Care Pathway/Service	**Personal Dental Services - Orthodontic Services**
Commissioner Lead	**NHS England, Midlands & East (East)**
Provider Lead	
Period	
Date of issue	**14 December 2018 – VA301118 Vs 4.4**

1. Background

National/Local Context

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.

In order to deliver this vision and implement the pathways, NHS England partners, Health Education England (HEE) and Public Health England (PHE), specialist societies and others who have contributed to its development will need to respond in the implementation phase by unlocking structural and cultural barriers to support transformational change in dental service delivery.

The future reflected in the recently published NHS Long Term Plan will dissolve the artificial divide between primary dental care and hospital specialists; it will free specialist expertise from outdated service delivery and training models so all providers can work together to focus on patients and their needs.

Whilst recognising progress has been made in improving oral health and access to services over the past few years, it is acknowledged that inequality in oral health experience and inequity in access to primary and specialist care continues to exist. NHS England Dental Commissioning Guides focus on the commissioning and delivery of specialist Care Pathways whereas the gateway to specialist care relies on access to efficient and effective primary dental care services. Commissioners need to continue to ensure they commission primary care services appropriate to the needs of their population. This means making effective use of available resources by challenging primary care providers to deliver care by adopting appropriate recall intervals to provide capacity for new patient access. Achieving improvements in access to primary care will widen access to specialist care.

Commissioners across NHS England Midlands & East (East) have been working with clinicians through the local dental networks and the orthodontic managed clinical networks, establishing dialogue between the services in primary, secondary and community care, and making changes where possible to improve access and quality.

Many orthodontic Personal Dental Service (PDS) Agreements are due to expire on **31 March 2019**. There is a legal requirement set out in the 2015 European procurement directives which requires NHS England to carry out a competitive tender process.

No part of this specification by commission, omission or implication defines or redefines mandatory or additional services.

Description of the national picture

Orthodontic care includes the provision of advice and education for patients, parents and other health-care professionals. It includes monitoring the development of teeth and providing interceptive measures with appliances where appropriate. The majority of orthodontic work is carried out with removable and fixed appliances when all the deciduous teeth have been lost. In certain situations input from other disciplines is required, such as restorative/paediatric dentistry (patients with missing or damaged adult teeth), or maxillofacial and oral surgery (to manage impacted teeth or significant jaw discrepancies beyond the scope of correction with braces alone). Additional support services for complex multi-disciplinary treatments such as management of patients with cleft lip and palate, facial deformities or syndromes may be required.

The Index of Orthodontic Treatment Need (IOTN) is a clinical assessment of malocclusion severity utilised within the NHS to select those individuals who would benefit most from orthodontic treatment. The majority of NHS orthodontic treatment above IOTN (Dental Health Component) 3, (Aesthetic Component) 6 is supervised or carried out by specialists.

Specialists will frequently operate a team approach to orthodontic care with the support of primary care practitioners, orthodontic therapists and orthodontic nurses working under their direct supervision.

Transforming Services

The points below set out NHS England's approach for commissioning orthodontic services in NHS England Midlands & East (East):

- Managed clinical networks (MCNs) will enable clinicians to shape and influence service redesign through working with commissioners and patients. In developing, redesigning, procuring and monitoring services, arrangements will be made to involve patients, carers and the public, and the organisations that advocate for them including Health Watch;
- Contracts will include key performance indicators (KPIs) which will underpin quality;
- GDPs will require appropriate training to support valid referrals (including familiarisation with IOTN, importance of good oral hygiene and suitability of patient);
- The aim is to have a single point of entry for orthodontic services via a referral management system;
- Referrals will include an agreed minimum data set;
- Agreed definitions and standards for waiting times both for review of referral, assessment, advice and treatment 'starts' from optimum treatment time;
- Use of a nationally agreed Care Pathway to take into account:
    - Provision for freedom of movement and choice for patient, including the opportunity for second opinions.
    - Needs-led procurement and planning;
- Case complexity descriptors;
- Use of IOTN;
- Training of future workforce: undergraduates, Dental Care Professionals (DCPs), GDPs, Dentists with enhanced skills, and experience, Specialists, Consultants;

- Opportunities to develop and enhance the use of skill mix in Orthodontic care delivery to increase capacity within resources;
- Maintenance of core skills and enhanced Continuing Professional Development for all members of the Orthodontic team;

1.1 Description of Speciality

Orthodontics is the dental specialty concerned with facial growth, development of the dentition and occlusion, and the assessment, diagnosis, interception and treatment of malocclusions and facial irregularities.

1.2 Aims of the Orthodontic Service

The overall aim is to provide equitable, accessible, high quality and cost effective specialist orthodontic services from April 2020, in line with the National Guide for Commissioning Orthodontics, 2015 and National Health Service (Personal Dental Services Agreements) Regulations 2005 as amended.

The service will deliver orthodontic treatment to those patients who were assessed and accepted for treatment who meet the required IOTN as defined within Schedule 1, Part 2, 4 (3) of the National Health Service (General Dental Services Contracts) Regulations 2005 and PDS equivalent.

Orthodontics is mainly provided for children and adolescents up to the age of 18 years old who meet the agreed criteria for NHS treatment and for adults where there is clinical justification and where prior approval has been agreed with the commissioner.

The provider must treat all eligible patients in accordance with the Regulations without discrimination. There are no geographical boundaries. The patient must be under the regular continuing care of a GDP.

1.3 Assessment of Orthodontic Treatment Need

Population need

In 2008/09 a national epidemiological oral health survey of 12 year old children was undertaken across England. Orthodontic need was also assessed as part of the survey providing primary care trust based epidemiological Orthodontic needs assessment for the first time. The examiners were all calibrated with a Regional and National standard and trained in Index of Orthodontic Treatment Need (IOTN) assessment. The level for identifying someone as having an Orthodontic need was an IOTN dental health component (DHC) score of 4 or above (the same level used in the 2003 National Child Dental Health Survey) and/or an Aesthetic Component (AC) of 8 to 10.

The 2008/09 survey estimated the amount of normative orthodontic need. The population representative sample indicated that the prevalence of orthodontic clinical need is between 30.5% & 33% of the child population. The range is wide, but includes prevalence levels that have been found from previous research. Children with poor oral hygiene or active caries were included in the assessment.

There are a number of methods for assessing need; however, published studies and surveys have consistently reported that around one third of children, in any given population, will need and want Orthodontic treatment. Anecdotal evidence suggests that demand for orthodontic treatment is rising as the health and expectations of the population improve.

Prior to the re-procurement, a comprehensive orthodontic needs assessment had been carried out for each Midlands & East (East) NHS local office areas. These have been used alongside updated population data and data projections, on children aged 12 residing in the area, shown below, to assess the capacity required'

	Populations projected for CCGs	33% of 12 year olds	Populations projected for CCGs	33% of 12 year olds	Populations projected for CCGs	33% of 12 year olds
	2018	**2018**	**2019**	**2019**	**2021**	**2021**
East Anglia	25,960.28	8,566.89	26,948.27	8,892.93	28,144.42	17,664.20
Essex	23,813.37	7,858.41	24,342.87	8,033.15	25,383.46	8,376.54
	49,773.65	**16,425.30**	**51,291.15**	**16,926.08**	**53,527.87**	**26,040.74**

Most children attend full time education; treatment should cause minimum disruption to this, hence convenient for travel to and from appointments, minimising travel distance, and be designed to enable access to all who need and want it, mindful of potential barriers faced by those from disadvantaged backgrounds and those with special need as well as the need for services to be large enough to be viable. Both population size (estimate for 2021) and access were taken into account by the commissioning team when deciding the capacity and distribution of the service required, i.e. lots.

The full orthodontic needs assessment for each Local Office is available on the NHS England – Midlands & East website

https://www.england.nhs.uk/mids-east/info-professionals/

1.4 Contract Type and Length

The agreement is offered under the terms of the National Health Service (Personal Dental Services Agreements) Regulations 2005, as amended. The PDS regulations identify mandatory and additional services. The clinical services to be provided are those deemed additional services.

The agreement will be for 7 years in the first instance with the option available to both parties to extend for up to a further 3 years by mutual agreement.

1.5 Level of Orthodontic provision

The clinical service will comprise provision at levels 2 and 3a as defined in the Commissioning Guide for Orthodontics, 2015 (see Appendix A) and includes:

- Patients requiring orthodontic treatment for the management of skeletal discrepancies (removable, functional and fixed appliances).
- Patients with restorative problems, which do not require complex multidisciplinary care with secondary care input.
- Patients with impacted teeth where the Oral Surgery / Orthodontics liaison can be managed from the specialist practice.
- Advice to those providing Level 1 or 2 care.

1.6 Expected Outcomes

National Key Performance Indicators (KPIs) have been developed in order to ensure consistency of outcomes across the country. These KPIs have been developed alongside the Orthodontic Assurance Framework – Orthodontic indicators as set out in the Guides of commissioning dental specialities – Orthodontics.

