

Care Pathway/Service	Personal Dental Services - Orthodontic Services (v.1.10)
Commissioner Lead	NHS England, Midlands & East (North Midlands, Central Midlands and West Midlands areas)
Provider Lead	
Period	See section 1.4
Date of issue	30 Jan 2019

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1. Background

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.

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 should justify such treatment and outweigh any detrimental effects.

1.2 Aims of the Orthodontic Service

The overall aim is to provide equitable, accessible, high quality and cost effective specialist Orthodontic Service in line with the National Guide for Commissioning Orthodontics, 2015 and NHS (Personal Dental Service Contracts (Regulations 2005) and any subsequent revisions.

The service will deliver orthodontic treatment to those patients up to the age of 18 years old with an Index of Orthodontic Treatment Need (IOTN) 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, defined in Section 1.5, that are not expected to be within 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 and/or complex shared cases), and only with the prior agreement of the Commissioner in writing. The exceptional circumstances must be documented in the patient record.

The provider must treat all eligible patients and not discriminate in any manner contrary to the relevant regulations. There are no geographical boundaries. The patient must be under regular continuing care of a General Dental Practitioner.

Dental service provision must be in accordance with best practice as set out in the following guidance or subsequent legislation changes:

- High Quality Care for All – Next Stage Review, 2008
- NHS Constitution, 2009
- Implementing care closer to home, 2007
- Modernising Medical Careers
- NHS Personal Dental Services Agreements
- Ionising Radiation 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 Fitness to Practice
- GDC Standards
- Caldicott principles
- The Hazardous Waste Regulations
- The Health and Safety at Work Act (1974) statement of policy with respect to the health and safety at work of all employees
- Decontamination of Dental Instruments – Health & Technical Memorandum (HTM) 01-05, Parts 1 and 2” (DoH 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 Specialties - 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 and Next Steps (2017)
- Working Together to Safeguard Children (2018)
- Making Every Contact Count
- Delivering Better Oral Health (2017)
- UK Government's Sustainable Development Strategy
- NHS England Long Term Plan 2019

1.3 Assessment of Orthodontic Treatment Need

There are a number of methods for assessing need, however, published studies and surveys have consistently reported that around one third (33%) of children, in any given population, will need and want orthodontic treatment.

An assessment of the need for Orthodontic services has been carried out in each of the NHS England – Midlands & East, Local Offices. 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 contract is offered under the terms of the NHS (Personal Dental Services Agreements) Regulations 2005 (PDS) effective from 1st April 2006 and any subsequent revisions. The PDS regulations identify mandatory and additional services. The clinical services to be provided are those deemed additional services. The contract length is 7 years with the option of a further 3 year extension.

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, who 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.

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

1.6 Expected Outcomes

The provider will ensure the following:

- The delivery of safe and appropriate care.
- Patients receive a written treatment plan outlining the proposed care, alongside the standard FP17DCO NHS Documentation.
- Patients are offered a choice of routine appointments to include: early mornings, late afternoon and weekend appointments. These appointments will be prioritised for patients at key educational stages. All providers should be able to offer and demonstrate appointments outside of school times and other times that are convenient to patients. See section 3.6.
- Patients are contacted within 5 working days following clinical triage of the referral form to determine eligibility to agree an appointment date.
- The initial assessment appointment takes place within 12 weeks of receipt of a fully completed referral.
- Where patients' needs are outside the scope of the service they are referred to a more appropriate provider of care.
- Patients needing to be referred to secondary care are identified within 12 weeks and then referred within 10 working days of the need being identified.
- Patients are assessed and scheduled for treatment in a timely manner based on clinical/age need.

Additionally providers will be required to:

- participate in and support the approved dental training programmes, in conjunction with the Managed Clinical Network (MCN) for Orthodontics, Health Education England (HEE), and NHS England;
- ensure the service is represented at and actively engages with the MCN for Orthodontics, this includes attending meetings and participation in the MCN's programme of work as agreed locally;

- comply with information requests from the Orthodontic MCN/NHS England as required under clauses 211 and 212 of the Personal Dental Services Agreement (e.g. linked to Key Performance Indicators).

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.

Patients will only be offered one course of NHS-funded routine Orthodontic treatment in line with the National Guide for Commissioning Orthodontics (2015) and NHS (Personal Dental Service Contracts) Regulations (2005) and any subsequent revisions unless there are exceptional cases. Such cases include where interceptive or growth dependent treatment has been undertaken and IOTN remains greater than 3.6. Any patient not meeting these circumstances would need to apply via the commissioner who will seek clinical advice –where necessary on whether a second course of treatment should be approved.

There may be occasions where an appliance has to be removed during a course of treatment to allow a patient to undergo other procedures such as diagnostic services. Recommencing treatment would not constitute a new course of treatment.

2.2 Service Description

Clinical service provision in line with 'Level 2 and 3a' provision as described in the Guide for Commissioning Specialist Services - Orthodontics, 2015 (**see Appendix A**).

