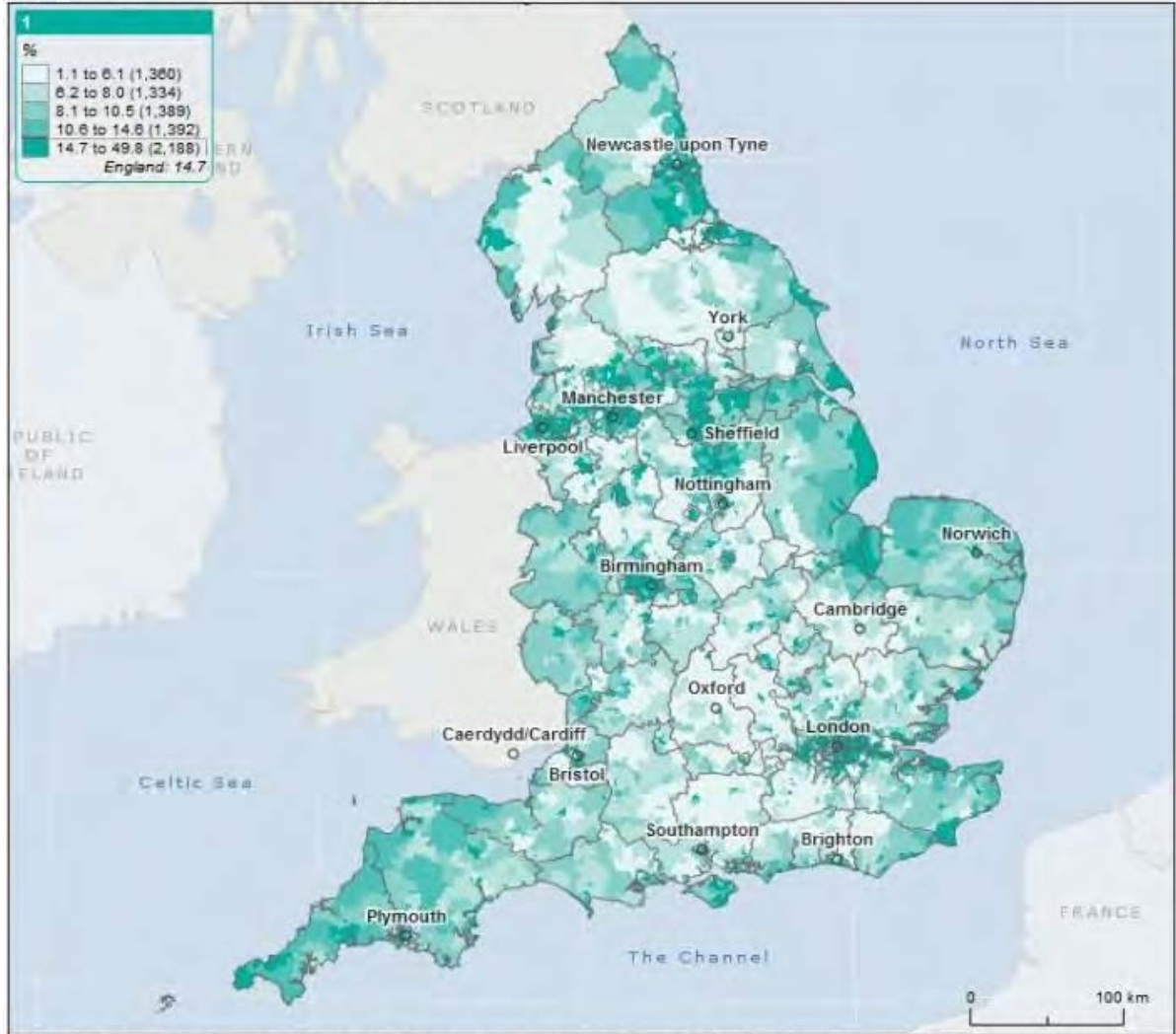
**Deprivation**

Social disadvantage is associated with the three most common oral diseases experienced by people in England, these being dental caries, periodontal disease and oral cancer. It is therefore essential for commissioners to understand levels of social disadvantage within the local population.

The maps below (Figure 6) show proportions of the population with various levels of income deprivation and its relationship with self-reported poor or very poor health.

**Figure 6**

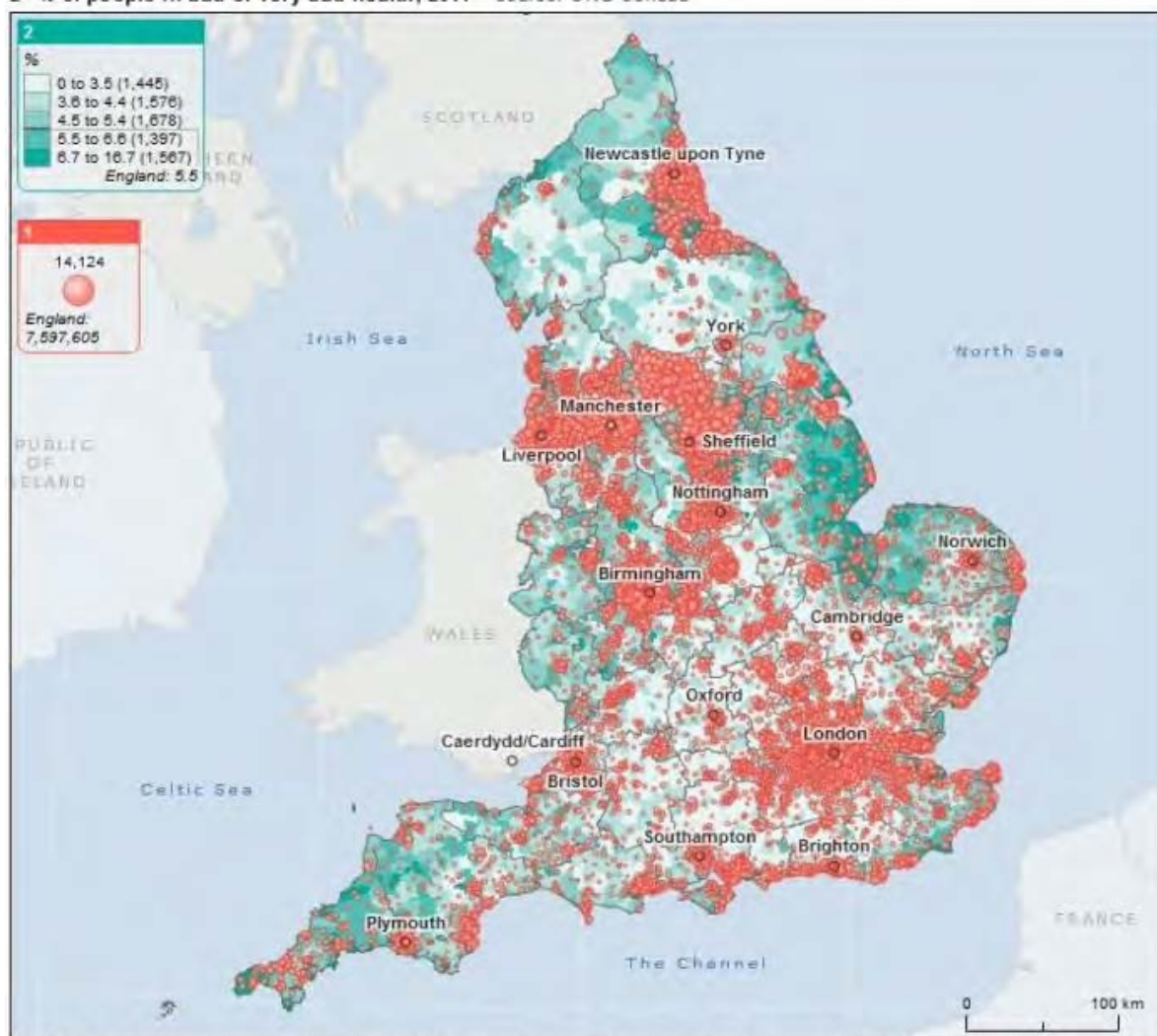
% living in income deprived households reliant on means tested benefit, Income domain score from the Indices of Deprivation, 2010 - source: CLG © Copyright 2010



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1 - Number living in income deprived households reliant on means tested benefit, Income domain score from the Indices of Deprivation, 2010 - source: CLG © Copyright 2010

2 - % of people in bad or very bad health, 2011 - source: ONS Census



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Local data on population deprivation and its association with many health-related indicators can be found at:

[http://www.localhealth.org.uk/#v=map4;i=t1.income\\_dep;l=en](http://www.localhealth.org.uk/#v=map4;i=t1.income_dep;l=en)

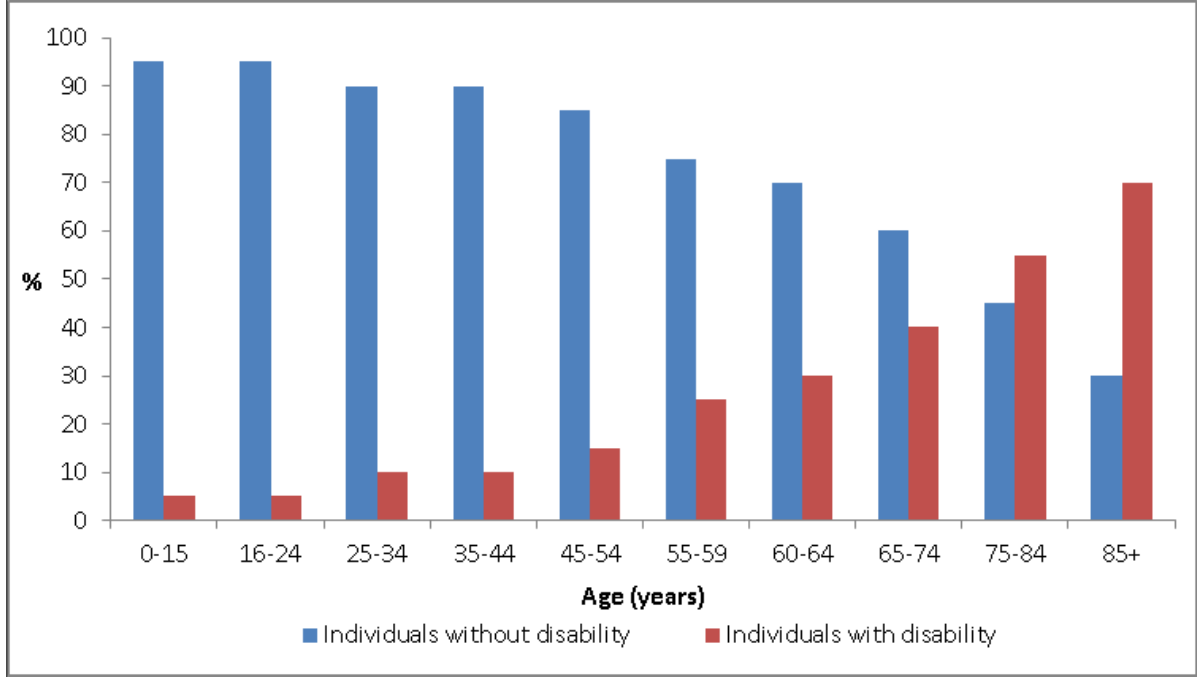
## 7.2 Disability

There were just over 10 million disabled adults living in the UK (Papworth trust, 2013). This was equivalent to 24% of the population. Approximately 1 in 5 people in the UK has a disability. Whilst only 17% of disabled people are born with a disability, there is a strong correlation with age and the majority acquire disability in later life (Figure 7). There is a wide spectrum of need and dependency and not all disabled adults will require specialist care; wherever possible, mainstream dental services in primary care should be responsive to their needs.

Disabled people tend to live in more deprived areas primarily due to lower incomes and social housing allocation policies. Geographically, the largest percentages of disabled adults in England live in the North East (34%) and North West (31%) of the country with lower percentages in London (25%), the East (27%) and the South East of England (27%). The prevalence of disability varies with ethnicity. In Great Britain, White adults (29%) report having a higher percentage of impairments than other ethnic groups, while Chinese and other ethnic groups show the lowest percentage

(19%). As a result of their impairment, disabled adults from Black or Black British ethnic backgrounds report a greater impact on daily living activities as compared with adults from a White ethnic background. Disabled people make up around one third of the NHS service users in Britain.

**Figure 7. Proportion of the population with a disability by age group**



Source: Age UK, 2012

Based upon governmental information, it is estimated that nationally there are approximately 900,000 adults with learning disabilities, of whom 21% are known to disability services (Emerson *et al.*, 2011). The Public Health England Improving Health and Lives Learning Disabilities Observatory provide learning disability profiles at local authority level. The profiles can be accessed at: <http://www.improvinghealthandlives.org.uk/profiles/>.

Further information is available from the Projecting Adult Needs and Information System (PANSI) <http://www.pansi.org.uk/>.

### 7.3 Bariatric groups

Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health (WHO, 2014). The WHO definition of obesity is a Body Mass index (BMI) greater than or equal to 30. Obesity in women is associated with income with prevalence highest in the bottom two income quintiles. There are no significant differences in the prevalence of obesity in men from different income groups (HSCIC, 2013d). Provision of dental care for bariatric people may require special dental equipment and access to services may be more difficult if the level of obesity has impacted on mobility and health. Those with a BMI of 50 or more may be housebound and require specialist care and support. There is no national bariatric database in England. Local data may be obtained from GP surgeries.

## 7.4 Mental health

Mental health problems are one of the most common health conditions. It is estimated that in any one year, one in four British adults experiences at least one mental disorder and one in six experiences this at any given time (Singleton *et al.*, 2000). Moreover, many people who have drug and alcohol dependency also experience underlying mental health problems.

People with severe mental illness are more likely to have poorer oral health than the general population. These may be as a result of medications used to treat their mental health illness. A compounding factor is that these medications can also increase risk of obesity and diabetes. The prevalence of dementia is increasing and dementia is now a public health priority (PHE, 2014).

Whilst the majority of people with mental health problems can be seen within the general dental practice setting, some will need the care of specialists in special care dentistry. Kisely *et al.* (2011) reported that people with severe mental illness were more likely to have lost all their natural teeth and have higher levels of dental caries.

People with mental health problems are also less likely to access dental services routinely as are socially excluded groups including prisoners, alcohol and substance misusers and homeless people. Consideration needs to be given locally to these groups to ensure equitable access to dental specialist services.

## 7.5 Health related behaviours

There are a number of characteristics relating to people's lifestyles that are associated with comparatively lower levels of oral health. The most prominent are tobacco use, alcohol consumption and substance misuse. Comparatively higher rates of these health related behaviours suggest that a population will have higher levels of oral disease and a corresponding increased need for services.

