NHS England South
Personal Dental Services Orthodontic
Service Specification

Service Specification Number	NHSES-O1
Service	Orthodontics
Commissioner Lead	NHS England South
Period	April 2019 Contract term 7 years with option for further 3 years
Date of Issue	19 February 2018

Note Data packs to include

- **Draft Personal Dental Service (PDS) Agreement**
- **Details of lots (lots specific to each PDS Agreement to be added prior to signing)**

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1. Background

1.1 National/Local Context

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

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

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artificial divide between primary dental care and hospital specialists; one that will free specialist expertise from outdated service delivery and training models so all providers can work together to focus on patients and their needs.

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

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

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

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

1.2 Description of the Speciality

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

1.3 Description of the National Picture

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

The Index of Orthodontic Treatment Need (IOTN) is a clinical assessment of malocclusion severity utilised within the NHS to select those individuals who would benefit most from orthodontic treatment. The majority of NHS orthodontic treatment above IOTN 3.6 is supervised or carried out by specialists.

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

1.4 Population Need

In 2008/9 a national epidemiological oral health survey of 12 year old children was undertaken across England. As well as surveying oral health, Orthodontic need was also assessed, giving for the first time a primary care trust based epidemiological orthodontic needs assessment. The examiners were all calibrated with a Regional and National standard and trained in Index of Orthodontic Treatment Need (IOTN) assessment. The level for identifying someone as having an orthodontic need was an IOTN dental health component (DHC) score of 4 or above (the same level used in the 2003 National Child Dental Health Survey) and/ or an aesthetic component (AC) of 8 to 10.

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

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

As part of the preparation for the procurement of specialist led orthodontic services needs assessments were carried out in each NHS England – South, Local Office. These needs assessments are available on request. The findings from the needs assessments have been used to inform the development of lots for the procurement.

1.5 Workforce

Orthodontic care can be provided by a multidisciplinary team of clinicians which may include general dental practitioners (GDPs), orthodontic dental therapists, dentists with enhanced skills and experience, specialists and consultants.

2. Transforming Services

The points below set out NHS England's approach to commissioning orthodontic services in NHS England – South from 1 April 2019:

- managed clinical networks (MCNs) will enable clinicians to shape and influence service redesign through working with commissioners and patients. In developing, redesigning, procuring and monitoring services, arrangements will be made to involve patients, carers and the public, and the organisations that advocate for them including Health Watch;
- contracts will include key performance indicators (KPIs) which will incentivise quality;
- it is recognised that many GDPs will require appropriate training to support valid referrals (including familiarisation with IOTN, importance of good oral hygiene and suitability of patient);
- the aim is to have a single point of entry for orthodontic services where there is no a referral management system;
- referral management will move to electronic referrals, where this is not already in place;
- referrals will include an agreed minimum data set;
- agreed definitions and standards for waiting times both for review of referral, assessment, advice and treatment 'starts' from optimum treatment time. Patients and referring dentists will have access to waiting time data and will use this information when considering where to refer for treatment;
- contracts will support the use of skill mix in orthodontic care delivery;
- maintenance of core skills and enhanced continuing professional development (CPD) for all members of the orthodontic team;
- when deciding which services should be commissioned, commissioners will take account of the above in determining orthodontic need.

3. Service Definition

3.1 Aims and Objectives of Service

The overall aim is to provide equitable, accessible, high quality and cost effective specialist orthodontic services from April 2019, in line with the National Guide for Commissioning Orthodontics, 2015 and NHS PDS Regulations 2005 and any subsequent revisions.

The service will deliver orthodontic treatment to those patients who were assessed and accepted for treatment up to the age of 18 years old who meet the required IOTN as defined within Schedule 1, Part 2, 4 (3) of the National Health Service (General Dental Services Contracts) Regulations 2005 and PDS equivalent.

Orthodontics is mainly provided for children and adolescents who meet the agreed criteria for NHS treatment and for adults where there is clinical justification and where prior approval has been agreed with the commissioner.

The provider must treat all eligible patients 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 GDP.

3.2 Contract Type and Length

The contract is offered under the terms of the NHS (Personal Dental Services Agreements) Regulations 2005 effective from 1 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 agreement will be for 7 years in the first instance with the option available to both parties to extend for up to a further 3 years by mutual agreement.

