Guides for commissioning dental specialties – Special Care Dentistry

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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artificial divide between primary dental care and hospital specialists; one that will free specialist expertise from outdated service delivery and training models, so all providers can work together to focus on patients and their needs.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; implementation and the 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 and to 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 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 will ensure there is national consistency in the NHS commissioning offer for dental specialist services and how they are delivered. 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 MCNs which will work closely with Commissioners, Dental 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.

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 through having patient representatives on every group and

by convening a patient review group which have helped develop the content. This is outlined in detail in the patient engagement and stakeholder engagement appendices (Appendices 3 and 4, respectively, in the overarching guide).

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 every stakeholder group with an interest in dentistry, as outlined in the acknowledgments (Appendix 6 in the overarching guide), stakeholder engagement appendix and governance model in the appendices (Appendices 4 and 2, respectively, in the overarching guide).

This is the beginning of a process. Locally, Commissioners need to undertake work to understand the specialist services currently provided, by who and where. The quality and quantity of those 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 what needs to happen next and agree local priorities. Commissioners will need support to identify current dental resources, to allow flexibility locally, 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 Innovation and 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. For example, expanding the use of the NHS number within dentistry.

There will be 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).

The implementation phase will include supporting Commissioners to identify what could and should be undertaken nationally or regionally; and what should be supported by the Commissioning Support Unit locally. However, the first steps for Commissioners on publication of 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 the 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 and quality.

4 What is Special Care Dentistry?

4.1 Description of the specialty

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

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

4.2 Description of the national picture

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

These services operate under different contractual arrangements and identification of the volume of Special Care Dentistry provided by each sector or provider at the present time is not possible.

Data are available for people accessing CDS, but not all of the people will have special care needs as CDSs often provide a range of services, including specialist paediatric dentistry services and general dental services.

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

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

It is clear that most Special Care Dentistry provided under a GDS contract cannot be quantified; current data collected in the FP17 form and submitted to the BSA limits the ability to capture and identify this group of patients. Special Care Dentistry provided in the hospital sector does have a separate specialty code 451 that is not widely used. There are no separate or specific treatment function codes for Special

Care Dentistry. Treatment is often recorded utilising Restorative and/or Oral Surgery codes, which may not reflect the true cost of providing this service.

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

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

Current contracting arrangements have led to variability in activity targets, contract monitoring and quality measurement. IT systems are different in each sector and there is no standard software system for recording and reporting Special Care Dentistry. The British Dental Association Casemix tool is used by many CDSs to measure patient complexity, but this does contain a subjective element which makes comparison challenging.

This variability has hampered benchmarking and results in patchy and inconsistent provision for patients who are often least able to navigate the system.

4.3 Description of the workforce and training

4.3.1 Workforce

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

Special Care Dentistry can and does form part of routine care provided by primary care dentists on an ‘informal’ basis. The majority of Special Care Dentistry at a specialist level is delivered by salaried dental services and in 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 by and large hosted by secondary care trusts. Care is largely outpatient based and could be suitable for general or advanced mandatory primary care contracting. However, due to historic hosting arrangements, with the acute trusts, care is currently paid for at secondary care tariff; including the Level 1 care which is required for teaching

In the CDS dentists may be employed under Salaried Dentists Terms and Conditions (most commonly) and can be described as Band A, B or C dentists. Band A dentists are qualified dentists post vocational training and are often referred to as Dental Officers. Band B dentists are more senior with greater experience and often referred to as Senior Dental officers. Band C dentists are either on a specialist list (and called Band C specialists or Specialists in X specialty) or else Clinical Directors (the clinical

leaders of the service). The competencies required for each type of dentist are included in the Summary Agreement Nov 2007[1].

Some dentists in the CDS may work under Hospital Terms and Conditions and be employed as Consultants, Specialty Registrars or Dental Core Trainees. These dentists still have to be on the performer list if providing care under a GDS contract or PDS agreement

Dental Care Professionals (DCP) include dental hygienists and dental therapists, as well as dental nurses many of whom will have completed post-basic qualifications in both sedation and Special Care Dentistry. Many CDS employ a number of dental therapists, in particular, as they can provide the less complex dentistry required in addition to the work done by Special Care Dentists as part of their overall treatment plan. Dental therapists and hygienists also provide treatment under inhalation sedation, following suitable training and competency assessment.

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

Workforce planning for Special Care Dentistry is vital as the skills required often take many years of experience to obtain, in addition to training pathways and qualifications.

The current specialist workforce is uneven in its distribution, with most being concentrated in Greater London and the North West. This is a result of the transition arrangements when the specialty was established, rather than needs based approach. In addition the age profile shows that almost 50% of the specialists which equates to 146 are likely to retire in the next 10 years, but only 21 are currently in training. Future training needs to align to the population needs.

A further issue is the low number of consultants in post (fewer than 40) which limits consultant provision and training of new entrants to replace potential leavers from the specialist list. In addition, the enhanced role of MCNs in overseeing local provision of specialist care, including Special Care Dentistry, means a further pressure on consultant time and expertise available.

A significant number of specialist service providers are involved in the delivery of clinical training and education for a variety of sectors including dental undergraduate and postgraduates and dental hygiene and therapy courses.

[1] https://www.bda.org/dentists/advice/working-in-the-salaried-services/spdcs/Documents/spdcs_-_summary_agreement__-_november_2007.pdf

4.3.2 Training

Competent primary care delivery at Level 1 complexity depends on sufficient training at dental undergraduate level and in Dental Foundation Training / Dental Core Training.

The Education Outcomes Framework Department of Health, Education Policy 2013[2] (Gateway Reference 18774) described the framework required to measure progress in 'improvements in education, training and workforce development' in order to 'monitor the outcomes of the education and training system in the wider health and care system'.

To enable members of dental teams to meet the competencies required at Level 1 to provide care for patients with special care needs, it is important that dental schools, universities and other training centres incorporate Special Care Dentistry within their curricula as a specific specialty subject.

Development of clinical Special Care Dentistry skills and competencies in undergraduates relies on additional learning opportunities. Some provider services deliver teaching of undergraduates as part of their service offer. This should include teaching and exposure to Special Care patients.

4.4 Description of the complexity levels

The Department of Health advanced care pathway working group defined procedures and modifying patient factors that describe the complexity of a case. The levels of complexity do not describe contracts, or practitioners or settings. Levels 1, 2 and 3 care descriptors reflect the competence required of a clinician to deliver care of that complexity.

Level 1 outlines what a dentist on completion of undergraduate and dental foundation training (or its equivalence) would be expected to deliver. Therefore, Commissioners expect that level of competence as a minimum competency standard for performers on the NHS performer list. Most practitioners develop interests, skills and competence with experience. The majority of General Dental Practitioners operate above this level in a number of the specialist areas including Special Care Dentistry.

This guide outlines the strategic framework for delivery of a Special Care Dentistry patient care pathway. Many practitioners in primary care who are not on the specialist list deliver care at Level 2 complexity. Commissioners expect the same standards of quality and outcome regardless of provider or setting. Every practitioner delivering Level 2 care complexity on referral will be expected to have a formal link with a consultant-led MCN.

The care pathway is based on three levels of case complexity:

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175546/Education_outcomes_framework.pdf

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

Level 2 – 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 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 - Special care needs that require management by a dentist recognised as a specialist in Special Care Dentistry at the GDC-defined criteria;

Level 3b - Special care needs to be managed by a dentist recognised as a specialist in Special Care Dentistry at the GDC defined criteria and holding consultant status.

4.4.1 Levels of Care

Level 1 Care

As with other specialties, the majority of Special Care Dentistry patients will initially be seen within primary care dental services. This is within the remit of a provider of NHS primary dental care mandatory services as defined above and within minimum service specification. It is challenging to describe the Special Care Dentistry scope of practice for a provider of Level 1 care. Within this specialty, complexity may relate to the patient and their specific additional needs, as opposed to the planned dental procedure. Clearly this is very varied and likely to change, dependent on the clinical situation and over time.

Whilst the complexity of this particular group of patients may necessitate more specialised care for operative interventions e.g. conscious sedation, general anaesthesia, providers of primary care are integral to the provision of basic care, appropriate preventive intervention and continuing care. Due to challenges of providing treatment in this group, the importance of good prevention cannot be over-emphasised. Primary care teams should focus on providing high quality and effective oral hygiene and diet advice, fluoride therapy and, where appropriate, liaise with carers to facilitate this.

Services should provide clear information regarding their facilities to inform patient choice. Providers of Level 1 care should make reasonable adjustments to facilitate access for Special Care Dentistry patients in terms of time, equipment and facilities. All patients should be treated with equality, respect and dignity.

Dentists need to be conversant with current guidance relevant to Special Care Dentistry patients, for example safeguarding training, obtaining consent and management of patients taking certain medication. Patients suitable for management within routine primary care should be treated safely and effectively and not disadvantaged through inappropriate and unnecessary referral.

Whilst Special Care Dentistry patients may receive the majority of their care from primary dental care teams providing Level 1 care, it is recognised that the diverse needs and complexities of this patient group (e.g. access, communication, cooperation and medical issues) might necessitate shared care for a short period of time or a specific treatment episode. Providers of Level 1 care need to appreciate their own level of competence and make clinical judgments based upon knowledge, evidence and risk assessment. Appropriate referrals should be made to Special Care Dentistry services in a timely fashion and in accordance with local protocols.

In some cases where contractual frameworks, infrastructure, team experience and training allow, conscious sedation techniques might be used to facilitate routine treatments within a primary care setting. In addition, providers of Level 1 care may be able to deliver treatment for Special Care Dentistry patients following the provision of a treatment plan from a Special Care Dentistry specialist provider.

The need and demand for Special Care Dentistry is expected to increase over time. Many Special Care Dentistry patients have and will wish to maintain a long-term continuing care relationship with their local practitioner. The general dental practice team provider is an essential member of an evidence-based, preventive-focused care pathway.

Level 2 and 3 care

All Level 2 and Level 3 care providers will take an active role in the consultant led MCN

Casemix category	Level 2 care: Dentist with enhanced skills or experience	Level 3 care: Registered Specialist/ Consultant
Communication	Significant communication difficulties due to multi-sensory or cognitive impairment	No verbal communication ability due to severe cognitive impairment
Co-operation	Presents with a disability, psychological or mental health state that means: • only limited examination is possible • significant treatment interruption due to inability to co-operate, inability to tolerate procedure or inappropriate behaviour resulting in only a limited examination May require: • Advanced anxiety and behaviour modification techniques, e.g. progressive desensitisation, Cognitive Behavioural Therapy • Conscious sedation for moderate phobia / gagging, or concomitant disabling/ medical / mental health condition	Presents with severe disability or mental health state that prevents them from co-operating with dental examination and/or treatment. May require: 1. Specialist experience of managing combative, agitated or inappropriate behaviour in patient at risk of harm to self or others 2. Basic/Advanced sedation techniques dependant of level of co-operation, anxiety and treatment required 3. Assessment of patient requiring dental treatment under GA 4. Significant clinical holding involving Level 2 or 3 holds / multidisciplinary working