National Key Performance Indicators (KPIs)	***Excellent OR Band A*** [1]	***Acceptable OR Band B*** [2]	***Unacceptable OR Band C*** [3]
Number of Case Starts (Total number of commissioned UOA's divided by 22.5 - in line with agreement established with the profession) % UOAs assess and accept compared to total UOAs delivered	Above 93%	*Between 90% & 93%*	Less than 90%
A total of 20 cases to be PAR scored by an independent calibrated examiner and conform to BOS standards on an annual basis *(10 consecutive cases every six months between April and September and October and March, to be randomly selected by Dental Services)*	75% of patients assessed have a PAR score reduction of 80% or more	*75% of patients assessed have a PAR score reduction of between 70% & 79.9% or more*	*75% of patients assessed have a PAR score reduction of less than 70%* [4]
Case Starts vs Case Completions [5] *Options for period; six monthly; annual; cumulative – to be confirmed*	*Above 95%*	*Between 90% & 95%*	*Less than 90%*
PROMS/PREMS around patient experience – these are based on national patient survey produced by Dental Services on behalf of NHS England [6]	Not applicable – data will be used for triangulation purposes only	Not applicable – data will be used for triangulation purposes only	Not applicable – data will be used for triangulation purposes only

There must be active clinical [7] participation in the Orthodontic Managed Clinical Network (MCN) [8]	Engagement with [9] local MCN which includes attending meetings and participation in the MCN's programme of work	No engagement with [10] local MCN

[1] No action required by contractor or commissioner.
[2] No action required by contractor or commissioner.
[3] Formal discussion between contractor and commissioner and a SMART action plan to be agreed by both parties to increase performance above band C – contractor to have an appropriate length of time to improve prior to a formal remedial notice being issued for example a quarter, six months, or less – the expectation is that this will be mutually agreed between both parties and give a reasonable length of time for the contractor to improve performance before any formal contract sanctions are considered.
[4] Provider should be given the opportunity to have a further 10 cases scored to avoid a situation where the low score is down to bad luck, this should form part of the action plan.
[5] Denominator to include all case starts, numerator to include cases completed, cases abandoned or discontinued are not to be included.
[6] Patient survey is currently undergoing a national refresh, led by our Clinical Advisor for Orthodontics.
[7] Representative must be a clinical specialist or dentist with enhanced orthodontic skills.
[8] It was envisaged this indicator could be reported via a self-declaration on the COMPASS system. A form will be designed which would include information on how the provider has engaged with the MCN. Evidence to support the self-declaration will be required from contractors.
[9] Expectations in band A and B are consistent.
[10] Lack of engagement with the MCN would be seen as a concern for Commissioners.

Orthodontic Assurance Framework – Orthodontic indicators

NHS England's Dental Assurance Framework provides a set of indicators that provide high level assurance for commissioners, whilst recognising that no one set of indicators could, in itself, provide absolute assurance of quality, nor could it necessarily identify best practice. It is designed to assure commissioners that contract holders and providers are on course to meet their obligations under their contract / agreement. The current orthodontic indicators are detailed below and are measureable via existing datasets and are collated by the Business Services Authority.

Delivery England %	
UOA Delivered	% of Contracted UOA Delivered (Year to Date)
Assessment	
Assessments by category	% of assessments that are Assess and fit appliance
Assessments by category	% of assessments that are Assess and refuse
Assessments by category	% of assessments that are Assess and review
Age at assessment	% of reported assessments and review where patient is 9 years old or under
Treatment	
Cases reported complete as a function assess and fit appliance	Ratio of reported **concluded** (completed, abandoned or discontinued) courses of treatment to reported assess and fit appliance.
Type of appliance used	% of **concluded** (completed, abandoned or discontinued) courses of treatment reported as using removable appliances only.
Outcomes	
UOAs reported per completed case	Ratio of the number of UOAs reported per reported **completed** case (not including abandoned or discontinued cases)

Reported PAR Scoring: actual versus expected	% of contracts not meeting their expected reporting of PAR scores
Abandoned or discontinued care	% of **concluded** (completed, abandoned or discontinued) courses of treatment where treatment is reported as abandoned or discontinued

2. Scope

2.1 General Principles

The service will deliver orthodontic treatment to those patients up to the age of 18 years old with an Index of Orthodontic Treatment Need as defined within Schedule 1, part 2, 4 (3) of the National Health Service (General Dental Services Contracts) Regulations 2005 and PDS equivalent (currently Dental Health Component 3 Aesthetic Component 6 or above). The service is aimed at those patients who require orthodontic procedures outside the remit of general dental practitioners or hospital services.

Care for adults (aged 18 years and over) will not normally be carried out except in exceptional circumstances (e.g. orthognathic cases), and only with the prior agreement of the commissioners in writing. The exceptional circumstances must be documented in the patient record.

The agreement **excludes** all mandatory services and the following additional services:

- Sedation Services
- Minor Oral Surgery
- Domiciliary services
- Dental Public Health Services

The provider must treat all eligible patients as defined within this service specification and not discriminate in any manner contrary to the relevant Regulations.

Eligibility for treatment is as defined in the relevant NHS Regulations and Commissioning guide for orthodontics.

2.2 Service Description

The service will include:

- Assessment and treatment delivered according to each patient's clinical needs, including interceptive treatment and in hours urgent care;
- Treatment that includes examination, taking of radiographs, diagnosis, preventative care, advice, planning of orthodontic treatment, supply and repair of orthodontic appliances including retainers for a period of 12 months following the completion of active orthodontic treatment;
- Appropriate referral to other healthcare providers for mandatory or advanced mandatory services or any other appropriate and necessary healthcare;
- Advice to the patient and other clinicians where appropriate.

Orthodontic treatment should only be undertaken in situations where it is believed to be in the patient's best interests in terms of their oral health and/or psychosocial wellbeing.

In all situations the clinical advantages and long-term benefits of orthodontic treatment must justify such treatment and outweigh any detrimental effects.

Patients will only be offered one course of NHS funded routine orthodontic treatment unless there are exceptional circumstances. Such cases include where interceptive or growth dependent treatment has been undertaken prior to the age of 10 and the IOTN remains greater than 3.6, a further course of treatment can be commenced without seeking commissioner approval.

Where a patient does not meet these circumstances, the patient's orthodontist would need to seek approval from their commissioner, providing evidence of the patient's exceptional clinical circumstances. There may be occasions when an appliance has to be removed during a course of treatment to allow a patient to undergo other procedures such diagnostic services; the removal and replacement of an appliance does not constitute a new course of treatment and this is part of one (original) course of treatment.

The clinician should ensure that the co-operation, motivation, aspirations and general health of the patient are consistent with the provision of orthodontic treatment, particularly their ability to maintain good oral hygiene to ensure no harm is done. They should also ensure that the patient and carer are willing and able to commit to frequent attendance, which may be during school hours, over the course of orthodontic treatment and are aware of the need to wear appliances and retainers. The exception to this is patients requiring assessment for interceptive extractions or advice only.

The clinician should ensure that an oral health assessment/review has been carried out and that the information collected and the risks identified are reviewed and shared with the patient before entering treatment.

It is not generally in the patient's best interest to plan and deliver orthodontic treatment in the absence of a stable oral environment when the risk of dental disease is high.

2.3 Whole System Relationships

All service providers are required to ensure clinical representation and performer participation into the core Orthodontic Managed Clinical Network (MCN) / LDN agreed work programme.

Service providers will work closely with the Orthodontic MCN to implement and improve the patient pathways and ensure that the patient receives a high quality service.

Service providers and performers will also work with local health and wellbeing services by referring or sign-posting patients (and/or their family members) to lifestyle services e.g. smoking cessation; healthy eating; physical activity.

Referring GDPs will be expected to work with local secondary care providers.

2.4 Interdependencies

All providers are required to ensure their performers become pro-active members of the Orthodontic MCN. Service providers and performers will work closely with the Orthodontic MCN to implement and improve the patient pathways and ensure that patients receive a high quality service.

There is interdependency with secondary care for the provision of complex orthodontic provision (complexity 3b). The provider will need to demonstrate effective working relationships with secondary care colleagues to ensure appropriate management of complex cases and appropriate management of complications outside the scope of the service in accordance with the agreed pathways.

2.5 Relevant networks

Relevant networks include, but are not limited to:

- NHS England;
- Orthodontic MCN;
- Local Dental Network (LDN);
- Clinical Commissioning Groups (CCGs);
- Sustainability and Transformation Partnerships (STPs);
- British Dental Association (BDA);
- Local Dental Committees (LDC);
- Other relevant clinical networks;
- Local Authority Health and Wellbeing Boards and Scrutiny Committees;
- Health Education England (HEE) and Postgraduate Deanery;
- Healthwatch;
- Referral Management Centre (if appropriate)
- British Orthodontic Society;
- Community Dental Services

3. Service Delivery

The Contractor shall provide orthodontic services to a patient by providing to that patient an orthodontic course of treatment.

The Contractor may provide orthodontic services that are not provided by virtue of an orthodontic course of treatment where:

- It provides a repair to an orthodontic appliance of a person; and
- The orthodontic course of treatment in which that orthodontic appliance was provided is being provided by another contractor, hospital or relevant service provider under Part 1 of the Act and the distance to return to the original orthodontist is unreasonable. NB: buddy or cover arrangements for other practices who are closed due to holiday, sickness, training, etc, is a personal arrangement between practices and an FP17O claim may not be submitted.