Data relating to smoking are available at local authority level through local tobacco control profiles, which provide population rates for various tobacco related health indicators including oral cancer registrations:

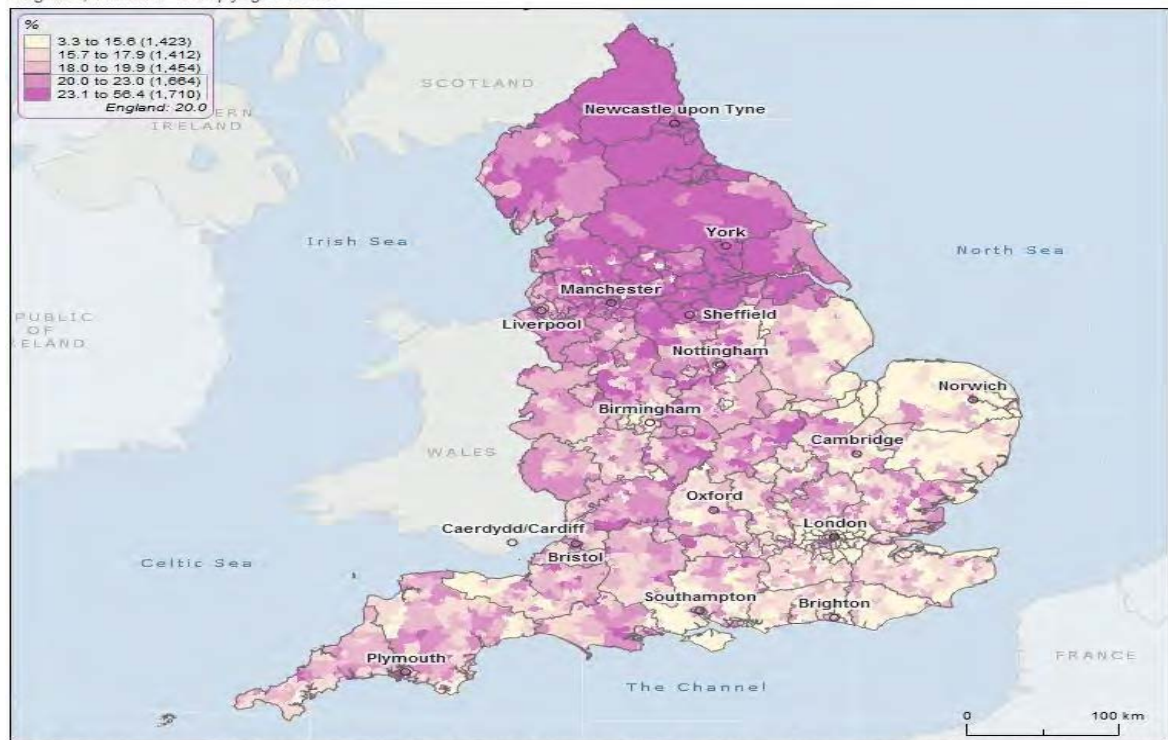
<http://www.tobaccoprofiles.info/profile/tobacco-control/data>

The impact of over or inappropriate consumption of alcohol has both short and long-term consequences for oral health. Probably the most notable is the impact on trauma, sustained through alcohol-induced violence.

The map below shows modelled data relating to binge drinking (Figure 8).

**Figure 8**

Percentage of the population aged 16+ that binge drink, modelled estimate, 2006-2008 - source: Public Health England, NHS IC © Copyright 2010



Source: Public Health England Knowledge Gateway

Local data can be found at:  
<http://www.localhealth.org.uk/#v=map4;i=t2.bingedrinking;l=en>

Data relating to violence can be found at:  
<http://www.eviper.org.uk/data.html>

A further area for consideration because of its negative impact on oral health is drug use. Data on rates of substance misuse within a population in England can be found at:  
<http://www.apho.org.uk/resource/view.aspx?RID=126453>

## 7.6 Describing relevant diseases and conditions

The need for oral healthcare services arises from a variety of congenital and acquired diseases and conditions. The next section highlights national-level incidence statistics for relevant diseases and conditions and then signposts the reader to sources where they can easily gather relevant data for the population that they serve. Whilst this is useful in planning primary dental care it is difficult to translate or predict what proportion of a given population will need specialist dental care and some synthetic analysis and local interpretation will be required.

The main oral diseases are described below.

### 7.6.1 Dental caries (tooth decay)

Tooth decay is a process of destruction of tooth tissue by toxins produced by bacteria living in the mouth reacting with sugars in the diet. It has consequences which include pain and infection and the need for dental treatment. There are marked inequalities in both the prevalence and severity of tooth decay across England with associations relating to age, ethnicity and deprivation status. In addition, one of the best predictors of future tooth decay experience is past tooth decay experience. With this in mind, commissioners need to understand tooth decay prevalence and severity for a range of ages.

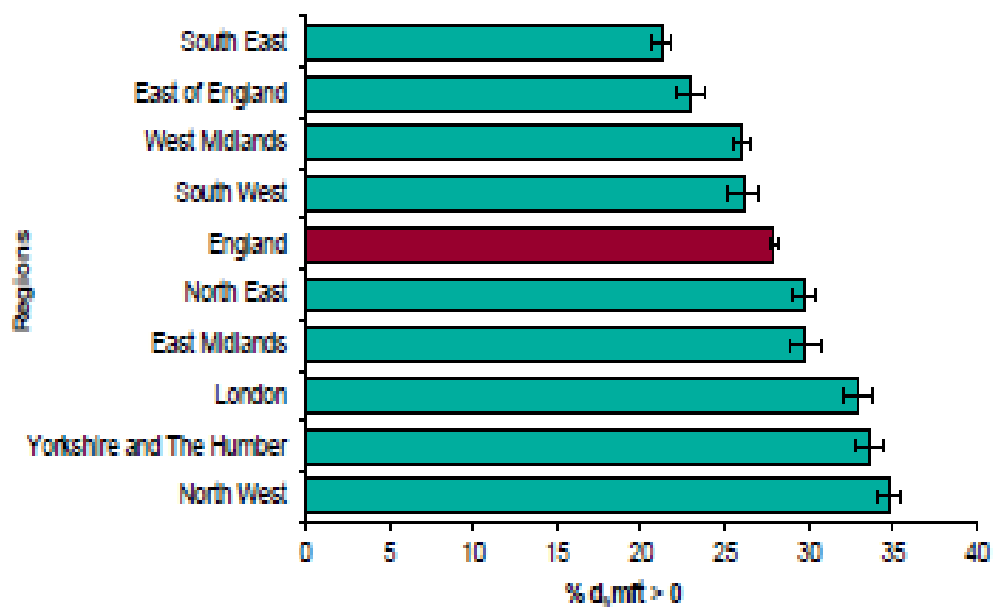
The first national survey of three-year-old children was carried out in 2013 in England. The survey found that 12% of three-year-old children had experienced tooth decay having one or more teeth that were decayed, missing or filled because of decay. Local variation, which demonstrates significant differences across England, can be found at:

[http://www.nwph.net/dentalhealth/survey-results%203\(12\\_13\).aspx](http://www.nwph.net/dentalhealth/survey-results%203(12_13).aspx)

Regular surveys of the oral health of five-year-old schoolchildren, carried out to nationally agreed standards and published by PHE are considered to be a useful measure of a population's oral health.

The graph below (Figure 9) illustrates the inequalities that existed at regional level in 2012 relating to the prevalence of tooth decay in five-year-old schoolchildren, in England.

**Figure Prevalence of tooth decay in five-year-old schoolchildren, 2012**



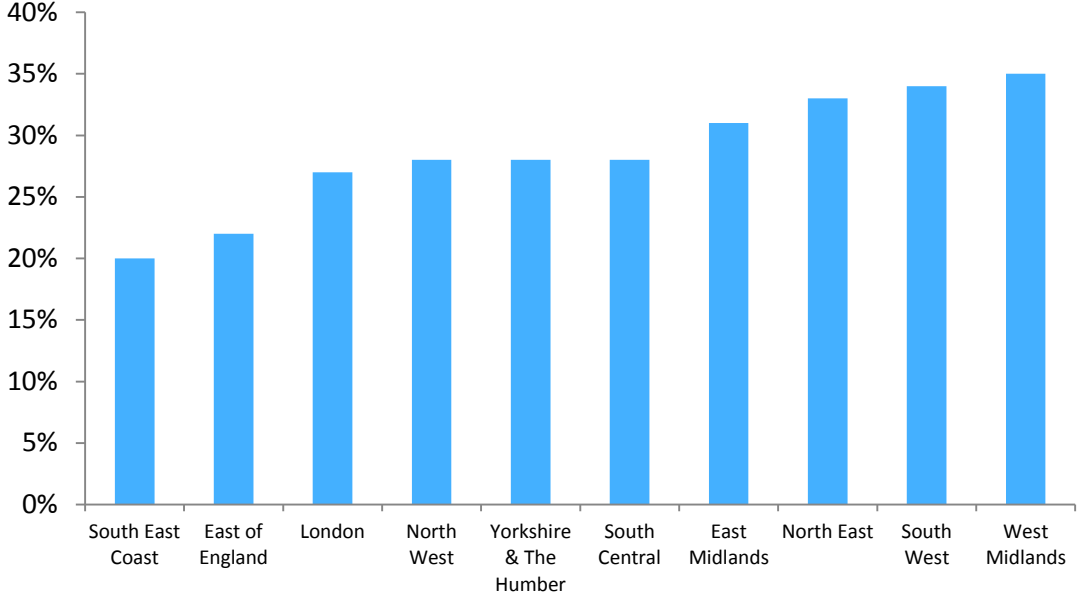
Source: PHE, 2013

Data at local authority level can be sourced from <http://www.nwph.net/dentalhealth/caveatnew.htm>

In 2009 just under one third of adults (31%) had obvious tooth decay in either the crowns or roots of their teeth (ADHS, 2009). There were social variations in tooth decay experience with adults from routine and manual occupation households being more likely to have decay than those from managerial and professional occupational households (37% compared with 26%). The prevalence of decay in England fell from 46% in 1998 to 28% in 2009 and this trend was reflected in all age groups.

There was variation in the levels of tooth decay across the country (Figure 10).

**Figure 10**



The prevalence of decay in the crowns of the teeth varied with age, with the highest prevalence in adults aged 25 to 34 (36%) compared with those aged 65 to 74 (22%). Levels of decay rates affecting the root surfaces of the teeth also varied with age. Seven per cent of adults had active root decay with 1% of 16 to 24 year olds affected compared with 11% of 55 to 64 year olds and 20% of 75 to 84 year olds.

The proportion of adults who have experienced decay and for whom complex procedures are required or their patient modifying factors are such that they require level 2 or 3 restorative or oral surgery is difficult to estimate, not least because in many areas of England specialist restorative services tend to be offered only in dental hospitals or privately.

PUFA (Pulp Involvement, Ulceration, Fistula, Abscess) a recently developed index of clinical consequences of untreated dental caries was reported in the 2009 ADHS. It provides a measure of broken down teeth that may require urgent and/or specialist attention particularly in adults with other complicating medical conditions. Overall 7 % of adults had one or more PUFA lesions. There was variation across England ranging from 4% affected in Yorkshire and the Humber to 10% in the South West. Adults in this group are more likely to require urgent care and oral surgery and a proportion will require Level 2 or 3 treatment.

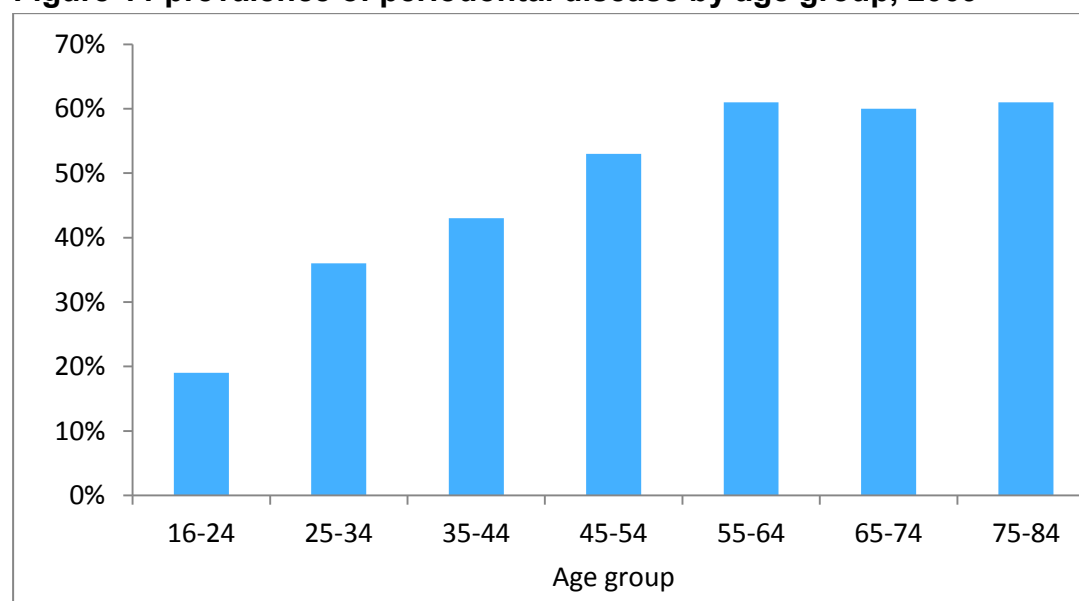
## 7.6.2 Periodontal disease (gum disease)

Periodontal disease destroys the ligaments and bone that support teeth. Susceptible patients develop the disease because their immune system reacts to the accumulation of bacterial plaque. Bacteria and their products within the plaque cause inflammation in the tooth's supporting tissues. The consequences can lead ultimately to tooth loss. It is a chronic silent disease until at an advanced stage.

In 2009 ADHS 45% of adults had pockets of 4mm or more and 5% of that group were under 35 – when disease is progressing in young adults a specialist view is recommended. Severe pocketing was less common affecting 9% of the population. There is an aggressive form of periodontal disease which affects (0.1% Caucasians and 2% Afro-Caribbean) young adults. Diabetes sufferers have an increased risk of periodontal disease and active periodontitis makes stabilising diabetes more difficult.

The prevalence of periodontal disease increases with increasing age (Figure 11).

**Figure 11 prevalence of periodontal disease by age group, 2009**



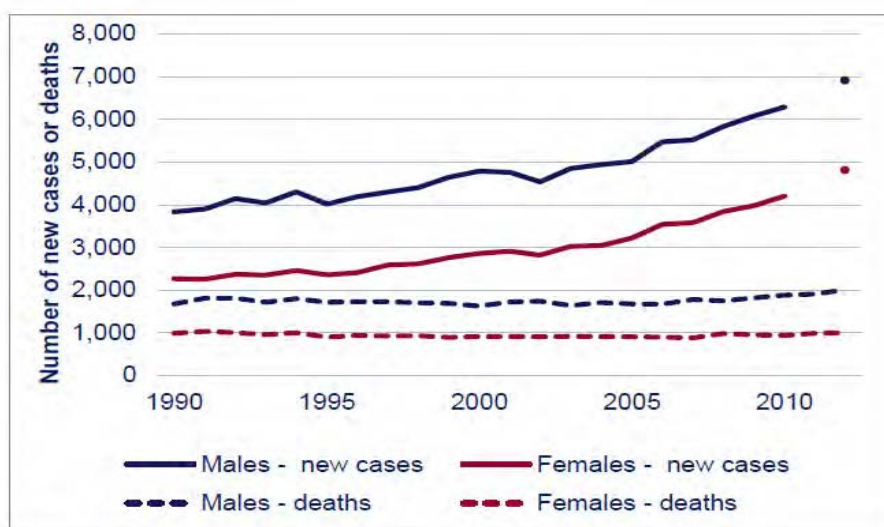
Regional data relating to adult dental health can be found at:

<http://www.hscic.gov.uk/pubs/dentalsurveyfullreport09>

### **Mouth (oral) cancer**

The impact of the disease and its treatment can be very severe. The main risk factors for oral cancer are tobacco and alcohol usage and these have a synergistic effect. The incidence of mouth cancer is increasing and with it the number of associated death in England (Figure 12).