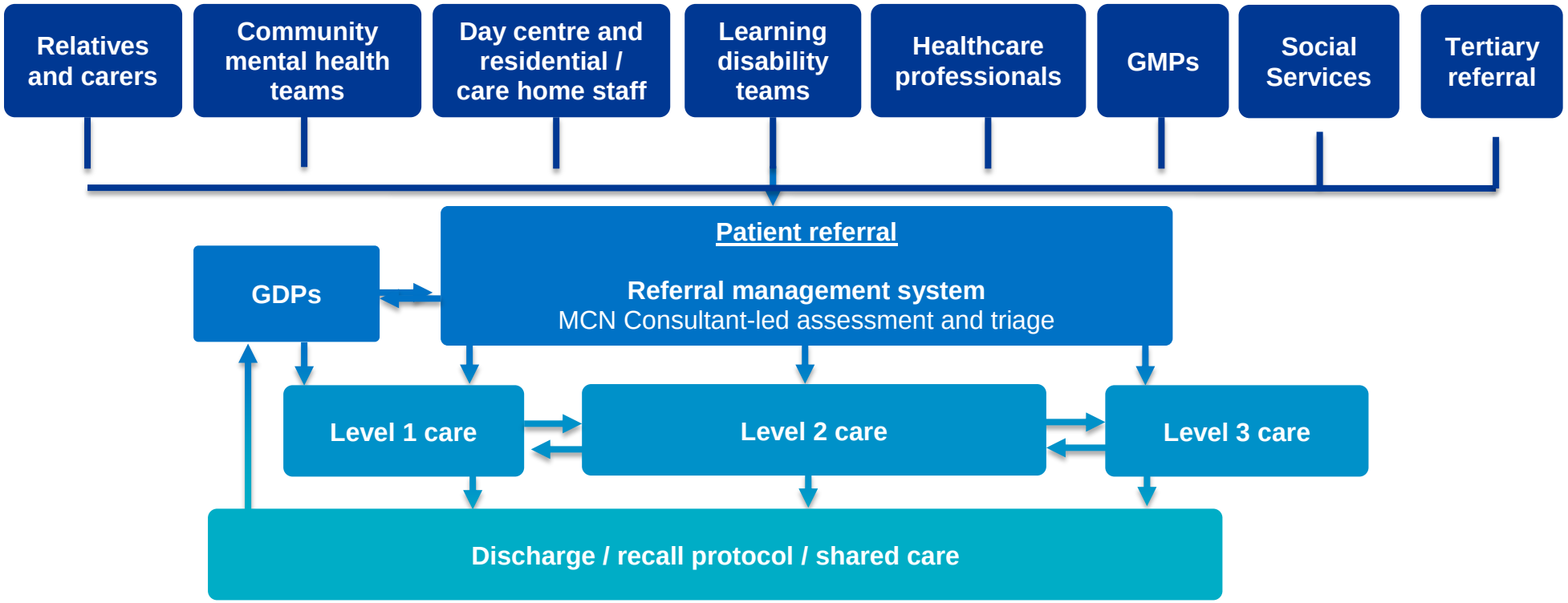
	• Clinical holding of patient should only be undertaken following risk assessment and by a dental team with appropriate training in clinical holding [3]	
Medical	ASA 3 moderately controlled medical condition(s) Progressive degenerative medical/ disabling condition: intermediate stage where specialised service of risk assessment is required • Management under specialist supervision	ASA 3 unstable and ASA 4 medical condition i.e. significant risk of medical emergency Progressive degenerative medical / disabling condition: advanced stage May require: • multifactorial / multispecialty medical risk assessment • treatment in medically supported hospital setting • use of conscious sedation in ASA III/IV conditions • shared medical care e.g. haematology, radiology, oncology, cardiology, respiratory medicine
Access	Requires NHS transport to access dental surgery and/or special equipment to transfer to dental chair (manual handling risk assessment, hoist)	Patients who require secondary care facilities for access
Oral risk	Oral hygiene requires support of third party	Access to oral cavity for dental treatment severely restricted by major positioning difficulties, inability to open mouth, or dysphagia problems Patient unable to tolerate home oral care provided by 3rd party Requires multi-disciplinary management of oral care with high risk factors for oral disease
Legal and ethical	Best interests require 2nd clinical opinion Doubtful or fluctuating capacity to consent, clinician required to make best interest decision and consult/ correspond to do so	Patients requiring a Deprivation of Liberty standard or a court decision regarding their oral care. Clinician required to make a non-intervention decision where there is extreme difficulty in providing care and it is not in the patients best interests to provide active treatment

[3] http://www.bsdh.org.uk/userfiles/file/guidelines/BSDH_Clinical_Holding_Guideline_Jan_2010.pdf

The levels described in this document refer to the complexity of the case with regard to procedural and/or patient modifying factors and the skill set and competencies of the provider and / or their team and not the setting where care may be delivered.

Competencies of clinicians for each of the three levels of care are described in a competency framework Appendix 2.

Figure 4.1. Summarised illustrative patient journey



People with additional or special care needs may receive most of their care from a GDP for most of the time. Occasionally they may have an exacerbation of their condition, or require treatment that requires more specialised management, and may require a referral. This shared care may be for a short period of time or for a specific episode of care. Once the episode of care or period of time has ended, they may safely be discharged back to their GDP for routine care and monitoring.

However, there are patients whose condition is such that they will always require either specialised or specialist care. In these circumstances it will not be possible for their routine care to be provided by a General Dental Practitioner and so they will be cared for by a more specialised service.

For some patients, it may be appropriate for shared-care arrangements to exist, where a specialist or consultant supports a GDP with treatment planning or patient management advice.

5 Assessing need for Special Care Dentistry

This section of the commissioning guide describes how the need for special care dental services can be assessed and signposts relevant information to inform the needs assessment. The UK population is increasing, ageing and becoming more diverse and all of these changes have implications for commissioning special care dental services. Assessing oral health needs for special care dental services is complex as the needs reflect the wide range of disability and complexity of disability within this client group, rather than the complexity of a dental condition, for example the treatment complexity of misaligned teeth.

A needs assessment should be completed, working closely with a consultant in dental public health, Public Health England and the Local Professional Network (LPN) as part of the commissioning process. It 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.

5.1 Oral health needs in special care groups

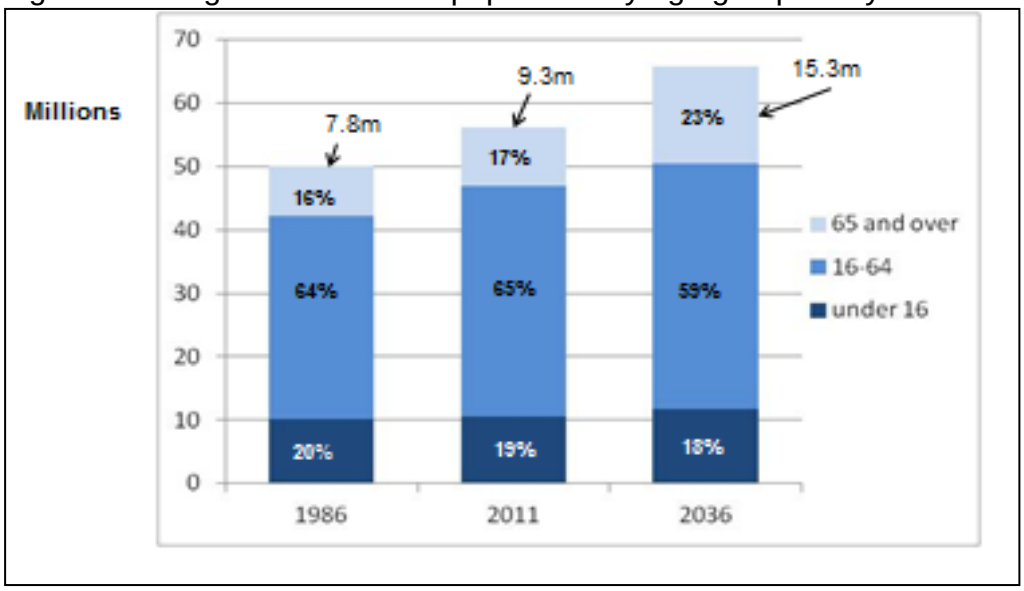
Special care groups experience varying levels of disability and ill health and there is a spectrum of need and complex additional care needs across the population. Importantly, disability does not imply need and, for many people, treatment can be provided within the general dental practice setting, whilst those at the more severe end of the spectrum may require more specialised Special Care dental services[4].

5.2 Older people

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 5.1).

[4] British Society for Disability and Oral Health (2006) Commissioning tool for Special Care Dentistry. http://www.bsdh.org.uk/guidelines-and-publications/Guidelines_Publications_Journals.php

Figure 5.1. England and Wales population by age group and year

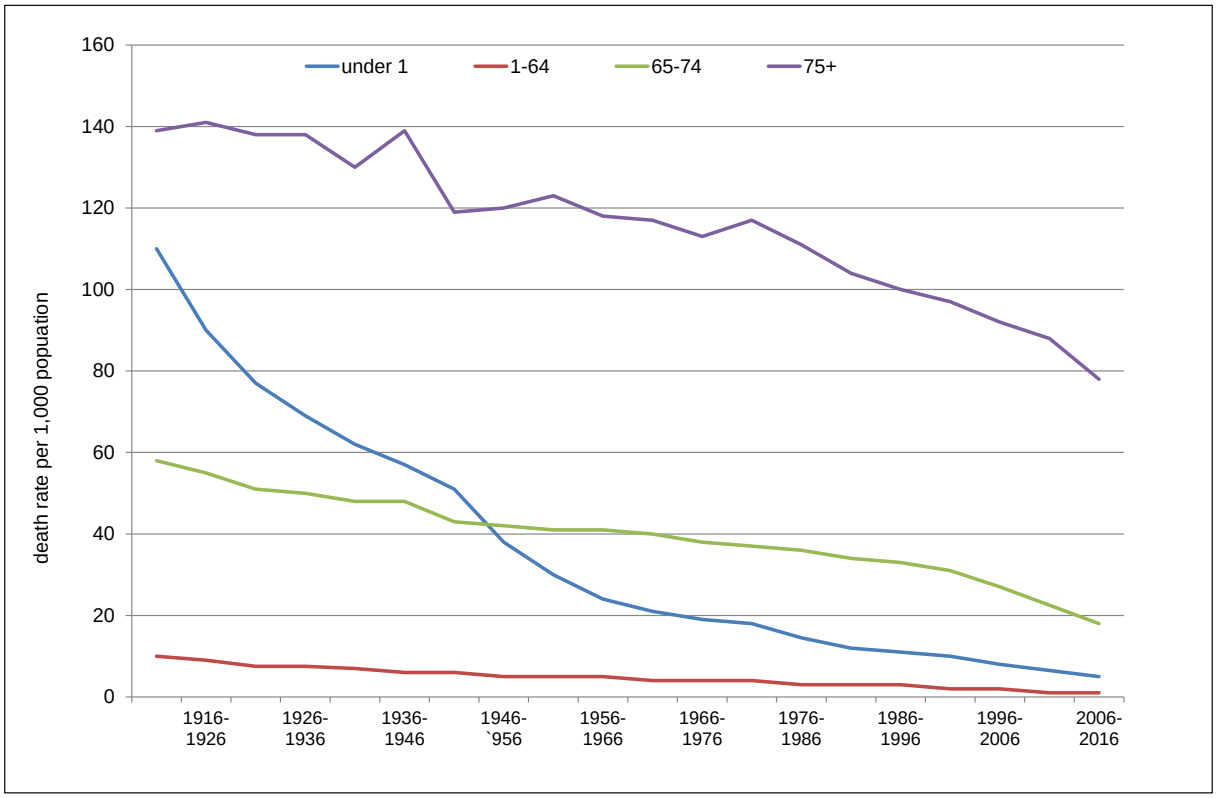


Source: ONS, 2013

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 5.2) combined with a decline in increasing life expectancy and overall past decline in fertility rates. In England, the proportion of the population aged 65 years and over is expected to increase from 17% in 2010 to 23% in 2035[5]. This older population is also increasing in diversity with increasing numbers of black minority ethnic older people, as first and subsequent generations reach older age.

[5] Office for National Statistics (2013) Population Ageing in the United Kingdom, its Constituent Countries and the European Union. http://www.ons.gov.uk/ons/dcp171776_258607.pdf

Figure 5.2. Drivers of population ageing



Source: ONS, 2013

Information describing population estimates and population trends can be sourced from the Office for National Statistics.

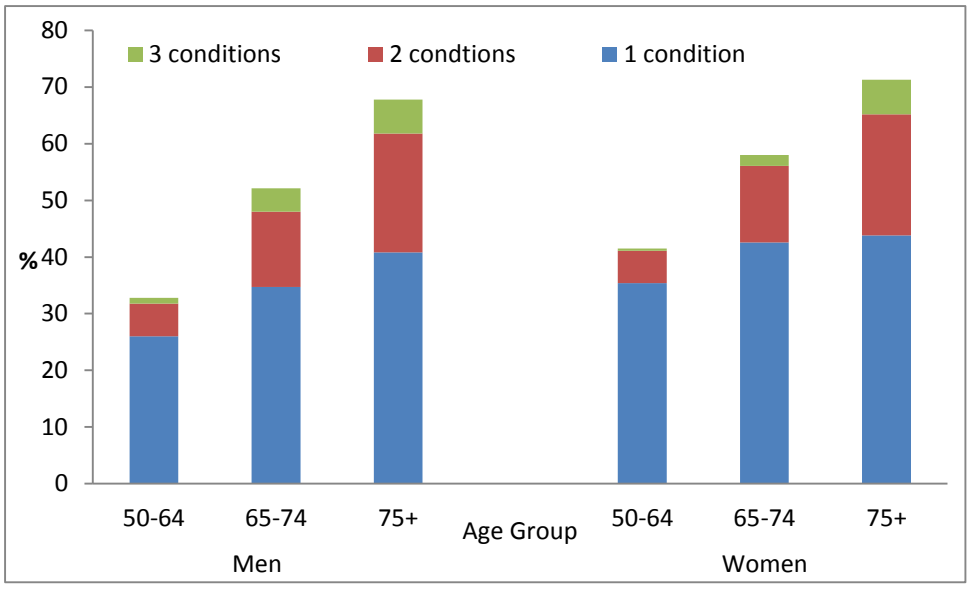
Information describing the number of older people living in nursing homes based upon GP registration data may be accessed via the Health and Social Care Information Centre and the Projecting Older People Population Information System (POPPI).

Older people have increased levels of dental caries (tooth decay), periodontal (gum) diseases and tooth wear. They are also more likely to have fewer natural teeth and to wear a denture. Information on the oral health of older people is available from the National Adult Dental Health Survey.

Older people are also more likely to have limiting long-term medical conditions and the likelihood of having more than one condition increases with increasing age (Figure 5.3)[6].