Any referrals received that fall outside of the referral management protocol will not be funded under the contract unless prior approval has been received from the Commissioner in writing.

Referrals may also be redirected from secondary care providers where patients have been referred and following assessment are deemed not meet the level 3b complexity.

3.1 Service Requirements

The provider will:

- Ensure that service provision conforms to all mandatory standards and relevant guidance;
- Provide a clinical service in line with 'Level 2 and 3a' provision as described in the Guides for commissioning dental specialties – Orthodontics 2015;
- Ensure that where referrals are deemed inappropriate, or where additional information is required to establish appropriateness, they respond to the referring dentist within 20 working days to request clarification, confirm reason for rejection or arrange onward referral to appropriate level 3b providers;
- Liaise with the referring practitioner and provide a written report containing the clinical decision and treatment/referral provided; reports to be sent within 20 working days of the completion of the assessment and ultimately the completion of the course of treatment;
- Provide high-quality, timely and appropriate care as determined by the presenting clinical condition;
- Patient assessed as eligible for treatment should be scheduled for treatment in a timely manner based on clinical need.
- Maintain good working relationships with colleagues in and outside the NHS who contribute to the overall care of all patients to ensure that treatment is conducted in the most appropriate, efficient and effective manner;
- Monitor to seek to improve service satisfaction rates to include NHS Friends and Family;
- Implement a programme to ensure that feedback from service users is sought and acted upon;
- Monitor and seek to improve treatment outcomes using the Peer Assessment Rating (PAR) provide a report of PAR score improvement to the commissioner on request;
- Follow the commissioner's referral pathways which will be notified to the provider;
- Deliver care within a defined timescale recognising the provider's contract;

Performers will ensure that:

- The patient and carer are aware that the NHS will only fund one course of treatment, with the exception of interceptive treatment commenced prior to the patient's 10th birthday, and once the treatment has commenced the patient and their treatment will not be transferable to an alternate practice apart from exceptional circumstances;
- The co-operation, motivation, aspirations and general health of the patient are consistent with the provision of orthodontic treatment, particularly their ability to maintain good oral hygiene to ensure no harm is done;
- The patient and carer are willing and able to commit to frequent attendance, which may be during school hours, over the course of orthodontic treatment and are aware of the need to wear appliances. The exception to this is patients referred for advice only;
- The patient is provided with the Patient/Orthodontist Agreement outlining their responsibilities during the course of treatment.
- The patient has read and understood the British Orthodontic Society leaflet entitled 'What Are the Risks of Orthodontic Treatment?';
- The patient understands that they will be given a separate written NHS orthodontic treatment plan. This outlines details of the braces and retainers that they will be given, in addition to other important facts about their proposed treatment;
- The patient understands that once braces have been fitted they will need to attend on a regular basis for adjustments, normally every 6 to 8 weeks and they have been informed by

the orthodontist and/or treatment co-ordinator how long the patients active treatment is likely to take;

- The patient understands that they need to keep their teeth and braces clean and follow the advice of the orthodontists and their staff. If the patients cleaning does not reach the acceptable standard they understand that their teeth might be permanently marked and that the orthodontist may suggest that the braces are removed early and the patient's treatment 'discontinued'. The orthodontist is required to provide appropriate advice on lifestyles during orthodontic treatment;
- If the patient's fixed braces are broken repeatedly, the patient understands that the orthodontist may be forced to terminate treatment and that the patient will not be able to access this treatment elsewhere on the NHS;
- The patient and/or carer understand that the patient will need to attend the appointments on time and on the correct day. If the patient is late, the orthodontist may be unable to see the patient since his/her treatment session might subsequently run late and thus inconvenience all other patients scheduled to attend after the failed appointment. If the patient misses their appointment or cancels without giving 24 hours' notice, the patient will be offered the next available appointment (usually six to eight weeks after the date of the failed/late cancelled appointment). Should this happen on two occasions without genuine reason, with the agreement of the NHS England Local Office, the patient's treatment may be terminated prematurely and they will not be able to access further treatment elsewhere on the NHS;
- The patient understands that, if retainers are removable, they need to be worn in accordance with the instructions given to the patient;
- Once the braces are removed, the responsibility for the future position of the patient's teeth depends on the patient wearing the retainers long term;
- The patient understands that the practice will supervise retention for a period of one year only (the cost of this supervision is included in the NHS contract) and that the patient will be discharged back to their GDP after this period. Following this year period, replacement retainers will be charged for on a private basis regardless of age or exemption status;
- If removable or fixed retainers are broken or lost during this initial one year period, there will be a charge unless the breakage is as a result of fair wear and tear;
- The patient understands that, at the end of this initial year of retention, the patient's treatment at the practice will be complete. There will be a charge for any further appointments, the repair or replacement of removable retainers and the repair or replacement of bonded retainers as this is not NHS treatment;
- The patient understands that teeth may try to move throughout life due to continued growth/development or other biological changes and that the patient is strongly recommended to continue with part-time wear of the retainers on a permanent basis (i.e. for life). The orthodontist cannot be responsible for any movement of the patient's teeth if they choose to stop wearing the retainers;
- If the patient contacts the practice, or any other orthodontist, subsequent to ceasing the wear of their retainers with a problem that their teeth are moving out of alignment, the patient realises that any further treatment may involve the use of fixed appliances. There will be a charge for a review appointment (to assess the problem) and subsequent treatment is unlikely to be available on the NHS unless there are very exceptional circumstances that can be evidenced;
- Where patient's needs are outside the scope of the service they are referred to a more appropriate provider of care.

3.2 Workforce

The staff composition will be as follows:

- Dentists with additional skills and experience to manage the procedural or patient complexity in Orthodontics
- Suitably trained and experienced dental healthcare professionals i.e. dental nurses/ hygienists/orthodontic therapists
- A dental nurse who will support the Orthodontist at all times
- A registered specialist in orthodontics

The provider will ensure:

- That robust practice management is in place to address issues arising from the patient pathway e.g. validation of patient data, management of patient complaints and issues, management of clinical information;
- That all dental/Orthodontic staff must have the appropriate clinical indemnity, either through an approved defence organisation or through their employment;
- That all staff supplied hold valid registrations and evidence of continuing professional development for on-going registration including participation in peer review and audit;
- That the performers have the skills to manage vulnerable patients who may have addiction, mental health illnesses and anxiety/phobia.

For level 3 care, as Level 2 care, but to include:

- Suitably experienced and qualified specialist Orthodontists with the following qualifications: Accredited consultant (Level 3b)/ Entered on GDC specialist list (Level 3a).

Each performer providing 3a complexity treatment must maintain a minimum of 50 NHS case starts per year, this may be carried out across multiple NHS contracts. It will be the individual contract holder's responsibility to ensure this requirement is achieved and reported to the commissioner.

As a minimum, each contract will have one performer who is a registered specialist in orthodontics and engaged in the day to day delivery of the service and patient care. The same specialist may lead more than one contract but providers must be able to demonstrate that if this is the case the specialist is able to provide adequate supervision for all contracts. All non-specialist clinicians delivering the service must be able to demonstrate the correct level of skill and competency to complete level 3a procedures to an appropriate standard.

(**See Appendix B and 3.3 below for more details on clinical skills and competencies)**

3.3 Clinical Competencies

Description of the Complexity Levels

There are several factors which need to be considered when describing the complexity level of an orthodontic case. These include the type of malocclusion, the technical difficulty in improving function and aesthetics, together with any patient modifying factors.

The provider will carry out both complexity 2 and 3a cases, it must be specialist led (Specialist to be defined as a dental practitioner entered on the GDC's list of those entitled to use the title "specialist in orthodontics). Level 2 can be undertaken by practitioners, under specialist supervision and with a formal link to a consultant-led MCN. This includes dentists who have enhanced skills and/or experience; non-specialists who have demonstrated the competencies detailed in the Curriculum for the Primary Care Dentist with a Special Interest in Orthodontics, either by obtaining the Diploma in Primary Care Orthodontics or by demonstrating equivalence.

Level 3a complexity must be carried out under the supervision of a registered specialist in orthodontics with the skills and experience to manage level 3a procedural or patient complexity. In order to maintain skills and competencies a specialist must lead the service, overseeing the assessment, treatment planning and supervision of other clinical staff.

Providers will be expected to provide evidence that clinical support staff (i.e. nurses/therapists) hold valid registration with the GDC. A qualified dental nurse (or one on an approved training programme) must support the treating clinician at all times. Additionally, all clinical staff must have the appropriate DBS checks, clinical indemnity and comply with health requirements e.g. have immunity to specified diseases.

Complexity Descriptors

Level 1 carried out by general dental practitioners

- Recognise malocclusion and normal occlusion.
- Ensure oral health is good prior to referral.
- Perform basic orthodontic examination, review the level of complexity and be familiar with (IOTN), explain to a patient what orthodontic treatment may involve and make valid and timely referrals.
- Monitor post orthodontic care maintenance.

Level 2 may be carried out by specialists or non-specialists

- Patients in the developing dentition requiring straightforward interceptive measures.
- Removable appliances in patients without skeletal discrepancies.
- Non-complex fixed appliance alignment in patients without skeletal discrepancies or significant anchorage demands.