3.3 Service Description

The service will include:

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

3.4 Service Requirements (Provider)

The provider will:

- ensure that service provision conforms to all 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;
- ensure that where referrals are deemed inappropriate, or where additional information is required to establish appropriateness, they respond to the referring dentist within 10 working days, apart from exceptional circumstances such as unplanned sickness, to request clarification, confirm reason for rejection or arrange onward referral to appropriate level 3b providers;
- liaise with the referring practitioner and provide a written report containing the clinical decision and treatment/referral provided; reports to be sent within 10 working days of the completion of the assessment, the end of active treatment at the point retainers are fitted and ultimately at discharge 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 to seek to improve service satisfaction rates to include NHS Friends and Family and treatment outcomes using the Peer Assessment Rating (PAR);
- implement a programme to ensure that feedback from service users is sought and acted upon;
- follow the commissioner's referral pathways which will be notified to the provider;
- 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 that robust procedures are in place to address issues arising from the patient pathway eg 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 at the end of this document).

3.5 Excluded from the Service

The contract is limited to orthodontic treatment within complexity level 2 and 3a and therefore excludes all mandatory services and the following additional services:

- sedation services;
- domiciliary services;
- minor oral surgery;
- dental public health services;
- orthodontic complexity level 1 and 3b cases.

3.6 Service Requirements (Performer)

Performers will ensure that for each new course of treatment:

- the patient and 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;
- the co-operation, motivation, aspirations and general health of the patient are consistent with the provision of orthodontic treatment, particularly their ability to maintain good oral hygiene to ensure no harm is done;
- the patient and carer are willing and able to commit to frequent attendance, which may be during school hours, over the course of orthodontic treatment and are aware of the need to wear appliances. The exception to this is patients referred for advice only;
- the patient has read and understood the British Orthodontic Society leaflet entitled 'What Are the Risks of Orthodontic Treatment?';
- the patient understands that they will be given a separate written NHS orthodontic treatment plan. This outlines details of the braces and retainers that they will be given, in addition to other important facts about their proposed treatment;
- the patient understands that once braces have been fitted they will need to attend on a regular basis for adjustments, normally every 6 to 8 weeks and they have been informed by the orthodontist and/or treatment co-ordinator how long the active treatment is likely to take;

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

unlikely to be available on the NHS, including replacement retainers, unless there are very exceptional circumstances that can be evidenced;

- patients will receive a written treatment plan outlining the proposed care;
- patients will receive a Patient/Orthodontist Agreement outlining their responsibilities during the course of treatment.
- the delivery of safe and appropriate care;
- a choice of routine appointments including early mornings and late afternoon appointments prioritised for patients at key educational stages;
- where patient's needs are outside the scope of the service they are referred to a more appropriate provider of care.

3.7 Referral Acceptance and Data Collection/Submission

Providers must comply with the requirements listed below:

- the service will only use the referral management process as identified by the relevant Local Office;
- the service will only use electronic data interchange (EDI) to submit claims to the Business Services Authority;
- providers will ensure the referral is reviewed for appropriateness within 10 working days of the referral being received by the specialist practice, apart from exceptional circumstances such as unplanned sickness, returning any that are incomplete;
- all referrals will not automatically warrant an assessment appointment to be offered. 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 not warrant an assessment should be returned requesting additional information. Where the referral suggests that an assessment is appropriate this should be offered within 12 weeks from the date of receipt of referral (not date of review of referral);
- if waiting 12 weeks for an assessment appointment would result in the patient reaching the age of 18 prior to assessment they should be offered an earlier assessment appointment before their 18th birthday so that where they have sufficient IOTN treatment can be offered without the need to seek commissioner approval. In these instances the assessment FP17O must be kept open so that when the patient starts treatment over the age of 18 it is still covered under the NHS as they were under 18 at the time of assessment;
- following assessment where a patient meets NHS criteria and is ready to commence treatment they should be placed on a treatment waiting list if it is not possible to start treatment immediately. The placement on the waiting list is to be prioritised by the patient's clinical need;
- following assessment where a patient is offered NHS treatment as part of the informed consent process, a Patient/Orthodontist Agreement must be used;
- providers will communicate the outcome of the assessment with the referring practice within 10 working days, either confirming acceptance of the patient for treatment or provide an explanation why treatment has not been offered;
- where further treatment is required before orthodontic treatment can commence eg extraction or exposure, this should be undertaken/arranged by the patient's GDP (where this is complex the GDP is to arrange a referral);
- the submission of FP17O for a case start is required within 62 days, except where this is an transfer case that is being completed as the contract has the

capacity due to treat due to the number of discontinuation or abandoned cases (see 9.1.2), or where the patient was assessed under the age of 18 but treatment is due to commence when the patient is over the age of 18;

- 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;
- submission of an FP17O for completion/abandoned/discontinued cases are required within 62 days of treatment completion/abandon/discontinue;
- providers will inform the referring practice when active treatment is complete (at the point retainers are fitted) or has been discontinued or abandoned within 10 working days;
- the orthodontic assurance framework (OAF) will be used in the quarterly monitoring of the contract.