The service will include:

- assessment for eligibility to NHS treatment;
- treatment services, including interceptive treatment, in-hours urgent care treatment (available to all patients who are being provided with the service under this contract as well as, in exceptional circumstances, patients who are accessing orthodontic care elsewhere and are unable to access urgent care under their regular orthodontist) delivered according to their clinical condition;
- treatment will include examination, taking of radiographs, photographs, and study models, diagnosis, preventative care, advice, planning of orthodontic treatment and supply and repair of orthodontic appliances including retainers for a period of 12 months following the completion of active orthodontic treatment;
- the appropriate referral to other healthcare providers for advanced mandatory services and / or any other appropriate and necessary healthcare;

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.

2.4 Interdependencies

There is interdependency with secondary dental care for the provision of advanced orthodontic procedures. The provider will need to demonstrate effective working relationships with secondary care colleagues to ensure appropriate management of complications outside the scope of the service in accordance with the agreed pathways.

2.5 Relevant networks

These include but are not limited to the following:

- NHS England
- Managed Clinical Network (MCN) for Orthodontics
- Local Dental Network (LDN)
- Clinical Commissioning Groups (CCGs)
- Sustainability and Transformation Partnerships (STPs)
- Integrated Care Systems
- Secondary Care Providers
- British Dental Association (BDA): local Sections

- Local Dental Committees (LDC)
- Other relevant clinical networks
- Local Authority Health and Wellbeing Boards and Scrutiny Committees.
- Public Health England (PHE)
- Health Education England (HEE) and Postgraduate Deanery
- Healthwatch

3. Service Delivery

3.1 Service Requirements

The provider will:

- ensure that service provision conforms to relevant guidance and standards;
- provide a clinical service in line with 'Level 2 and 3a' provision as described in the Guide for Commissioning Specialist Services - Orthodontics, 2015;
- receive and acknowledge appropriate referrals via the designated Referral Management Service (RMS) (where available);
- ensure 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 3.6 or other clinical factors that would warrant an assessment are returned to the referring General Dental Practitioner (GDP) with an explanation as to why the patient has not been offered an assessment;
- work with GDPs to improve their orthodontic referrals with the aim of ensuring that referrals are appropriate;
- 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;
- for referrals that are deemed inappropriate following clinical triage of the referral form or face to face clinical assessment, respond to the referring dentist within 10 working days to request clarification, confirm reason for rejection or arrange onward referral to level 3b providers where clinically appropriate;
- liaise with the referring practitioner and provide a written report containing the clinical decision and treatment/referral provided. Reports to be sent within 10 working days of the completion of the assessment, the end of active treatment at the point retainers are fitted and ultimately discharged following the period of retention;
- provide high-quality, timely and appropriate care;
- maintain good working relationships with colleagues in and outside the NHS who contribute to the overall care of any patients to ensure that this is conducted in the most appropriate, efficient and effective manner
- monitor and seek to improve service satisfaction rates to include NHS Friends and Family, Patient Recorded Outcome Measures (PROMS), treatment outcomes using the Peer Assessment Rating (PAR)¹ and Patient reported experience measures (PREMS);
- implement a programme to ensure that feedback from service users is sought and acted upon;
- follow the commissioner's referral pathways as advised the MCN;

¹ As set out in Clauses 155-160 of the Personal Dental Services Standard Contract

- deliver care within a defined timescale recognising the provider's contracted activity level;
- patient assessed as eligible for treatment should be scheduled for treatment in a timely manner based on clinical need/age;
- ensure robust procedures are in place to address issues arising from the patient pathway, e.g. validation of patient data, management of patient complaints and incidents, management of clinical information/data security – the Care Pathway for the service is attached at **Appendix C** (Summarised Illustrative Patient Journey).
- ensure that patients with orthodontic emergencies such as debonded brackets and bands, lost modules and fractured removable appliances have access to an urgent appointment within two working days

The provider 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 FP170 claim must not be submitted when repair to appliances are carried out as part of a buddy/ cover arrangement with another practice.

The performer providing the service will:

- 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;
- 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. The exception to this is patients requiring assessment for interceptive extractions or advice only;
- provide the patient with a written agreement setting out expectations both from the patient and provider and including comprehensive information about their treatment as set out in Section 6 (standardised template as agreed by the MCN);
- ensure that the patient and/or carer is 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;
- ensure that following the one year retention period, the patient's NHS Treatment will be officially completed and the patient will be discharged back to their General Dental Practitioner.
- ensure that replacement retainers are provided and charged for in line with Regulation 11 of the NHS Dental Charges Regulations 2005 (see Section 5.3). If a fixed retainer is used, it usually remains in position for at least 5 years - replacement retainers issued after the first year will be charged for on a private basis regardless of age or exemption status.

- ensure that where a patient's need is outside the scope of the service they are referred to a more appropriate provider of care.