Patient modifying factors may result in referral to 3a or 3b

Level 3a carried out by specialist practice or as a training case in secondary care by prior agreement

- Patients requiring orthodontic treatment for the management of skeletal discrepancies (removable, functional and fixed appliances).
- Patients with restorative problems which do not require complex multidisciplinary care with secondary care input.
- Patients with impacted teeth where the oral surgery/orthodontics liaison can be managed from specialist practice.
- Advice to those providing level 1 or 2 care.

Patient modifying factors may result in referral to 3b

Level 3b carried out by secondary care

Only level 2 and 3a are being commissioned under this contract

- Patients with clefts of the lip and/or palate or craniofacial syndromes.
- Patients with significant skeletal discrepancies requiring combined orthodontics and orthognathic surgery.
- Patients who require orthodontics and complex oral surgery input (for example, multiple impacted teeth).
- Patient with complex restorative problems requiring secondary care input in a multidisciplinary environment.
- Patients with complex medical issues, including psychological concerns, which require close liaison with medical personnel locally.
- Patients with medical, developmental or social problems who would not be considered suitable for treatment in specialist practice.
- Complex orthodontic cases not considered suitable for management in specialist practice.
- Referrals where advice or a second opinion is required from a secondary care.

General Dental Practitioners

Providers will return any incomplete or inappropriate referrals.

Any referrals that require additional clinical information to explain the need for advice or where there is no indicator that the patient has a minimum IOTN (Dental Health Component) score of 3 or other clinical factors that would warrant an assessment should be returned to the referring GDP with an explanation as to why the patient has not been offered an assessment.

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

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

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

If dental treatment is required before orthodontic treatment can commence this should be communicated to the referring GDP who is responsible for undertaking or arranging referral for treatment e.g. extraction or exposure to undertake themselves or refer where this is complex.

3.4 Location(s) of Service Delivery

The service delivery locations have been determined based upon CCG area populations to provide a good geographical spread and ease of access for patients. Premises must be based within the geographical area(s) set out in Appendix E.

Providers will need to demonstrate that the premises proposed for the delivery of the service are in a convenient location taking into consideration population densities (e.g. close to schools, places of work, good transport links or homes) within the defined geographical area(s) as set out in the lotting strategy published on the NHS England Midlands and East web page (https://www.england.nhs.uk/mids-east/info-professionals/) as advised as part of the procurement process. The locations should be easily accessible to patients arriving by foot, public transport and car.

3.5 Premises Requirements

Providers are required to secure facilities and equipment suitable for service delivery. The provider must indicate potential premises and number of surgeries planned for the provision of the service, this may include the development of outreach clinics (as a hub and spoke arrangement), plans to work with other practices or other innovations.

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

The provider shall ensure that the premises used for the provision of the orthodontic service:

- Are suitable for the delivery of orthodontic services and meet the reasonable needs of the patients;
- Are registered with the Care Quality Commission (CQC);
- Comply with the Equality Act 2010;
- Comply with the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15.** 'Premises' and 'equipment' are defined in the regulations;
- Are compliant with Decontamination in primary care dental practices (HTM 01-05) Best Practice (as opposed to essential criteria);
- Has equipment and facilities that conform to relevant standards/regulations and are maintained regularly in line with guidelines and manufacturers protocols;
- Has appropriate radiographic facilities, as part of their contractual provision, e.g orthopantomogram (OPG) or lateral cephalometric radiology has appropriate and sufficient waiting room accommodation for patients and carers;
- The telephone number to be used by patients and or professionals in connection with the delivery of the orthodontic service must not start with the digits 087, 090 091 or consist of a local personal number, unless the service is provided free to the caller;
- Ensure any dental laboratory services used meet with GDC guidance, EU legislation and complies with all relevant and current guidelines and legislation;
- Ensure that safe processes and working environment are in place. This will include training of staff in relevant processes and procedures;
- Ensure all legal requirements relating to radiological guidance are met;
- Appropriate premises and equipment such as radiographic facilities e.g. Dental Panoramic Tomography, Lateral Cephalometric radiograph and any appropriate equipment must be at every site, include any drugs to deal with medical emergencies – as recommended by Resuscitation Council UK

3.6 Accessibility and Opening Hours

The service will be flexible and responsive to patient need in accordance with the Equality Act 2010 and the Health and Social Care Act 2012. Wheelchair access is particularly important.

The service must offer a choice of routine appointments including early mornings and late afternoon appointments for patient's e.g. at key educational stages, apprenticeships. It is expected that a minimum of 30% of appointments are available outside of school hours during term time per week unless it can be evidenced that an alternative provision is required to meet local need.

Opening hours should be a minimum of five days a week, access outside of school hours and should be set to maximize attendance from children from all socio-economic backgrounds. A proportion of appointments must be available before 9am, after 5pm and at weekends and the details of the exact requirements will be agreed locally with Commissioners based on feedback from patient surveys.

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

3.7 Patient Pathway(s)

See **Appendix C** for the commissioned illustrative patient pathway

Providers must adhere to referral management protocol (as developed by the MCN and agreed with NHS England) in line with the principles of this specification.

The provider will demonstrate, on request, that robust procedures are in place to address issues arising from the patient pathway e.g. validation of patient data, management of patient/carer complaints and incidents, management of clinical information/data security.

3.8 Training

The provider will be required to provide advice and training to referrers to ensure appropriate referrals, and to participate in and contribute to, an agreed programme of continuing professional development for all relevant clinicians, both within the contracted service and externally.

3.9 Safeguarding

The Provider shall:

- Ensure they have a named professional that takes a lead and is appropriately trained in relation to adults at risk and children safeguarding as set out in Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework 2015, and in line with Working Together (2018), Adult Intercollege Document (2018) Care Act (2015), Children Act (1989) and Children Act (2004);
- Have policies and procedures in place that meet the requirements set out in current guidance and legislation pertaining to Adults at Risk, Safeguarding Children and Looked After Children (LAC) as well as specific and local arrangements as prescribed by the Local Safeguarding Adult Boards (LSABs) and the Local Safeguarding Children Boards (LSCBs). Policies must

comply with legislation that underpins safeguarding, e.g. Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS), PREVENT.

- The safeguarding policies must include managing allegations against staff, and the chaperoning of children, young people and adults at risk. Ensure that records are retained of incidents relating to allegations made against staff working with children, young people and adults at risk. This will include details of referrals/discussions with the Local Authority Designated Officer (LADO) and outcome of the allegation;
- Contribute to serious case reviews (SCRs), domestic homicide reviews (DHRs) and multi-agency case reviews as requested by the LSABs and LSCBs and Child Death Review Process. The Contractor will actively seek and accept support from the named professional leads for safeguarding within the CCG;
- Use appropriate LSAB & LSCB local authority endorsed systems to make safeguarding referrals and ensure that such information is appropriately flagged within the health care record;
- Ensure that they are compliant with safer recruiting; DBS Standards and the Lampard Recommendations, and
- Ensure that all staff have access to training, development and supervision in relation to all aspects of safeguarding children and adults at risk, including MCA and DoLS and will ensure that in-house training packages/resources used are in line with professional body recommendations, requirements of the LSABs, additionally for children as per Working Together to Safeguard Children 2018 and Intercollegiate Document (Safeguarding Children: Roles and Competences for Health Care Staff) 2014 and the Intercollegiate Document Adult Safeguarding Roles and Competencies for Health and Care Staff (2018).

3.10 Governance and Information:

The provider must ensure that:

- They have robust governance and quality assurance programmes in place to ensure a safe environment for all service users;
- They have safe processes and working environment in place, that will include ensuring that there are up to date policies and processes, that staff are familiar with these and have the relevant training;
- Legal requirements relating to radiological legislation and guidance are met;
- Dental laboratory services used meet with GDC guidance, EU legislation, are registered with the Medical Devices Agency and work within the relevant legislation;
- Dental services are in accordance with best practice as set out in the following guidance (This list is not exhaustive but includes the following):

    - High Quality Care for All next stage review 2008
    - NHS Constitution, 2009
    - Implementing Care Closer to Home, 2007
    - Modernising Medical Careers
    - NHS Personal Services Agreements
    - Ionising Radiation (Medical Exposure) Regulations
    - British Orthodontic Society, Orthodontic Radiographs Guidelines (2015)
    - British Orthodontic Society, Guidelines on Supervision of Qualified Orthodontic Therapists (2012, updated 2016)

- British Orthodontic Society, Professional Standards for Orthodontic Practice (2014)
- AIDS/HIC infected Healthcare worker Guidelines
- Equality Act, 2010
- Human rights Act, 1998
- Dental Practitioners' Formulary
- GDC Standards for the Dental Team
- GDC Standards
- Caldicott Principles
- The Hazardous Waste Regulations, 2005
- The Health and Safety at Work Act (1974) Statement of Policy with Respect to the Health and Safety at Work of All Employees
- Disability Discrimination Act (1995) and Disability Equality Duty (DED) 2005
- Decontamination of Dental Instruments: Health Technical Memorandum (HTM) 01-05, Parts 1 and 2, 2013
- Health Protection Agency Guidance on Infection Control, Communicable Diseases for Primary and Community Care within the Local Area
- Securing Excellence in Dental Commissioning, NHS Commissioning Board 2013
- Guide for Commissioning Dental Specialities – Orthodontics, 2015
- British Orthodontic Society, Clinical Guidelines on retention (Revised 2013)
- Royal College of Surgeons of England, National Clinical Guideline for the Extraction of First Permanent Molars in Children (2014)
- Five Year Forward View, NHS England 2014.