Figure 5.3. Proportion of the older population with one or more medical conditions, by age group and gender

[6] English Longitudinal Study of Ageing (2009) http://www.elsa-project.ac.uk/

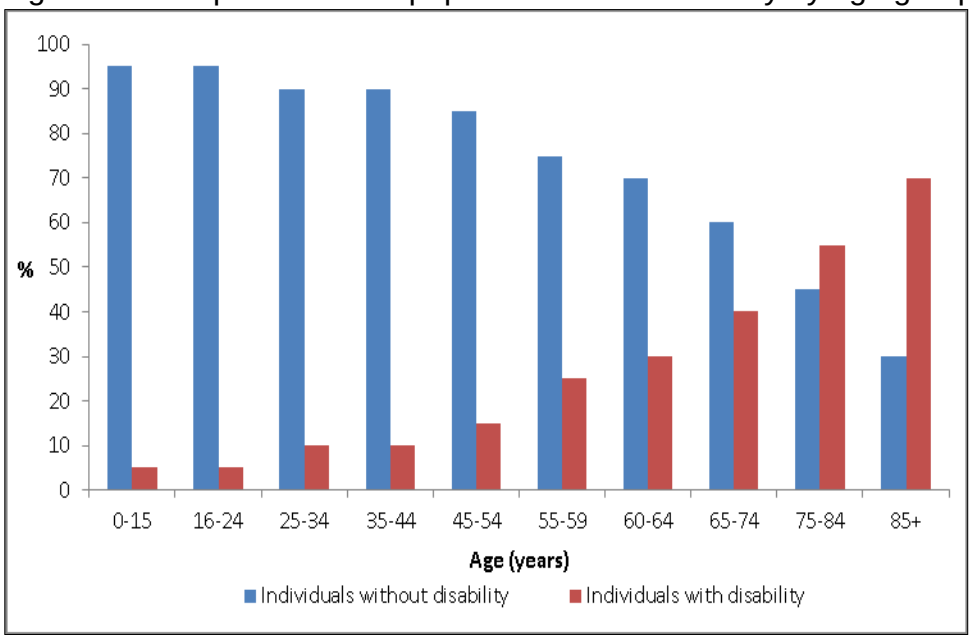


Source: ELSA, 2009

5.3 Disability

Approximately 1 in 5 people in the UK are classified as disabled. Only 17% of disabled people are born with an impairment and there is a strong correlation with age and the majority of people acquire impairments in later life (Figure 5.4).

Figure 5.4. Proportion of the population with a disability by age group



Source: Age UK, 2012

Disabled people tend to live in more deprived areas, primarily due to lower incomes and social housing allocation policies. Geographically, the largest percentage of disabled adults in England live in the North East (34%) and North West (31%) with lower percentages in London (25%), the East (27%) and the South East (27%). The prevalence of impairments 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.

5.3.1 Learning Disability

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[7]. The Public Health England *Improving Health and Lives – the Learning Disabilities Observatory* provides learning disability profiles available at a local authority level, which include the number of people with learning disabilities[8].

Further information is available from the Projecting Adult Needs and Information System (PANSI)[9].

5.3.2 Mental Health

Mental health problems are one of the most common health conditions. Each year, approximately one in four adults in the United Kingdom will have mental health problems and one in six experiences this at any given time[10] and one in ten children needs support or treatment for mental health problems. 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 lost all their natural teeth and have higher levels of tooth decay than the general population. This may be as a result of medications used to treat their mental health illness. People with severe mental illness are also less likely than the general community to access dental services[11]. 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. Adults in secure mental health accommodation have particular difficulties in accessing dentistry.

Information on the number of people in the population with mental health problems is available from the Health and Social Care Information Centre[12].

5.3.3 Adults with severe dental anxiety

People who are unable to tolerate treatment under local anaesthesia alone have a spectrum of needs. Many can receive treatment in general dental practice, but others

[7] Emerson E and Baines S (2011) Health inequalities and people with learning disabilities in the UK. http://www.emeraldinsight.com/doi/abs/10.5042/tldr.2011.0008
[8] http://www.improvinghealthandlives.org.uk/profiles/.
[9] http://www.pansi.org.uk
[10] Singleton et al. (2000) *Psychiatric morbidity among adults living in private households*. London, Office for National Statistics.
[11] Kisely et al. (2011) Advanced dental disease in people with severe mental illness: systematic review and meta-analysis**.** *British Journal of Psychiatry*. 199 187-93.
[12] http://www.hscic.gov.uk/searchcatalogue?topics=0%2fMental+health&sort=Relevance&size=10&page=1#top

need care at specialist level from the specialty with the most relevant remit. Therefore, people needing general dentistry procedures with concomitant medical, disability or mental health problems should be referred to Special Care Dentistry; those requiring specialist Restorative or Oral Surgery procedures should be referred to these specialties. Those with dental phobia at the severe end of the spectrum such that it has prevented them from accessing dental care may be referred to Special Care Dentistry by their GP or urgent care services.

The services provided should integrate the use of behavioural management techniques including cognitive behavioural therapy (CBT) with conscious sedation and, if necessary, general anaesthesia; and fully utilise the skills of trained dental nurses. In addition, all specialist training programmes should incorporate training in managing patients with severe anxiety.

5.4 Dementia

The prevalence of dementia is increasing and dementia is now a public health priority[13]. Dementia affects over 830,000 people in the UK. Around 23 million of the UK population has a close friend or family member with dementia[14].

Approximately 5% of people aged 65 years or older live in institutions and it is estimated that 62% of these people will have dementia. This will have implications for the type of care that should be provided.

5.5 People with medically compromising conditions

A range of common medical conditions compromise the ability to carry out the physical activities of daily living when they are severe or poorly controlled. As disease becomes increasingly restrictive, oral health tends to be neglected and people may present to services in a crisis situation with extensive oral health needs. It may be necessary to commission tertiary services for these people from specialised centres.

Coronary heart disease, respiratory disease, diabetes, hypertension, transient ischaemic attack and liver failure are some of the conditions that have implications for dental treatment. They often exist together as co-morbidities. This requires careful risk assessment to evaluate the impact of dental treatment to minimise the risk of triggering a medical emergency or the healing or bleeding complications that may arise from their medical condition or from the side-effects of their medication. Some will need the care of a specialist in Special Care Dentistry, sometimes involving other medical/dental specialties, conscious sedation and treatment in a medically supported setting.

5.6 Bariatric groups

[13] Public Health England (2014) Big ambitions https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319696/Business_plan_11_June_pdf.pdf
[14] Alzheimer's Research UK (2015) http://www.alzheimersresearchuk.org/dementia-statistics/

Being overweight and obese are defined as abnormal or excessive fat accumulation that may impair health[15]. The World Health Organisation 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 and lowest in those in the highest income quintile. There are no significant differences in the prevalence of obesity in men from different income groups[16]. Obesity in adults is associated with cardiovascular diseases, diabetes, musculoskeletal disorders and some cancers[13]. Obesity in children is linked to long term physiological and psychological health risks and can persist into adulthood[14]. The estimated cost to the NHS of excess weight is £5 billion each year[17].

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.

5.7 Additional factors determining need

The need and demand for Special Care Dentistry is expected to increase over time. Influencing factors include changes in the demography of the population, health and dental service delivery, public values and patient expectations. Specific factors include:

- Lower mortality rates of children with complex disabilities and increasing numbers surviving into adulthood;
- Increased life expectancy of people with disabilities;
- Improvements in medical care; and,
- Increasing number of older people who are more likely to develop disabilities coincidentally or as a consequence of ageing[2].

In order to predict demand for services, it is important to relate the population proportions to actual population figures. This is particularly important given the projected UK population increase between 2010 and 2020[18]. Traditionally, the NHS dental epidemiological programme and the decennial adult dental health surveys have not routinely collected information describing the oral health of adults with additional or special care needs. More recently, local supplemental surveys of adults with learning disabilities and adults in contact with domiciliary services have been carried out in some areas in England. Analysis of the data is currently being carried out.

[15] http://www.who.int/mediacentre/factsheets/fs311/en/
[16] HSCIC (2013) Health Survey for England 2012 http://www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch11-Child-BMI.pdf
[17] Department of Health (2011) *Healthy lives, healthy people: a call to action on obesity in England* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213720/dh_130487.pdf
[18] http://www.ons.gov.uk/ons/rel/npp/national-population-projections/2010-based-projections/stb-2010-based-npp-principal-and-key-variants.html

6 Understand current provision

At the same time as carrying out a needs assessment, Commissioners need to understand their current position, so that gaps and duplication can be identified. Prioritisation of resource is important.

Below is a Toolkit to aid identification of what is currently being provided, its value and quality. This table can be replicated for each provider.

6.1 Service analysis

Special Care Dentistry: Provider Number details		
Name: Main contact address:	Contract type: PDS; CDS; HDS Contract value: Contract currency (UDAs unique patients etc.) and numbers	Service specification available? Y/N What other services does the provider deliver as well as Special Care Dentistry?
Other locations from where services are provided:		
Location 2	Number of surgeries	Facilities/Treatment modalities available:
Location 3	Number of surgeries	Facilities/Treatment modalities available:
Acceptance and waiting time information		
What are the patient acceptance criteria? (Including transitional arrangements)	What are the waiting times for treatment for: Routine care: Day case: Admitted care: Urgent care:	What are the discharge criteria? What is the referral pathway?: Is paperwork available?
Number of patients on	Number of registered	Number of referrals per

waiting lists for: Assessment: Treatment: Recall:	patients (do not include those treated on referral and discharged)	month (average)
Staffing information		
Number of qualified dentists:	Number of dentists of the specialist list:	Number of consultants:
Number of dental therapists:	Number of dental hygienists:	Number of dental nurses:
Operational Information		
Opening hours	What are the arrangements for urgent care?	What are the arrangements for public holidays?
Quality Information		
Are CQC inspection reports available? Y/N	Does the contract include quality KPIs? Y/N If yes what are these? Are reports available? Y/N	Are patient experience measures collected? Y/N If yes what are these? Are reports available? Y/N
Is Casemix information available? Y/N	Is there a managed clinical network for Special Care Dentistry? Y/N Name of chair:	Do all staff have a formal link to the MCN (if available) Y/N

7 Transforming services

The NHS Five Year Forward View, published in October 2014[19], states *'Increasingly we need to manage systems – Networks of Care – not just organisations';* this aligns with the purpose of this Special Care Dentistry commissioning guide. These services need to be integrated and delivered around the needs of patients, not organisations or training programmes. NHS England Commissioners need to work with MCNs to break down barriers, to how care is provided between primary and community care and hospitals. The Five Year Forward View is particularly relevant for Special Care Dentistry. It aims to focus on creating and protecting health not just treating ill-health and providing isolated episodes of care.

Current inefficiencies in the system are recognised, but this commissioning guide is not just about reducing costs, but releasing resource from one part of the system and using it more effectively in the dental system. It is intended to support a change in culture. This guide is about supporting Commissioners, providers and clinicians to work together to ensure that resources invested by the NHS in Special Care Dentistry 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.

As responsible clinical stewards, consultants and specialists in Special Care Dentistry can assist in leading change and provide a more effective use of constrained resources by broadening their influence with colleagues in primary care clinicians.

The focus is on commissioning the entire dental pathway as a single, consistent, and integrated model of service delivery. This reflects that, as a general principle, the NHS should be offering the same high standard in terms of quality, value and outcome of care wherever in the country it is delivered.

This commissioning guide recognises that 'One size does not fit all' and is intended to stimulate debate and action locally. However, transformational and transactional change is required in the delivery of Special Care dental services and Commissioners are encouraged to review need and local current services, using the enablers set out in the patient journey within this guide as a benchmark, to set pace and direction locally. An assessment of how much progress has been made locally should be the first step and a priority for Commissioners. People who need Special Care Dentistry should have access to out of hours advice and care where this is indicated. Commissioners will need to ensure that this group of patients are not forgotten when reviewing their commissioning for out of hours care.

The NHS is moving towards seven day working and Special Care Dentistry will need to plan to respond to this challenge. The MCN may provide a workable solution that will be dependent on local needs and circumstances. The detail of this will need to be considered as part of the implementation phase.

[19] http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

7.1 Service Redesign

Delivering care for people with additional or special care needs may require a redesign of the overall local system of services, depending on the level of care required. One mechanism for achieving this is the establishment of a MCN for Special Care Dentistry. Where a consultant in Special Care Dentistry is in post then it is expected that the MCN will be led by them with job planned time to ensure capacity and accountability. However, where there isn't a consultant in post it may be necessary to encourage providers to establish a consultant in Special Care Dentistry. It may be necessary, that where a consultant isn't available that a specialist in Special Care Dentistry undertake this role during transition.

This MCN should include consultants and specialists in Special Care Dentistry. Consideration might be given to the inclusion of other clinicians delivering Special Care Dentistry. Research has shown that the success of such a network is dependent on the drive, energy and commitment of the lead clinician[20].

Working in partnership with Commissioners, the MCNs need to use the current Service Analysis and the needs assessment, plus local knowledge to design an integrated system (including hospital, community and primary care providers) for delivering the levels of care required. The MCN will need to consider referral flows and adopt a consistent acceptance and discharge criteria based on the levels of care included in this guide.