3.2 Workforce

The Orthodontic service will be led by dentists who are General Dental Council (GDC) registered specialists in orthodontics.

This service is being commissioned to provide Level 2 and 3a care and therefore, in line with the Commissioning Guide, must be specialist led:

- care may be delivered using skill mix e.g. orthodontic therapist or dentist but all care must be overseen by an orthodontic specialist;
- the provider must maintain effective communication with commissioners and Local Dental Network (LDN) through Orthodontic MCN to ensure high quality patient care.

All new patient assessments and treatment planning to be undertaken face to face by a registered specialist in orthodontics.

A specialist must review treatment at the start and prior to completion and be compliant with BOS Guidelines on Supervision of Orthodontic Therapists (April 2017 and its revisions), including the supervising dentist seeing the patient at least every other visit.

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

3.3 Clinical Competencies

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. (See **Appendix A** for complexity of Orthodontic Treatment)

As the contract will carry out complexities 2 and 3a cases, it must be specialist led. Level 2 can be carried out by practitioners under the supervision of a registered specialist in orthodontics, with a formal link to an MCN. This includes dentists who have enhanced skills and/or experience; for example 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.

Each performer providing Level 2 and 3a complexity must maintain a minimum of 50 case starts per year, this may be carried out across multiple contracts.

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.

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 clinical indemnity.

All performers and clinical support staff should work within their scope of practice and be able to demonstrate evidence of appropriate CPD for on-going registration as well as participation in a robust clinical governance programme including peer review, appraisal and personal development planning, clinical audit and the management of Serious Incidents. All staff should undertake an annual programme of mandatory training including the management of medical emergencies and resuscitation and child CPR.

Where required clinical supervision will be applied to quality assure care. Where new staff are engaged a programme of induction should be mandated.

All members of staff who provide clinical care to patients should have received appropriate training to provide lifestyle advice using the principles of Making Every Contact Count.

3.4 Location(s) of Service Delivery

The lots have been determined based upon the orthodontic needs assessment, local boundaries and population/patient flows. Details of the geographical areas for specific lots from which the provider must deliver the service are set out in the lotting strategy published on the **NHS England Midlands & East web page** (<https://www.england.nhs.uk/mids-east/info-professionals/>), details of which will be confirmed within the published procurement documentation.

Please note that the service delivery site(s) for each lot are required to be within the geographical boundaries specified. The localities, areas or postcodes do not reflect the source of referrals or patients place of residence.

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

3.5 Premises Requirements

The provider will be expected to secure facilities suitable for service delivery.

The provider must indicate potential premise(s) 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.

Where a hub and spoke arrangement is indicated, agreement will be reached with the commissioner in relation to the required opening hours at the satellite (spoke) site(s). This should be proportionate to the indicated level of activity within the lotting. Although assessments may take place at the hub site, a proportion of treatment appointments must be provided at the satellite site to ensure that services are accessible to the local population.

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

The provider will ensure that the premises used for the provision of the Orthodontic service are:

- suitable for the delivery of an orthodontic services, i.e. meet the current legal and professional standards for the provision of primary care dental services and will be subject to approval by NHS England;
- equipped to meet the reasonable needs of all patients. To offer both consultation and treatment facilities in a confidential and private setting, enable parent/carer to accompany the patient as required, with reasonable adjustments for people with additional needs or learning disabilities;
- that 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;
- compliant with HTM01-05 best practice standards;
- equipped to deal with emergency situations and provide equipment including oxygen, drugs and resuscitation facilities, decontamination (and other equipment as appropriate);
- registered with the Care Quality Commission (CQC);
- compliant with the requirements of the Equality Act 2010;
- provide appropriate waiting-room accommodation for patients and carers;
- provide a preventative focused environment including
 - smokefree policy
 - ensuring the practice is configured to support breastfeeding
- ensure that equipment and facilities conform to relevant standards / regulations and are maintained regularly in line with guidelines and manufacturers protocols;
- ensure any laboratory services are registered with the Medical Devices Agency and work within the relevant legislation;
- have in-house access to Dental Panoramic Tomography. In addition the provider should have access to other appropriate radiographic facilities as part of their contractual provision i.e. Lateral Cephalometric radiography; where a hub and spoke (satellite) arrangement exists provision of OPG would be desirable dependent on the expected level of activity at the satellite site – for smaller sites it may be acceptable for patients to access these facilities in the hub
- ensure that robust governance and quality assurance programmes to ensure a safe environment is in place for all service users; and
- ensure all legal requirements relating to the use of radiographic equipment are met.

3.6 Accessibility and Opening Hours

The service will be flexible and responsive to individual patient need in accordance with the Equality Act 2010 and the NHS and Social Care Act 2008. Wheelchair access is particularly important.

The provider will ensure that there is a choice of routine appointments, including early mornings and late afternoon appointments, to meet the need of patients 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 allow for access outside of school hours and should be set to maximise 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.

