NHS England and NHS Improvement - South East region
Special Care and Paediatric Dentistry Services Commissioning
Questions and Answers

January 2021

A high volume of comments and questions was received by email following the market engagement event on 24 November 2020. All submissions have been considered and discussed at length by the Commissioning team.

The immediate action taken has been to review the timescale for the re-commissioning of Special Care and Paediatric Dentistry services and investigate through internal governance channels whether any pause can be built into the process. We expect to report back by late January about whether the planned timescale can be varied. We have excluded comments which only relate to the timescale and its ramifications from the questions answered below. We have also indicated where further work is needed to address some of the queries raised to ensure clarity for all who are interested and involved in delivering dental services.

Question	**Answer**
Specification	
1. Where organisations currently provide level 2, 3a and 3b services for adults and paediatrics, through Community Dental Services and/or Hospital Dental Services, please can you clarify what services will be included in the re-commissioning process?	We will consider this when finalising the specification.

Question	Answer
2. In line with the service specification, does all 3b for adults and paediatrics need to be done outside CDS and to which providers will patients be referred?	The specification will be reviewed again in light of the feedback in relation to 3b care. This will be done alongside reference to the NHS England guide for commissioning dental specialties – Special Care Dentistry, published in 2015 and the NHS England guide for commissioning dental specialties – Paediatric Dentistry, published in 2018.
3. Within the service specification, the commissioner asks for level 3 care to be managed by specialist/consultant staff. Given the shortage in the current workforce of staff with these qualifications, please can the commissioner clarify what is expected by the word 'managed'?	Services will be specialist led with at least one specialist for Special Care and one specialist for Paediatric Dentistry. This means clinical leadership of multi-disciplinary teams to deliver services, to include confirmation of team membership and roles; development and oversight of treatment plans; clinical supervision and training; team appraisals; policies to underpin the delivery of care etc.
4. Do the commissioners have any data of the likely numbers of patients that fall into level 3a and 3b of care complexity?	This data is not available as all existing service providers currently deliver a mixture of 3a and 3b of care but do not consistently categorise this.
5. With so few paediatric specialists, can the commissioners clarify what the expectations are for managing large numbers of children?	The specialist will manage the most complex cases and work with the wider team to manage the care of all patients eligible to receive treatment from the service. See question 3 above. It is recognised that there are limited paediatric specialists and this is part of the reason why we decided to adopt larger lot sizes to ensure adequate skill mix.
6. With the demand for Special Care Dentistry set to increase, is a review of current planning assumptions around local needs in contractual arrangements being considered for the future?	There are no plans to formally review contractual arrangements to take into account potential increase in demand in the future. Activity and referrals will be monitored throughout the contract. NHSE/I will create an investment reserve during the life of the contract which will be available to address future demands on the service.

Question	Answer
7. If a service's capacity becomes fully committed, will their status be changed on the directory of services?	Services would be kept open on the directory of services and it would be the responsibility of each service to prioritise referrals in line with clinical best practice. The KPIs will be used to ensure appropriate referrals are being accepted by the service in line with the service specification and there will be regular reviews of the achievement of waiting time targets and patient satisfaction with waiting times.
8. What wait list management support will be available / required by providers across the system if a large number of redirected referrals were received?	Commissioners would discuss waiting lists with providers as part of contract management and support. A large number of redirected referrals would not be expected given the referral criteria and electronic referral system in place.
9. What commercial mechanism will be put in place to deal with cross border activity where patients eligible to access services within a particular lot include those who may not reside in that lot or within the geography covered by NHS England and NHS Improvement South East?	There is no need for a commercial mechanism to be in place for cross border activity and there are no plans to introduce any. The movement of patients is in a number of directions. Patients should be able to attend the service most geographically convenient to them. Patients who live inside the NHS England and NHS Improvement South East region and/or are registered with a GP within the area would be eligible to attend a South East service for any planned care.
10. Please clarify the extent of the successful provider's responsibilities in relation to ensuring access to General Anaesthetic (GA) facilities given that services are dependent on acute trusts providing these facilities.	The provider must be able to secure these facilities by means of a Service Level Agreement with the provider of the required facilities.
11. Please can you specify the volume of GA activity within the service specification.	There are no plans to include activity figures for GA in the specification, but this will be included from year 4 in terms of sessions and expected numbers of patients treated. It will remain a notional 'target' for the life of the contract and any subsequent extensions.