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

- The provider must assign responsibility for IG to an appropriate team member;
- The policy must address the overall requirements of information quality, security and confidentiality;
- All contracts, staff, contractor, third party, contain clauses that clearly identify responsibilities for confidentiality, data protection and security;
- All staff members are provided with awareness and training across the IG agenda;
- The provider must implement IG Information Security management arrangements to ensure the NHS Digital Statement of Compliance is satisfied;
- The provider must ensure that all staff and all those working for or on behalf of the provider where applicable comply with the terms and conditions set out in the RA01 form;
- The provider must ensure that all correspondence, fax, email, telephone messages, transfer of patient records and other communications are conducted in a secure and confidential manner;
- The provider must ensure patients are asked before using their personal information that is not directly contributing to their care and that patients decisions to restrict the disclosure of their personal information is appropriately respected;
- The provider must be fully computerised, for examples, but not limited to, electronic patient records, ability to submit electronic FP17O claims by EDI transfer, access Compass to update contractual information and access schedules, submit Friends and Family Test date, work with any electronic referral management system in place (or be able to work with future systems);
- The provider must only use nhs.net email account/s when transferring patient identifiable information and other confidential or sensitive information.

4. Prevention, Self-Care and Patient Carer Information

Each performer must ensure that the patient and/or carer has a clear understanding in advance of treatment what will happen to them during the treatment, who will be responsible for delivering each element of care and why, e.g. the patient may be returned to their GDP for extractions.

Prior to initiation of treatment, the patient and/or carer should be provided with the following information verbally and in writing, where appropriate utilising a translation service, given in such a way that it supports the patient's ability to give valid consent to initiate treatment:

- written treatment plan detailing the outcome of the assessment, such that the patient is clear why a specific treatment opinion has been selected, estimated length of treatment and visit frequency
- what to expect during treatment;
- what is expected of them including self-care, compliance, and under what circumstances treatment will be terminated, eg poor attendance, poor oral health, abusive behaviour;
- any additional costs the patient may experience, eg payment for replacement of broken appliances under Regulation 11 and equipment such as wax, toothbrushes etc;
- a Patient/Orthodontist Agreement;
- FP17DCO form.

4.1 Patient Information

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

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

Prior to the start of treatment, the patient and/or carer should be provided with the following information verbally and in writing using the Patient Agreement as specified below.

- treatment plan including length of treatment and frequency of visits
- what to expect during treatment
- what is expected of them including self-care, compliance and under what circumstances treatment will be terminated e.g. poor attendance, poor oral hygiene, abusive behaviour (patient contract could be inserted here)
- any additional costs the patients may experience e.g. payment for replacement of broken appliances under Regulation 11 and equipment such as wax, toothbrushes etc.
- the information should be given in such a way that it supports the patient's ability to give informed consent to initiate treatment.

Providers will be required to:

- ensure the patient and/or carer has a clear understanding in advance of what will happen to them during the treatment, who will be responsible for delivering each element of care and why, for example, the patient may be returned to their GDP for extractions
- ensure informed consent is gained for all patients prior to initiating assessment and/or treatment

- have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults
- have in place a policy that meets the commissioners' and CQC requirements for safeguarding children and adults.
- The provider should evidence that all patient information and consent processes have involved patients/carers in its development and that it is regularly reviewed and updated

4.2 Acceptance criteria, data collection/submission

Providers must comply with the requirements listed below:

- The service will only use the referral management process as identified by the relevant Local Office;
- Patients who are assessed as not ready for orthodontic treatment should be discharged and referred back to the referring GDP*;*
- The service will only use electronic data interchange (EDI) to submit claims to the Business Services Authority;
- Providers will review the referral for appropriateness within 20 working days of the referral being received by the specialist practice, returning any that are incomplete;
- Not all referrals will automatically warrant an assessment appointment to be offered. Any referrals that require additional clinical information to explain the need for advice should be returned within 20 working days requesting the additional information; including where there is no indicator that the patient has a minimum IOTN score of 3 or other clinical factors that would not warrant an assessment. Where the referral suggests that an assessment is appropriate this should be offered within 12 weeks;
- If waiting 12 weeks for an assessment appointment would result in the patient reaching the age of 18 prior to assessment they should be offered an earlier assessment appointment before their 18th birthday so that where they have sufficient IOTN treatment can be offered without the need to seek commissioner approval. In these instances the assessment FP17O must be kept open so that when the patient starts treatment over the age of 18 it is still covered under the NHS as they were under 18 at the time of assessment;
- Following assessment where a patient meets NHS criteria and is ready to commence treatment they should be placed on a treatment waiting list if it is not possible to start treatment immediately. The placement on the waiting list is to be prioritised by the patient's clinical need;
- Following assessment where a patient is offered NHS treatment as part of the informed consent process, a Patient/Orthodontist Agreement must be used;
- Providers will communicate the outcome of the assessment with the referring practice either confirming acceptance of the patient for treatment or provide an explanation why treatment has not been offered;
- Where further treatment is required before orthodontic treatment can commence e.g. extraction or exposure, this should be undertaken/arranged by the patient's GDP by referral through the agreed oral surgery pathway;
- The submission of FP17O for a case start is required within 62 days, except where this is an transfer case that is being completed as the contract has the capacity to treat due to the number of discontinuation or abandoned cases
- A course of orthodontic treatment for a patient aged under 10 years will accrue 4 units of orthodontic activity (UOA) regardless of the number of assess and review appointments, this is inclusive of 1 UOA for the assessment;

- A course of orthodontic treatment for patients aged between 10 and 17 will accrue 21 UOAs regardless of the number of assess and review appointments, this is inclusive of 1 UOA for the assessment;
- Where a course of orthodontic treatment for patients aged over 18 has been approved by the commissioner, this will accrue 23 UOAs regardless the number of assess and review appointments, this is inclusive of 1 UOA for the assessment;
- Submission of an FP17O for completion/abandoned/discontinued cases are required within 62 days of treatment completion/abandon/discontinue;
- Providers will inform the referring practice when treatment is complete or has been discontinued or abandoned;
- The orthodontic assurance framework (OAF) will be used in the quarterly monitoring of the contract.

4.3 Management of failed appointments

Providers are expected to demonstrate effective methods of monitoring and reducing failures to attend to improve service utilisation and improve treatment outcomes. As a minimum this should include the use of a written agreement setting out expectations both for the patient and provider (standardised template to be agreed by the MCN).

4.4 Referral Route

The NHS England commissioned e-RMS (where available) will be the only route for all referrals from primary dental care providers.

In the event that the Orthodontic e-RMS is not operational for any reason and on direction from the commissioner, the provider will only accept referrals on the approved referral template and in accordance with the MCN/commissioner approved referral protocol. Each referral data set will be complete to the service standard and include necessary x-rays and patient history.

4.5 Referral source

Source of referrals will usually be via General Dental Practices (GDPs).

Referrals will be forwarded to the service provider via the referral management process (where available) unless otherwise directed by the NHS England Commissioner.

Patients seeking to transfer into the area and between local providers will be accepted according to the NHS England agreed protocol as outlined in the Dental Policy Book.

Referrals may also be received from secondary care providers, in accordance with the locally developed protocol, where patients have been referred but do not meet the level 3b complexity.

4.6. Procedure on referral

- All referrals will be made via the e-RMS system (where available) on the MCN approved referral template. Where the e-RMS is available any referral forms sent outside the e-RMS system should be returned to the referring GDP unless otherwise directed by NHS England. Where the e-RMS is not available, only referrals on NHS England approved forms which are fully completed can be accepted.

- The referrer (GDP) will (in consultation with the patient/carer) select a referral target (orthodontic provider).
- All referrals will include digital copies of relevant radiographs where available.
- Receipt of the referral will be acknowledged by the orthodontic provider (to the referrer) within 5 working days.
- All referral forms will be subject to clinical triage to determine eligibility for assessment.
- Incomplete or inappropriate referrals will be returned to the referring GDP.
- Any referrals that require additional clinical information to explain the need for advice or where there is no indicator that the patient has a minimum IOTN score of 3 or other clinical factors that would warrant as assessment will be return to the referring GDP with an explanation as to why the patient has not been offered an assessment.
- Patient will be contacted within 5 working days of receipt of fully completed referral to be offered an appointment date.
- Patient to be offered an assessment within 12 weeks of receipt of fully completed referral.
- Once booked, the provider will make information available to the patient giving details of the provider and 'what to expect'.
- The clinician should ensure that an oral health assessment/review has been carried out and that the information collected and the risks identified are reviewed and shared with the patient before entering treatment. It is never in the patient's best interests to plan and deliver orthodontic treatment in the absence of a stable oral environment when the risk of dental disease is high.
- The detailed clinical aspects of the proposed orthodontic treatment should be considered to ensure that it will be beneficial to the patient.
- Once the clinical face-to-face assessment has been undertaken, the provider will correspond with the referrer indicating the findings and outcome within 10 working days.
- If dental treatment is required before orthodontic treatment can commence this will be communicated to the referring GDP. The Orthodontist will be responsible for advising on the dental treatment required before orthodontic treatment can commence. Dependant on the complexity this could involve a referral to secondary care, a tier 2 provider or back to the GDP in line with the National Commissioning Guide for Oral Surgery and Oral Medicine, using the locally agreed referral management system/process.
- Patients accepted for treatment will be provided with a written agreement setting out expectations both for the patient and provider (standardised template to be agreed with the MCN).