The provider will ensure, where reasonable, equity of access to patients with special needs, including learning and sensory difficulties, vulnerable and hard to reach groups and patients with protected characteristics.

3.7 Patient Pathway(s)

See **Appendix C** for the commissioned orthodontic 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. The provider is also expected to demonstrate a shared care approach and will support the GDP in ensuring good oral hygiene throughout treatment.

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.

3.9 Safeguarding

The provider will ensure:

- valid consent is gained from all patients and/or carers prior to initiating assessment and/ or treatment;

- effective and robust arrangements are in place to promote and safeguard the health and wellbeing of children/young people and vulnerable adults;
- all staff must receive annual safeguarding training to the appropriate level;
- a safeguarding policy that meets legal and CQC requirements for Safeguarding Child/ Young Person is in place in line with the recommendations of local safeguarding partners;
- a named safeguarding practice lead is in place who ensures that staff recognise their training needs, undertake appropriate training and are able to access appropriate support and advice on safeguarding matters
- Compliance with the Disclosure and Barring Service

3.10 Governance and Information:

The provider will be required to demonstrate compliance with the General Data Protection Regulation (GDPR) which came into force 25 May 2018 and the Data Protection Act 2018.

The Data Security and Protection Toolkit is an online NHS Digital self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards (please refer to (www.dsptoolkit.nhs.uk for more information about the DSP Toolkit). The provider must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The provider must be able to confirm and evidence the following:

- they are registered with the Data Security and Protection toolkit;
- they have completed an initial assessment of compliance with the DSP Toolkit assertions and (mandatory) evidence items or published a Satisfactory V14.1 of the IG Toolkit;
- have an action plan in place to address any areas of non-compliance, with clear timescales by which this be achieved.

The provider must have in place an Information Governance (IG) Policy that includes the following:

- The provider must be fully computerised, for example, but not limited to, electronic patient records, ability to submit electronic FP170 claims by EDI transfer, access Compass to update contractual information including annual superannuation reconciliation returns and access schedules, submit Friends and Family Test data, submit annual complaints returns, work with any electronic referral management system in place, have an up to date website;
- Provider must have the ability to manage patient appointments through text messaging or other social media, for patient/carer satisfaction surveys to be completed using social media or on-line and for staff to access the internet for professional use.
- Provider must assign responsibility for Information Governance to an appropriate member of staff.
- Policy must address the overall requirements of information quality, security and confidentiality;
- All contracts, staff, contractor and third party, contain clauses that clearly identify responsibilities for confidentiality, data protection and security;
- All staff members are provided with awareness and training across the Information Governance agenda;

- Provider must implement its IG Information Security management arrangements to ensure the NHS CFH Statement of Compliance (SoC) is satisfied;
- Provider must ensure that all staff and all those working for or on behalf of the Provider comply with the terms and conditions set out in the RA01 form;
- Provider must ensure patients / carers are asked before using their personal information that is not directly contributing to their care and that patient's / carer's decisions to restrict the disclosure of their personal information is appropriately respected.
- The provider will have an active NHS.net account.
- The provider must only use nhs.net email account/s when transferring patient identifiable information and other confidential or sensitive information and ensure transmission is to a similarly secure address.

4. Referral, Access and Acceptance Criteria

4.1 Acceptance criteria

The service will accept any patient under the age of 18 (at the point of referral receipt) who is eligible for NHS care and who is referred via the Referral Management Service (RMS) where available.

Patients must be assessed clinically by a specialist orthodontist as having a treatment need prior to their 18th birthday as defined within Schedule 1, Part 2, 4 (3) of the National Health Service (General Dental Services Contracts) Regulations 2005 and PDS equivalent, i.e.

- Grade 4 or 5 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 and have prior approval from the Commissioner.

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.

All patients who fulfil the IOTN criteria above must also have good oral hygiene and be actively supported in the prevention of dental diseases throughout orthodontic treatment.

4.2 Management and recording 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).

When a child misses an appointment, it should be recorded as 'Was Not Brought' rather than 'Did Not Attend' as the consequences to the patient of it being missed are important considerations, particularly if treatment is not completed.

4.3 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.

4.4 Referral source

Source of referrals will usually be via General Dental Practitioners (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.

4.5 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 an assessment will be returned 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 clinician should also ensure that prevention of dental disease is a focus throughout the treatment pathway.
- 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.
- The orthodontist will liaise with the GDP to ensure a shared care approach to oral hygiene throughout treatment. The GDP remains responsible for interventions such as fluoride varnish and routine assessments.
- 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).

Waiting times for treatment should be based on clinical need. As a general rule the expectation is that patients who meet the NHS eligibility criteria will commence treatment within 18 week of the face to face clinical assessment.

For the avoidance of doubt – patients should not be counted as being on the treatment waiting list until they have been assessed as meeting the NHS criteria and judged as ready to start treatment including reaching the appropriate developmental stage and the patient has acceptable oral hygiene.

4.6 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.