Question	Answer
12. On page 15 of the service specification it is stated that "As part of the GA pathway the service must ensure that it has access to timely orthodontic assessments for patients being considered for extractions of first permanent molars. The service must have a formal arrangement with local orthodontic services to ensure that they are able to achieve this". Do commissioners have an agreement with orthodontists to provide timely slots for orthodontic assessments?	The service should act in accordance with the local arrangements for the management of the orthodontic assessments in relation to first permanent molars with referrals made in line with these arrangements to local orthodontic providers.
13. What are the commissioner's intentions to address Orthodontic care for patients with behavioural difficulties, learning disabilities and autism (to those who fall into the higher tiers defined in the Special Care and Paediatric Dentistry commissioning guidelines).	This is commissioned from either primary or secondary care Orthodontic providers depending on patient complexity. The NHS Commissioning Guide for Orthodontics states the following: **Level 3b:** Treatment undertaken by practitioners who are on the Specialist List for Orthodontics and have undergone an approved period of further post-specialist training or who can demonstrate equivalence. Level 3b orthodontic treatment is generally delivered within a **secondary** care setting. Includes: • 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

Question	Answer
14. In terms of the KPI's listed on page 64 of the specification, and specific to Point 2 (assessment within 12 weeks) - 95% target - Would commissioners consider a remote patient contact as contributing towards this target?	The anticipated pause in re-commissioning will allow us to revisit the specification and review KPIs. However, we consider that this would satisfy the requirement so long as a clinically robust and appropriate decision can be made about the next steps in the patient's care with the appropriate records kept and reported in relation to the assessment.
15. In terms of the KPI's listed on page 64 of the specification, and specific to Point 3 (proportion of patients to start treatment within 18 weeks) – Please can you confirm if this is from receipt of the referral or completion of the assessment?	This is from receipt of referral in the case of patients treated in a clinic setting. If having attended a clinic, the patient is then identified as needing treatment under GA then the 18 week period starts from the date of referral from the Special Care and Paediatric Dentistry clinic as this is a nationally mandated target under the NHS Standard Contract.
16. Why are looked after children not a priority group in the service specification?	Looked after children are not a clinical category necessarily requiring treatment via the Special Care and Paediatric Dentistry service. If looked after children have no additional clinical needs they should be able to attend Primary Care Dental Services as other children would do. However, if the child has any of the clinical indicators as described by the specification, they may then meet the required criteria for shared care with a specialist provider or receive care on an ongoing basis with the specialist provider as their routine provider.
17. There is no reference to autism/ autistic spectrum disorders. Could this population be considered for inclusion?	Patients, child or adults, who are on the autistic spectrum would be eligible for referral to the service where they met the required clinical criteria in the specification.
18. Could the specification capacity increase and extend dental care to the homeless population?	If any patient who identifies as homeless has additional needs which meet the clinical criteria set out in the specification, then they would be eligible for a referral to the specialist service. Self-referrals would be permitted for homeless patients and relevant agencies would be informed of this provision.