**Figure 12: Incidence and mortality trends for head and neck cancer, England 1990 to 2010**



Source: National Cancer Intelligence Network

Local data on incidence rates are available from:

<http://ncin.org.uk/Profiles/HeadNeckAtlas/atlas.html?indicator=i9&date=2006-2008>

### 7.6.3 Tooth Wear

Teeth wear away as a natural part of life so the extent and severity of tooth wear is age related. Tooth wear can happen in a range of ways. Tooth tissue can dissolve as a result of exposure to dietary or other acids, it can be worn away by contact with something else (such as a toothbrush and abrasive paste) or the two arches of teeth can grind against each other and be worn away. Typically, these processes occur together and the overall result is loss of tooth tissue with a change in the shape and form of the tooth. Whilst wear is a natural process, sometimes it can be rapid and destructive and may be very complex to treat.

In 2009, 77% of dentate adults had some wear of their anterior teeth. Overall, 15% had moderate wear and 2% had severe wear. Severe tooth wear, especially in younger adults, can require specialist oral rehabilitation.

Moderate tooth wear increased from 11% in 1998 to 15% in 2009, although severe wear remains uncommon.

### 7.6.4 Cleft Lip and Palate

1 in 700 of all babies born in the UK will have a cleft lip and/or palate. In England there were 509 finished consultant episodes for primary closure (F03.1) (339 boys and 170 girls) and 160 (F03.2) for revision of primary closure. This condition often results in orthodontic and restorative specialist care and impacts on oral and

maxillofacial surgery. Outcomes of care have markedly improved by centralising care in specialist units with access to multidisciplinary teams.

### 7.6.5 Orthodontics

There are two main elements to assessing orthodontic treatment need:

- Normative need - professionally judged need in a population cohort as defined following a clinical examination using a clinical index such as IOTN. This represents the capacity to benefit from healthcare;
- Demand - expressed need that is presented for treatment.

In any given population it has been repeatedly shown that approximately 30% of 12 year old children will need and want orthodontic therapy. A detailed needs assessment methodology is included in the orthodontic strategic framework.

### 7.6.6 Anxiety / Sedation

12% of adults with extreme anxiety had a positive PUFA score compared with only 5% of those with no or low levels of anxiety. Adults requiring complex, specialist advanced dental care who are not normally anxious may have a need for sedation.

The control of pain and anxiety is fundamental to the practice of dentistry; some patients clearly need sedation for routine dental treatment whilst others do not. The principal reason for using conscious sedation is to enable dental treatment to be carried out for a patient who is so anxious that he or she may avoid the treatment completely or find it extremely stressful. Also, some patients who are happy to undergo routine dental treatment with local anaesthesia alone may be distressed if more unpleasant procedures such as surgical procedures or advanced restorative procedures are undertaken with local anaesthesia alone. Clinical decision making is a complex process. An indicator of sedation need (IOSN) has been developed that can be used when making a referral to assess the need for sedation. When tested, it illustrated that about 7% of the adult population may require sedation due to anxiety or complexity at some point during their lifetime; with 2.8% expressing a high need for sedation.

### 7.6.7 Adults with severe dental anxiety

Patients who are unable to tolerate any treatment under local anaesthesia alone have a spectrum of needs. Many can receive treatment in primary care but others need care at specialist level from the specialty with the most relevant remit. Therefore, severely anxious patients needing dental procedures with concomitant medical, disability, mental health or social exclusion problems may be referred to relevant specialty; however, where referral guidelines are agreed, this may be to Special Care Dentistry for continuing or shared care.

The options for managing dental anxiety are illustrated in figure below. The services provided should integrate the use of behavioural management techniques including Cognitive Behavioural Therapy (CBT) with conscious sedation and, if necessary,

General Anaesthesia. Specialist training programmes should incorporate training in managing patients with severe anxiety.

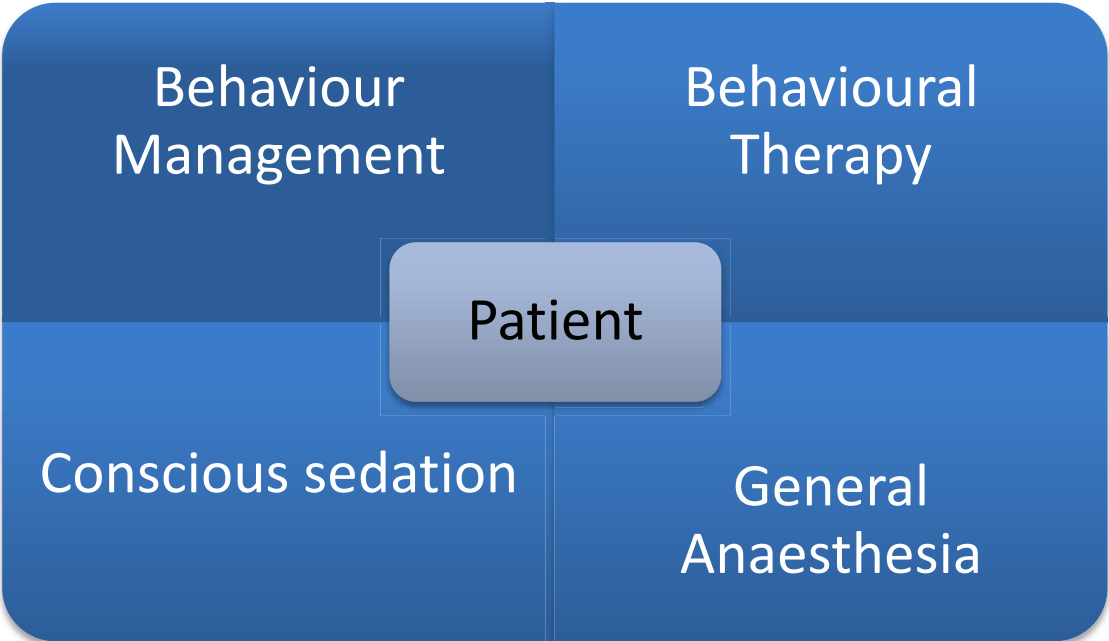


Figure 13. The Options for Managing Dental Anxiety  
Source: IACSD *Conscious sedation in the provision of dental care, Oct 2014*

## 8 Vulnerable and socially excluded patients

Vulnerable patients can be defined as anyone who needs extra support in finding a dentist, visiting a dentist, receiving dental care, or looking after their oral health.

This does not include groups that cannot exercise choice and require care within Special Care Dentistry. Some Community Dental Services (CDS) have contracts tailored to meet the additional needs and demands of hard to hear groups but most attend general dental practitioners and may include the following:

- Looked after children;
- Adults with mental health disabilities/problems;
- Dependent older people living alone/in care homes;
- People with limited / no English;
- Homeless and insecurely housed people;
- Traveller communities;
- People released from custody;
- Recent immigrants

Commissioners and providers of specialty services will need to consider the needs of these groups in accessing specialist services. However, commissioners should first focus efforts on making sure primary dental care is available and responsive to the needs of vulnerable groups and that they can access specialist dental care if and when required.

### 8.1 Information

Information that is available and provided for vulnerable patients is not always in a format that they find accessible. Advocates could play a role in providing information to vulnerable and excluded groups to promote oral health and facilitate use of specialist services when required. This could be supported by sharing accurate timely information via voluntary and community organisations – this is true of all dental services and not only relevant to delivery of specialist dental care pathways.

Different types of information should be used in varied formats to suit the different vulnerable groups. For example storyboards and/or 'text in bubbles'. There needs to be comprehensive information for carers and buddies of vulnerable patients available from both primary and secondary care providers. Information needs to be improved for 16+ age groups through the transition from children to adult services, particularly where there are additional care needs.

Commissioners need to identify where information on accessible services should be available. Partnership working between healthcare, social care and education should also be considered to improve communication and sharing of information on where and how to access services.

## 8.2 Advocacy

There is a need to consider and build advocacy support for vulnerable and excluded groups in their use of all dental services but especially if they require specialist care.

- Advocate available to help interpret/ provide necessary information to clinician.
- Advocate to help patients keep appointments.
- Carer/advocate to receive appropriate information, training and guidance on how to support and maintain a patient's oral health.
- 

Advocates should only become involved with the consent of the patient or, if they lack capacity, when it has been assessed to be in their best interests.

## 9 Current activity in specialist care and secondary care

The application of coding and tariff for dental specialties is not consistently adopted by secondary care providers in England, nor are there outpatient procedure codes for all dental specialties. Ensuring consistent coding and collection of aggregate analytical data in dental specialties will be one of the first tasks within implementation. This is necessary at local and national level in order to understand the activity currently being delivered and for benchmarking. Therefore, given data limitations, the following information is considered for illustrative purposes only. Commissioners will need to analyse and be familiar with secondary care data at local level. Ensuring accuracy of data collection, to agreed coding standards and timely reporting is one task that may be helpful to complete once a quarter nationally to support commissioners.

Region level summaries of secondary user service (SUS) data were extracted for Inpatient and outpatient activity data occurring between April 2012 and November 2013 for the following treatment function codes:

Code	Specialty
140	ORAL SURGERY
141	RESTORATIVE DENTISTRY
142	PAEDIATRIC DENTISTRY
143	ORTHODONTICS
144	MAXILLO-FACIAL SURGERY
217	PAEDIATRIC MAXILLO-FACIAL SURGERY
450	DENTAL MEDICINE SPECIALTIES

There is variation between the regions in activity per head of populations. London has the most elective day case activity and outpatient activity and the least non-elective inpatient activity. Non-elective activity for the south is also low. Comparison of dental activity by treatment function code shows variation in the proportion of activity attributed to treatment function code. Overall activity for the London region shows the most diverse use of treatment function codes. Further detail of these findings can be found in the following sections.

### 9.1 Outpatient activity

London has a higher amount of outpatient activity per head of population. The ratio of follow-up to first attendances is highest in the South region.

#### 9.1.1 Inpatients

Comparison of inpatient activity shows London has higher elective day case activity and lower non-elective activity than other regions and the England average London also shows the lowest proportion of non-elective dental inpatient activity per head of population by region

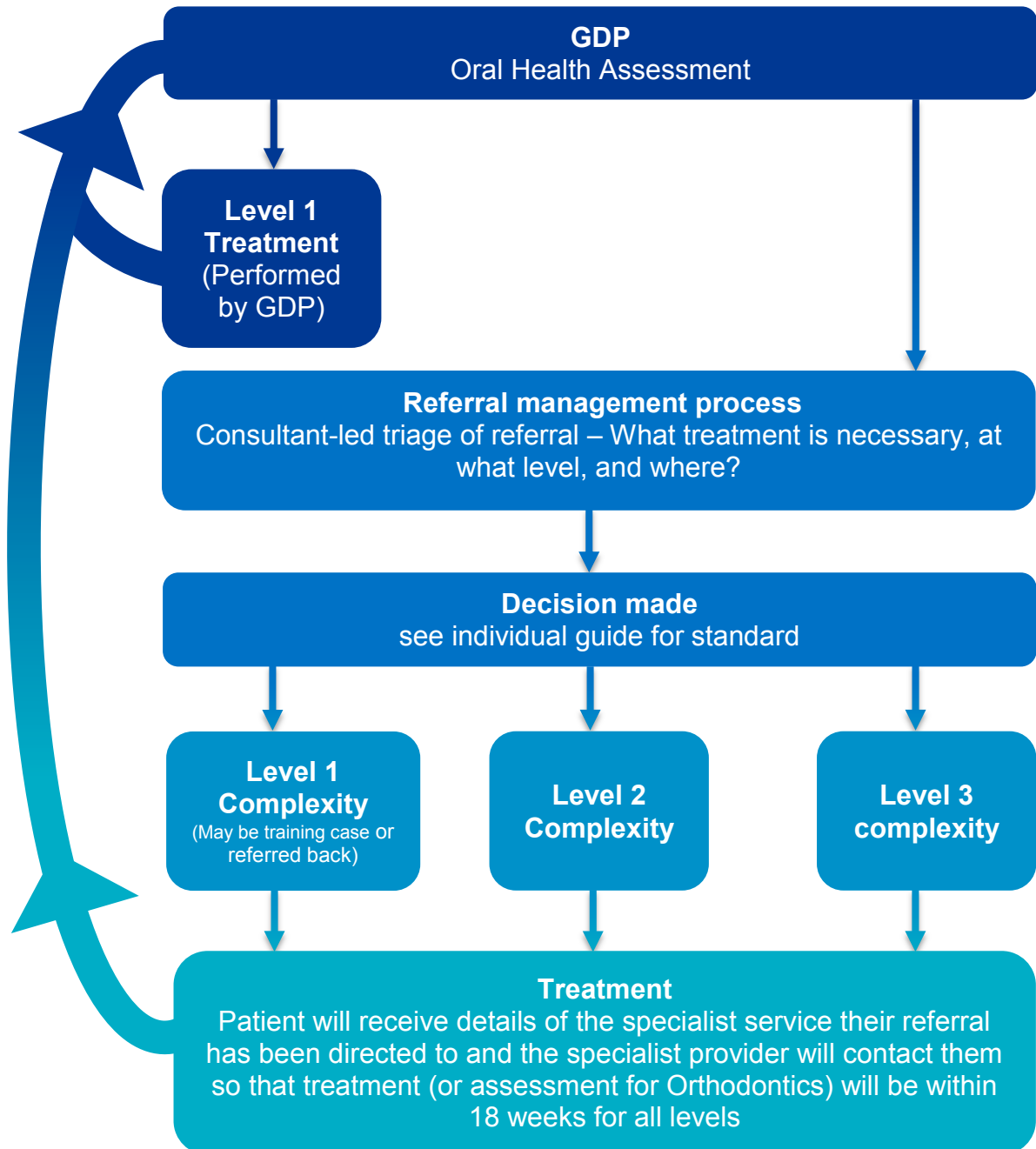
There is variation in the proportion of activity by dental treatment function code by region. The highest proportion of activity is coded as oral surgery (140). The proportion of activity coded as oral surgery ranges between 60 and 72% outside London. For London the proportion coded as oral surgery is lower at 37%. London has a greater proportion of treatment coded as maxillo-facial surgery (37%) and paediatric dentistry (17%) compared to other regions.

### 9.1.2 Outpatients

There is less variation in the proportion of activity by dental treatment function code for outpatient activity compared to inpatient activity. For England overall, over a third (34%) of outpatient activity is coded as oral surgery. London is the region with the lowest proportion of activity coded as oral surgery (26%) and the broadest spread of activity coding. The South region has the highest proportion of outpatient activity coded as maxillo-facial surgery (24%) and orthodontics (34%).

## 10 The patient journey proposed in the specialist commissioning guides

### 10.1 The summarised illustrative patient journey



## 10.2 Vision for the patient journey

Every patient journey to specialist dental care should begin with a visit to his or her primary dental care practitioner (GDS or CDS) from whom they receive regular care; this may be an NHS or private primary care provider. If a patient does not attend a dentist routinely and are referred by another health care professional e.g. their medical practitioner, a referral management process may, if appropriate, direct the referral to a primary care dentist or to a specialist provider.