4.7 Exclusion criteria

The Orthodontic e-RMS (where available) or provider should identify excluded or non-eligible patients before being assessed. The service will not accept for assessment:

- patients 18 years of age or over (at the point of receipt of the referral), unless given prior agreement by the Commissioner;
- patients for whom the e-RMS (where available) protocol has not been adhered to;
- patients who have been referred / currently awaiting assessment at an alternative provider;
- patients who do not fulfil the IOTN or clinical criteria;
- patients seeking a second course of treatment without explicit agreement from the commissioner;
- transfer patients where prior approval has not yet been provided by the Commissioner and;
- Level 1 and 3b treatment.

4.8 Response time & detail and prioritisation

Initial assessment appointment with the service should be offered on a date within 12 weeks of receipt of a fully completed referral providing this is compatible with the provider's contracted activity levels to ensure compliance with the 18 weeks requirement. Providers should liaise with the Commissioner where this is not possible for a sustained period of time so that the patient pathway can be managed.

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;

4.9 Data collection / submission

Providers must comply with the data requirements listed below:

- The service will only use Electronic Data Interchange (EDI) to submit claims to the Business Services Authority.
- The service will only use the Referral Management (where available) process as identified by the relevant local NHS England office.
- Providers are required to submit FP17O forms to NHS dental Service within 2 months of a case assessment and case start
- Providers are required to submit FP17O forms to NHS Dental Service within 2 months of a case completion, or where treatment has been abandoned or discontinued. If appropriate other agencies will also be informed.
- Providers are required to submit waiting list and waiting times' data in line with the MCN agreed protocol.

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 were not brought for appointments (WNB) 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 liaised with the GDP and explained the consequences of the non-compliance to the patient and/or carer and are satisfied that all reasonable efforts have been made to ensure the patient is in a position to continue with their care.

- **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:

NHS orthodontic contract holders:

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). No UOAs are credited but the contract holder is entitled to 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).

NHS contract holders with no orthodontic element within their contract:

Contract holders with no orthodontic element within their contract should manage patients who request the repair or replacement of orthodontic retainers by referring the patient back to the orthodontic provider who completed the treatment.

The NHS GDS Regulations (2005) do not permit holders of mandatory services contracts to claim UDA activity for the repair / replacement of orthodontic retainers.

6. Prevention, Self-Care and Patient and Carer Information

Providers will ensure that patients and/or carers are provided with relevant verbal and written information in a variety of formats, where appropriate standardised by the MCN and where necessary utilising an interpretation or translation service. They will also be required to provide information concerning the outcome of the assessment, such that the patient and/or carer are clear why a specific treatment opinion has been selected. Reasonable adjustments should be made where necessary for people with disabilities. This may include additional communications with patients and carers, priority appointments or easy read materials. The need for reasonable adjustment should be recorded on a patient record.

Orthodontic care is a partnership therefore, prior to initiation of treatment, the patient and/or carer should be provided with the following information verbally and in writing on what can be expected of the clinician and what is expected of them:

- Information in accordance with contemporary standards for informed consent
- Treatment plan including an estimation of length of treatment and visit frequency
- What to expect during treatment
- the British Orthodontic Society leaflet entitled 'What Are the Risks of Orthodontic Treatment?'
- What is expected of them in terms of commitment including self-care, compliance, and under what circumstances treatment will be terminated e.g. poor attendance, poor oral hygiene, abusive behaviour
- 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 active treatment is likely to take;
- maintenance information including that they need to keep their teeth and braces clean and follow the advice of the orthodontist and their staff. If the patient's 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'. All members of staff should be able to provide appropriate advice on lifestyles taking a whole family holistic approach;

- Patients and their carers should be advised regarding the importance of attending their general dental practitioner for regular check ups, preventive care and treatment throughout their course of orthodontics, It is important that they understand the distinct roles of the orthodontist versus the general dentist.
- If the patient's fixed braces are broken repeatedly, the patient and /or carer has been advised 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 has been advised 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 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 or advance notification, the patient's treatment may be terminated prematurely and they will not be able to access further treatment elsewhere on the NHS; additional consideration should be given when dealing with patients from vulnerable or hard to reach groups to ensure they are not inadvertently disadvantaged.
- the patient and/or carer has been advised that, if retainers are removable, they need to be worn in accordance with the instructions given to the patient and/or carer;
- 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 and/or carer has been advised 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 general dental practitioner (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;
- that, at the end of this initial year of retention, the patient's treatment at the practice will be complete, and that there will be a charge for the repair or replacement of removable retainers and the repair or replacement of bonded retainers as this is not NHS treatment;
- 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 stop wearing their retainers;
- if the patient or carer 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 to realign teeth may involve the use of fixed appliances. Subsequent treatment required is very unlikely to be available on the NHS, including replacement retainers, unless there are very exceptional circumstances that can be evidenced;
- Any additional costs the patient may experience e.g. payment for replacement of broken appliances under Regulation 11 and equipment such as wax, toothbrushes etc.
- Confirmation that the orthodontic practice will supervise retention for a period of ONE year only (the cost of this supervision is included in the NHS contract). If removable or fixed retainers are broken or lost during this initial one year period, there will be an NHS patient charge unless the breakage is as a result of fair wear and tear (with no UOA's credited).