Question	Answer
19. It needs to be clear in the specification that there is a responsibility to ensure people do not fall through gaps and work with other services so that general dentistry makes the reasonable adjustments as required under the Equality Act, including addressing the long waiting times which can exacerbate people's anxiety about going to the dentist.	The commissioned service will have a key role in providing clinical strategic leadership to the wider dental system within the area. The service (through the strategic lead) will be responsible for bringing together local stakeholders, both dental and non- dental, to improve and develop local pathways and care for children and adults with additional needs. This will involve working with established and emerging local networks. General Dental Practitioners (GDPs) would continue to hold responsibility for patients during the referral to specialist services.
20. How will commissioners monitor and share data on the use of GA and sedation on people with learning disabilities especially when this is for routine or preventable dental conditions.	As above, this is part of the leadership role for Special Care and Paediatric Dentistry services.
21. There are older people, those with dementia and other needs in residential care. The specification needs to make a distinction regarding capacity to understand. There are those who, with explanation, can make an informed choice whereas those who lack capacity have decisions made in their best interests.	Best interest decision making and multidisciplinary team working will be part of the practice of Special Care and Paediatric Dentistry services.
22. Will re-commissioning limit access to CDS referral? Shared care with GDPs will not have additional support or funding.	Part of the leadership role of services is to provide support to GDPs though no additional funding is available for this purpose directly to GDPs.

Question	Answer
23. Will contracts be reviewed for outcomes and delivery to ensure continuous improvement?	The anticipated pause in re-commissioning will allow us to revisit the specification and review KPIs.
24. There is currently a shortage of defined specialist and consultant dental staff. While Health Education England (HEE) and the Deaneries are responsible for providing adequate numbers of Special Care and Paediatric Dentistry specialist training posts there are not enough available. What consideration have the commissioners given to workforce planning in relation to the service delivery?	It is recognised that there are limited specialists and this is part of the reason why we decided to adopt larger lot sizes to achieve adequate skill mix. We have also secured a longer-term contract duration for workforce reasons to ensure sustainability. The NHS People Plan does reference workforce planning. Health Education England as part of the Local Dental Network (LDN) would be the lead for this in the South East.
25. Who has been involved in the transition of the penultimate version of specification document, which we had sight of, to the final document?	The specification has been developed through a working group and has shared drafts with a range of stakeholders such as MCNs, LDCs, LDNs and Consultants in Public Health. All comments have been taken into consideration. However, the anticipated pause in re-commissioning allows us to revisit the service specification and further engage with various stakeholders.
26. What Dental Public Health Services are to be delivered as part of this specification/contract?	Dental Public Health is outside the specification and the commissioned service. Local authorities retain responsibility for commissioning dental public health services. The commissioner expects the service to play a leading role in improving the oral health of the patients who attend on a regular basis and also to work with other stakeholders to support health improvement amongst more vulnerable people.

Question	Answer
27. Domiciliary care – are additional domiciliary services going to be procured for patients who do not meet the criteria listed in section 7, i.e. level 1/level 2?	There are no plans to commission additional domiciliary services at this stage.
28. Sedation – are additional sedation services going to be procured for patients who do not meet the criteria listed in section 7, i.e. level 1/level 2?	This is under review as part of planning for the commissioning of Sedation either due to contracts expiring at the same time or falling outside the scope of what is to be provided by the Special Care and Paediatric Dentistry providers.
29. The exclusions listed in the specification are going to create gaps in service provision. How are the dental commissioners going to ensure that these patients will continue to be able to access dental care?	A gap analysis exercise has been conducted in relation to the disaggregation of services from existing Community Dental Services. There is a programme of re-commissioning of services to ensure no gaps in provision of services.
Accreditation	
30. Can the commissioners clarify when the responsibilities of the provider in terms of accreditation will be defined?	This is still under discussion with the Office of the Chief Dental Officer.
Funding	
31. It is noted that some of the contract values are less than the current contract values, please can you explain the reasons behind this?	The funding formula is 70% based on population and 30% based on the weighted health needs assessment criteria. The GA figure is ring-fenced. Funding for dental services will remain with Integrated Care System geographies, taking into account disaggregated services which may be re-commissioned separately.