The dentist will complete a comprehensive examination to assess risk and need. The patient should receive information on their individual oral health status and risk of dental disease together with tailored preventive advice on what they can do to maintain and/or improve oral health. If a patient needs dental treatment, the primary care provider delivers comprehensive primary dental care. If a patient requires a complex procedure, has modifying factors that make routine dental care complex, or requires additional equipment or facilities to deliver care then a referral to a specialist service maybe required.

In many cases the dentist may be competent to provide level 2 care complexity and will do so for their own patients; however, some may need to make a referral to a specialist provider in a primary or a secondary care setting. The referral will be triaged and directed to a Level 2 or 3 care complexity provider as appropriate and assessed in a consultant-led triage; as part of a referral management process. Occasionally a patient will visit his or her medical practitioner with oral or dental problems either because they do not have a regular dentist or because they are anxious, in pain, unwilling to pay a patient charge, not aware that a dentist could treat their problem or unable or unwilling to find a primary care dentist.

It is important the referral process, at the beginning of the patient journey to specialist dental care, captures these GP referrals, those from private dental providers and patients who attend A&E to ensure that these patients have access to an appropriate primary or specialist care to meet their needs. Reporting on these, and `in-practice` for specialist care, referrals will assist commissioners to identify inefficiencies and understand vulnerable and hard to hear groups' need for accessible care and provide pointers on how to make existing primary care services more responsive to their needs; this may be ready access to a primary care dentist for pain relief.

## 10.3 Referral

These commissioning guides propose a referral management process. The referral will be made by a primary care dentist within one week of a decision to refer a patient. Other sources of referrals to dental specialties will be identified and managed. A core data set will be provided by the referrer (as detailed in individual specialty guides). It will allow an appropriate triage decision within specified timescales. Referrals are then directed to an appropriate level of specialist service taking account of any local arrangements and patient choice. The patient may have a unique reference number to track progress of their referral, but ideally dentistry will

begin to use NHS numbers as this would underpin robust data collection and reporting to enable integration of dental services within NHS England. In anonymized form this data set will also allow commissioners to understand the complexity of referred cases to support needs assessment.

In the implementation phase of this work each specialty will develop information on what care a patient can expect. The benefits and risks of treatment will be outlined, as will detail on procedures including expected recovery period, together with information on what a patient needs to do to prevent future problems. Information will also be provided on the amount of time needed to attend appointment, particularly when the pathway requires multiple visits over a period of time. A contact for the triage process and full details of the central assessment centre (if one is being used) should be given to the patient together with waiting times and choice of specialist providers. In time, outcomes will be available and shared with patients to assist choice of provider decisions. The patient should leave the referring dentist fully aware of the next steps that have been agreed and their responsibility to attend appointments and follow advice.

## **10.4 Treatment**

The patient will commence treatment within 18 weeks of the assessment (for Orthodontics: case starts should commence within 18 weeks of the optimum time period for therapy to commence so that cases of greater priority can be accommodated).

The patient will be reminded of the specialist care they have agreed to, where they have been referred to, whether a responsible adult needs to attend, whether sedation or general anaesthetic is necessary, and whether care might be provided on the same day as assessment. Each of the individual specialty framework guides will outline the details required within the patient care pathway.

The details of any cost of treatment, and post-op instructions, any type of incapacity that may occur following treatment, any type of anaesthesia used, how long the procedure may take, whether a chaperone is needed, and a phone number for future treatment or follow up issues should have been provided to the patient.

## **10.5 Discharge/ feedback**

The patient will be informed of what to expect post-treatment. The patient would be made aware of who to contact if there is any problem. The patient will be contacted after discharge to assess the outcome of procedures. This will be within 24 hours for oral surgery and as appropriate for other specialties

Patients will be asked about the outcomes of the specialist care they have received and followed-up if any complications are reported.

## 10.6 Other issues

Waiting times and treatment times should be made explicit at every stage of the journey and will be covered in detail in the implementation phase of this work. Patients requiring Level 2 care complexity (through procedural difficulty or modifying factors) may have care carried out by their own dental practitioner. Many experienced dentists have the experience, skills, competence, confidence and equipment to do so safely. Patients often prefer more familiar surroundings. It is not the intention of these strategic commissioning guides to change this care delivery model. In time the MCN may have a role with quality assurance as outcome measure reports will be shared with local clinical networks, allowing clinicians to identify where quality could be improved using local benchmarks. Delivery, patient safety and quality within NHS mandatory contract delivery are currently assured through other processes of contract and performance management by commissioners and are outside the scope of these specialist commissioning guides. In time all practitioners may have a formal link to a consultant-led network in their particular areas of interest. However, any practitioner accepting referrals of Level 2 complexity *will have* a formal link and the specialist commissioning guide requirements will be adopted by all Level 2 and 3 specialist providers.

## 11 Workforce

### 11.1 Workforce

NHS and private primary care providers deliver the majority of dental care in England. Many NHS practices provide both to their patients. Most dental practices will employ dental care professionals who will include nurses, hygienists, and therapists. Occasionally services may also be provided by clinical dental technicians and dental technicians.

It takes time to train skilled staff; for example, 5 years undergraduate training for dentists and up to 14 years to train specialists to consultant level. There is a need to review the way in which we plan and train the dental workforce and this work will be taken forward by HEE. Multidisciplinary working must be the norm if dentistry is to embrace the direction set in the Five Year Forward View. A HEE dental workforce advisory group (Dental HEEAG) is established and will oversee future workforce plans to meet future needs and support the implementation of change required in dentistry.

The table below illustrates the current numbers registered by role and the numbers on the specialist list. There is wide variation in numbers between specialties not fully explained by population or service need. Whilst HEE have 399 funded dental specialist training places (2015/16 Commission) the services delivered by the training programmes are funded by the NHS through tariff.

The current breakdown of registered professionals with the GDC for England is:  
(Source GDC Register October 2014)

	Male	Female	Gender Unknown	Total
Dentist	17124	14400	1	31525
Dental Therapist	108	1978		2086
Dental Hygienist	204	5199		5403
Dental Nurse	543	40792		41335
Orthodontic Therapist	7	310		317
Dental Technician	4054	1129		5183
Clinical Dental Technician	235	15		250

There are currently 13 specialties recognised by the General Dental Council. Table 14 below provides a breakdown of numbers by specialty registered with the GDC (note these are UK figures)

Specialty	Male	Female	Total
Dental and Maxillofacial Radiology	13	12	25
Dental Public Health	55	61	116
Endodontics	203	62	265
Oral and Maxillofacial Pathology	20	11	31
Oral Medicine	50	19	69
Oral Microbiology	3	4	7
Oral Surgery	547	208	755
Orthodontics	725	644	1369
Paediatric Dentistry	61	180	241
Periodontics	240	116	356
Prosthodontics	347	92	439
Restorative Dentistry	239	79	318
Special Care Dentistry	103	217	320

## 11.2 Training

Dental training at all levels requires trainees to carry out regular direct patient care under supervision. All dental service contracts should clarify that trainees can be involved in service delivery where the training post has been approved by the Postgraduate Dental Dean. HEE and its constituent Local Education and Training Boards (LETBs) are responsible for workforce development and commissioning of education and training for the healthcare workforce and need to reflect the requirements of NHS England.

Commissioners should ensure they have formal arrangements to share dental service commissioning plans with their LETB dental lead (usually the Postgraduate Dental Dean or Director) and should be aware of the training needs and delivery in place. Changes to service commissioning and delivery can have a significant impact on training provision and the best outcomes for all concerned are achieved when both aspects are considered at the outline planning stage.

### 11.2.1 Undergraduate training

Undergraduate training mostly takes place in dental hospitals although many dental students, dental therapy students and dental hygienist students also carry out supervised clinical practice in approved NHS training clinics or practices in primary care. Training and education costs are funded by a combination of HEFCE, HEE (SIFT) and NHS England.

### 11.2.2 Postgraduate training

Dental foundation training is a year-long programme in primary dental care that is compulsory for UK graduates to complete to enable them join the NHS Performers List without conditions and hence deliver primary care.

There are approximately 900 training places in England, funded by Health Education England. Foundation dentists deliver NHS services and the costs are also funded by HEE.

Dental core training is a programme lasting between one and three years that is undertaken after dental foundation training. Its purpose is to enable dentists to acquire additional skills and experience in particular areas of dentistry.

Dental specialty training lasts between 3 and 5 years and is mostly undertaken by dentists who will join a GDC specialist list on completion. They are usually based in dental teaching hospitals and district general hospitals with placements in primary care increasingly included. These are partly funded by HEE (salaries, study leave and a contribution to costs of providing clinical educational support) and other costs are funded by employers.

Service delivery by dental specialty trainees contributes to the total activity delivered by the employing provider and these costs are not funded by HEE.

## 12 Data content for the commissioning guides

### 12.1 Service redesign

The strategic importance of changing the way data are collected across primary and secondary care settings cannot be overstated.

It is anticipated the first three individual specialty guides will be published in 2015, although implementation will be a longer term programme of work, the details of which are to be agreed. However, in order for the guides to be implemented and to commission and manage services effectively, changes to existing data collection and reporting are expected to be required across primary and secondary care.

Currently primary and secondary care data are collected separately using different coding systems that are not directly comparable. Following implementation of the guides, where care is commissioned on the basis of the level of care (Level 1, 2, or 3) provided rather than by the type of provider, it will be important that data are comparable across primary and secondary care providers in order to properly commission and manage services and enable appropriate benchmarking and comparison.

In order to fully implement the commissioning guides, potentially significant changes to primary and secondary care dental data collection are required and a programme of work will need to be defined and appropriately supported. There may be some aspects of data collection that can be developed locally until national solutions are implemented.

The table below sets out data and data processes currently available to commissioners and short- and medium-term developments on a national level to improve data.

<b>Available now</b>	Primary Care data from BSA
	Secondary Care data from SUS
	Data challenge system in NHS Standard Contract
	Analysis of Treatment Function Codes and OPCS codes
	Inclusion of preferred data option in contracts that are being procured
	Referral information from Trusts re: high referrers
<b>Short Term (April to September 2015)</b>	Develop use of GDP practice code
	Identification Rules Document for Secondary Dental
<b>Medium Term - to be considered</b>	Electronic FP17
	Use of FP17(RN) for all referrals into Advanced Mandatory Services and Secondary Care
	Use of NHS number
	Development of more detailed reports for NHS Outcomes Framework
	BSA baseline data sets
	PROMs/PREMs measures
	Data identified by complexity in BSA data and SUS data

## 12.2 What data need to be collected?

### 12.2.1 Baseline needs data

Commissioners will need to be able to consider baseline needs assessments in order to commission appropriate services. In order to ensure a consistent approach to needs assessments and effective use of limited resources it is suggested a series of standard reports could be made available from reported data to support local baseline needs assessments.

### 12.2.2 Referral Data

Referral data are currently collected through a variety of means including local reporting as well as limited central data collection for primary dental services in relation to individual courses of treatment (FP17 data). Given the large numbers of referrals from primary dental care providers, it is suggested that collection of referral information from primary dental care should be prioritised and improved to include details of the type of services / care patients are referred for, the level of care required and, ideally, the provider the patient has been referred to. Local implementation of referral management processes should ensure that all relevant information and a consistent data set as identified in the illustrative patient journey is collected.

### 12.2.3 Data Challenges to Secondary Care Data

Under the NHS Standard Contract commissioners should state in the contract which Tariff Function Codes (TFC) they commission from a provider.

Any data allocated through SUS to dentistry that sit outside the commissioned TFCs should be challenged. This is a monthly process, usually provided by the CSU team. Unidentified or out of area CCGs will also be identified.

Commissioners will also check the Health Resource Groups that sit under these TFCs to ensure it is a dental procedure under the rules. Any queries should be checked with CSU and commissioners and then raised with the provider.

Non commissioned activity – backing data can be requested and checked before authorising for payment, in accordance with guidance for the lawful validation of provider invoices<sup>4</sup>.

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<sup>4</sup> <http://www.england.nhs.uk/ourwork/tsd/ig/in-val/>

#### **12.2.4 Future work**

Clarifying current data sources

A task group has been set up to develop a Secondary Dental Identification Rules document which can be incorporated into the NHS Standard Contract and will reduce the variation of coding between different Trusts. This is expected to be available by September 2015 in time for the Commissioning Intentions timetable for 2016/17

#### **12.2.5 Primary and secondary care data**

There are currently differences between coding of procedures in primary and secondary care and, as a result, benchmarking and comparison of similar services is difficult. A core referral data set collected at point of referral, use of standard treatment codes, NHS number and the recording and reporting of these at point of delivery of care would allow data to be shared across the two systems. The processes for sharing of this information between organisations will be reviewed to ensure that they have a firm legal basis.

#### **12.2.6 Patient Reported Outcome Measures (PROMs) / Patient Reported Experience Measures (PREMs)**

Key PROMs and PREMs may be collected across all types of care in the future, with these being supplemented by additional specialty specific measures.

Currently PROMs and PREMs may be collected by a variety of means including local service-specific surveys. The Friends and Family test has been implemented across NHS dental services. The National Health Service, Business Services Authority (NHSBSA) currently carries out small numbers of postal patient surveys for NHS primary dental care providers, with patients being sampled from the course of treatment (FP17) data submitted to the NHSBSA. The primary purpose of these questionnaires is to establish matters of probity (patient identity, treatment dates, charges paid, etc.) rather than to collect PROMs / PREMs.

The Dental Contract Reform Programme includes a number of patient experience measures within Dental Quality and Outcomes Framework (DQOF) and pilot contracts have around 700 patients sampled annually from FP17 data by the NHSBSA. Proposed uses of patient information to track outcomes and experiences will be subject to review to ensure that they have a firm legal basis.

In future any central administration and collection of individual patient PROMS/ PREMs data may need to consider additional more cost effective methods of data collection such as online or email surveys, particularly if survey data are required in significant numbers for reliable benchmarking and/ or performance management.

Collection of PROMS/ PREMS in secondary care is covered by the NHS Standard Contract and any relevant CQUINs.

## **12.3 Challenges**

### **12.3.1 Data Collection**

Primary and secondary care dental providers currently use different data coding and a variety of electronic and paper data collection methods. The central collection of a consistent data set and its reporting, to allow comparison across providers and services, is difficult to achieve while this is the case. A possible solution is to move to complete electronic data collection. With consistent data collection and coding set it would be feasible to benchmark services to drive up quality, improve value and care to patients.

## **12.4 NHS Outcomes Framework**

Earlier this year place-holders were put forward by NHS England for the inclusion of two dental outcome indicators in the NHS Outcomes framework. One of these indicators relates to numbers of decayed teeth, the rationale being that a reduction in numbers of decayed teeth may be equated with improved oral health. This indicator was accepted for inclusion in the NHS Outcomes framework to be published in the autumn and cites FP17 data as the source data for the indicator.

## 13 Commissioning guide finance content

### 13.1 Overarching principles

The Commissioning Guides for dental specialist services describe a needs-led outcome-focused care pathway approach to deliver improvements in quality, outcomes and value for money in all settings. It is important that the guides are not looked at in isolation as it is expected there will be some changes that will result in financial gains, and others requiring additional investment. It will be for commissioners to plan and manage their resources to meet the needs of their populations, following the principles within all the dental commissioning guides.