An integrated system may work on a hub and spoke basis, with a number of centres where more complex care can be provided, equipped for Level 2 or 3 care and staffed by Specialists or Consultants in Special Care Dentistry. These are likely to be multi-surgery centres, so that the extended dental team can work under the leadership of a specialist and training/support can be offered to primary care practitioners wishing to extend their skills. The location of the hub centres and how these relate to the other locations where Special Care Dentistry is delivered will need to be considered by the MCN and Commissioner offices in partnership with the LPN, Health Education England (HEE), PHE and patient and carer groups. The solutions may be different in urban and rural communities.

Shared care between primary and specialist providers must be facilitated, so that patients benefit from cohesive service provision.

The role of early prevention in the care of people with additional or special care needs must be emphasised and enhanced. Often these patients are the most challenging to treat and so preventing the need for interventive treatment is cost effective but more importantly safer and more beneficial for the patient and carer. Making prevention work in practice involves more than fluoride application. It involves ensuring that preventive messages are tailored to meet the needs of individuals and should include oral health advice like tooth brushing instruction, diet advice, lifestyle advice, as well as clinical preventive interventions. Prevention can often be carried out in patients' homes and in spoke locations, avoiding the need for travel and transport. Care of patients with additional or special care needs often takes longer due to the nature of their presenting problems and additional needs. As well as

[20] Skipper, M (2010) Managed Clinical Networks. British Dental Journal 209(5), 241–2.

informing patients, there is often a need to ensure that carers are aware of the preventive messages and able to support the self-care needed.

With appropriate training, dental nurses can undertake preventive care as described above. Use of dental hygienists and therapists as part of a larger team can allow the specialists to carry out treatment planning, support of the team and more complex or challenging treatment cases.

People with additional or special care needs often use a wide variety of other health and social care services. Self-care for these patients should be integrated in the delivery of the pathway. The MCN should promote the inclusion of an oral health assessment and preventive care plan for all people with additional Special Care Dentistry needs. They may wish to work more collaboratively with their LPN to ensure the wider implementation addressing inequity and inequalities.

As a guide, the geographic area covered by the MCN is likely to need a range of services and facilities. The locations of care need to be considered and included in the hub and spoke model, so that more specialised equipment or services are available to patients at locations within an acceptable travelling distance.

All providers need to be able to offer oral health assessment, prevention and advice, for primary care.

Across the MCN geographic area there will be a need for providers to be able to offer a breadth of services which will require specialist equipment and skills such as conscious sedation, Cognitive Behavioural Therapy (CBT), secondary care facilities for the treatment of patients under General Anaesthesia, wheelchair recliners and hoists and bariatric facilities.

Domiciliary care should be available against a clear set of criteria, consistently applied and developed in partnership with the Commissioners, the LPN and patients by the MCN.

Consideration should be given to the use of new and emerging technologies e.g. Skype and teledentistry, may be particularly useful for patients with mobility and access concerns. It can certainly have a place in respect of prevention programmes.

Critical to the successful delivery of Special Care Dentistry are good working relationships at a local level between the dental provider and social care agencies involved in the care of an individual, for example, social services, mental health care providers, residential and day care providers and local voluntary organisations. Commissioners need to understand that this activity is necessary and requires resourcing. Additionally, development of MCNs will play a pivotal role in ensuring that the oral health needs of patients with additional needs are met. An important remit of the MCN will be to promote the implementation of relevant clinical guidelines and service frameworks. The development of appropriate outcome measures and benchmarking service delivery and quality of care will promote the adoption of examples of good practice within the network. Furthermore, the implementation of care pathways, agreed protocols for referral and improved communication between clinicians will ensure the delivery of safe, reliable care within an agreed time frame.

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

7.2 Workforce implications

There are implications for the future work force and training in the transformed services. Clinical leadership will be essential, both in running the MCN, but also in delivery of care involving the extended dental team.

It is recommended that a skills audit is undertaken by the MCN and a training development plan put in place, in conjunction with HEE locally, for the existing members of the workforce.

Workforce planning should follow development of the MCN plan for service delivery and the skills audit (which itself should follow the needs assessment and current service review). The workforce details, Appendix 3 clearly show that the current Special Care Dentistry workforce will see a sharp decline in the next 10 years and therefore the number of consultants and specialists and those in training will need to be increased in line with need. However numbers will vary across England and it will be necessary for each MCN in conjunction with the Commissioners and HEE to consider the local requirements.

One consultant per MCN should be the minimum, with succession planning put in place. Practitioners providing Level 2 care will need to be formally identified and their capacity, location and skill set compared to that which is needed.

It is likely that existing DCPs will need more training, in particular to work with people with additional or special care needs and deliver prevention at locations remote from the dental surgery.

Involvement of the wider healthcare team will also have training implications, as will a focus on self-care for patients and their carers. However, Special Care Dentistry needs to meet this challenge and take prevention seriously to reduce reliance and need for interventional treatment that is costly and may have serious implications for patients' health and wellbeing.

In order to address the challenges and need for change, an appropriately developed Organisational Development (OD) programme and consultant training to build leadership capacity should be considered. This would support the cultural change required in setting up this system.

7.3 Challenges and enablers

The incomplete knowledge about current provision provides the greatest challenge to service redesign and engagement of the current workforce to solve this will be essential.

The establishment of a robust MCN for Special Care Dentistry will involve time and resource. This will provide the engagement and clinical voice to improve capacity and

quality to influence the service commissioned and ensure care provided is aligned to local needs and agreed pathway for accessing specialist services.

Workforce challenges about number and location of consultants and specialists have been outlined above. Training of the current workforce is patchy; more and consistent training is required for the entire dental team.

Technical challenges include the different IT systems used that don't communicate with each other, making referral around the pathway and shared care difficult. Ensuring all Special Care Dentistry dentists and primary care providers have nhs.net email addresses is essential. Web-based solutions to data transfer may then be enabled.

Cultural changes include the greater use of DCPs and engagement of the dental workforce with the wider healthcare workforce and vice versa. An Organisation Development approach could be used, including clinical leadership and other non-clinical training and development.

Structural changes include the estate necessary for new ways of working; for example, use of the wider team, provision of care closer to home and establishment of specialist centres with equipment necessary for more complex cases. This will require imaginative solutions, and may require capital investment.

Variations in the current coding systems make it difficult to collect accurate data about patients accessing Special Care Dentistry services. Special Care Dentistry patients, especially those managed under GA, are often coded to other dental specialties e.g. Oral Surgery, Restorative dentistry, or anaesthetic consultants making data unreliable. They are more likely to be coded to any of the other dental or anaesthetic consultants, particularly around GAs. There needs to be consideration given to the establishment of specialty specific tariffs and use of the specialty code to identify specialist provision and complexity of procedure and patient. Any coding changes need to be consistent across both secondary and primary services. Coding and capture also need to improve within primary care to smooth the transition of shared care, episodic care and 'hand on hand off' interactions between Special Care Dentistry and GDPs. Predicting declining or increasing dependency and preventing patients slipping through the net needs to be better communicated and formally agreed between Primary Care and Special Care dental services.

7.4 Data Collection

The illustrative patient journey below describes a number of performance data collection items which providers will need to generate themselves and which will require local performance management from Commissioners with support and engagement from a MCN. Commissioners can also, with support from an MCN, generate much of the needs assessment information required. However, in the next year, nationally work will be carried out to enable much of the data collection to happen. For example, development of the FP17 to include Casemix data will enable

the BSA data currently provided to be triangulated against current information. See Chapter 12 of the accompanying overarching introductory framework.

8 Illustrative journey of a patient

Primary Care Services			
Illustrative Patient Journey	**Standards**	**Metrics**	**Enablers**
<u>Information about services</u> Patients can find information about local dental services suitable to their additional needs. Commissioners must ensure that information on Special Care Dentistry is available wherever patients are likely to seek it	Dental practices and specialist providers ensure information about the services they provide is readily accessible in web based and written forms[21]. Specialist providers ensure: • their service name is appropriate to role • key intermediaries have referral information including specialist nurses, medical specialists, local charities/ patient groups	'Mystery shopper' Web search to locate information availability on: • acceptance of new patients for NHS care • accessible premises and related facilities • domiciliary care • specialist services including acceptance criteria and referral process.	MCN in Special Care Dentistry: • under the umbrella of a LPN • led by Consultant in Special Care Dentistry and included in their job plan • involves Commissioners • involves Consultant in Dental Public Health re local population needs assessment • communicates with GDS/PDS primary care contractors • leads local service communication strategy which involves public information providers to include service information on: NHS Choices website NHS 111 operator information LDC websites NHS trust websites • Interdependency of MCN with clinical networks including those for long term conditions and dementia

[21] http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

Primary care provision Adults with a mild to moderate physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors receive continuing primary dental care in General Dental Practice	Providers of GDS/PDS primary care ensure provision of a level of care that patients in these groups can reasonably expect. In doing so they should: • be aware of current guidelines relevant to Special Care Dentistry. • understand the importance of prevention for these groups for whom dental disease or the consequences of its management places them at additional risk. • be familiar with specialist Special Care Dentistry services available locally and refer appropriately. It is recognised that: • there is a spectrum of need and complexity which means shared care is appropriate in some cases • the threshold for referral varies between clinicians according to experience. They have a duty of care to be aware of the boundaries of their own competence as well	Practice policies and procedures include reasonable adaptations to accommodate the additional needs of patients in these groups Number and % of patients on practice database with a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability % treatment plans which include diet / fluoride advice, and oral hygiene support Complaints, comments about service access for patients with additional needs (role for disability / patient groups) All other expected standards in the GDS contract/PDS agreement. Metrics are already covered in the existing Dental Assurance Framework.	Practice IT systems collect and report this information GDPs and LDC engages with MCN to achieve representation of local GDPs Practice systems to include the ability to record patients with a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability MCN engages with local deanery in making available: • awareness training for GDPs on local Special Care Dentistry referral guidelines • Signposting to guidelines relevant to Special Care Dentistry Specialist providers engage and support GDPs in the continuing care of appropriate individual patients with additional needs.

	as the need to avoid discrimination [22] by referring people whose needs can reasonably be expected to be met in mainstream services.		

Referral to Specialised Service			
Illustrative Patient Journey	**Standards**	**Metrics**	**Enablers**
Referrer completes the referral form ensuring required data set is complete, to include: • medical history • social/mental health history • disability needs • IOSN/ Casemix tool as appropriate • radiographs Information regarding referral process explained to patient and/or carer. Responsibility for care of patient remains with referring dentist until seen and accepted for care by specialist service and shared care arrangement may be agreed.	Decision to refer is appropriate i.e. meets referral criteria Referral made within one week, unless patient requires urgent treatment when referral to be made the same day Patient/carer information about specialist referral provided at the point of referral (NHS England approved) Patient is given choice of specialist providers where options exist. Specialist services to accommodate rapid response for those patients who require urgent assessment	% of referrals received that: • have complete referrer details • have complete patient demographic and contact details • are appropriate to acceptance criteria % of patients/ carers: • informed about specialist service referral • referred within 1 week of decision to refer • referred the same day, if urgent.	Referral acceptance criteria and adherence to NHS England Special Care Dentistry referral guidance Referral guidance and the requirements of minimum data set communicated to referrers Electronic pro-forma and referral system. Referral IT system able to produce reports on referral patterns by practice and practitioner

[22] http://www.gdc-uk.org/Newsandpublications/Publications/Publications/Standards%20for%20the%20Dental%20Team.pdf

Triage of referrals			
Illustrative Patient Journey	**Standards**	**Metrics**	**Enablers**
Specialist/consultant led team triages the referral to identify the complexity of the patient's needs using appropriate clinical risk assessment measures and complexity tools. Patient/carer receives information on where and when assessment/consultation will take place. Patient has choice of appointment time and location.	Referrals to be triaged within 1 week or same day if urgent referral. Triage outcome for non-urgent patients communicated within one-week to: • Patient/carer • Referrer	% Referrals that are: • triaged within 1 week • same day (urgent) • requiring Level 3 care • requiring Level 2 care • requiring Level 1 care • requiring additional facilities • rejected	Job plan of Special Care Dentistry specialist/consultant includes leading team in triage and validation of referrals Triage team according to local arrangements

Clinical assessment for Specialised care			
Illustrative Patient Journey	**Standards**	**Metrics**	**Enablers**
Clinical assessment and treatment planning undertaken under the care of a specialist / Consultant in Special Care Dentistry. Individualised risk assessments as necessary e.g. for patients with:	Clinical notes document: • outcome of risk assessments • agreed treatment plan and grade of staff providing the treatment • arrangement for continuing care needs	% patients: • treated by grade of staff • requiring specific procedures or facilities e.g. IVS /GA, hoist wheelchair tipper, bariatric facilities	Specialist providers review workforce plan, skill mix, facilities and estates planning and report via MCN Level 2 provider Service Level Agreement (SLA) in place

• ASA III / IV medical conditions • Challenging behaviour Complex manual handling / clinical holding requirements • Relevant support to Level 2/ 3 patients who fail to attend appointments to ensure they receive help in accessing services. Consider contacting safeguarding team	All records completed using key diagnostic words and procedure codes agreed toolkit.	Numbers of: • cancellations by provider. • failures to attend / late cancellations by patient. Appraisal and peer review in place and outcomes benchmarked and reported through MCN	including supervision by consultant / specialist as part of job plans Choice of provider and performance metrics published. Consistent diagnostic, procedure and tariff toolkit available and used by all providers. Consultant/Specialist led HEE to ensure that appropriate training is available to ensure a work force capable of meeting Special Care Dentistry patients' needs.