Providers should be able to demonstrate that the information is provided in such a way that supports the patient and/or carer's ability to give valid 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 valid consent is gained and recorded for all patients prior to initiating assessment and/or treatment (access to a professional interpretation service during consultation and treatment where this is relevant and appropriate);
- have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults;
- ensure the patient and/or carer are aware that the NHS will usually only fund one course of treatment, with the exception of interceptive treatment, and once the treatment has commenced the patient and their treatment will not be transferable to an alternate practice apart from exceptional circumstances;
- ensure the patient has read and understood the British Orthodontic Society leaflet entitled 'What Are the Risks of Orthodontic Treatment?';
- ensure the patient and/or carer 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;
- ensure the patient and/or carer 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 active treatment is likely to take;
- ensure the patient and/or carer understands that the patient needs to keep their teeth and braces clean and follow the advice of the orthodontist and their staff. If the patient's 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;
- ensure that, if the patient's fixed braces are broken repeatedly, the patient and/or carer 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;
- ensure the patient and/or carer understands that the patient will need to attend the appointments on time and on the correct day. If the patient is late, the orthodontist may be unable to see the patient. 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 or advance notification, the patient's treatment may be terminated prematurely and they will not be able to access further treatment elsewhere on the NHS; additional consideration should be given when dealing with patients from vulnerable or hard to reach groups to ensure they are not inadvertently disadvantaged. Where a patient's course of treatment is discontinued for repeated failure to attend then notification should be provided to NHS England. Records should be kept of attempts to contact the patient and any appointments offered, declined or missed.
- ensure the patient and/or carer understands that, if retainers are removable, they need to be worn in accordance with the instructions given to the patient;

- ensure the patient and/or carer understands that, 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 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.

The provider should provide the patient with a written agreement signed by both parties setting out expectations both from the patient and provider (standardised template to be agreed by the MCN and NHS England).

7. Performance Targets – Quality, Performance & Productivity

A summary of the national KPIs, bandings and contract sanctions is set out below.

Formal contract monitoring of the national KPI's will only take place following a full two years of commencement of service in line with the national agreement.

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.

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 best practice 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 NHTA documentation (e.g. FP17dco)	100% of patients	MCN mediated Annual Audit
Prevention	There is a prevention pathway for all patients undergoing orthodontic treatment.	100% compliance	Annual Report
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	15% return rate and 80% of the response is	Quarterly returns via MCN & NHSFFT

	<p>Family test (NHSFFT)</p> <ul style="list-style-type: none"> • 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 	good or better according to MCN agreed standards	
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	<p>In addition to the BSA schedule/Dental Assurance Framework (DAF) data, reports to be produced showing the following (where not available via and RMS):</p> <ol style="list-style-type: none"> 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%	<ol style="list-style-type: none"> 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

8. Activity

Please see **Appendix E** for the expected activity for each contract lot (including the number of UOAs with an anticipated level of case starts in each financial year).

A course of orthodontic treatment for a patient aged under 10 years will accrue 4 units of orthodontic activity (UOA) regardless 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 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.

In addition to delivering the expected activity, the provider may be required to take over the care for a cohort of patients currently in treatment and retention.

Until the outcome of the procurement process is known it will not be possible to confirm which contracts will be required to accept a cohort of patient transfers to continue treatment in addition to the new patients that will deliver the contracted UOAs.

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

Patient transfers between providers during treatment not associated with the procurement of new contracts – **see Appendix D**

9. Finance - see also Schedule 4 of the Personal Dental Services Agreement

9.1 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 patient **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, divide 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:

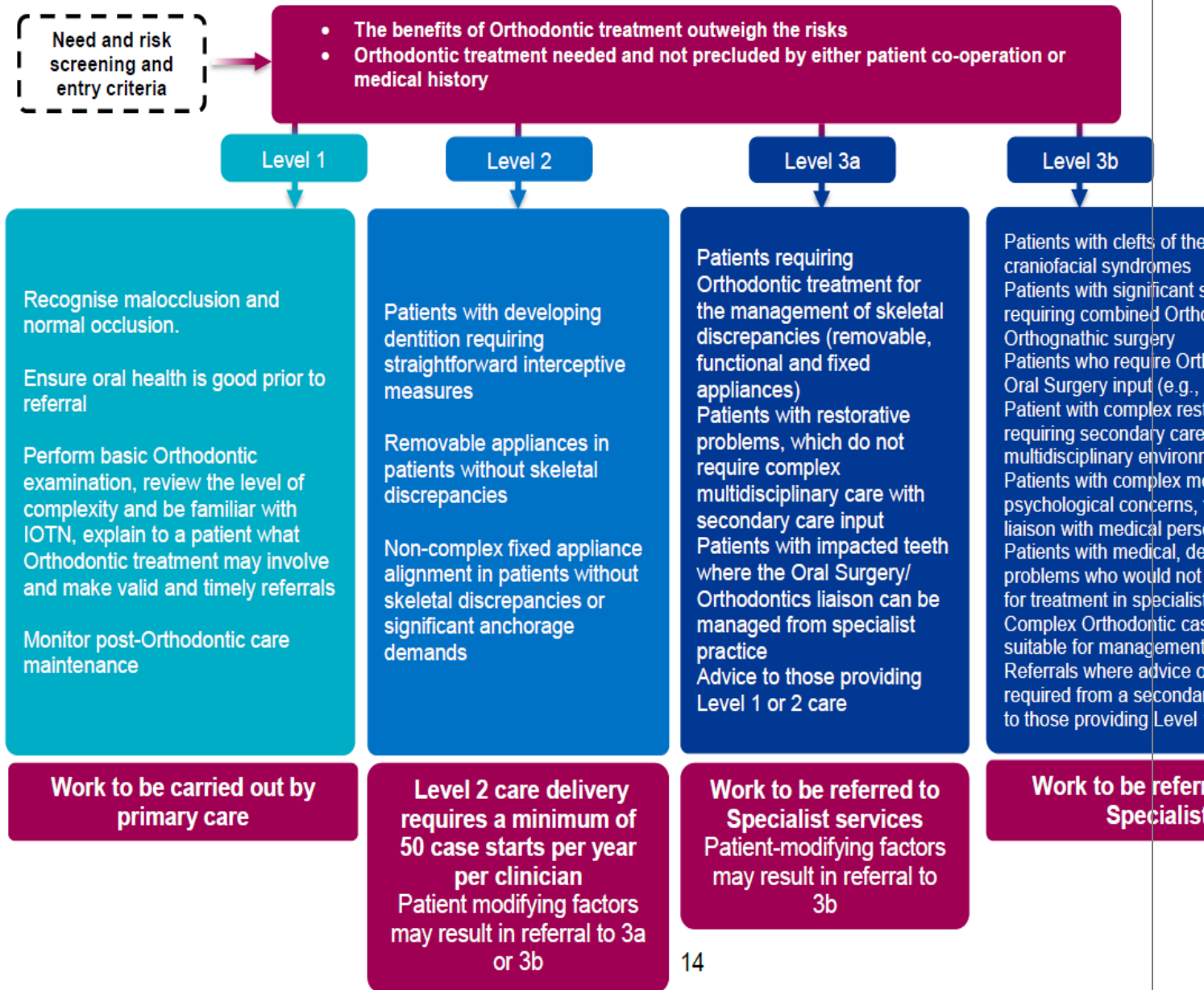
- Bid price (UOA rate) multiplied by number of UOAs commissioned **above** number of UOAs commissioned under the old contract multiplied by 85% to give Year 1 total contract value
- Bid price (UOA rate) multiplied by number of UOAs commissioned **above** number of UOAs commissioned under the old contract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