4.7 Assessment only appointments

Providers will work with the Orthodontic e-RMS (where available), the MCN and commissioners to ensure that clinical and patient information is developed to reduce inappropriate referrals in line with local pathways. It is fully acknowledged that assessments only are an important part of service delivery but unnecessary occurrences as a consequence of inappropriate referrals or repeat assessments should be audited by the provider and flagged to the MCN.

4.8 Exclusion criteria

The Contractor shall only provide orthodontic treatment to a person who is assessed by the Contractor following a case assessment as having a treatment need in:

- grade 4 or 5 of the Dental Health Component of the Index of Orthodontic Treatment Need (see *The Development of an Index for Orthodontic Treatment Priority*: European Journal of

Orthodontics 11, p309-332, 1989 Brooke, PH and Shaw WC – the article is also available at www.dh.gov.uk or

- grade 3 of the Dental Health Component of that Index with an Aesthetic Component of 6 or above.

Unless the Contractor is of the opinion, and has reasonable grounds for its opinion, that orthodontic treatment should be provided to a person who does not have such a treatment need by virtue of the exceptional circumstances of the dental and oral condition of the person concerned. The exceptional circumstances must be documented in the patient record.

4.9 Response time & detail and prioritisation

The definition of a treatment waiting list is as follows:

An orthodontic assessment has been undertaken, the patient has been judged to meet the NHS criteria, the patient is ready to commence treatment and has accepted the offer of orthodontic treatment.

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

- Review of referral – 5 working days;
- Receipt of referral to assessment appointment – 12 weeks;
- Assessment to treatment start (see above definition) – prioritised according to clinical need.

5. Discharge Criteria and Planning

5.1 Procedures on Discharge

Providers are expected to follow the British Orthodontic Society guidance 'Liability of Practitioners for continuing care after completion of active treatment'.

Taking into account local safeguarding protocols:

- **Patients whose treatment is complete**
  On completion of treatment, the referring GDP and the patient will receive a discharge summary (including the URN where available) within 10 working days. If appropriate, other agencies will also be informed

- **Patients whose treatment is not complete**
  Patients who do not attend for appointments (DNA) will be discharged according to the DNA protocol (agreed by NHS England). Where appropriate, other agencies may be informed. The provider should be able to demonstrate that they have made reasonable efforts to contact the patient and/or carer and inform them what will happen if they don't attend.

  Where patients are discharged due to non-compliance with the treatment requirements, the provider will need to be able to demonstrate that they have explained the consequences of the non-compliance to the patient and/or carer.

- **Patients who do not commence treatment**.
  If a patient fails to attend for their initial assessment, they will be discharged back to the referring GDP.

5.2 Information Standards

Discharge information will:

- Include the URN (where available) and the NHS Number (where known)
- Contain clear instructions for the patient's GDP for any on-going care
- Clear instructions to the patient and/or carer regarding the use of any retainers and the consequences of non-compliance
- Contain a summary of the treatment provided
- Contain details of continued treatment to be given by the service
- Be sent to the referring GDP within 10 working days of treatment completion date.

5.3 Replacement Orthodontic Retainers

NHS England's policy regarding the management of patients who require (or request) the repair or replacement of NHS funded orthodontic retainers is below:

Retainers Lost or Broken Beyond Repair by an Act or Omission by the Patient

Where a retainer is lost or broken beyond repair by an act or omission by the patient this should be managed using Regulation 11 of the NHS Dental Charges Regulations 2005 (30% of a Band 3 patient charge per retainer). Where patients application is approved no UOAs are credited, the provider will retain the patient charge.

Repair or Replacement Necessitated by 'fair wear and tear"

During the supervised retention period (normally a minimum of 12 months), the repair or replacement should be provided free of charge to the patient (with no UOAs credited).

6 Performance Targets – Quality, Performance & Productivity

The table below sets out the local performance targets applicable to this service:

Local Performance Targets	***Indicator***	***Threshold***	***Method of Measurement & Frequency***
QUALITY			
Control of Infection	Premises to conform to HTM 01 05 essential standards and other relevant national standards	100% compliance	CQC report / other national quality assurance reports IPS 6 monthly audit tool As determined by CQC/ IPS - 6 monthly
Premises & Equipment Compliance	Premises to conform to standards set by CQC and other relevant national standards	100% compliance	CQC report / other national quality assurance reports As determined by CQC

Personalised Treatment Plans	Patients are assessed and provided with a written orthodontic treatment plan alongside standard NHSA documentation (e.g. FP17dco)	100% of patients	MCN mediated Annual Audit
Clinical outcomes	The provider will undertake a minimum of one clinical audit in addition to PAR scoring per annum agreed with the local commissioners/MCN plus regional audits as agreed.	100% compliance	Annual Report
Service User Experience	A patient and carer experience survey agreed by the MCN is offered to all patients upon discharge or completion of their treatment that incorporates the Friends and Family test (NHSFFT) • Did you feel sufficiently involved in the decisions about your care? • How satisfied are you with the NHS dentistry received? • Other validated Patient Reported Outcome and Experience Measures (PROMS/PREMS) as determined by the MCN	15% return rate and 80% of the response is good or better according to MCN agreed standards	Quarterly returns via MCN & NHSFFT
Experience Improvement Plan	All complaints/Incidents/concerns/ compliments monitored by type/source (including web reviews on NHS Choices)	100% compliance	Quarterly reporting
	Action plans developed to address areas of concern raised in patient feedback / complaints. Re-audit every six months	Action plans for top 3 areas of concern	Bi annual report
PERFORMANCE & PRODUCTIVITY			
Activity Reporting	In addition to the BSA schedule/Dental Assurance Framework (DAF) data, reports to be produced showing the following (where not available via and RMS): 1. Numbers of patients awaiting assessment and treatment 2. Referral to treatment time 3. Assessment outcome data (eg patient refused or not suitable for treatment) 4. DNA frequency 5. Other metrics as agreed with MCN	100%	1. Monthly Report 2. Monthly Report 3. Quarterly Report 4. Quarterly Report 5. To be determined by MCN

Referral management	Patients contacted within 5 working days of receipt of referral to be offered an appointment date	100%	Annual Audit
	Patients offered assessment within 12 weeks of receipt of fully completed referral	100%	Annual Audit
	All referrals to be processed via the e-RMS, or where not available via the agreed local referral management process	100%	Quarterly Audit

6.1. Activity

The UOAs required for the geographical area being commissioned will be set out in the lots to be procured. Until the outcome of the procurement is established it will not be possible to confirm which contracts will accept a cohort of patient transfers to continue treatment in addition to the new patients they will accept that will deliver the contracted UOA baseline. This will be determined by the transition arrangements agreed with the incumbent provider.

NHS England is committed to ensuring continuity of care for patients, wherever possible.

NHS England will adopt a step up and step down contractual framework that will determine the UOAs for new providers that secure a contract that does/does not take on patients currently in treatment and retention and where existing providers secure a contract that is for greater or less activity than they are currently contracted to provide.

7. Finance - see Schedule 4 of the Personal Dental Service Agreement

NHS England's national methodology has been used to establish a UOA price for a "stable" practice that has a cohort of patients already in treatment, in retention as well as taking on new patients. This will be a benchmark price of £56.89 (2017/18). Potential bidders should consider local market factors such as contract size and location when submitting their proposed contract price.

As detailed below a stepped contract value may be necessary for years 1 and 2 where a new contractor does not take over a caseload of patients currently in treatment or retention.

7.1 Pricing of orthodontic contracts

Steady state contract (no change to the number of Units of Orthodontic Activity commissioned)

- Bid price (UOA rate) multiplied by number of UOAs commissioned.
- Complete all treatments commenced prior to new contract commencement with no additional payments.

N.B. Total contract value payable covers assessments for treatment, new case starts and providing care and treatment for a cohort of patients.

New contracts (not previously in place, commencing on 1st April 2019; no pre-existing caseload)

- Bid price (UOA rate) multiplied by number of UOAs commissioned *85% Year 1
- Bid price (UOA rate) multiplied by number of UOAs commissioned *96% Year 2
- Bid price (UOA rate) multiplied by number of UOAs commissioned *100% Year 3 onwards

In the event the provider is required to take on an existing caseload, i.e. patients who have already commenced treatment elsewhere and are still in active treatment, the following payments will be applicable:

- Payment of £662 to complete treatments for each patient still in active treatment with a fixed appliance. Monies paid over 2 financial years – 70% in year 1; 30% in year 2.