4. Outcomes

4.1 Peer Assessment Rating (PAR)

Orthodontics is one specialty where a clinical outcome measure has been developed and is in use in both primary and secondary care. The PAR index is considered to be a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. The PAR score gives a measure of improvement in malocclusion and compares occlusion pre and post orthodontic treatment.

The PAR index is primarily designed to look at the results of a group of patients, rather than an individual patient, as there are always a small number of patients where the index does not fully represent the result obtained. Therefore a sample of scores is normally collected and an overall percentage score obtained. For PAR to be accurate and reproducible, any individual completing PAR scoring must be trained, calibrated and independent.

As individual patient outcomes may be influenced by many factors it has been proposed that an appropriate quality standard would be that 75% of completed cases should exhibit a reduction in PAR score greater than 70%, with 5%, or fewer, completed cases having a reduction in PAR lower than 30%.

4.2 Dental Assurance Framework – Orthodontic Indicators

NHS England's Dental Assurance Framework provides a set of indicators that provide high level assurance for commissioners, whilst recognising that no one set of indicators could, in itself, provide absolute assurance of quality, nor could it necessarily identify best practice. It is designed to assure commissioners that contract holders and providers are on course to meet their obligations under their

contract/agreement. The current orthodontic indicators are detailed below and are measureable via existing datasets.

Area compared to England (red worse performing than national level, green better performing than national level).

Delivery		England %	AT	AT %
UOA Delivered	% of Contracted UOA Delivered (Year to Date)			
Assessment				
Assessments by category	% of assessments that are Assess and fit appliance			
Assessments by category	% of assessments that are Assess and refuse			
Assessments by category	% of assessments that are Assess and review			
Age at assessment	% of reported assess & review for patients 9 years or under			
Treatment				
Cases reported complete as a function assess and fit appliance	Ratio of reported **concluded** (completed, abandoned or discontinued) courses of treatment to reported assess and fit appliance.			
Type of appliance used	% of **concluded*** (completed, abandoned or discontinued) courses of treatment reported as using removable appliances only.			
Outcomes				
UOAs reported per completed case	Ratio of number of UOAs reported per reported **completed** case (not including abandoned or discontinued cases)			
Reported PAR Scores, actual versus expected	% of contracts not meeting their expected PAR scores			
Abandoned or discontinued care	% of **concluded** (completed, abandoned or discontinued) courses of treatment where treatment is reported as abandoned or discontinued			

4.3 Key Performance Indicators (KPIs)

In order to drive continuous service improvement, the provider will be required to:

- meet number of case starts to assessment ration (total number of commissioned UOA's divided by 22.5 – agreed with the profession);
- 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);
- case starts versus case completions;
- PROMS/PREMS around patient experience;
- ensure all performers have active participation in the Orthodontic Managed Clinical Network.

5. Premises

5.1 Premises and Equipment Requirements

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

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

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

- are suitable for the delivery of orthodontic services and meet the reasonable needs of patients;
- are registered with the Care Quality Commission (CQC);
- comply with the Disability Discrimination Act (DDA) with a minimum of one surgery wheelchair accessible;
- are compliant with HTM01-05 Best Practice (as opposed to essential criteria);
- has equipment and facilities that conform to relevant standards/regulations and are maintained regularly in line with guidelines and manufacturers protocols;
- has appropriate radiographic facilities, as part of their contractual provision, eg orthopantomogram (OPG) or lateral cephalometric radiology. For the avoidance of doubt where a hub and spoke (satellite) arrangement exists it is not essential that both the hub and spoke has these facilities and it is acceptable for patients to access these facilities at one site only;
- has appropriate and sufficient waiting room accommodation for patients and carers;

- the telephone number to be used by patients and or professionals in connection with the delivery of the orthodontic service must not start with the digits 087, 090 091 or consist of a local personal number, unless the service is provided free to the caller.

5.2 Location of Services

The service delivery locations have been determined based upon the orthodontic needs assessment, orthodontic planning areas and populations to provide a good geographical spread and ease of access for patients. Premises must be based within the location(s) set out in Appendix D.