There is an expectation that service redesign that may include moving care where appropriate from secondary care to a primary care environment could deliver financial savings for the NHS. Further, by ensuring that all Level 1 services are delivered within GDS/PDS mandatory services, the NHS will achieve greater efficiency from investment in dental services as presently there is a potential to pay twice. Resources released could be directed to areas or specialties within dentistry that cannot meet identified or changing need. These will be required to establish MCNs. There is evidence of over-investment in some specialist and geographic areas, but there are other areas and new ways of working where further investment is required, specifically to address inequalities and equitable access for all patient groups. It is impossible to provide a detailed national financial impact analysis as pace and scale of service transformation at the individual commissioner level will vary.

The analysis presented below is the best estimate that can be made with the present data. The caveats to the data are presented clearly, including the fact that some areas have already made progress in shifting services to primary care.

### 13.2 The Process

It is important to note that commissioners will need to work within their existing budgets and any costs incurred on implementation will need to be met within existing budgets.

To demonstrate the financial impact of implementation of the commissioning guides and to provide a national estimate for the upfront costs associated with implementation along with expected savings to the NHS, commissioners were asked to provide the costing information outlined below:

- extract activity and finance performance data from SLAM;
- collate IMOS contractor information;
- collate full year UDA performance.

These figures were added to illustrate the potential savings around year 1, 2 and 3.

Caveats:

Some of the predicted savings may be reused within the acute sector if not tightly managed by dental commissioners such as substitution to other clinical areas i.e. OMFS/Oral Surgery teams delivering increased plastics/surgical dermatology cases that are often coded as 'skins' . Such care should be commissioned by CCG and not be funded from secondary care dental resource.

The figures only give a *national* estimate of whether the pathway will be cost-neutral, deliver savings or have additional costs to current services. Commissioners would need to complete a local and detailed assessment before planning for service redesign and implementing the pathway. The figures within the spreadsheet do not incorporate a detailed assessment of patients who may require a level one complexity treatment but have complex medical or social needs which would indicate treatment by a Level 2 provider. The figures do incorporate a figure for cases that may remain but this is a broad estimate for the purposes of national assessment.

An assumption has been made about how Trusts will code and how code definitions fit into levels of care complexity. More detailed work needs to be completed for contract discussions with Trusts when implementing the pathways. Commissioners need to consider how to ensure that Teaching Trusts receive an adequate number of routine or intermediate patients for training undergraduates and postgraduates. They can implement a consistent contract and payment for Level 1 and 2 care ensuring that secondary care tariff is not being used for primary care case delivery.

Patient charge revenue is not considered as part of this assessment. Assumptions have been made about the cost of triage and MCN running costs which may differ locally. The formula assumes that for Oral Surgery contracts all courses of treatment are 3 UDAs. Commissioners need to carry out a more robust local analysis as part of implementation which should include doing the above for every Trust; a template is available to support local analysis, which can be requested via the CDO office.

The figures shown below are for England. The spreadsheet showing the change by previous Area Teams is in Appendix 5. Some Commissioners made joint submissions. The figures do not incorporate any growth estimate or DDRB uplifts or tariff deflators and are based on a standard assumption of movement of activity from an acute setting to primary or intermediate over the three year period.

The figures show that there is a national efficiency saving potential of £6,612,375 over three years by implementing the pathway. It is important that any procurement and investment takes place in the same financial year that the savings are made. Commissioners need to carry out detailed analysis and consider procurement options based on local needs.

It is important to note that some commissioners have started the process including realising the savings outlined below.

	Reference Costs	Year 1 change from reference year	Year 2 Change from Reference Year	Year 3 Change from Reference Year
Total for England	£1,642,809,415	-£5,544,698	-£6,609,729	-£6,612,375

#### Movement of activity planning assumptions

	Tier 1	Tier 2	Tier 3
Year 1	50%	10%	0
Year 2	15%	30%	0
Year 3	5%	20%	0

## 14 Commissioning intentions and procurement

In developing, redesigning, procuring and monitoring services arrangements should be made to involve patients, carers and the public, and advocate organisations, including Healthwatch.

NHS England is ambitious to secure better value, quality and outcomes for patients. These guides 'give permission and direction' to commissioners and LPNs to align to the strategic direction. Commissioners should not wait until services require re-procurement but should seek to promote change and improvement within current commissions, particularly if they are seeking extensions to existing agreements.

When implementing the commissioning guides, commissioners with support from PHE dental public health, LPN and the Commissioning Support Units (CSUs), will assess current service delivery and quality, and local health need to determine whether a new or transformed healthcare service is required. Where NHS England is undertaking a transition to a new or re-designed service, commissioners and CSUs should first consider whether any existing contractual arrangements could be used to deliver the required services and changes.

Where there is a contract for healthcare services already in place, it may be possible to use variation or change processes in those contracts to secure incremental change to service provision. This can only apply where this does not materially alter the nature of the contract as originally procured such that it amounts to a new contract.

Commissioners, via CSUs, will have access to appropriate procurement advice before following this route. NHS England also has national policies and standing financial instructions that all Commissioners and CSUs adhere to.

### 14.1 Commissioning support services

The following services, to support implementing new or transformed services will be accessed via commissioners from CSUs. It may be appropriate to undertake wider re-design of services across a number of commissioners with appropriate economies of scale. NHS England needs to ensure the relevant procurement rules are followed and adhered to when implementing care pathways that may require procurement processes.

### 14.2 Procurement requirements

#### 14.2.1 Business Intelligence

The guides provide framework detail on minimum requirements. Commissioners may further enhance these minimum standards but should consider: these elements of the core framework will allow national benchmarking and comparisons to be drawn for future planning.

- Information collection starts with understanding population needs
- Information analysis – contract analysis
- Information analysis – clinical outcomes
- Information analysis – patient experience
- Capacity planning and modelling
- Data validation
- Query Management
- Database management
- Monitoring of PROMs /PREMs and service specification standards

#### **14.2.2 Procurement and market management**

- Market analysis - share overarching guide
- Early market engagement - where required share specialty guides
- Support with stakeholder engagement and consultation
- Tendering to point of contract award

#### **14.2.3 Provider Management**

- Provider management – ensuring contract delivery to concept and principles of these guides

## 15 Contracting

### 15.1 General Dental Practitioner provision

These services are provided under existing contractual arrangements for primary care dentistry.

All providers of NHS services are required to make reasonable adjustments for patients with additional needs. The description of Level 1 care complexity is outlined in the individual guides in the patient journey and describes the minimum expectation of primary care contract delivery. The description of the procedural difficulty or patient modifying factors necessitating care at Level 2 and 3 provides a guide to GPs and commissioners to the factors that should be considered when a patient is deemed appropriate for onward referral.

Providers offering effective care arrangements in primary care should not see the above as an instruction to refer particular patients on. It is important to stress that providers and commissioners take a flexible approach to the definitions above. Assessing eligibility for a Level 2 or 3 referral will be individual and peer reviewed. An MCN-led feedback system from providers of Level 2/ 3 care can be used by commissioners to monitor referral patterns from primary care and provide intelligence to assess that GPs are referring appropriately.

### 15.2 Level 2 care complexity

Contracting for dental specialties has been challenging for commissioners. Previous guidance has implied that units of dental activity are an unsuitable currency for specialist dental care provision. For all dental specialist provision commissioners need to:

1. Understand how well the needs of particular patient groups are being met;
2. Understand how active providers under block contract arrangements are;
3. Be assured of the quality of services provided;
4. Be assured that services represent value for money.

These guides define eligibility and complexity levels of care. A contract along with its specification for these services can use the direction this series of guides offer.

Commissioners require contracts that provide effective incentives. However, NHS services are littered with examples of contract remuneration forms which are unsuitable for a standardised contractual framework which incentivises good practice. Commissioners must not rely on a provider's goodwill to offer flexibility by imposing a tariff that disincentivises providers from offering treatment to more complex patients. Commissioners are required to address inequality. Any contractual currency or penalty which penalises a provider for offering services to vulnerable patients is incompatible with the NHS Constitution.

A block PDS contract for the provision of specialist dental care, with a robustly applied acceptance criteria and a performance management framework based on

metrics described above within the illustrative patient journey offers assurance for commissioners on the points described above and may be a suitable vehicle. Work on more detailed advice on contractual framework will be continued during implementation. For some services a NHS standard contract might be suitable.

PDS contracts for level 2 services should still submit data via BSA. This will allow commissioners to analyse activity to the same level as primary care. As described above, further information in relation to referral patterns from primary care dentists should also be shared to provide commissioners the intelligence to ensure that GPs are providing appropriate care.

### **15.3 Level 3 care complexity**

Services under Level 3 will generally be provided via the NHS Standard Contract, subject to the same standards as every other service provided through it. Specialty codes are available, however inconsistencies in data capture and reporting need to be addressed. There are no national tariffs available for Special Care Dentistry within secondary care. Currently, these services are coded under Oral Surgery, Maxillo-Facial or Restorative specialties or hidden within block contracts and therefore difficult to identify. A specialty code is now available to code activity to SUS. It is therefore recommended that commissioners through dialogue with secondary care providers ask them to use this code to enable commissioners to identify that activity and ensure that services provided are offered in accord with NHS Constitutional standards.

## 16 Minimum standard specification

### 16.1 National/local context and evidence base

#### 16.1.1 General legislation and guidance

- High Quality Care for All – next stage review, 2008
- NHS Constitution, 2009
- Implementing care closer to home, 2007
- Modernising Medical Careers
- NHS Personal Services Agreements
- HTM 01-05
- Ionising Radiation Regulations
- AIDS/HIC Infected Healthcare worker Guidelines
- Equalities Act, 2010
- Disability Discrimination Act
- Human Rights Act 1998
- Dental Practitioners' Formulary
- GDC Fitness to Practice
- GDC Standards
- Caldicot principles
- Decontamination legislation

#### 16.1.2 Scope

- Aims/objectives
- Scope/Care pathway from individual guides inserted
- Population covered
- Acceptance/exclusion criteria
- Procedures to be delivered e.g. case complexity as outlined in guides and inclusion criteria
- Interdependencies with other services

#### 16.1.3 Applicable Service Standards

- National Standards
- Local Standards

#### 16.1.4 Key Service Outcomes

- To provide optimum patient care
- To reduce referrals into secondary care for Level 2 specialist services.
- To provide a positive patient experience through increased access to the service and increase patient perceived quality of life following effective treatment
- To provide cost effective practice

### 16.1.5 Generic PROMs and PREMs

#### Generic PROMs list

**Q: “Are you able to speak and eat comfortably”**

- 1 I am able to both speak and eat comfortably
- 2 I have slight discomfort when either speaking or eating
- 3 I have considerable discomfort when either speaking or eating
- 4 I have significant discomfort when either speaking or eating

**Q: “Did you have any problems in the hours after the procedure was carried out?” *Elaborate problems?***

- 1 I had no problems in the hours after the procedure was carried out
- 2 I had slight problems in the hours after the procedure was carried out
- 3 I had considerable problems in the hours after the procedure was carried out
- 4 I had significant problems in the hours after the procedure was carried out

**Q: “Are you still suffering ill effects from the procedure that you had?”**

- 1 I have no ill effects after the procedure
- 2 The ill effect still persists slightly after the procedure
- 3 The ill effect still persists considerably after the procedure
- 4 The ill effect still completely persists after the procedure

**Q: “Did you seek advice or assistance relating to the procedure and its effects in the days after the procedure?”**

- 1 No, I did not seek any advice or assistance in the days after the procedure
- 2 Yes, I sought out advice or assistance passively, e.g. internet, reading, etc.
- 3 Yes, I sought out advice or assistance in person, e.g. dentist, GP, etc.

#### Generic PREMs List

**Q: “Did you feel sufficiently involved in the decisions about your care?”**

- 1 No, I felt like I was not sufficiently involved in the decisions about my care
- 2 Yes, I felt like I was somewhat involved in the decisions about my care
- 3 Yes, I felt like I was sufficiently involved in the decisions about my care

**Q: “How satisfied are you with the NHS dentistry received?”**

- 1 Not at all satisfied
- 2 Somewhat satisfied
- 3 Very satisfied
- 4 Completely satisfied

### 16.1.6 Performers

- Allocation criteria
- Competence
- Qualifications
- References
- Interview
- Portfolio
- Skills test

- MCN/LDN
- Communication skills

#### 16.1.7 **Service description**

- Access/location
- Hours of operation
- Referrals management
- Radiographs required
- Waiting times
- Data protection
- Payments
- Care delivery
- Post-operative care
- Discharge

#### 16.1.8 **Generic specialist provider requirements**

- Health and safety
- Employers' liability insurance
- Electricity at work regulations
- Pressure vessel and autoclave regulations
- Ionising radiation protection regulations
- Hazardous substance risk assessment
- COSGG
- RIDDOR
- Compliance with water byelaws
- Disability access requirements
- CQC
- Risk management policy
- Business continuity plan
- Whistle-blowing policy
- Confidentiality
- Complaints
- Booking system
- Staffing
- Staff indemnity insurance
- Staff appraisal
- Staff PDP

#### 16.1.9 **Facilities and equipment**

- Dental chair and operating light
- High volume aspiration
- Recovery area
- Emergency drugs including portable oxygen
- Airway adjuncts
- Appropriate monitoring equipment

- Arrangements for sharps disposal/clinical waste

#### 16.1.10 **Care Pathway**

- Pre procedure instructions
- Medical History forms
- Consent forms
- Post procedure instructions

#### 16.1.11 **Patient experience**

- Care with dignity
- Patient feedback mechanism in place

#### 16.1.12 **Professional standards**

- Audit
- Record keeping

#### 16.1.13 **Education and Training**

- Undergraduate
- Postgraduate
- Specialty trainees
- Remedial training

#### 16.1.14 **Performance Indicators**

- PREMS/PROMS as described
- Productivity
- Timescales
- Waiting list
- DNAs
- Written care plans
- Treatment provided
- Serious Untoward Incidents
- Planned and unplanned follow-up appointments
- Plaudits and complaints
- Results of user and service audits and improvements

## 17 Establishing a Managed Clinical Network

All providers of dental specialist services on referral should be contractually bound to engage and participate within a MCN for the specialist area of interest. Commissioners can use this overarching guide and directions to stimulate shadow MCNs establishing.

There are a number of core principles for MCNs to follow.

### 17.1 The MCN must be managed

Each network must have clarity about its management arrangements, including the appointment of a person who is recognised as having overall responsibility for the operation of the network. This should be a consultant wherever possible. Each network should produce a written annual report to the commissioners to whom it relates; each annual report must be available to the public

### 17.2 Have a defined structure and strategy

Each network must have a defined structure which oversees the pathway and overcoming of barriers to implementation. They will receive data allowing benchmarking and have a line of sight across the pathway.

Each network must have a clear statement of the specific clinical and service improvements which patients can expect as a result of the establishment of the Network

### 17.3 Use a documented evidence base

Each Network must use the specialty commissioning guide approach and measures and documented evidence base, where these are available, and must be committed to the expansion of the evidence base through appropriate research and development;

### 17.4 Must contribute to any multi dental specialty, multi-disciplinary and multi professional MCNs

Once managed specialty networks become established in dentistry it will be important that there is communication and joint working between the different specialty networks. Patients often require the input of more than one dental specialist and an over-arching clinical network can describe how patients navigate this locally so commissioners are assured and that systems and pathways meet patient need.