- Payment of £126 for each patient still in active treatment with a removable appliance. Monies paid in year 1

- Retention payment per patient who have not yet completed their 12 month retention period - £25. Monies paid in year 1

Scale down contracts (reduced number of UOAs commissioned when compared to numbers commissioned pre new contract commencement)

- Bid price (UOA rate) multiplied by number of UOAs commissioned

Payment to complete treatments

- Payment of £662 to complete treatments for each patent **above** contracted activity post new contract commencement and still in active treatment with a fixed appliance. Monies paid over 2 financial years – 70% in year 1; 30% in year 2.

- Payment of £126 for each patient still in active treatment with a removable appliance. Monies paid in year 1.

- Retention payment per patient who has not yet completed their 12 month retention period from de-bond prior to new contract commencement - £25. Monies paid in year 1

N.B: In order to calculate the number of patients for whom payment to complete treatment can be made, the number of patients in treatment pre new contract commencement is identified. In order to calculate the number of patients for whom treatment will be completed with no additional payment made, divide the number of UOAs to be commissioned under the new contract by 22.5 UOAs to give the expected annual number of patients in treatment. Then multiply by 1.75 to denote that average length of a course of treatment is 21 months.

Providers can then achieve payment to complete treatments by subtracting the number of patients to be treated post new contract commencement from the numbers in treatment pre new contract commencement. See example below for illustrative purposes:

Using an example of an existing contract of 6,000 UOAs with a total contract value of £330,000 using the benchmark price of £55 per UOA (£55 used for illustrative purposes only; for the avoidance of doubt the UOA price for the new contract will be applied) –

contract SCALING DOWN by 750 UOAs to 5,250 UOAs. *(NB: Example makes the assumption that all patients in treatment have fixed appliances)*

Step 1*: Determine the expected annual number of patients taken into treatment for the new recurrent contract, in the example above 5250 divided by 22.5 equals 233 patients. Multiply the annual number, i.e. 233 by 1.75 to give a total number of expected patients in treatment of 408.*

Step 2*: Determine the number of cases in treatment under the existing contract, i.e. 6000 UOAs /22.5 x 1.75 = 467 patients (used for illustrative purposes only – the actual validated number of patients in treatment would be used).*

Step 3*: Take the number of patients determined in Step 2 (i.e. 467), minus the total number of patients determined in Step 1, (i.e. 408 patients) to give the total number of patient for whom additional payment would be applicable (59 patients).*

Step 4*: Multiply the number of additional patients from Step 3, ie 59 by £662 close down payment – equates to a payment of £39,058, of which 70% is paid in year 1 and 30% in Year 2.*

Scale up contracts (increased number of UOAs commissioned when compared to numbers commissioned pre new contract commencement)

- Bid price (UOA rate) multiplied by number of UOAs commissioned under the previous contract
- Complete all treatments commenced pre new contract commencement with no additional payments.

Additional contracted activity:

- Bid price (UOA rate) multiplied by number of UOAs commissioned ***above*** number of UOAs commissioned under the old contract multiplied by 85% to give Year 1 total contract value
- Bid price (UOA rate) multiplied by number of UOAs commissioned ***above*** number of UOAs commissioned under the old contract multiplied by 96% to give Year 2 total contract value.
- Bid price (UOA rate) multiplied by number of UOAs commissioned ***above*** number of UOAs commissioned under the old contract multiplied by 100% Year 3 total contract value onwards.

In the event the provider is required to take on additional patients who have already commenced treatment elsewhere and are still in active treatment, the following payments will be applicable:

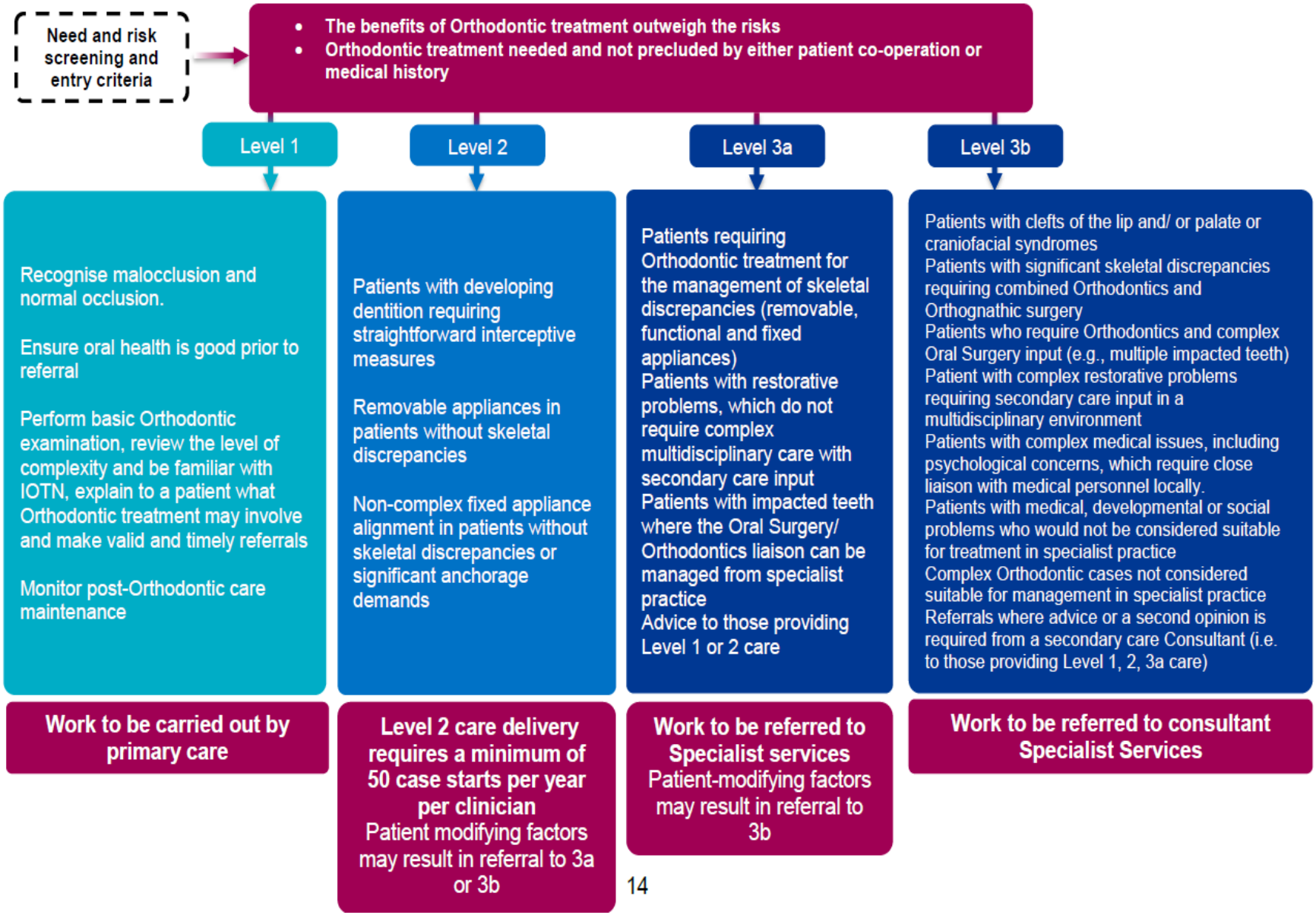
- Payment of £662 to complete treatments for each patient still in active treatment with a fixed appliance. Payment of £126 for patients with removal appliance. Monies paid over 2 financial years – 70% in year 1; 30% in year 2.

- Payment of £126 for each patient still in active treatment with a removable appliance. Monies paid in year 1.

- Retention payment per patient who has not yet completed their 12 month retention period from de-bond - £25. Monies paid in year 1

NB: DDRB uplift is not applicable to the payments to complete treatment rates outlined above, i.e. £662 for patients in active treatment with a fixed appliance, £126 for patients in active treatment with a removable appliance, and £25 fee for patients in retention.