Level 2 and 3 Specialised care provision			
Illustrative Patient Journey	**Standards**	**Metrics**	**Enablers**
Adults with moderate to severe physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors can receive appropriate specialised care which is time-limited or ongoing, according to their individual needs. Communication with relevant health and social care	Waiting times to treatment start within 18 weeks or 2 days, if urgent Inter-visit length i.e. length between appointments should be appropriate to meet optimal clinical standards and sensitive to patients special needs Waiting times for GA do not exceed 18 weeks or 4 weeks if clinically urgent	Number and % of patients treated: • within 18 weeks of receipt of referral • within 2 days, if urgent Appraisal and peer review in place and outcomes benchmarked and reported through MCN % of patients	Activity reports matched against population needs assessment Local specialised services have sufficient specialised staffing and supporting skill mix Staff are given access to sufficient levels of specialised training and CPD in line with recommendations from specialist organisations and GDC

professionals e.g. GPs and consultants re: medical history Multidisciplinary assessment and care arranged as necessary Consultation with family members, advocates and carers re: best interests in those lacking capacity to consent Special arrangements made for care in appropriate service setting Patients provided with information regarding: • after care following treatment • post-operative emergency contact details	Specialised treatment undertaken to a high standard All treatment plans include prevention Timely management of problems arising during treatment Service complies with standards of environment accessibility and facilities / equipment required for Special Care Dentistry delivery, including sedation Clinical records comply with standards on record keeping, including consent process Patients/carers able to contact the service during surgery hours throughout the course of treatment	• treated in shared care model • who attend for a single course of treatment • in ongoing care arrangements % treatment plans which include diet / fluoride advice, and oral hygiene support % clinical records which comply with standards	Treatment outcome measures developed Gold standards published on equipment and environment reviewed as part of SLA. Consistent diagnostic and procedure tool used by all Level 2 care providers Clear distinction between levels of care

Discharge and Continuing care			
Illustrative Patient Journey	**Standards**	**Metrics**	**Enablers**
Arrangement appropriate to each individual made for discharge to GDP, recall or shared care	Patient / care provider has all necessary information on: • who is providing continuing care • self-care / assisted care to	**PROMs collected and reported on routinely within one month of completion of care** Through home check reporting	Adequate admin and IT support

	maintain oral health GDP informed of a patient's discharge within 1 month	and surveys • Did you get what you needed? • Did you have any problems over course of treatment? • Did you need to seek advice or assistance outside of scheduled appointments? • If the problem you were referred with caused you to be unable to eat comfortably or socialise with confidence – is that now resolved? • Would you recommend this provider to a friend	

9 Procuring services

9.1 Minimum standard specification

Commissioners may need to refer to the Guide for Commissioning Specialist Dentistry Services for details on the minimum specification for Level 1 care. The detail contained in the table below is the minimum that should be included within a specification for services. Commissioners should also consider elements such as location of services, hours of operation. The illustrative patient journey also contains details of standards which should form part of any specification.

This is not a comprehensive service specification; these areas need to be included in addition to other requirements.

Minimum Specification for Commissioning Special Care Dentistry

Level 2 Care	Level 3 Care
Facilities In addition to the requirements at Level 1, identified in the introductory guide, providers of Level 2 care should ensure that they are able to provide (not every surgery, but across the service): Hoists to facilitate patients being moved and transferred safely; Wheelchair recliner; Positioning aids should be available; Where manual transfer, hoisting or lifting of patients into the dental chair is not appropriate, equipment should be available to safely recline wheelchair patients in order to carry out dental treatment; Arrangements for transport of patients requiring more than one handler should be available (e.g. two-person ambulances); Staff trained to use them; A variety of communication aids should be available; and, Facilities for the safe treatment of bariatric patients.	Facilities In addition to the requirements at Level 1 and Level 2, premises providing Level 3 services should include: Access to facilities for providing general anaesthesia; and, Medically supportive hospital settings to enable care of people with highest medical risk.

Equipment to support the delivery of conscious sedation to the contemporaneous standard (MCN to provide advice as appropriate)	
<u>Training</u> Mental health risk assessment; Working knowledge of mental capacity Act; Moving and handling, especially of people with limited mobility; Safe use of specialised equipment e.g. hoists and positioning aids; Behavioural modification skills; Non-verbal communication methods; Accessing the mouth in people with limited ability to co-operate; Best interest decision-making; Clinical holding skills; Intermediate life support (ILS); Continuing professional development of relevance to Special Care Dentistry; Conscious sedation techniques; Certificate in Special Care dental nursing; and Certificate in dental sedation nursing, if sedation is provided; Clinical staff available within the service with additional training in CBT and hypnosis; Hygienist and therapy staff to have undertaken additional training in the care of adults with special care needs.	<u>Training</u> Training for the dental team at Level 3 should include all of the above and: Medical risk assessment; Conscious sedation techniques as applied to medically compromised patients and patients with behavioural problems; General anaesthetic clinical assessment skills; Skills to support leadership development; Skills to support collaborative working with medical specialities in secondary care including haematology, cardiology, oncology and mental health; Specialist/consultant included on specialist list.
<u>Access</u>	<u>Access</u>

Providers should provide rapid access within 48 hours for patients who require it.	Providers should provide rapid access within 48 hours for patients who require it Dedicated theatre sessions should be available each week for patients who require GA. There should be sufficient sessions so any patient who requires treatment under GA does not have to wait longer than 4 weeks
Clinical Governance As Level 1 and in addition: Providers have appropriate risk management policies and processes and be able to demonstrate how risks are monitored, reviewed and managed; Providers review clinical and other standard operating procedures on a regular basis and be able to demonstrate that this is undertaken and staff appropriately informed; Two qualified clinicians available to participate in best interests decisions when necessary.	Clinical Governance As Level 2 Clinical leadership from a Consultant in Special Care Dentistry
Information Governance As Level 1	Information Governance As Level 1 and 2

9.2 Innovation

Special Care Dentistry services would be delivered through a consultant-led MCN. Commissioners and the MCNs, operating within transformed services, would ensure that the correct level of competence, quality and outcome were achieved for patients who require Special Care Dentistry, regardless of setting.

Primary care clinicians would competently deliver Level 1 Special Care Dentistry services as a minimum, but many to develop skills and experience to deliver complexity up to Level 2 to this group of patients. They may require episodic support from specialists within a shared-care model. Supervised undergraduate clinicians would deliver an agreed proportion of Level 1 cases as part of their training.

Consultant-led support would be provided for those clinicians lacking core clinical skills (either self-referred or identified through the referral management system) to enable them to deliver Level 1 care competently.

The Special Care Dentistry pathway would ensure that primary care dental teams and other medical and social care colleagues would understand how to refer a patient. This system would comprise robust, consultant-led triage, take into account local skill mix, and efficiently direct those patients without a primary care dentist to one or for those with more complex Special Care Dentistry needs to the most appropriate provider and location.

Dentists with enhanced skills and experience or specialists would be responsible for the timely delivery of the majority of complex care in primary care. There would be consultant/specialist-led assessment/assurance of clinicians' competency to deliver care effectively.

Responsive Level 3 care would be delivered, to include care under a GA if needed.

Appropriate individual needs assessment and use of Special Care Dentistry codes in secondary care and collection of similar coding information from Level 2 primary care providers would provide more accurate data regarding local provision of Special Care Dentistry services and complexity.

Consistent use of PREMs and PROMs and quality indicators would provide data with respect to the quality of service provision, clinical effectiveness and patient experience delivered by providers. These data could be used for benchmarking and annual review of services.

10 Quality and outcome measures

This section will describe how patient experience and outcome could be measured and reported. It will also describe how the clinical improvement is captured and clinical effectiveness is measured. It will also outline how Commissioners will measure the value of the investment made in terms of patient outcomes and impact on oral health.

Quality and outcome measures used in Special Care Dentistry will be used by a variety of groups including:

- Commissioners
- Patients
- Patients' carers and families
- Profession

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

Therefore, it is proposed that the quality and outcome measures look at five key areas:

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

Greater standardisation of data across primary and secondary care needs to be achieved in the longer term to ensure measures are meaningful and that the same data are being measured across different services and localities, particularly if used in benchmarking or comparative analysis. Currently, central data collection/ submission for Special Care dental services is variable and it is possible that these data may not reflect the complete service picture. It should be reviewed alongside local and hospital data. There are potential issues in the way certain treatments are currently coded and some overlap between primary and secondary care codes. This will need to be taken into account when measuring quality and outcomes. Consideration needs to be given to how various forms of treatment link together, particularly across the primary/secondary care interface. It is anticipated that, in the long-term, collection of referral data will need to be reviewed with the potential development of additional data markers regarding level of care. Appendix 6 provides greater details on each of the key assessment areas.

10.1 Measuring Quality and Outcomes

Measurement of quality and outcomes against the key assessment areas will require use of quantitative and qualitative measures and be flexible, taking account of the range of care and specific types of patients treated.

10.1.1 Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)

The use of appropriate PROMs and PREMs will be essential to measuring all five key areas as listed above and as discussed within the document: *Strategic Framework for Commissioning Dental Specialities – Introduction.*

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

Selected specialty specific PROM for Special Care Dentistry:

Question	**Has the procedure made a positive effect on your daily living?**
Responses	Yes
	No

Selected specialty specific PREM:

Question	**Were your concerns and/ or anxieties managed well during the procedure?**
Responses	Yes
	No

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

With regard to additional specialty-specific PREMs, many service users would expect suitable disabled access, if required, so they may particularly value other, more qualitative aspects of the service. These include having adequate time to understand the proposed treatment and what it will entail for delivery of their care, feeling valued as a service user and the particular attitude and approach of staff members.

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

10.1.2 Clinical Outcome Measures

The following are examples of evidence which could be used to demonstrate that appropriate processes and protocols are in place:

- Reference to CQC inspection reports and CQC Outcomes
- Use of appropriate agreed local checklists highlighting aspects of the service and relevant facilities, such as signage and accessible information
- Audits including:
    - Use and prescription of high fluoride toothpaste and varnish where appropriate
    - Provision and review of oral care plans
    - Use of visual aids where appropriate to patient needs
    - Patient and carer involvement in decisions about care
    - Recognising, recording and management of pain

Guidance may need to be developed to support audit and to ensure outcomes are recorded and reported which enables comparison and benchmarking of services.

The World Health Organisation's International Classification of Functioning, Disability and Oral Health provides a consensual description of human functioning, with and without disability. An international group has started the process of developing a practical ICF tool in the domain of oral health. This tool could be used to define and report outcome measures in clinical practice, research and epidemiology and, while it is not clear when this will be available, it may provide valuable clinical outcome measures in the longer term.

10.1.3 Value and Impact

The value for money of the service will be a combination of economy, efficiency and effectiveness.

Measuring the impact of a service will need to consider the following as part of the contract monitoring:

- cost of the service
- how closely the service is meeting local oral health needs
- how closely the service meets users' needs
- clinical outcomes achieved in terms of reducing health inequalities and improving oral health
- comparison against other services, taking care to compare or benchmark against other similar service providers treating similar groups
- local surveys to test access (patient/carer questionnaires)
- reviewing access to other health care services and compare against access to dentistry
- exploring any barriers to care
- efficiency and effectiveness

Efficiency and effectiveness measures might look at access, waiting times, provision of urgent care / freedom from pain, some of which could be collected using PROMs. Provision of appropriate urgent care is recognised to be difficult as while those able

to access dental services can normally be seen quickly, their condition may necessitate referral for GA or sedation before their care can be properly managed. Similarly, arranging an emergency domiciliary visit can take more time to organise, but the importance of the right clinical outcome for the patient needs to be emphasised.

Safety is considered of paramount importance in Special Care Dentistry in view of the range of conditions patients may have; quality and outcome measures should reflect this issue.

Measurement of the time spent on administration and liaison with carers, family and other healthcare professionals needs to be considered and appropriate ways of capturing this data. There should be some recognition of the time required e.g. to liaise with all appropriate medical professionals when working with complex medical cases and to provide holistic care.

In view of the complex needs of some service users, numbers of short notice cancellations and failed appointments may be higher than elsewhere. It may also be unrealistic to expect some patients to wait if a clinic is running late (for example, some patients with Autism Spectrum Disorder).

Some appointment time may be lost if it should prove impossible to carry out treatment on a particular day and longer appointments may be required to provide treatment.