In time there will be a need for dental clinical networks to contribute to multi-professional MCNs. There must be clarity about the role of each health professional in the network, particularly where new or extended roles are being developed as part of the network. Each network should include patient representation in its management arrangements. NHS England has set as one of its priorities public and patient participation. The custodian of dental multidisciplinary treatment, planning, delivery and sequencing of care, is the specialist accepting the original referral. If

they are not the most appropriate clinician they refer the case to the Chair of the relevant MCN. There should to be a process in place where the Chairs of the MCNs communicate with each other so treatment plans can be agreed jointly when required.

#### **17.4.1 What is the hierarchy of decision making?**

The specialist who receives the original referral is accountable for the overall sequencing and delivery of that patient's care, including assessing the need for other dental specialist input. They could remain the custodian of Dental Multi-Disciplinary Team (DMDT) care. If they need to involve another dental specialist (they would do so via the relevant MCN Chairs) and a joint clinic arranged. If a more relevant custodian of care is agreed at the joint clinic - this should be reported and recorded. If multidisciplinary care is required, the entire treatment plan needs to be decided at the outset in a joint clinic and then communicated to the referring GDP via a letter copied to the patient; this plan should identify the named custodian of care.

### **17.5 Have a clear policy on disseminating information to patients**

Each MCN must have a policy of sharing information with patients using the generic commissioning guide patient information as they develop. This should include local detail on services changes, improvements, innovation and limitations and importantly self-care messages.

### **17.6 Have a commitment from all health professionals in the MCN to practice in accordance with the network principals**

All providers of specialist dental care must take part and contribute to the network. All the health professionals who make up the network must indicate their willingness to practice in accordance with specialty guide pathways and with the general principles governing the network

### **17.7 Have a quality assurance programme**

The MCN members will share information from the consistent data set, which can be benchmarked, including PROMS and PREMS to support service improvements by peer review, education and support.

### **17.8 Develop its education and training potential**

The educational and training potential for networks should be used to the full, through exchanges between those working in primary care, including specialist practices and those working in dental hospitals or secondary care settings. Networks' potential to contribute to the development of clinicians with enhanced skills and experience concept should also be kept in mind, and networks should develop appropriate affiliations to universities, the Royal Colleges and HEE.

## **17.9 Ensure that all health professionals in the MCN actively participate in audits**

All clinicians in the network must participate actively in audit and in open review of results.

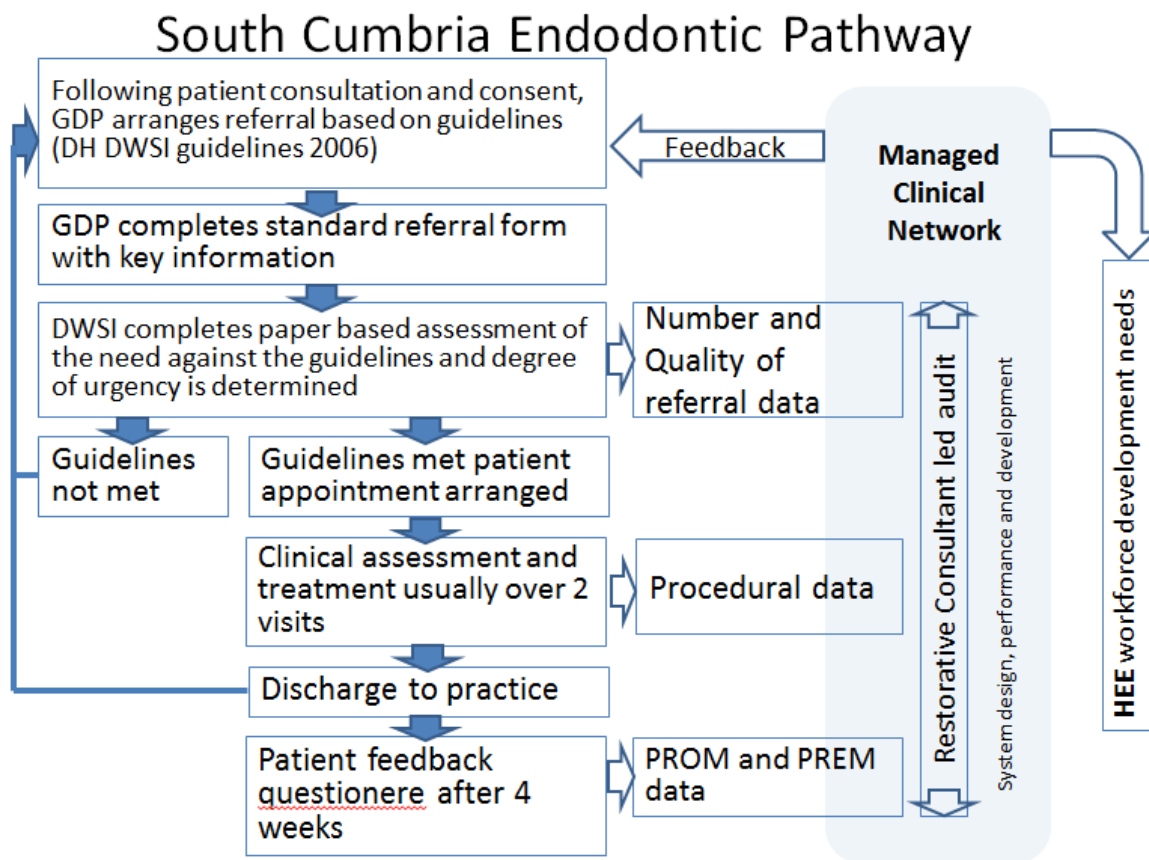
## **17.10 Have a CPD programme in place for all staff and ensure that staff are able to move within the network in ways to improve patient access and maintain professional skills**

All networks must include arrangements for the effective delivery of training ensuring that those on specialist training pathways have sufficient experience and supervision with cases of clinical and patient complexity. The networks can also take an influential role in transforming undergraduate, postgraduate, remedial and training for clinicians with enhanced skills and experience, so training opportunities follow patients receiving care rather than patients following established training arrangements. This needs to be influenced, implemented and monitored locally in an environment which supports ambition and innovation.

## **17.11 Explore the potential**

There must be evidence that networks allow professionals to come together to explore the potential to generate better value for money, service improvement and more interesting career opportunities for clinicians.

This is an example of an existing MCN from South Cumbria.



## 18 Generic patient reported outcome and experience measures

As part of the development of these guides, consideration has been given to nationally-reported PREMs and PROMs. A generic set of measures have been agreed for all guides. Patient and public engagement in the production of these measures has formed a cornerstone of their inclusion. These sets of aggregated data will need to be collected on a national basis and will allow for benchmarking and service improvement.

These PROMs and PREMs will be supplemented by clinical outcome measures and these are detailed in each of the relevant guides and included in the minimum specification.

## 18.1 Patient Reported Outcome Measures

<b>Question</b>	<b>Are you able to speak and eat comfortably?</b>
<b>Responses</b>	I am able to both speak and eat comfortably
	I have slight discomfort when either speaking or eating
	I have considerable discomfort when either speaking or eating
	I have significant discomfort when either speaking or eating

<b>Question</b>	<b>Did you have any problems in the hours after the procedure was carried out?</b>
<b>Responses</b>	I had no problems in the hours after the procedure was carried out
	I had slight problems in the hours after the procedure was carried out
	I had considerable problems in the hours after the procedure was carried out
	I had significant problems in the hours after the procedure was carried out
	<i>Free text to allow specifying of problems</i>

<b>Question</b>	<b>Are you still suffering ill effects from the procedure that you had?</b>
<b>Responses</b>	I have no ill effects after the procedure
	The ill effect still persists slightly after the procedure
	The ill effect still persists considerable after the procedure
	The ill effect still completely persists after the procedure

<b>Question</b>	<b>Did you seek advice or assistance relating to the procedure and its effects in the days after the procedure?</b>
<b>Responses</b>	No, I did not seek any advice or assistance in the days after the procedure
	Yes, I sought out advice or assistance passively, e.g. internet, reading, etc.
	Yes, I sought out advice or assistance in person, e.g. dentist, GP, etc.

## 18.2 Patient Reported Experience Measures

Question	Did you feel sufficiently involved in the decisions about your care?
Responses	No, I felt like I was not sufficiently involved in the decisions about my care
	Yes, I felt like I was somewhat involved in the decisions about my care
	Yes, I felt like I was sufficiently involved in the decisions about my care

Question	How satisfied are you with the NHS dentistry received?
Responses	Not at all satisfied
	Somewhat satisfied
	Very satisfied
	Completely satisfied

## Appendix 1 – What is a health needs assessment?

A health need can only exist when an individual has an illness or disability for which there is an acceptable cure (Matthew, 1971). Health needs may be described from the perspective of the service recipient or that of the service provider (Chestnutt *et al.*, 2013). Different types of health need exist, including need defined by health professionals (normative need), needs defined by service users (felt need), actions taken by service recipients to utilise health services (expressed need or demand), need between similar groups of people (comparative need) and the difference between need for health services and service provision (unmet need) (Bradshaw, 1972; Carr and Wolfe, 1976). A health needs assessment usually aims to identify the unmet health needs of a defined population to enable targeting of resources to improve health and reduce health inequalities.

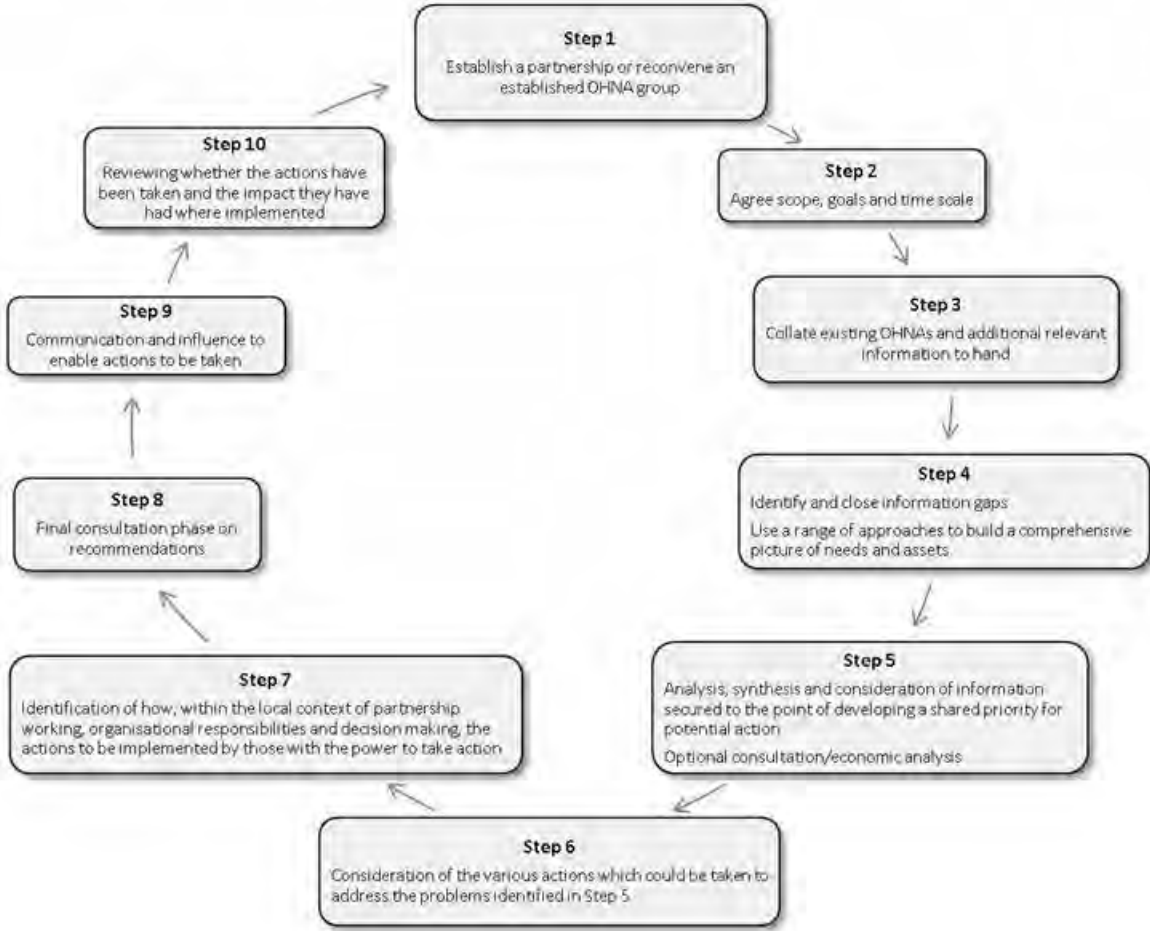
An oral health needs assessment (OHNA) therefore involves establishing and describing the oral health of a population, ascertaining their needs, measuring the capacity of existing services to meet these needs. Where these gaps exist, identifying new or alternative ways in which such gaps can be prioritised and filled (Chestnutt *et al.*, 2013). Consultants in dental public health as public health advisors to the NHS have the expertise to undertake oral health needs assessments and support NHS England to commission high quality, safe and effective oral healthcare services, leading to improved access, patient outcomes and experience. However, there are difficulties in determining need, uptake and demand for oral healthcare services due to limited information sources. Commissioning services that meet the needs of the population within available resources remains challenging.

A recent review (Chestnutt *et al.*, 2013) of existing methods for undertaking oral health needs assessments found that there was no one format for an OHNA and no evidence was available on how to conduct an ideal OHNA that results in changes that are clinically- and cost- effective. Chestnutt *et al.* proposed a 10 step approach for carrying out an OHNA (Figure 1).