Question	Answer
32. How is inflation going to be taken into account across a 10 + 2 year contract? Will the contract hold a clause to reflect inflation being applied annually?	The PDS contract will be uplifted by agreed DDRB settlements each year in line with the PDS Regulations. The GA (NHS standard) contract uplift will be in line with the nationally agreed approach each year.
33. Why are UDAs being used as the contract currency when known to disadvantage higher needs patients? There is the potential for providers to be penalised from year 4.	Units of Dental Activity are required by the PDS Regulations 2005 (Part 5, para 13). The anticipated pause in the re-commissioning process will allow us to revisit the service specification including the contract currency.
34. Is there capital funding available to achieve any aspect of the service specification on premises.	The contract value includes the full cost of services including costs associated with premises and a rolling equipment replacement programme. There will be no additional funding for capital throughout the life of the contract.
35. The specification indicates that the GA contract requires all patients who need this level of care and any other appropriate treatments are to be managed under a set financial amount block contract. To fully assess potential options for delivery, would the commissioners be able to share how this contract value was costed and the expectations are in terms of delivery and patient numbers?	The GA contract value is based on current GA contract values, so will not be subject to the capitation formula that will be applied to the PDS contracts. See question 11 for more details.

Question	Answer
36. Please could the commissioners explain what would happen if the numbers of GA patients presenting requiring an array of additional treatments exceeded the block contract value?	If a patient requires treatment from another speciality at the same time, that speciality would charge under their tariff as currently happens.
37. What adjustment will you make to funding for significant population increases?	Please see question 6.
38. Please provide further details on using a weighted approach with UDAs and case mix?	Please see Appendix D of the service specification.
39. Please can the commissioners confirm that annual tariff uplifts for hospital level activity will be included in the contract and financial envelope?	The NHS standard contract is subject to annual uplifts which are notified each year.
Re-commissioning process	
40. Will there be financial (or other) criteria applied which will determine or limit the overall number of lots which a provider could apply for, assuming it is assessed as a capable provider for any single lot?	Assessment criteria at Stage 1 will include a financial sustainability element. We anticipate releasing relevant information at Stage 1.
41. Can a provider apply for a single lot as both a single provider and as part of a consortia type arrangement at Stage 1 and/or 2?	No. If bidding as a lead provider within a lot, this excludes the provider from being a material sub-contractor within the same lot as this creates a conflict of interest. Similarly, a provider may only be identified as a material sub-contractor to a single lead provider with a single lot.

Question	Answer
42. Is the Provider Capability Assessment a series of pass/fail type criteria, or are there scored elements requiring commissioner evaluation?	We anticipate releasing relevant information at Stage 1.
43. Would the fact that there are multiple providers being assessed as being capable automatically default to the competitive pathway at Stage 2?	Provider Capability Assessment will take place in each individual lot at Stage 1. If there is only one expression of interest in a given lot, from a suitably qualified provider with the demonstrated capability and capacity to deliver services for that lot, then we anticipate undertaking an assurance process carried out with that provider. Alternatively, if there is more than one capable provider in the lot, then this would result in inviting competitive bids instead.
44. How will providers for services that may be disaggregated from the core special care adult and paediatric contract be determined? It maybe that there are efficiencies to be gained by a provider bidding for these in parallel.	Some services which are currently delivered under Community Dental Services contracts will also be re-commissioned under separate contracts. These re-commissioning processes may be based on different lots to Special Care and Paediatric Dentistry services with different schedules, but it was planned that all services should commence from 1 April 2022, those procurements will be extended to the same timeframe as the Special Care and Paediatric Dentistry services. Potential providers will be able to consider whether they wish to bid for each service as they are tendered or otherwise re-commissioned. The commissioners do not envisage inviting combined bids for one or more services.
45. Will data provided at Stage 1 list the current single surgery clinics?	We anticipate releasing relevant information at Stage 1.