Making sure appointment times are fully utilised by confirming appointments and having short-notice cancellation systems in place is therefore important to ensure surgery time is used as efficiently as possible.

11 Contracting

11.1 General Dental Practitioner Provision (Level 1)

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 services above (Paragraph 4.4.1) describes what this looks like for General Dental Practitioners/ providers of Level 1 care. The description of patients requiring care at Level 2 and 3 and the factors affecting eligibility provide a guide to GDPs and Commissioners to the factors that should be considered when a patient is deemed appropriate for onward referral, beyond the reasonable adjustments patients should expect from a provider of services, through a GDS/PDS contract.

Providers offering effective care arrangements in primary care should not see the above as an instruction to refer particular patients. 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 complexity 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 GDPs are referring appropriately.

11.2 Level 2 Provision

Contracting for Special Care Dentistry has been challenging for Commissioners. Previous guidance has implied that units of dental activity are an unsuitable currency for services such as Special Care Dentistry which apply the Casemix model.
Provided often through Community Dental Services, Special Care Dentistry has not been visible enough to Commissioners wishing 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.

This guide has defined eligibility and what quality looks like for Special Care Dentistry. A contract along with its specification for these services can use these definitions.

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. For example, PbR excludes various high cost/ low volume items from national PbR tariff in many cases, to ensure that providers are not unfairly penalised

financially or disincentivised from offering particular procedures or services. Providers of Special Care Dentistry accept patients who require a flexible service that is responsive to individual need. Commissioners must not rely on a provider's good will to offer this 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 from offering services to vulnerable patients is incompatible with the NHS Constitution.

A block PDS contract for the provision of Special Care Dentistry, 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 is a suitable contractual vehicle for these services.

A recent exercise conducted through previous Area Teams established that many Commissioners are unable to effectively identify these services. If unknown, to enable the effective tendering of or contracting of Level 2 & 3 Special Care Dental Service, Commissioners must challenge providers to offer a breakdown of costs, where services are being provided in conjunction with other services. Other services provided within the same contract (often a CDS), could include Paediatric dentistry, which Commissioners may deem suitable to retain as a complete service alongside Special Care Dentistry; it could also include other services such as OOH provision, primary care access or any other specific dental specialty like Oral Surgery or Orthodontics.

PDS contracts for Level 2 services should still submit data via BSA. This will offer Commissioners the ability to analyse activity to the same level as primary care. However, further information in relation to application of Casemix can be used to triangulate that BSA data to provide assurance that a provider is offering service appropriately to the right patients. 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 GDPs are making reasonable adjustments. However, Commissioners must be aware that referrals will come from a variety of appropriate sources as well as primary care dentistry.

11.3 Level 3 Provision

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. However, there are no national tariffs available for Special Care Dentistry within secondary care. These services will currently be either coded under Oral Surgery, Maxillofacial 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 relation to NHS Constitutional standards. MCN.

All providers of Special Care Dentistry should all be contractually bound to engage and participate within a MCN for Special Care Dentistry.

12 Next steps

This guide provides a strategic framework for commissioning Special Care dental services in the future. Following publication there will be further work on implementation; however, the enablers, direction and tools are articulated and can be used by Commissioners to make progress locally and begin to set the groundwork for change.

As a minimum, Commissioners should ensure they have completed a needs assessment and reviewed current service provision. Establishing MCN networks, linked to Dental LPNs and Commissioners, would also assist in making progress to achieve the aims of this guide and develop partnership working with clinicians.

Appendix 1 – Casemix model

Department of Health care services are required to ensure that services are provided to meet the needs of **all** the population for whom they have responsibility. The Department of Health in England recently published 'Valuing People's Oral Health'; a good practice guide for improving the oral health of disabled children and adults. This guide highlights the importance of incorporating oral care into all healthcare plans. It acknowledges that some disabled children and adults present barriers and challenges to primary and secondary care providers when providing dental care.

In the British Society for Disability and Oral Health document 'Commissioning Tool for Special Care Dentistry' it is recommended that commissioners appraise (sic) themselves of the complex needs of many patients accessing Special Care Dentistry. As such, contracts must reflect the additional time and resources required to provide care for this group of patients.

One piece of information recommended in Valuing People's Oral Health is 'an assessment of the degree of difficulty in carrying out dental treatment, based on the individual's impairment or disability and the impact this has on providing a responsive service.' The Casemix model is designed to measure this additional complexity of providing dental care for disabled children and adults, in comparison to providing equivalent care for the 'average' patient. The model has been developed at the British Dental Association by clinicians with many years' experience in providing Special Care Dentistry. The model has been widely field tested, and consulted with other societies with a specific interest in Special Care Dentistry.

The model describes the complexities presented by the patient across six parameters. The complexities measured are those of the patient in respect of dental care provision and not of the actual dentistry to be provided. Each individual episode of care is measured separately, thus the model reflects the actual complexity experienced in providing a specific course of treatment. This ensures the model is realistic in describing resource needs for example a patient requiring full operating general anaesthetic facilities for a simple dental filling may not require such facilities for those courses of treatment when only dental hygiene is undertaken.

The model is not a contract currency per se, but is intended to be one of a number of indicators to be used to monitor and ensure adequate provision of dental services for disabled children and adults. A provisional weighting system has been applied to these criteria and this allows comparison between, for example, different operators' caseloads or different clinics. It is anticipated that as usage increases benchmarking between different services will be undertaken. Additionally, in some parts of the country the criteria contained within the model are being used to determine whether specific patients are eligible to be accepted for referral by Special

Care Dentistry services, or should be retained for continuing care by these services once the initial course of treatment is completed.

Further information about the model is available at www.bda.org.uk; or from Consultants in Dental Public Health or Clinical Directors of Dental Services.

ABILITY TO COMMUNICATE

0	Free communication with adequate understanding between patient, carer and dental team.	0
A	Mild restriction. • Some difficulty in communication, but can overcome. Patient can communicate for themselves without intervention of 3rd party. • Patient has mild learning difficulty.	2
B	Moderate restriction. • Interpreter/ 3rd party required to communicate • Non- verbal communication.	4
C	Severe restriction. • No ability to communicate due to impairment. .	8

ABILITY TO CO-OPERATE

0	Patient will accept all restorative care and simple extractions with LA +/- standard behavioural management techniques	0
A	Full examination and/or simple treatment possible, but requiring additional support or behaviour management techniques.	3
B	Limited examination only possible. Clinical holding required Patient will accept limited restorative care of anterior teeth only with difficulty,	6
C	Patient requires general anaesthetic, sedation or other advanced management techniques to accept treatment	12

MEDICAL STATUS

Note: This criterion covers both issues where modifications have to be made to provision of dental care due to the patient's medical history and where a patient's medical history is not readily obtainable at a dental appointment.

0	Adequate medical history obtainable at appointment with no significant relevance to this course of treatment. No additional investigations required.	0
A	Medical history unable to be obtained at first appointment Further information required in order to complete medical history	2
B	Medical or psychiatric status complex or unstable, affecting the provision of treatment.	6
C	Multidisciplinary review required to treat Multidisciplinary appointment for medical reasons	12

ORAL RISK FACTORS

0	Minimal risk factors. • Stable oral environment; brushes twice a day with fluoride paste. • Can comply with all aspects of 'Delivering Better Oral Health' advice	0
A	Moderate risk factors • Can comply with most aspect of 'Delivering Better Oral Health' advice, • Good OH hindered by malocclusion /manual dexterity • Cariogenic diet resulting in uncontrolled caries • Course of treatment following period of neglect	3
B	Severe risk factors e.g. • Extensive support to achieve some aspects of 'Delivering Better Oral Health' advice • Oral hygiene relies on 3rd party to maintain • Patient does not spit toothpaste out • Altered salivation • Access to oral cavity severely restricted	6
C	Extreme risk factors e.g. • Unable to comply with any aspects of 'Delivering Better Oral Health' • High calorie supplementation • Regular sugar-containing medication • Severe xerostomia • PEG feeding • Immunocompromised	12

ACCESS TO ORAL CARE

0	Unrestricted. • Patient can access surgery without staff intervention. • Child accompanied by a parent	0
A	Moderately restricted • Patient who fails to attend, or cancels at short notice, more than once in a course of treatment. • Patient requires support to access the surgery e.g. carer attends; administrative support	2
B	Severely restricted • Specialised equipment required to attend the surgery (e.g. ambulance, hoist, wheelchair tipper, slide board)	4
C	Domiciliary care required*	8

*This criterion is intended **ONLY** for patients seen on a domiciliary basis in a hospital or nursing home. Do not use for operating theatre cases.

LEGAL AND ETHICAL BARRIERS TO CARE
Note: This criterion includes issues related to collection of patient charges as well as the actual provision of treatment

0	No legal or ethical issues affecting care; e.g. No problems with consent or parental responsibility.	0
A	Some legal/ethical difficulties may arise • Best interests decision not requiring additional correspondence	2
B	Moderate legal/ethical difficulties may arise • Fluctuating capacity to consent • Best interests decision requires additional correspondence with carers/ relatives • Financial responsibility requires further clarification • Parental responsibility requires further clarification	4
C	Severe legal/ethical difficulties • Multi-professional consultation/ case conference required • Referral to an IMCA • Safeguarding referral made	8

LEGAL AND ETHICAL BARRIERS TO CARE

Note: This criterion includes issues related to collection of patient charges as well as the actual provision of treatment

0	No legal or ethical issues affecting care; e.g. No problems with consent or parental responsibility.	0
A	Some legal/ethical difficulties may arise • Looked after children. • Parental responsibility requires further clarification. • Financial responsibility requires further clarification. • Clinician required to make a best interests decision, not requiring a second opinion • Clinician required to assess capacity and provide treatment. Informal consultation with family and carers; No AWI certificate issued	2
B	Moderate legal/ethical difficulties may arise • Children in foster care. • Fluctuating capacity to consent due to psychiatric illness. • Clinician required to assess capacity and AWI certificate issued. Consultation with welfare attorney/ carer	4
C	Multi-professional consultation required in order to overcome legal/ethical difficulties • Best interest meeting/ case conference required. • Referral to other colleagues SLT or clinical psychologists/ case conference/ 2nd dental opinion required before AWI issued or where there is a dispute	8

Appendix 2 – Competency framework for Special Care Dentistry practitioners

The three year specialist training programme in Special Care Dentistry describes the knowledge, skills and attitudes required to be a specialist and for holding a certificate of completion of speciality training (CCST) (Royal College of Surgeons, 2009). The learning outcomes are categorised within the following key areas:

- Biological sciences of relevance to Special Care Dentistry;
- Concepts of impairment, disability, functioning and health;
- Behavioural sciences;
- Impairment, disability and oral health;
- Oral health care and oral health promotion for specific people/population groups with impairment and disability;
- Oral health care planning for the individual;
- Clinical Special Care Dentistry;
- Legislation, ethics and clinical governance; and,
- Research, statistics and scientific writing.

On completion of training, holders of the CSST are entitled to use the term specialist in Special Care Dentistry if on the General Dental Council specialist register. Additional training may be needed for appointment at consultant level.