The needs assessment undertaken as part of the process to implement this commissioning guide should include:

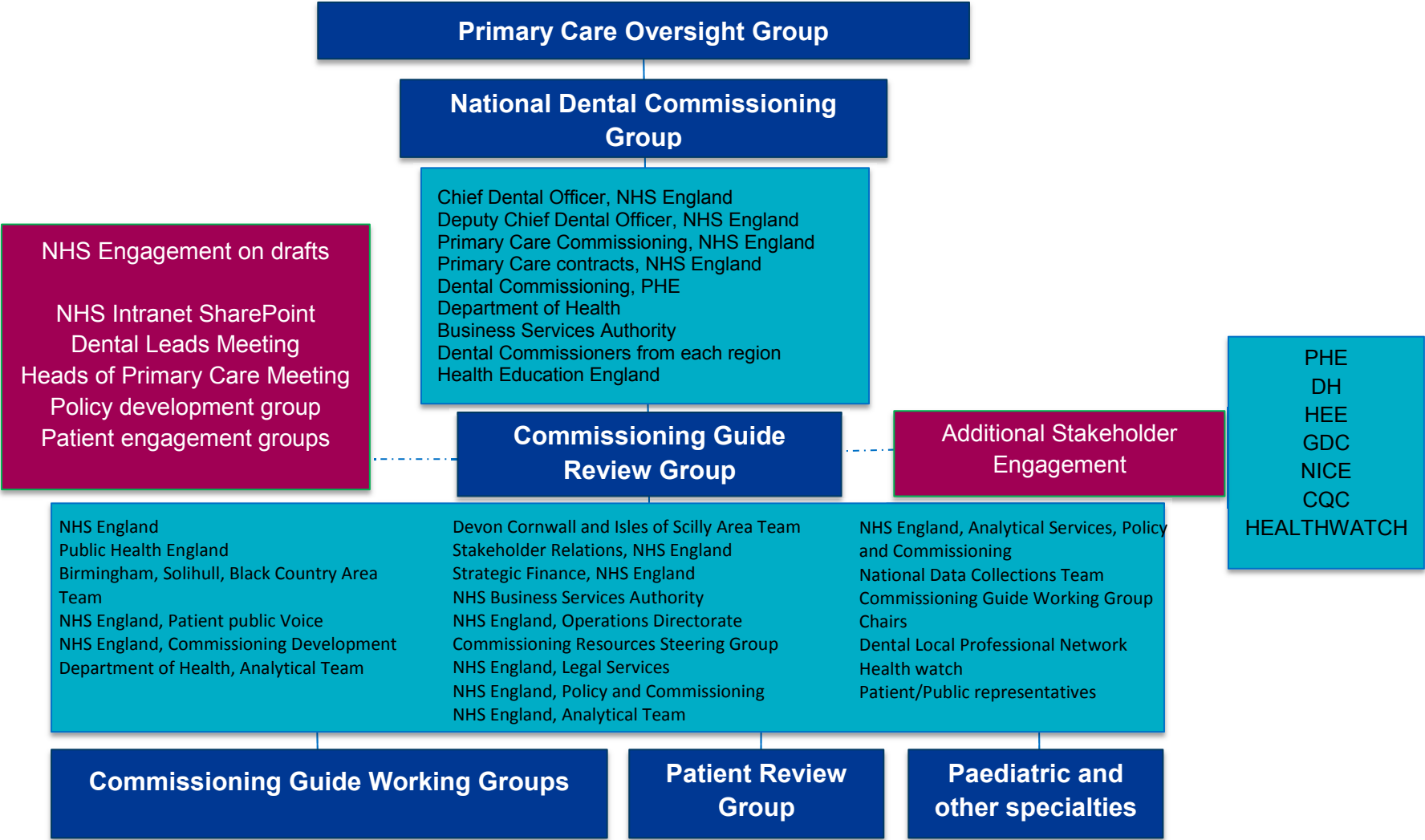
- A description of the oral health needs of the local population;
- A description of the special care groups in the local population;
- A description of the current oral healthcare service provision for special care groups;
- Identification of gaps in service provision against local needs; and
- Recommendations for the future development of special care dental services in line with the commissioning guide.

**Figure 1. The 10 Step Approach for an Oral Health Needs Assessment**



Source: Modified from Chestnutt *et al.*, 2013, p56

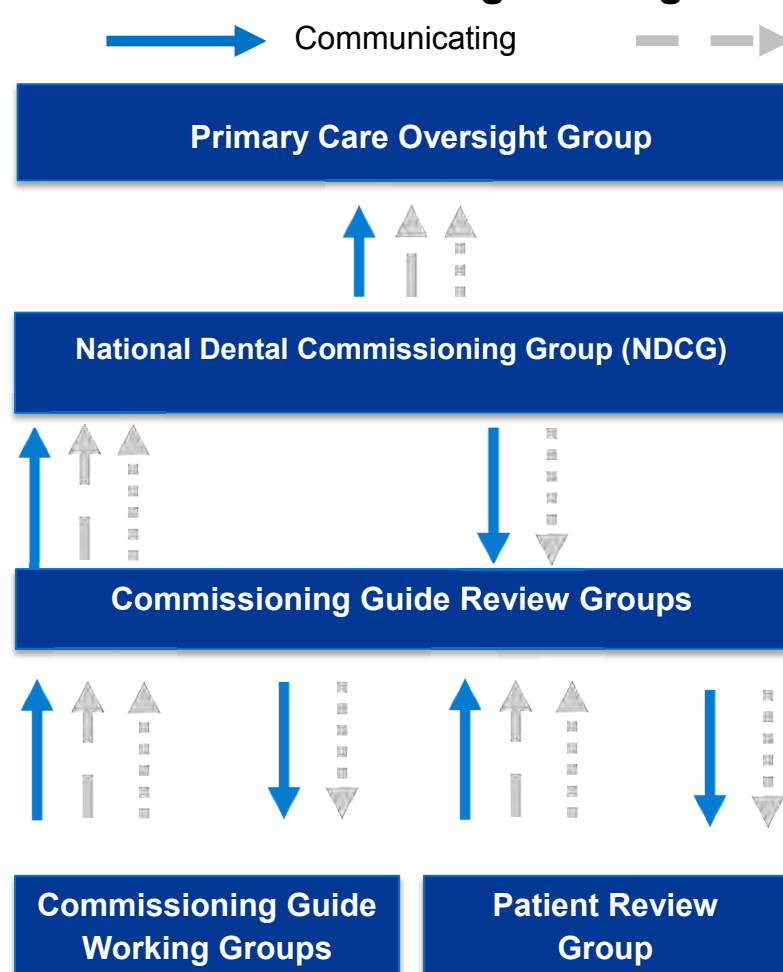
# Appendix 2 – Programme Governance Model



Orthodontic WG	Oral Surgery and Oral Medicine WG	Restorative Care WG	Special Care WG	Patient Review Group
<p>Chair Primary Care Secondary Care NHS Business Services Authority Department of Health Health Education England Public Health England Dental Local Professional Network Association of Dental Hospitals British Dental Association Faculty of Dental Surgery NHS England British Orthodontic Society Orthodontic therapist Commissioner Patient / public representatives Foundation training rep Royal College of Surgeons</p>	<p>Chair Primary Care Oral Surgeon Secondary Care Oral Surgeon NHS Business Services Authority Department of Health Health Education England Public Health England Dental Local Professional Network Association of Dental Hospitals British Dental Association Faculty of General Dental Practice NHS England SAS Grade Oral Surgeon British Association of Oral and Maxillofacial Surgeons Commissioner British Association of Oral Surgeons Oral Microbiologist British Society for Oral Medicine British Society for Oral and Maxillofacial Pathology Associate Postgraduate Dental Dean Fellow in training OMFS Royal College of Surgeons Patient / public representatives Primary Care Commissioning Dental Core Trainee</p>	<p>Chair Primary Care Secondary Care NHS Business Services Authority Senior Clinical Adviser Department of Health Health Education England Public Health England Dental Local Professional Network Association of Dental Hospitals British Dental Association Faculty of Dental Surgery Consultant in Dental Public Health NHS England NHS consultant NHS Restorative Dentist Restorative Dental Nurse Commissioner Patient / public representatives Primary Care Commissioning Association of Consultants and Specialists in Restorative Dentistry British Society for Restorative Dentistry Senior Registrars in Restorative Dentistry Group British Endodontic Society British Society of Periodontology British Society of Prosthodontics British Society of Dental Hygiene and Therapy</p>	<p>Chair Primary Care Secondary Care NHS Business Services Authority Department of Health Health Education England Public Health England Dental Local Professional Network Association of Dental Hospitals British Dental Association Faculty of Dental Surgery Faculty of General Dental Practice NHS England Dental Core Trainee British Society for Disability and Oral Health Inequalities lead Dental Care Professional Specialist in special care dentistry Commissioner Patient / public representatives British Society of Gerontology Postgraduate education, Wales</p>	<p>Serbjit Kaur-Chair Jenny Sleight Frances Newell Colette Bridgman Rob Haley Dionne Hilton Gill Heyes Debbie Lewis Ruth Kimberly Tony Lloyd Claire Jones Deborah Bridger Alice Tligui Alex Bax Heidi Treadwell Rob Dalziel Pam Peers Sue Parroy Mark Welch Mayra Crean Jean Gallagher Douglas Lewins Madeleine Wang Stuart Wallace Heather Boulton Ann Heaton Michael Osborne James Harris Leah Elcock Stan Burridge Helen Davies</p>

**Vulnerable groups**

## Programme governance group responsibilities



**Primary Care Oversight Group – Decision making group**  
 Agree overall strategy and make decisions about the programme

**NDCG – Advisory group**  
 An advisory group who will advise and suggest direction for the programme, as well as approving the final commissioning guides.

**CGRG - Link between national strategic direction of NHS England and overseeing the delivery**  
 Advise any national changes and make sure this work aligns to the national strategic direction of NHS England. Manage inter-programme dependencies, ensure alignment of working groups. Make decisions regarding the programme timeline and delivery, review and ensure that the commissioning guides produced are commissionable, financially viable and sign off the work of the working groups and provide a regular report on progress to the National dental commissioning group.

**Commissioning Guide working Group - the delivery**  
 To develop a needs-led outcome-focussed care pathway approach for dental service delivery and to produce an associated single operating commissioning framework to deliver improvements in quality, outcomes and value for money in all settings.

**Patient Review Group – Key group of Patient Representatives**

## Commissioning Guide Review Group – Membership

<b>Serbjit Kaur</b>	<b>NHS England</b> <i>Deputy Chief Dental Officer</i>
<b>Dionne Hilton</b>	<b>NHS England</b> <i>Programme Manager dental pathways</i>
<b>Colette Bridgman Rob Haley</b>	<b>Public Health England</b> <b>PCC Support</b>
<b>Donna Macarthur</b>	<b>Birmingham, Solihull, Black Country Area Team</b> <i>Head of Primary Care</i>
<b><i>Pending</i></b>	<b>NHS England, National Support Centre</b>
<b>Claire Jones</b>	<b>Healthwatch</b> <i>Healthwatch Manager, Strategic and Stakeholder</i>
<b>Surinder Sharma</b>	<b>Patient public representative</b>
<b>David Roberts</b>	<b>NHS England Commissioning Development</b> <i>National Lead for Dental, Pharmacy &amp; Optical Contracts and Projects</i>
<b>David Glover</b>	<b>Department of Health, Analytical Team</b> <i>Analyst, Dental and Eye Care</i>
<b>Nick Barker</b> <i>Tom Norfolk</i>	<b>Dental LPN</b>
<b>Andrew Harris</b>	<b>Devon Cornwall and Isles of Scilly Area Team</b> <i>Commissioner</i>
<b>John Whitehouse</b> <i>Anouska Curry</i>	<b>Stakeholder Relations, NHS England</b> <i>Stakeholder engagement</i>
<b>Joanne Lowther Ruth Gasser</b>	<b>Strategic Finance</b> <i>Primary Care Dental Finance Lead</i> <b>NHS Business Services Authority</b>
<b>Ceri Townley</b>	<b>NHS England, Operations Directorate</b> <i>Head of Specialised Services</i>
<b><i>Pending</i></b>	<b>Commissioning Resources Steering Group</b>
<b>Ray Avery</b>	<b>NHS England</b> <i>Health Inequalities Lead</i>
<b>Charlie Parker</b>	<b>NHS England Legal Services</b>
<b>Andrew Jackson</b>	<b>NHS England, Policy and Commissioning</b> <i>Head of Analytical Service</i>
<b>Katie Robinson</b>	<b>NHS England, Analytical Team, Primary Care Commissioning</b>
<b>Permjeet Dhoot</b>	<b>NHS England, Equality and Health Inequalities Team</b> <i>National Project Coordinator</i>

<b>Stephen Fell</b>	<b>NHS England</b> <i>Head of Assurance and Procurement</i>
<b>Frances Newell</b>	<b>NHS England, Patient Public Voice</b>
<b>Jenny Sleight</b>	<b>NHS England, Patient Public Voice</b>
<b>Steve Wilson</b>	<b>Burden Advice and Assessment Service</b> <i>Deputy Programme Head</i>
<b><i>Pending</i></b>	<b>Commissioning Development</b>

**Working group chairs (As required)**

<b>Alice Benton</b>	<b>Chair Orthodontics working group</b>
<b>Paul Coulthard</b>	<b>Chair Oral working group</b>
<b>Jimmy Steele</b>	<b>Chair Restorative working group</b>
<b>Janet Clarke</b>	<b>Chair Special Care working group</b>

## Appendix 3 – Commissioning Guide - patient engagement process

### Patient/carer involvement in developing commissioning guides

#### 1.1 Why is this important?

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, specifically in relation to patient/public involvement that Clinical Commissioning Groups (CCGs) and commissioners in NHS England should ensure:

- patients and carers participate in planning, managing and making decisions about their care and treatment, through the services they commission;
- the effective participation of the public in the commissioning process itself, so that services provided reflect the needs of local people.

Information on NHS England's vision and plans in this area can be found in the guidance '*Transforming Participation in Health and Care*'.<sup>5</sup> This guidance supports commissioners to improve individual and public participation, to better understand and respond to the needs of the communities they serve, and to support them in developing the culture, systems and processes which will make participation a reality.

NHS England is committed to ensuring that public and patient voices are at the centre of shaping our healthcare services. Every level of our commissioning system needs to be informed by insightful methods of listening to those who use and care about our services. The public and patient voice should be embedded into our commissioning processes in a range of ways, including insight and feedback to shape services, voices in the governance frameworks of our programmes of work, as well as patient and public participation in our assurance processes.

The core principles of public/patient participation are set out in the bite sized guides to patient and public participation, Guide 1 - Principles for participation in commissioning<sup>6</sup>:

- should be present across governance frameworks for policy and NHS England work programmes. This includes patient and public voice at both the detailed end of service development, and at the strategic overview.
- needs to be embedded, not seen as an 'add-on' part of the programme.
- Avoid creating isolated public and patient voices by having more than one patient and public voice (PPV) member within a working group. There will be large numbers of professionals at governance meetings, having several patient/public representatives is recommended to bring both balance and a range of diverse patient perspectives.

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<sup>5</sup> The Guidance can be accessed at [www.england.nhs.uk/ourwork/patients](http://www.england.nhs.uk/ourwork/patients)

<sup>6</sup> Guide 1 - Principles for Participation in Commissioning <http://www.england.nhs.uk/2014/03/13/pat-pub-participation/>

- Ensure the information is anonymised unless the patient has given explicit consent

In the development of the commissioning guides, NHS England has collaborated with many different stakeholders, including patients/carers, to ensure their perspectives have informed the development and that the above core principles above have been met. This has included having at least two patient/carer representatives on each of the four Working Groups, having a dedicated Patient Review Group to develop two specific chapters of the commissioning guides ('patient journey' and 'vulnerable and excluded groups'), and holding specific events targeted solely on focusing on the patient/carer experiences eg focus groups with children and young people.

*“Think I made a difference to the Oral Surgery/Medicine Commissioning Guide as we questioned lots of the decisions – patient reps were fully involved and made a difference”*

The patient involvement/engagement undertaken in the development of the commissioning guides falls within the Analyse and Plan and Design Pathways segments of the Engagement Cycle.<sup>7</sup>



We identified the needs and aspirations of the patients/public in the development of the commissioning guides which will ultimately improve dental care for all. The intention is that local commissioners will involve patients in procuring and monitoring dental services locally in the remaining segments of the engagement cycle. Commissioners should utilise the learning from the public/patient engagement

<sup>7</sup> Further information on the Commissioning Cycle can be accessed at [www.engagementcycle.org](http://www.engagementcycle.org)

undertaken so far to set standards and outcomes for service delivery which could be used within specifications, contracts and service level agreements. For example, contracts could specify:

- what engagement activities providers should undertake;
- what patient experience data providers should be collecting;
- how they should be reporting it;
- how they can take action in response to that data.