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

5.3 Additional Requirements

In addition to the requirements detailed in 6.1, the provider must ensure that:

- they have robust governance and quality assurance programmes in place to ensure a safe environment for all service users;
- they have safe processes and working environment in place, that will include ensuring that there are up to date policies and processes, that staff are familiar with these and have the relevant training;
- legal requirements relating to radiological legislation and guidance are met;
- dental laboratory services used meet with GDC guidance, EU legislation, are registered with the Medical Devices Agency and work within the relevant legislation;
- dental services are in accordance with best practice as set out in the following guidance
  - High Quality Care for All – next stage review 2008
  - NHS Constitution, 2009
  - Implementing Care Closer to Home, 2007
  - Modernising Medical Careers
  - NHS Personal Services Agreements
  - Ionising Radiation (Medical Exposure) Regulations
  - British Orthodontic Society, Orthodontic Radiographs Guidelines (2015)
  - British Orthodontic Society, Guidelines on Supervision of Qualified Orthodontic Therapists (2012, updated 2016)
  - British Orthodontic Society, Professional Standards for Orthodontic Practice (2014)
  - AIDS/HIC infected Healthcare worker Guidelines
  - Equalities Act, 2010
  - Human rights Act, 1998
  - Dental Practitioners' Formulary
  - GDC Standards for the Dental Team
  - GDC Standards
  - Caldicott Principles
  - The Hazardous Waste Regulations, 2005

- The Health and Safety at Work Act (1974) Statement of Policy with Respect to the Health and Safety at Work of All Employees
- Disability Discrimination Act (1995) and Disability Equality Duty (DED) 2005
- Decontamination of Dental Instruments: Health Technical Memorandum (HTM) 01-05, Parts 1 and 2, 2013
- Health Protection Agency Guidance on Infection Control, Communicable Diseases for Primary and Community Care within the Local Area
- Securing Excellence in Dental Commissioning, NHS Commissioning Board 2013
- Guide for Commissioning Dental Specialities – Orthodontics, 2015
- British Orthodontic Society, Clinical Guidelines on retention (Revised 2013)
- Royal College of Surgeons of England, National Clinical Guideline for the Extraction of First Permanent Molars in Children (2014)
- Five Year Forward View, NHS England 2014 (aspects relevant to dentistry).

6. Clinical Competencies

Description of the Complexity Levels

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

As the contract will carry out both complexity 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 a consultant led MCN. This includes dentists who have enhanced skills and/or experience; non-specialists who have demonstrated the competencies detailed in the Curriculum for the Primary Care Dentist with a Special Interest in Orthodontics, either by obtaining the Diploma in Primary Care Orthodontics or by demonstrating equivalence.

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

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

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

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

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 eg 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.

6.1 Complexity Descriptors

Level 1 carried out by general dental practitioners

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

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

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

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

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

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

Patient modifying factors may result in referral to 3b

Level 3b carried out by secondary care

- Patients with clefts of the lip and/or palate or craniofacial syndromes.
- Patients with significant skeletal discrepancies requiring combined orthodontics and orthognathic surgery.
- Patients who require orthodontics and complex oral surgery input (for example, multiple impacted teeth).

- Patient with complex restorative problems requiring secondary care input in a multidisciplinary environment.
- Patients with complex medical issues, including psychological concerns, which require close liaison with medical personnel locally.
- Patients with medical, developmental or social problems who would not be considered suitable for treatment in specialist practice.
- Complex orthodontic cases not considered suitable for management in specialist practice.
- Referrals where advice or a second opinion is required from a secondary care.

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

6.2 Training

The provider will be required to participate in and contribute to an agreed programme of continuing professional development for relevant clinicians.

It is acknowledged that a number of training cases are required for secondary care. A buddy arrangement may be established between secondary care providers with approved training placements and primary care orthodontic providers, where an agreed number of complexity 3a training cases will be redirected to secondary care with the patient/carer's agreement.

6.3 Governance and Information

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

- the provider must assign responsibility for IG to an appropriate member of staff;
- the policy must address the overall requirements of information quality, security and confidentiality;
- all contracts, staff, contractor, third party, contain clauses that clearly identify responsibilities for confidentiality, data protection and security;
- all staff members are provided with awareness and training across the IG agenda;
- the provider must implement IG Information Security management. arrangements to ensure the NHS CFH Statement of Compliance is satisfied;
- the provider must ensure that all staff and all those working for or on behalf of the provider where applicable comply with the terms and conditions set out in the RA01 form;
- the provider must ensure that all correspondence, fax, email, telephone messages, transfer of patient records and other communications are conducted in a secure and confidential manner;
- the provider must ensure patients/carers are asked before using their personal information that is not directly contributing to their care and that patients'/carers' decisions to restrict the disclosure of their personal information is appropriately respected;
- the provider must be fully computerised, for examples, but not limited to, electronic patient records, ability to submit electronic FP17O claims by EDI

transfer, access Compass to update contractual information 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 (or be able to work with future systems);

- the provider must only use nhs.net email account/s when transferring patient identifiable information and other confidential or sensitive information.