Competency Framework for Special Care Dentistry practitioners

Assurance Criteria	Primary care dentist (non-specialist)	Primary care dentist with enhanced skills[23]	Specialist in Special Care Dentistry	Consultant in Special Care Dentistry[24]
Experience	On GDC register as dentist.	*Accredited dentists with extended duties.*	Must be on Special Care Dentistry Specialist List with GDC.	Must be on Special Care Dentistry Specialist List with GDC and have completed an additional two years of training in Special Care Dentistry.
Qualifications	No additional qualifications necessary.	*No additional qualifications necessary.*		
Training in Special Care Dentistry	No specific training in Special Care Dentistry.	*A minimum of one session per week training under the direction of a Specialist in Special Care Dentistry for one year or equivalent. Special Care Dentistry*		
Teaching and Education	May have attended postgraduate courses of relevance to Special Care Dentistry.	*Evidence of attendance at courses of relevance to Special Care Dentistry.*	Supervision of higher training in Special Care Dentistry and provision of mentorship for	Leading higher training in Special Care Dentistry and provision of mentorship for Dentists with

[23] Competencies will be informed by the work of the SAC due to report Autumn 2014
[24] Career Development Framework for Consultant Appointments in Special Care Dentistry, RCS 2014

Assurance Criteria	Primary care dentist (non-specialist)	Primary care dentist with enhanced skills[23]	Specialist in Special Care Dentistry	Consultant in Special Care Dentistry[24]
		Supervision of training in Special Care Dentistry.	Dentists with Enhanced Skills and competency in Special Care Dentistry. Involvement in undergraduate &/or postgraduate training desirable.	Enhanced Skills and competency in Special Care Dentistry. Involvement in undergraduate &/or postgraduate training desirable.
Referral Base	Must accept referrals as defined by the terms of the Special Care Dentistry care pathway.	*Must accept referrals as defined by the terms of the Special Care Dentistry care pathway.*	Must accept referrals as defined by the terms of the Special Care Dentistry care pathway.	Must accept referrals as defined by the terms of the Special Care Dentistry care pathway.
Clinical Expertise	Clinical experience limited for patients with special needs. May undertake shared care with specialist or Dentists with enhanced skills and experience. Ability to recognise when the help and advice of a specialist or Dentists with Enhanced Skills and experience is required.	*Ability to carry out a range of clinical activity for patients with moderate needs. Ability to recognise when the help and advice of a specialist is required.*	Acceptance of a wide range of clinical cases for patients with complex needs. Taking a lead role for developing a local infrastructure for the delivery of Special Care Dentistry.	Acceptance of a wide range of clinical cases for patients with complex needs. Taking a lead role for developing a local infrastructure for the delivery of Special Care Dentistry, including service development and workforce planning.
Continuing professional development	May attend course of relevance to Special Care Dentistry.	*Participating in CPD of relevance to Special Care Dentistry. Participating in local MCN.*	Co-ordinating, providing and participating in CPD in Special Care Dentistry Participating in local MCN.	Leading, providing and participating in CPD in Special Care Dentistry Leading local MCN.
Facilities/ workplace	Practice should comply with the Equality Act.	*Provision of care as per specific contract (Section 7.1; Level 2).*	Clinical experience and training to provide care in a variety of clinical settings including primary and secondary care (Section 7.1; Level 3).	Clinical experience and training to provide care in a variety of clinical settings including primary, secondary and tertiary care (Section 7.1; Level 3).
Dental team/ multidisciplinary teams	Works with dental team and may not have any training in Special Care Dentistry (Section 7.3; Level 1).	*Dental team trained both formally and informally in Special Care Dentistry, appropriate to contracted activity,*	Dental team trained both formally and informally in Special Care Dentistry to include moving	Dental team trained both formally and informally in Special Care Dentistry to include moving

Assurance Criteria	Primary care dentist (non-specialist)	Primary care dentist with enhanced skills[23]	Specialist in Special Care Dentistry	Consultant in Special Care Dentistry[24]
		to include moving and handling, clinical holding, safeguarding, BLS/PLS etc. (Section 7.3; Level 2)	and handling, clinical holding, safeguarding, ILS/PLS etc. (Section 7.3; Level 3).	and handling, clinical holding, safeguarding, ILS/PLS etc. (Section 7.3; Level 3). Part of DMDT.

Appendix 3 – Workforce details

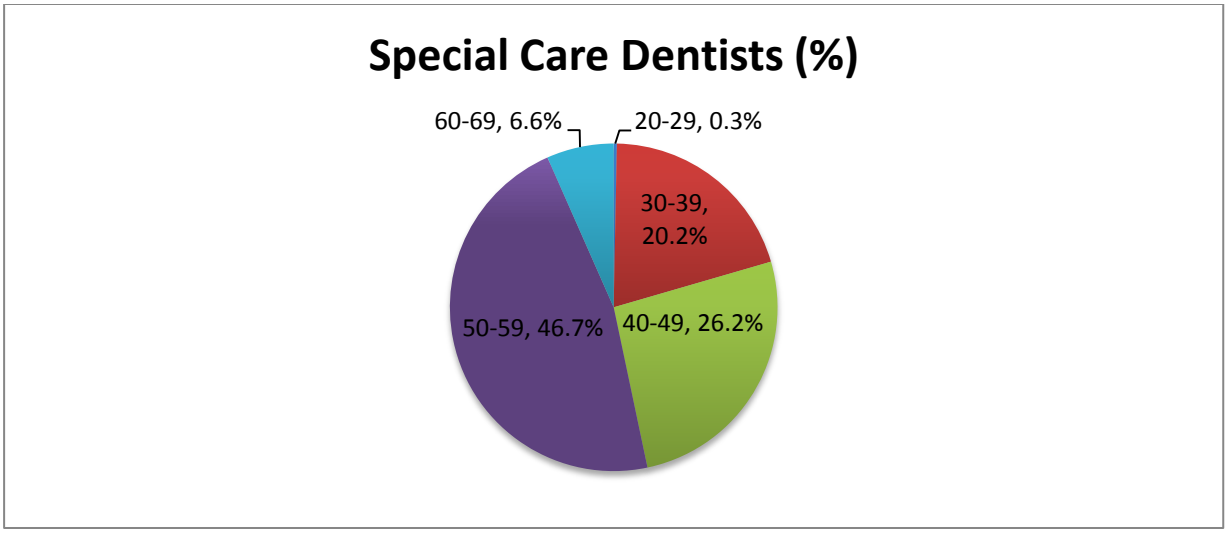
Specialist List

313 Dentists on Specialist list for Special Care Dentistry in UK

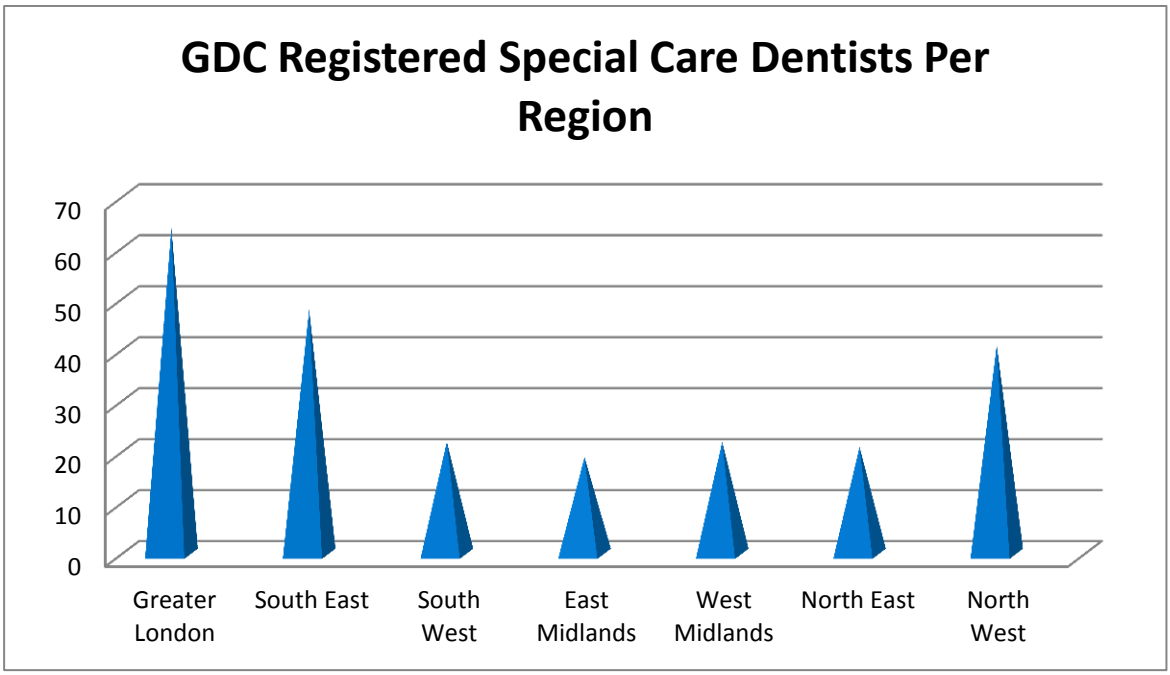
4 outside the UK

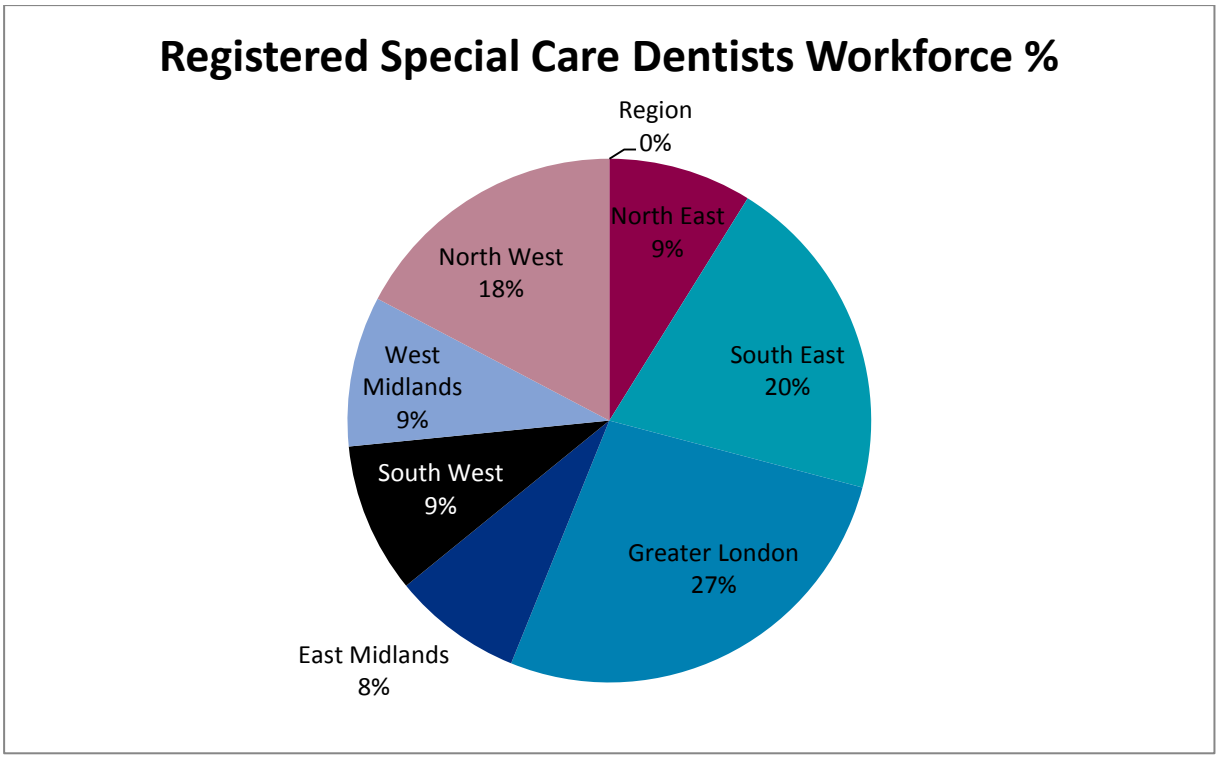
Total Number 317

Age Profile



Location of Special Care Specialists from registered address





Training numbers

Number of trainees England 21 in Post 3 vacant posts (April 2014)

A significant number of specialist service providers are involved in the delivery of clinical training education and to undergraduate dental, hygiene and therapy students and postgraduate dentists in training.

Commissioners are required to support this clinical training by commissioning sufficient volumes of Level 1 and 2 treatments from such providers to ensure an appropriate Casemix is available for teaching and training at undergraduate and postgraduate levels

Appendix 4 – What is a health needs assessment

What is a health needs assessment?

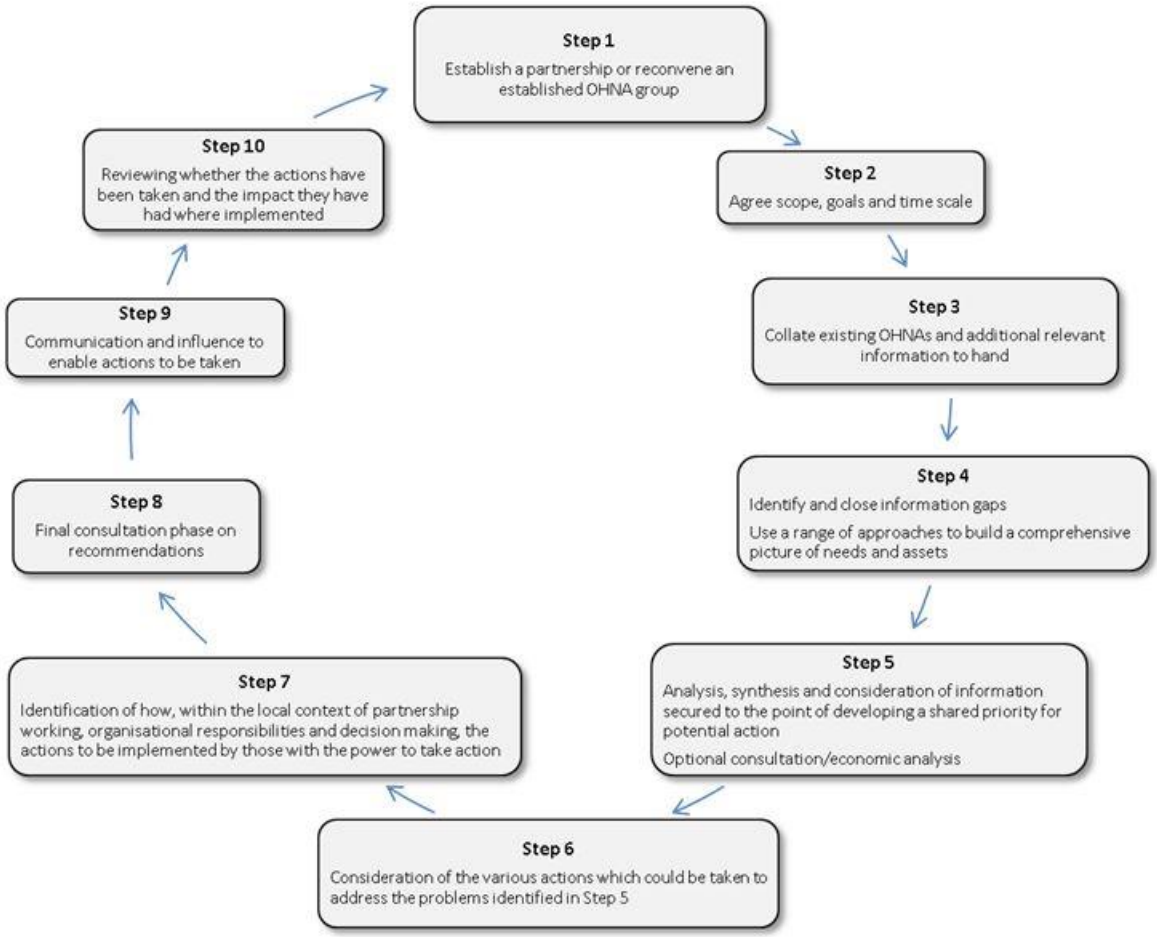
A health need can only exist when an individual has an illness or disability for which there is an acceptable cure (Matthew, 1971). Health needs may be described from different perspectives, from the perspective of the service recipient or that of the service provider (Chestnutt et al., 2013). Different types of health need have been described including normative need (need defined by health professionals), felt need (needs defined by patients), expressed need or demand (actions taken by service recipients to utilise health services), comparative need (need between similar groups of people) and unmet need (the difference between need for health services and actual service provision) (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 therefore involves establishing and describing the oral health of a population, ascertaining their needs, measuring the capacity of existing services to meet these needs and, where 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 dental services, leading to improved access, patient outcomes and experience. However, there are difficulties in determining need, uptake and demand for dental services due to limited information sources. Commissioning services that meet the needs of the population within available resources remains challenging.