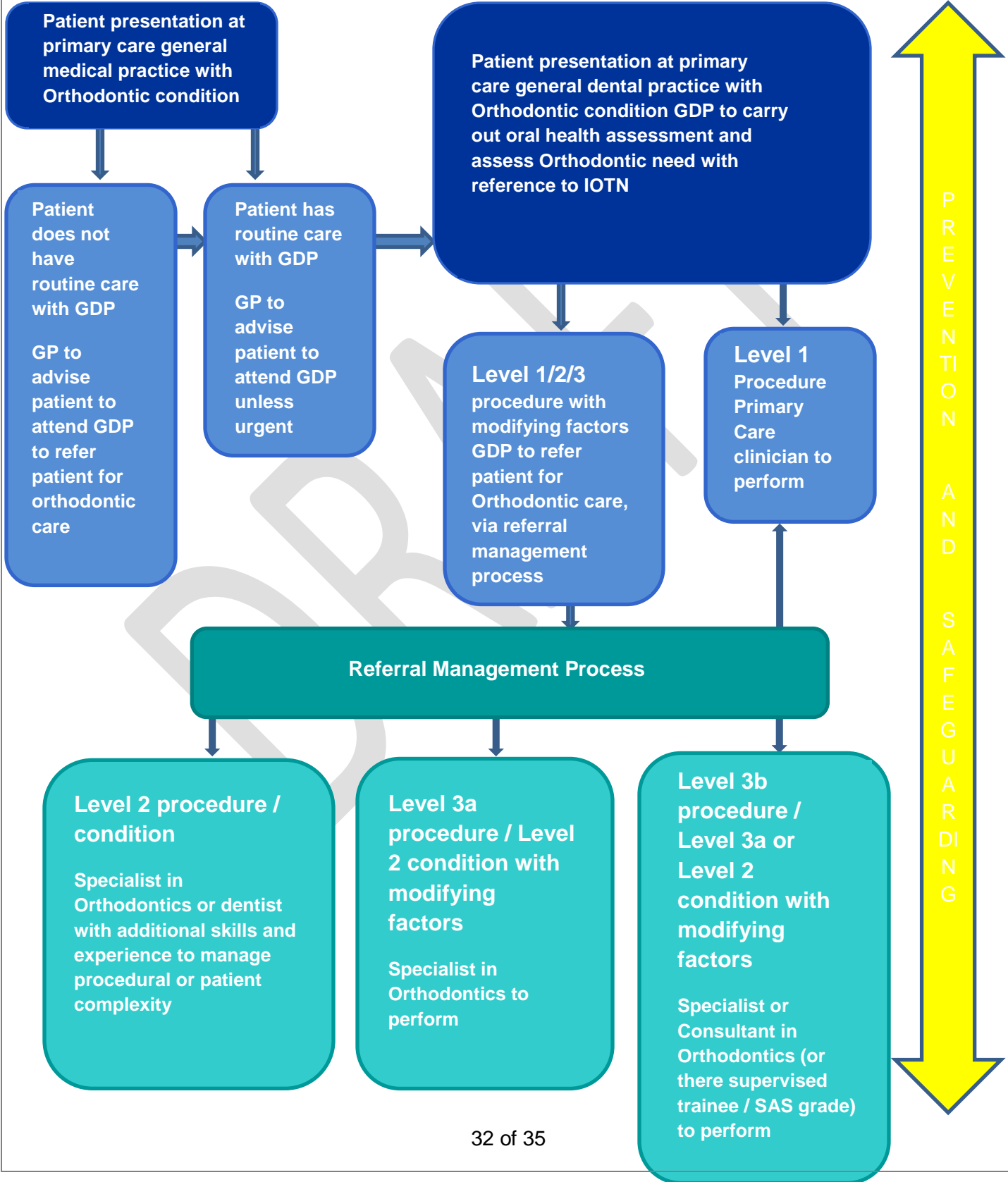
Appendix B – Essential Requirements

	Requirement
Clinical skills and competencies: Performer(s)	<ol style="list-style-type: none"> 1. Registered with General Dental Council 2. Currently on Performers List 3. Include a Specialist in Orthodontics on the register held by the UK General Dental Council <p>Evidence of clinical experience, on-going relevant CPD, peer review and audit</p>
Clinical skills and competencies: Chairside Dental Care Professionals	<p><i>GDC Registered Orthodontic Therapist</i> : Current skills outlined in the GDC Scope of Practice 2013 and work under the supervision of GDC registered dental practitioner as outlined in the British Orthodontic Society publication 'Guidelines on Supervision of Qualified Orthodontic Therapists'.</p> <p><i>GDC Registered dental nurse:</i> Current skills in chairside dental nursing for orthodontic procedures (where provided) and expanded duties subject to suitable training.</p>
Facilities	<p>Accessible, appropriately equipped and CQC registered clinical setting for the provision of orthodontic services. To include onsite access to:</p> <p>Digital OPG/lateral Ceph radiology equipment</p>
Record keeping	<p>Evidence of adequate clinical records keeping and a document management / data governance as well as compliance with relevant legislation / standards. Use of contemporary and secure practice/records management software. Recording 'Was Not Brought' for all child patients where relevant.</p>
Medical emergencies	<p>Evidence of training within last 12 months for all clinical staff</p>
Management of service: (interface with other clinical service providers and RMS)	<p>The provider will be fully computerised and will have in place appropriate IT to receive patient referrals safely and compliance with information governance standards</p> <p>All providers will have an operational nhs.net email account for transmitting and receiving confidential patient information.</p> <p>Able to communicate effectively (written and verbal) with primary and secondary care clinicians.</p>
Management of service: interface with patients	<p>Systems in place for receiving patient feedback and management of complaints / incidents</p> <p>The provider will have a robust computerised appointment and reminder systems</p> <p>Appropriate verbal and written information for patients in a variety of formats/media/languages appropriate to the local need</p> <p>Policy for minimising wasted appointment times due to failed appointments and cancellations</p> <p>Flexible and responsive service able to adapt to patients' needs including those with protected characteristics etc. and those with addiction, mental health illnesses and anxiety/phobia.</p>

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



PREVENTION AND SAFEGUARDING

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 make the patient aware that the previous orthodontist will need to be contacted to provide details of the treatment previously undertaken (see below) to include with the referral to the 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 and also that the transfer has been approved by the Commissioner.

The referral must be made using the Local Office's usual referral pathway. All providers should co-operate in providing information to the orthodontist taking over the care of the patient. This should include the original assessment, IOTN score, x-rays, models and photographs as a minimum and ideally the full patient record. Such information must be transferred securely and shared directly with the receiving clinician.

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

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