## 1.2 How were patients/carers involved?

Below are some examples of how patient involvement activities/events have helped to shape the development of the commissioning guides, with quotes from patients/carers involved.

Two patient involvement events were held whilst the commissioning guides were being drafted. The first gathered patient views on the current dental services provision and to understand priorities from a patient perspective with respect to the commissioning guides. A second event was held on 23<sup>rd</sup> of September to obtain patient/public views on the redrafts of the commissioning guides to ensure concerns/issues had been addressed.

The aim of the initial event was to gather together around 50 patients/members of the public (including people from vulnerable groups and carers) from a geographical and demographic spread. The invitation was circulated to many different stakeholders/networks including (but not limited to):

- Healthwatch England and local Healthwatch;
- CCG Lay assessors and Clinical Reference Group patient representatives;
- Voluntary Sector Strategic Partners;
- British Dental Association;
- NAPP;
- Regional Patient/Public Voice Leads for NHS England;
- Strategic Clinical Networks – Patient Engagement Leads;
- CQC;
- Other voluntary and community organisations.

The second event on the 23<sup>rd</sup> September was attended by 20 patients/carers. People said they felt genuinely engaged in the future work on dental services.

*“Encouraging that there was a specific focus on vulnerable and excluded groups.”*

The attendees were asked:

- To discuss which of the top 2 Patient Related Experience Measures (PREMs) they would prefer to give feedback on, to allow us to monitor and improve the experience of care for patients;

- To agree the top 4 Patient Reported Outcome Measures (PROMs) they think would allow us to measure and improve the quality of care most effectively;
- To agree what they would like to change about NHS dentistry services;
- To discuss what they liked about NHS dentistry services.

An online survey asking the same questions was also undertaken to gain additional insight and involvement. Several of the attendees on the day were from patient advocacy groups who, after the event, circulated the list of PROMs and PREMs to their members to obtain additional views regarding the top 4 PROMs and 2 PREMs. Overall, this aspect of involvement has reached hundreds of patients/members of the public.

### 1.2.1 Patient Review Group

As a result of the initial patient engagement event, a large number of people asked to become patient/carer representatives on the 4 Working Groups. As there were limited spaces on the working groups, and to accommodate the views of as many people as possible, it was decided to establish a Patient Review Group. This included patients, carers and voluntary/community organisations supporting potentially excluded groups eg homeless people. This group focused on the illustrative Patient Journey and the ‘vulnerable patients’ sections of the commissioning guides. The discussions from the meetings were used to formulate the first draft of these two sections which has resulted in the final chapters in the commissioning guides.

*“Patient Journey - I did stress the need for more patient information - telephone numbers with a named point of contact, when to expect a reply by letter, text or email, information explained about treatment, so that not only the patient but the family/parent/carer knows what to expect. This resulted in the Patient Journey containing a timescale of days/weeks regarding letters or contact from specialists for referrals that are realistic and acceptable to patients like me.”*

*“With our knowledge and experience, we extended the list of vulnerable patients from a few headings to many more, including homeless, those with special needs, those with other long term health conditions.”*

### 1.2.2 Children and Young People – targeted approach

In the development of the Orthodontics Commissioning Guide, a targeted approach was undertaken to ensure the views of children and young people were obtained. This involved a combination of digital involvement and face-to-face focus groups. The digital involvement used tweetchats which attracted small numbers of young people and their parents but yielded some useful insights that were then discussed further in subsequent focus groups. Two focus group discussions were then held in different parts of the country, with approximately 16 children and young people participating, aged between 9 and 21, and a separate group for parents/carers to share their experience. The valuable insight gained has been used in the development of the Orthodontics commissioning guide and it is intended that it will also inform specifications, tender and monitoring processes, and development of Patient Related Experience Measures.

*“I’ve put forward views of under 16s, vulnerable and younger people with long term health conditions who are often overlooked and not asked their views.”  
Quote from a patient/carer.*

### 1.3 Summary

We believe that the involvement described above demonstrates NHS England is committed to working and engaging with patients, carers and the public in a wide range of ways. Ensuring that people’s views are heard at all levels and across all parts of the healthcare system is essential for creating and delivering better health and care services. NHS England will consider the learning from patient involvement in the dental commissioning guides to help develop its future approach to public voice in dental commissioning at both national and local levels.

*“Being involved brings about change - your voice is heard and things you may think are obvious that are not being done, can be changed by sometimes such simple steps, helping to improve services”*

*“Being part of developing the commissioning guides was good fun. Many voices make changes, so speak up. If you want to change things, speak up, get involved!”*

## Appendix 4 – Stakeholder engagement for Commissioning Guides

Throughout the development of the Commissioning Guides there has been engagement with every group or type of stakeholder that has an interest in dentistry (please refer to the governance model). There are four working groups set up relating to each specialty to develop a needs-led, outcome-focussed care pathway approach for dental service delivery and to produce an associated single operating commissioning framework to deliver improvements in quality, outcomes and value for money in all settings.

Chairs for each of the four working groups were assigned. The Chair identified primary and secondary care clinicians and relevant societies to be included in their specialty working group. Letters were sent out to the president of each society and college to nominate someone to attend on the societies behalf. In addition, all groups had representation from NHS England dental and commissioning representatives, Public Health England, Health Education England, Department of Health, Business Services Authority, Faculty of Dental Surgery, Faculty of General Dental Practice, British Dental Association, the Local Professional Networks and patient/public reps. Healthwatch were also invited but only managed to nominate one individual.

As well as the working groups there was the Commissioning Guide Review Group (CGRG) which acted as the link between the national strategic direction of NHS England to oversee delivery, ensure that the commissioning guides produced are commissionable, financially viable and aligned with the vision of NHS England. This group consists of all the NHS England gateway teams; they provide assurance that all NHS England national communications are fit for purpose in terms of content & policy governance, affordability and in line with our Mandate, statutory requirements and Planning Guidance.

A Patient Review Group was set up to discuss and agree the vulnerable and patient journey sections of the guides. This group also reviewed the final drafts of the guides from a patient perspective. For more information on patient engagement throughout the process please refer to the patient engagement document.

Letters were sent to the following organisations informing them of the work when it was about to begin as well as giving them an opportunity to comment on the near final drafts of the documents in January:

- Public Health England;
- Department of Health;
- Health Education England;
- General Dental Council;
- National Institute for Health and Care Excellence;
- Care Quality Commission;
- Healthwatch.

Organisations which have been engaged with and/ or have been involved in the development of the guides are outlined in the governance model.

## Appendix 5 – Oral Surgery financial planning

	T1	T2	T3
Year 1	50%	10%	
Year 2	15%	30%	
Year 3	5%	20%	
	70%	60%	0%

Commissioners	Reference Year Costs	Year 1 Costs	Year 1 change from Reference Year	Year 2 Costs	Year 2 change from Reference Year	Year 3 cost	Year 3 change from Reference Year	Number of Trusts
Region 1			£0		£0		£0	
Region 2			£0		£0		£0	
Region 3			£0		£0		£0	
Region 4	£63,026,590	£63,019,100	-£7,490	£63,016,476	-£10,114	£63,015,733	-£10,857	4
Region 5	£67,713,814	£67,331,571	-£382,243	£67,272,735	-£441,079	£67,256,064	-£457,750	14
Region 6	£90,962,656	£90,509,459	-£453,197	£90,439,979	-£522,676	£90,420,293	-£542,362	14
Region 7			£0		£0		£0	9
Region 8			£0		£0		£0	
Region 9	£58,180,872	£57,983,152	-£197,720	£57,951,994	-£228,878	£57,943,166	-£237,706	14
Region 10	£105,199,617	£104,301,134	-£898,482	£104,164,862	-£1,034,754	£104,126,252	-£1,073,365	8
Region 11			£0		£0		£0	
Region 12	£135,063,805	£134,936,756	-£127,050	£134,916,198	-£147,607	£134,910,374	-£153,432	12
Region 13			£0		£0		£0	
Region 14			£0		£0		£0	

Commissioners	Reference Year Costs	Year 1 Costs	Year 1 change from Reference Year	Year 2 Costs	Year 2 change from Reference Year	Year 3 cost	Year 3 change from Reference Year	Number of Trusts
Region 15	£59,312,180	£58,960,237	-£351,943	£58,905,945	-£406,235	£58,890,563	-£421,618	11
Region 16	£71,096,648	£71,101,210	£4,563	£71,100,395	£3,747	£71,100,164	£3,516	9
Region 17	£419,111,670	£417,814,513	-£1,297,157	£417,407,612	-£1,704,058	£417,591,437	-£1,520,233	17
Region 18	£65,048,211	£64,419,212	-£628,999	£64,323,362	-£724,849	£64,296,205	-£752,006	2
Region 18	£79,020,570	£78,913,820	-£106,750	£78,896,308	-£124,263	£78,891,346	-£129,224	17
Region 19			£0		£0		£0	
Region 20	£85,788,682	£85,724,806	-£63,876	£85,713,724	-£74,957	£85,710,585	-£78,097	6
Region 21			£0		£0		£0	
Region 22	£89,110,012	£88,690,972	-£419,041	£88,626,615	-£483,397	£88,608,381	-£501,631	-
Region 23	£133,281,864	£132,751,937	-£529,927	£132,670,948	-£610,916	£132,648,001	-£633,863	11
Region 24	£120,892,225	£120,806,839	-£85,385	£120,792,532	-£99,693	£120,788,478	-£103,747	5
Total	Reference Year Costs	Year 1 Costs	Year 1 change from Reference Year	Year 2 Costs	Year 2 change from Reference Year	Year 3 cost	Year 3 change from Reference Year	
	£1,642,809,415	£1,637,264,718	-£5,544,698	£1,636,199,686	-£6,609,729	£1,636,197,041	-£6,612,375	

## Appendix 6 – Financial template

Access to the financial template can be accessed by contacting a member of the Chief Dental Officer's team at Skipton .

## Appendix 7 – Acknowledgements

NHS England would like to convey its sincere gratitude and appreciation to the individuals and organisations that made a significant contribution to the development of the Guides for Commissioning Dental Specialties – Introduction to the framework and the Commissioning Guides for Orthodontics, Oral Surgery and Oral Medicine, Restorative Dentistry and Special Care Dentistry.

Production of the Guide for Commissioning Dental Specialties – Introduction to the framework and collating and editing for all other guides.

Serbjit Kaur – NHS England  
Colette Bridgman – Public Health England  
Rob Haley – Primary Care Commissioning (PCC)  
Clare Jones – Primary Care Commissioning (PCC)

The work could not have been produced without the unwavering support, leadership and commitment shown by clinicians from primary and secondary care, individual practices, community dental services and by the following organisations for all other guides:

Association of Dental Hospitals  
British Association of Oral and Maxillofacial Surgeons  
British Association of Oral Surgeons  
British Dental Association  
British Endodontic Society  
British Orthodontic Society  
British Society of Dental Hygiene and Therapy  
British Society of Disability and Oral Health  
British Society of Gerodontology  
British Society for Oral Medicine  
British Society for Oral and Maxillofacial Pathology  
British Society of Periodontology  
British Society of Prosthodontics  
British Society for Restorative Dentistry  
Dental Local Professional Networks  
Faculty of Dental Surgery  
Faculty of General Dental Practice  
Health Education England  
Healthwatch  
NHS Business Services Authority  
Patient/Public Representatives  
Primary Care Commissioning (PCC)

Public Health England  
Royal College of Surgeons of England

## Appendix 7 – Glossary of Terms

Commissioning	The Department of Health defines commissioning as the means to secure the best value health care for the local population and tax payers
CBT	Cognitive Behaviour Therapy – A talking therapy that can help manage problems by changing the way one thinks and behaves.
CsDePH	Consultants in Dental Public Health.
CSUs	Commissioning Support Units.
CQUIN	The Commissioning for Quality and Innovation payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
Dental HEEAG	Dental Health Education England Advisory Group
GDS Contracts	General Dental Services Contracts.
HEE	Health Education England is a Special Health Authority of the Department of Health. Its function is to provide national leadership and coordination for the education and training within the health and public health workforce within England.
HEE (SIFT)	Health Education England Service Increment for Training
HEFCE	The Higher Education Funding Council for England promotes and funds high quality, cost-effective teaching and research, meeting the diverse needs of students, the economy and society.
IMOS	Intermediate Minor Oral Surgery
LETBs	Local and Education Training Boards.
Dental LPN	Dental Local Professional Network.
MCN	Managed Clinical Networks. Linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective service.
OPCS Codes	The Office of Population Censuses and Surveys (OPCS). This is a published procedural classification and coding of operations, procedures and interventions. This is a 4 character code system. The first character is always a letter and the other three are numbers. All codes beginning with

	“F” are related to the mouth.
OHNA	Oral Health Needs Assessment.
PDS Contracts	Personal Dental Services Contracts.
PHE	Public Health England.
PREMs	Patient Reported Experience Measures is a rolling programme of experience gathering which reports regularly to demonstrate experience trends and can be used to inform service development and improvement. This is usually completed through questionnaires.
PROMs	Patient Reported Outcome Measures are a quality of life measure, by measuring the quality of life before and after a treatment or intervention, then again a fixed amount of time after. This gives insight into the impact of a treatment or intervention to a patient’s life
Provider	The contract holder to provide a service.
SEICD	Securing Excellence in Commissioning NHS Dental Services.
UDA	Units of Dental Activity.

## Appendix 8 – DATA FLOW - Introductory Guide for Commissioning Dental Specialties

✚

DATA FLOW	ITEM NO	Personal / Anonymised Information	WHO FROM	WHO TO	RATIONALE
DF1	4.3	A	Referral management process	Commissioners and MCN	To understand needs, demand and identify trends
DF2	5.2	P	Referring dentist	Specialist provider	So that a patient with additional needs can be assessed
DF3	6.1	A	Dental observatory / PHE	All dental stakeholders	Collaborated survey data all taking individually and data used at population consent level to describe disease and trends
DF4	8.1	A	Service providers	Healthcare, Social care and Education	So that the public and patients are informed to access services
DF5	9	P	Hospital Coders	SLAM and SUS, CSUs	For payment of tariff
DF6	10.3	P	Referring dentist	Specialist provider	Ammonised aggregate of these data allows commissioners to see trends
DF7	12.2.1	A	Survey & population data (PHE)	Commissioners	To understand disease surveillance
DF8	12.2.2	P	Dentists	Specialists via a referral management service	For specialist treatment and /or advice
DF9	12.2.3	P	Coding Department	SLAM and SUS, CSUs	For payment of tariff
DF10	12.2.5	P	Clinicians and Coding Dept.	SLAM and SUS, CSUs	So patients can be tracked across primary and secondary care
DF11	12.2.6	A	Clinicians	Aggregated for NHS England Commissioners	To seek improvements and spot trends
DF12	12.2.6	P	Dentist	BSA and DH	To track patient experience and outcomes
DF13	12.2.6	A	Clinicians	Aggregated for NHS England Commissioners	To seek improvements and spot trends
DF14	12.3	P	Referring dentist	Specialist provider	So that a patient with additional needs can be assessed
DF15	17	A	Referral management process	Commissioners and MCN	To understand needs and demand
DF16	18.1	P	Patients	Clinicians	To assess the outcome of care
DF17	18.2	P	Patients	Clinicians	To assess experience of care