A recent review[25] 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 Oral Health Needs Assessment (Figure APP4.1).

[25] (Chestnutt et al., 2013)

Figure APP4.1 The 10 Step Approach for an Oral Health Needs Assessment



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

Appendix 5 – Pro-forma Referral Forms

Please note: Missing information in fields marked with an asterisk (*) will mean that the form cannot be processed and will be returned to the referrer. Please help to avoid unnecessary delay for patients.

1. Patient details					
Title				Referral date*	
Forename(s)*				Surname*	
Gender (✓)	M		F	NHS Number	
Tel				DOB*	
Address*					
Postcode*					
Main carer details					
Full name					
Address					
Telephone					

2. Referrer details			
Name*		Tel* *(Work)*	
Work address*			
Job title			
Email address *(nhs.net if available)*			

3. Patient General Dental Practitioner (GDP) details			
Patient does not have a dentist (✓)		I am the referring dentist (✓)	
Name			
Practice address			
Performer number			

4. Dental treatment (For GDP referrals)
What dental treatment does the patient need?* (State)
4.1 Ability to co-operate

What treatment have you attempted to provide?*
What difficulties were encountered?*

5. Main reason for referral* (See published acceptance criteria)			
Disability (✓)			
Medical (✓)			
Mental Health (✓)			
5.1 Disability information	**Details**		
Ability to communicate? (✓)	Partially impaired		
	Severely impaired		
Able to leave the home? (✓)	Yes		
	No		
Able to transfer to dental chair? (✓)	Yes		
	No		
Has capacity to consent? (✓)	Yes		
	No		
	Partially		
5.2 Medical history information (*All referrals)			
List main medical conditions*			
List all medications being taken*			
5.3 Mental health information			
Provide mental health diagnosis			
Extreme dental phobia? (✓)	Yes		No

6.0 Referrer signature*	
Date*	

Using your secure nhs.net e-mail account send the completed referral form and relevant radiographic images to:

Appendix 6 – Quality and outcome measures

Quality and Outcome Measures - Key Assessment Areas

The definition of Special Care Dentistry is broad and when looking at key assessment areas, consideration should be given to the range of services provided as it is likely that not all providers will be providing care to all groups of patients requiring Special Care Dentistry. When measuring quality and outcomes, even though the same key areas are being assessed, the measures used and their interpretation should be flexible, dependent on the types and range of care provided.

Access

Access measures should be linked to, and reviewed alongside, local oral health needs assessments and service capacity.
The following are important to consider when reviewing access:

- Referral pathway;
- Method of referral;
- Service location;
- Patient facilities i.e. parking, ramps, toilets, rails etc.;
- Adequate space in waiting area for people who use wheelchairs or mobility scooters;
- Waiting times for both routine and urgent care;
- Transport services;
- Domiciliary provision;
- Seamless care (multidisciplinary working);
- Continuity of care (e.g. transition stage from adolescent to adult and transfer to other services/locations on discharge);
- Flexibility with acceptance from various referral sources;
- Flexibility with acceptance from various referral sources.

Communication

Many patients requiring Special Care Dentistry will have specific communication needs. Some will have a sensory impairment; others may have problems with cognition.
The following should be considered:

- Signage and accessible information such as ‘Easy read’ should be available;
- Large print or easy read appointment cards should also be available, if required;
- Waiting area to include appropriate communication aids and space for people who use wheelchairs or mobility scooters;
- Ensuring involvement of patients, carers and families in decisions about care and treatment;
- Ensuring patients have adequate appointment time to discuss and consider treatment options;

- Ensuring the patient's wishes are listened to and taken account of during treatment planning, obtaining informed consent and delivery of care;
- Provision of appropriate training for the whole team in relation to communication skills;
- Ensuring staff have the appropriate skills when required e.g. Makaton, Sign along and have an understanding of the importance of non-verbal communication;
- Awareness of the environment and how to enable effective communication e.g. when a patient has a hearing impairment;
- Training and experience in caring for people with Autism, where communication strategies may need adaptation.

Value for Money (VFM)

There is evidence that patients requiring Special Care Dentistry need more time in general. The effective collection and reporting of information, using the Casemix tool, would demonstrate the severity and complexity of patients accessing a particular Special Care Dentistry service. There has to be a fair benchmark in comparing activity with resources utilised, which reflects the range of dependency and surgery time required.
The following should be considered:

- Effective use of skill mix and the wider team;
- Robust benchmarking once the guides have been implemented and national data sets agreed;
- VFM must take account of the balance between economics, efficiency and effectiveness;
- Awareness that there may be clinical justification for a patient to require treatment at different clinics, from different clinicians, for different elements of their care. This may not be seen as economical from a patient perspective if multiple attendances are required;
- Utilising opportunities to work together with other Specialty areas e.g. medical procedures such as diagnostic blood tests, audiology impressions for hearing aids can be performed at the same time as dental treatment under sedation or general anaesthesia;
- Appropriate currency measures and collection of PCR will need to be determined within the contracting arrangements; see Chapter 11.00.

Clinical Care

Where possible, the aim should be to achieve the same clinical outcomes for special care patients as for any other dental patients. However, it should be recognised that this is not always realistic. Current clinical outcome measures such as those being tested in the dental pilots looking at number of decayed teeth and periodontal indices such as Best Periodontal Examination (BPE) may not always be the most relevant quality measures for Special Care Dentistry, given the wide range of support which service users may, or may not, receive or need.

The following should be considered:

- Utilise a blend of qualitative and quantitative measures;
- Ensure the right processes and protocols are in place;
- Ensure processes and protocols are being used appropriately and effectively;
- Utilise reports from CQC inspections and clinical audits with triangulation of data;
- Patient reported outcome measures demonstrating effectiveness of care - including simple questions around function and oral health.

Patient Experience

The measures should be patient-focused and consider different ways in which service users can provide feedback. Addressing the different service users' communication needs may include using narrative and pictorial responses.
Other areas for consideration:

- Potential inequalities throughout the patient journey;
- Data which can be collected centrally using national surveys;
- PROMs / PREMs which can be collected by services at a local level;
- Triangulation of data;
- Evidence that PROMs/ PREMs are representative of the patient groups treated and not just those who can easily provide feedback.

While there is a requirement for NHS services to implement the 'Friends and Family' test, it should be recognised that, given the specialised nature of services such as Special Care Dentistry, the question is unlikely to be consistently interpreted within the intended context. The Special Care Dental services may not be appropriate or applicable to other family members or friends of the patient.

Appendix 7 – Membership of the Special Care Commissioning Guide Working Group

Janet Clarke	Chair – Associate Director, Dental Services, Birmingham Community Healthcare NHS Trust
Peter Bateman	British Dental Association
Vanita Brookes	Secondary Care
Ben Cochrane	Area Team Commissioner
Kerry Davis	NHS England, Dental Lead Contract Manager
Sally Eapen-Simon	Public Health England
Peter Frost	Faculty of General Dental Practice
Amanda Gallie	Dental Care Professionals
Ruth Gasser	NHS Business Services Authority
Richard Hague	Dental Core Trainee
Rob Haley	Primary Care Commissioning (Commissioning Guide Support)
Gill Heyes	Specialist in Special Care Dentistry
Paul Howlett	General Dental Practitioner
Dionne Hilton	NHS England, Dental Pathways Programme Manager
Kate Jones	Public Health England
Serbjit Kaur	NHS England, Deputy Chief Dental Officer
Alan Lewis	Commissioner, Assistant Contract Manager, Surrey and Sussex
Debbie Lewis	British Society of Gerodontology
Jane Luker	COPDEND / Health Education England
Donna Macarthur	Head of Public Health Commissioning
Avril Macpherson	Association of Dental Hospitals
Selina Master	Faculty of Dental Surgery
Michael Osborne	Patient / public representative
Trish Pashley	Department of Health, Head of Mental Health Delivery
Pam Peers	Patient / public representative
Nick Ransford	British Society for Disability and Oral Health
Carol Reece	NHS England, Senior Programme Manager, Dental, Pharmacy and Optical
Pepe Shirlaw	Dental Local Professional Network
Nick Stolls	Primary Care
Shelagh Thompson	British Society for Disability and Oral Health, Academic
Cem Yatak	NHS England, Programme Support

Appendix 8 – Glossary

ASA3	American Society of Anesthesiology Classification – A patient with severe systemic disease
ASA4	American Society of Anesthesiology Classification – A patient with severe systemic disease that is a constant threat to life
BDA	British Dental Association – A national professional association for dentists https://www.**bda**.org/
BSA	NHS Business Services Authority – http://www.**nhsbsa**.nhs.uk/
CBT	Cognitive Behavioural Therapy – A talking therapy that can help manage problems by changing the way one thinks and behaves
CDS	Community Dental Services – Dental services provided away from the dental surgery
DCP	Dental Care Professional – Dental nurses, dental hygienists, dental therapists, orthodontic therapists, dental technicians and clinical dental technicians.
FP17	Form Processing 17 - Providers submit forms (FP17) to us detailing dental activity data. The data recorded on the FP17 show the patient charge collected, the number of units of activity performed and treatment banding information
FTs	Foundations Trusts - Semi-autonomous organisational units within the National Health Service in England.
GA	General Anaesthetic – A medication used to cause a loss of consciousness rendering the patient unaware of the surgery
GDC	General Dental Council – Organisation that regulates dental professionals in the UK www.**gdc-uk**.org/
GDP	General Dental Practitioner - Dentist
GDS	General Dental Services – Dental services delivered on the basis of a contract
HEE	Health Education England – *www.***hee**.nhs.uk/
ILS	Intermediate Life Support – Management of a patient in cardiac arrest until the arrival of a cardiac team
LDC	Local Dental Committee - statutory bodies which are the professional organisations representing GDPs.
LPN	Local Professional Network - LPNs cover dentistry, pharmacy and eye health, and help drive service improvements and reduce health inequalities.
MCN	Managed Clinical Network – *See Guide for Commissioning Dental Specialty Services*
ONS	Office for National Statistics - www.**ons**.gov.uk/
PANSI	Projecting Adult Needs and Information Systems - Programme to explore the possible impact that demography and certain conditions may have on populations aged 18 to 64.
PbR	Payment by Results – A set of prices and rules to help local NHS providers and Commissioners provide best value to their patients

PHE Public Health England – protect and improve the nation's health and wellbeing, and reduce health inequalities https://www.**gov**.uk/government/organisations/public-health-england

PREMs Patient Reported Experience 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.

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.

SLA Service Level Agreement - - Agreement between service provider and user on scope, quality and responsibilities

Special Care Dentistry – *see* page 10.

UDA Units of Dental Activity – Units of measure by which GDPs are paid and, against which, performance is measured

WHO World Health Organisation – www.**who**.int/

References

BSDH definitions of hold levels at www.bsdh.org.uk

Audit of clinical holding in Special Care Dentistry – B Kerr, J A Edwards, S Moosajee, Z Shehabi, S Rafique Journal of disability and oral health 14-1 December 2012

Managed Clinical Networks - Skipper M, British Dental Journal 2010;11 241-242