Question	Answer
46. Will estates information list premises which are not HTM01-05 best practice compliant and the details?	HTM01-05 compliance has not been validated by the commissioner and it will be the existing providers' own declaration that any bidder will receive, in respect of the potential transfer of assets.
47. Will it be possible to visit premises either during Stage 1 and/or after a competitive tender is issued? 48. Could commissioners give an indication of the volume of potential TUPE'd posts at Stage 1, accepting that it may change over the course of the procurement activity? 49. Could commissioners indicate which clinical systems are used? 50. Could commissioners note the locations/Trusts where GA is performed in each lot? 51. Could commissioners indicate if there is digital radiography available (and specify information at each site)?	We anticipate releasing relevant information at Stage 1.

Question	Answer
52. Could you please clarify is it one contract being procured per county or are the counties being broken into individual contracts?	There will be 5 lots commissioned as a result of this process. While lots are based on county boundaries, some lots encompass more than one county, e.g. Berkshire, Oxfordshire and Buckinghamshire are a single lot. Each lot will have two contracts held between the commissioner and the lead provider: one PDS contract and one NHS standard contract (for the GA element). These lots, and the two contracts within them, will be for the whole geographic area covered by that lot. There will not be contracts held between commissioner and providers for smaller areas within the lots. While the commissioner requires the contracts described above to be entered into by a lead single entity, consortia and/or other forms of partnership/multiple-organisation submissions will be accepted. Sub-contracting arrangements between the lead provider and any sub-contractors, or other multiple-organisational arrangement are within the gift of potential providers to explore.
53. Unscheduled care services in some areas have sat under Community Dental Services. To plan workforce, site utilisation and how existing spaces can be used in future, is it known when the service specification for this service will be released?	Pre-procurement work is underway for Unscheduled (Urgent) Dental care and there will be engagement on the specification with the profession.
54. Does the procurement process, which allows for partnership and multiple organisation submissions make it explicit the need for relationships across primary care areas, and perhaps even social care provision. Could a Lead Dental org have a partnership with a social care provider and	The commissioned service will have a key role in providing clinical strategic leadership to the wider dental system within the area. The service (through the strategic lead) will be responsible for bringing together local stakeholders, both dental and non- dental, to improve and develop local pathways and care for children and adults with additional needs. This will involve working with established and emerging local networks.

Question	Answer
a PCN in the area? What work has NHSE&I already done to promote this?	We have delivered market briefing events to suggest new ways of working collaboratively, due to the larger lot sizes and aligned with Integrated Care Partnership footprint where possible.
55. Have lessons from previous procurements been learned, for instance, Orthodontics in the South East?	Key lessons have been drawn from previous commissioning exercises, including the benefit of collaborative working in NHSE/I and working towards a common offer of services to patients across the region.
56. Have stakeholders been sufficiently involved including GDPs?	Views have been sought from the profession to help to inform the commissioning of services. This included surveys for the existing CDS workforce and for GDPs. There have been discussions with LDNs, MCNs and LDCs and there have been two market engagement events to inform the profession and to gain feedback. This feedback has been considered in developing the service specification and evaluation criteria to be used during re-commissioning.
57. Is history of good service valued? Are the efforts of Community Dental service staff during the pandemic recognised?	The history of good service and support during the pandemic is recognised. There is significant NHSE/I resource being devoted to reviewing current services, working with the services on the development of the service specification, achieving approval for a 10 year contract, reviewing financial allocations and conducting an open and transparent process to re-commission services that will be sustainable into the long term.
58. Is there protection from profit being valued over service? Could commercial services be incentivised to do less conservative treatments?	The aim is to commission services to meet the needs of local people with an equitable distribution of financial resources to support this aim.

Question	Answer
59. Have patient perspectives been considered? For example, access issues as some find it hard to travel long distances to appointments, patients report it is hard to get through by phone and they aren't able to leave a message, long waiting time to appointment can lead to repeated emergency appointments with GDP.	The aim is to commission services to meet the needs of local people. This includes the location of geographically accessible clinic sites. The commissioner gained the views of patients through an online survey and using easy read surveys in existing service locations to gain feedback. This feedback has been considered in developing the service specification and the evaluation criteria to be used during re-commissioning.