Appendix A – Complexity of Orthodontic treatment



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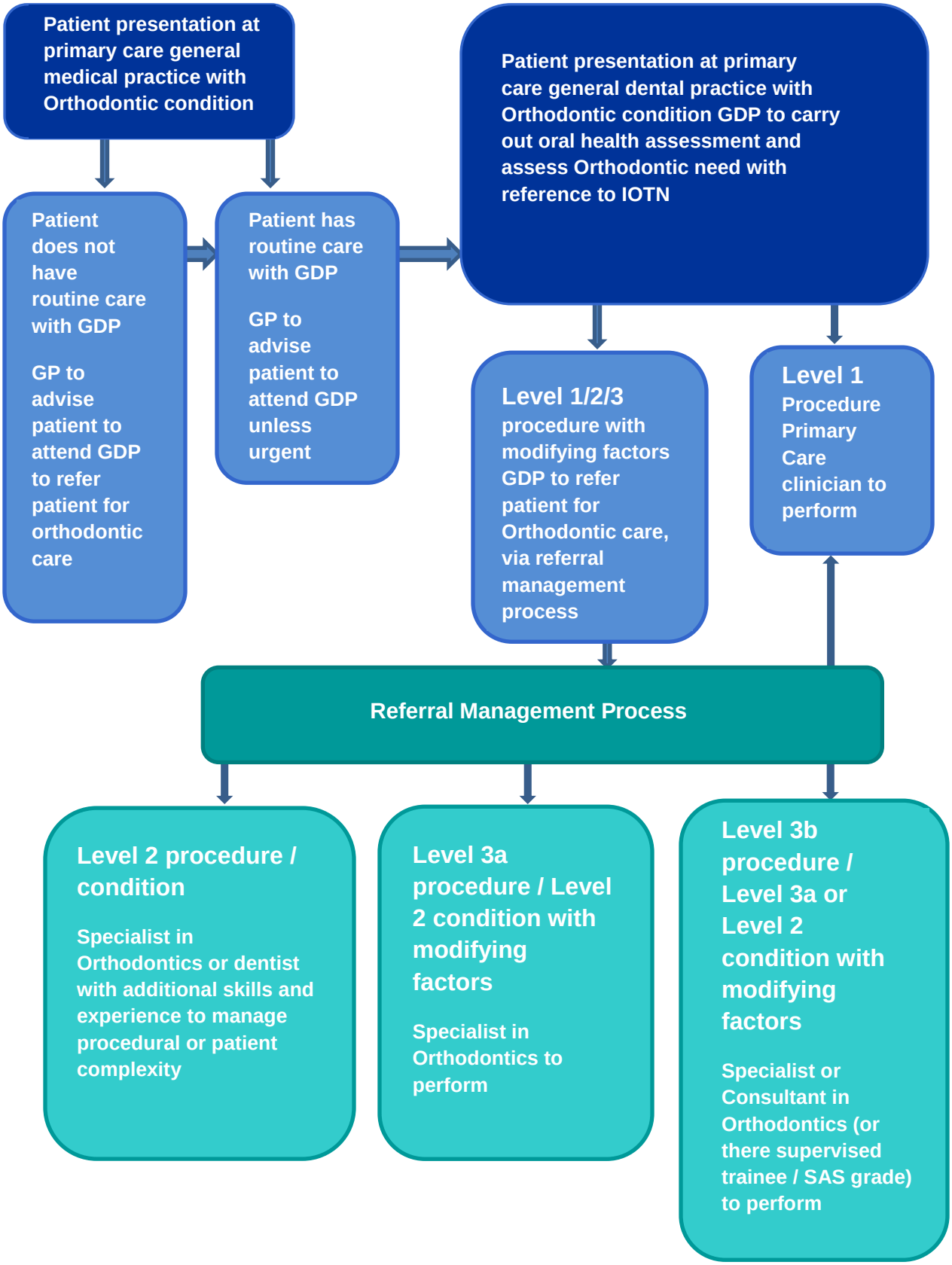
Appendix B - Provider Requirements

	Requirement
Clinical skills and competencies: performer(s)	1. Registered with General Dental Council 2. Currently on, or eligible for inclusion, on Performer List 3. Specialist in Orthodontics on the register held by the General Dental Council Evidence of clinical experience, on-going relevant CPD, peer review and audit
Clinical skills and competencies: Chairside Dental Care Professionals	*GDC Registered Orthodontic Therapist :* Current skills outlined in the GDC Scope of Practice 2013 and work under the supervision of GDC registered dental practitioner as outlined in the British Orthodontic Society publication 'Guidelines on Supervision of Qualified Orthodontic Therapists'. *GDC Registered dental nurse:* Current skills in chairside dental nursing for orthodontic procedures (where provided) and expanded duties subject to suitable training.
Facilities	Accessible, appropriately equipped and CQC registered clinical setting for the provision of orthodontic services. To include onsite access to: • Digital OPG/lateral Ceph radiology equipment
Record keeping	Evidence of adequate clinical records keeping and a document management / data governance as well as compliance with relevant legislation / standards. Use of contemporary and secure practice/records management software
Medical emergencies	Evidence of training within last 12 months for all clinical staff
Management of service: (interface with other clinical service providers and RMS)	The provider will be fully computerised and will have in place appropriate IT to receive patient referrals safely and compliance with information governance standards All providers will have an operational nhs.net email account for transmitting and receiving confidential patient information. Able to communicate effectively (written and verbal) with primary and secondary care clinicians with primary and secondary care clinicians
Management of service: interface with patients	Systems in place for receiving patient feedback and management of complaints / incidents The provider will have a robust computerised appointment and reminder systems Appropriate verbal and written information for patients in a variety of formats/media/languages appropriate to the local need Policy for minimising wasted appointment times due to failed appointments and cancellations Flexible and responsive service able to adapt to patients' needs including those with protected characteristics etc. and those with addiction, mental health illnesses and anxiety/phobia.
Management of service: interface with commissioners	The provider will be able to demonstrate computerised systems in place for reporting on performance, activity and quality of service

Appendix C - Illustrative Patient Pathway



Appendix D – Transferring between providers during treatment protocol

(see also Section 11.1 of the NHS England Dental Policy Book refers for transfers from outside of the UK)

This section is not applicable to patients who will be transferring as a result of a change of provider due to the procurement where separate arrangements will apply.

It is a provider's decision whether to accept transfer cases in both circumstances below. It is also a provider's decision whether any transfer cases continue with their original treatment plan or, following discussion with the patient and parent/carer, whether the treatment plan will change.

Transfers from outside of the UK

A GDP must establish that the patient is entitled to receive NHS care. If they are, the onus is on the patient (and not GDP or orthodontist) to obtain the relevant information from their original orthodontist so that the GDP can make a referral. The new orthodontist must establish from the information supplied by the original orthodontist whether the patient met the NHS eligibility criteria before their original treatment began, i.e. that they were under 18, an IOTN or at least 3.6 and have good oral health). If they did not (due to age or insufficient IOTN) and their current status does not meet NHS eligibility criteria the NHS will not fund continuation of treatment and this must be completed privately. If the patient cannot provide their original assessment and treatment information, it is their IOTN status at the time of referral that determines whether the NHS will complete their treatment (ie they must have an IOTN of at least 3.6). If the information supplied by the original orthodontist demonstrates that the patient met NHS criteria at the start of treatment, or their IOTN at the time they are referred in the UK, as the patient has not received NHS treatment to that point, they are entitled to a course of NHS treatment and 21 UOAs are claimable as a case start.

The transfer of patients already in an orthodontic course of treatment to and/or from other areas requirements

A patient is only entitled to one NHS funded course of treatment (this excludes where a patient still meets NHS criteria following interceptive treatment) apart from exceptional circumstances.

Although contractors are credited with 21 UOAs at the start of a course of treatment regardless of whether treatment is completed, payment of 1/12th the contract value is to provide care to a cohort of patients (case starts, in treatment and in retention). There will always be patients that do not complete treatment, this may free up capacity to take on transfer patients. Unless the number/work associated with incoming transfer cases is greater than the number/work of discontinued/abandoned course of treatment, providers may have the capacity to accept transfers within their existing contract payment. In these circumstances it is expected that providers would agree that it would not be good use of public money to submit a claim when accepting a transfer patient as this will use up a further 21 UOAs and deny another patient a course of treatment that year, extending the waiting times for treatment. Even where a claim has not been submitted at the start of a course of treatment, a FP17O claim should always be submitted on completion and NHS Business Services Authority, Dental Services validation rules allow this to be processed so this will balance the start to completion ratio. Where providers do

not agree to this arrangement they should discuss this on a case by case basis with the Commissioner.

Transfers are to be initiated by the patient's GDP; when a patient moves they should source a new GDP to ensure ongoing continuing care. Following discussion whether referral to a more local orthodontist to complete care is appropriate (i.e. the treatment is not almost complete or the distance is not considered great when considering this is for specialist treatment and changing orthodontist during a course of treatment can extend the duration of treatment) once the patient has chosen their preferred new orthodontist the GDS practice should contact the original orthodontist and obtain details of the treatment (see below) to refer to a new orthodontist.

If the transfer request is made by the original orthodontist, the new orthodontist must establish that the patient has a GDP for their ongoing continuing care before considering whether to accept the transfer.

The referral must be made using the Local Office's usual referral pathway and accompanied by the original assessment, IOTN score, x-rays, models and photographs as a minimum; ideally the full patient record should be included.

Where prior approval is not required (when this relates to a move and no claim for treatment will be submitted) the following should be considered when considering whether it is appropriate to accept the transfer:

- When will the treatment complete;
- Travel time would be unreasonable for the number of appointments remaining;
- The practice review of the start to completion ratio indicates capacity (taken from the Orthodontic Assurance Framework).

Prior approval is required where a second course of treatment relates to a move where the distance a patient is required to travel to complete treatment is considered unreasonable and a claim for treatment is to be submitted, and for any other reason than moving. In these circumstances the Local Office must be provided with the following in order to determine whether the second course of NHS treatment will be approved:

- Patient's original IOTN;
- Date original course of treatment commenced;
- Confirm still in active treatment and anticipated end of treatment date;
- If associated with a move, original address and new address plus original orthodontist address;
- If not associated with a move, reason for transfer – where the patient states this is as a result of a breakdown in patient/carer and orthodontist relationship or they are not happy with the treatment provided, this cannot be considered unless the patient has been through the formal complaints procedure to establish the full situation; the outcome of the complaints procedure should be provided.

Appendix E – Activity Requirements

Details to be included once the lotting has been finalised – At Stage 2 of the procurement process