6.4 General Principles

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

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

Patients will only be offered one course of NHS funded routine orthodontic treatment unless there are exceptional circumstances. Such cases include where interceptive or growth dependent treatment has been undertaken prior to the age of 10 and the IOTN remains greater than 3.6, a further course of treatment can be commenced without seeking commissioner approval. Where a patient does not meet these circumstances, the patient's GDP would need to seek approval from their commissioner, giving evidence of the patient's exceptional clinical circumstances. There may be occasions when an appliance has to be removed during a course of treatment to allow a patient to undergo other procedures such diagnostic services; the removal and replacement of appliance does not constitute a new course of treatment and this is part of one (original) course of treatment.

6.5 General Patient Factors

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

6.6 Patient's Oral Environment

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

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

6.7 Clinically Feasibility

The detailed clinical aspects of the proposed orthodontic treatment should be considered to ensure that it will be beneficial to the patient.

6.8 Replacement Orthodontics 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:

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

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

6.8.2 Repair or Replacement Necessitated by 'fair wear and tear"

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

6.9 Any Acceptance and Exclusion Criteria and Thresholds

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

grade 4 or 5 of the Dental Health Component of the Index of Orthodontic Treatment Need (see *The Development of an Index for Orthodontic Treatment Priority*: European Journal of Orthodontics 11, p309-332, 1989 Brooke, PH and Shaw WC – the article is also available at www.dh.gov.uk or

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

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

6.10 Orthodontic Course of Treatment

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

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

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

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

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

6.11 General Dental Practitioners

Providers will return any incomplete or inappropriate referrals.

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

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

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

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

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

6.12 Interdependencies

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

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

Relevant networks include, but are not limited to:

- NHS England;
- Orthodontic Managed Clinical Network (MCN);
- Local Dental Network (LDN);
- Clinical Commissioning Groups (CCGs);

- Sustainability and Transformation Partnerships (STPs);
- British Dental Association (BDA);
- Local Dental Committees (LDC);
- Other relevant clinical networks;
- Local Authority Health and Wellbeing Boards and Scrutiny Committees;
- Health Education England (HEE) and Postgraduate Deanery;
- Healthwatch.

7. Accessibility and Opening Hours

The service will be flexible and responsive to individual patient need in accordance with the Equality Act 2010 and the Health and Social Care Act 2008.

The service must offer a choice of appointments including early mornings and late afternoon appointments for patients at key educational stages. Opening hours should allow for access outside of school hours and should be set to maximise attendance from children from all socio-economic backgrounds eg evenings and weekends.

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

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.

7.1 Management of Failed Appointments

Providers are expected to demonstrate effective methods of monitoring and reducing failures to attend to improve service utilisation and improve treatment outcomes.

7.2 Patient Information

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

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

Prior to the start of treatment, the patient and/or carer should be provided with the following information verbally and in writing using the Patient/Orthodontist Agreement as specified by the relevant Local Office:

- written treatment plan detailing the outcome of the assessment, such that the patient is clear why a specific treatment opinion has been selected, estimated length of treatment and visit frequency;
- what to expect during treatment;
- what is expected of them including self-care, compliance, and under what circumstances treatment will be terminated, eg poor attendance, poor oral health, abusive behaviour;

- any additional costs the patient may experience eg payment for replacement of broken appliances under Regulation 11 and equipment such as wax, toothbrushes etc;
- the information should be given in such a way that it supports the patient's ability to give informed consent to initiate treatment;
- a Patient/Orthodontist Agreement;
- FP17DCO form or electronic equivalent.

Providers will be required to:

- ensure the patient and/or carer has a clear understanding in advance of what will happen to them during the treatment, who will be responsible for delivering each element of care and why, for example, the patient may be returned to their GDP for extractions;
- ensure informed consent is gained for all patients prior to initiating assessment and/or treatment;
- have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults;
- have in place a policy that meets the commissioner's and CQC requirements for safeguarding children/young persons. 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.

7.3 Safeguarding

Providers must ensure that:

- valid consent is gained from all patients prior to initiating assessment and/or treatment;
- they have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults. All staff must receive regular safeguarding training;
- they have in place a policy that meets the Commissioner's and CQC requirements for safeguarding children/young persons.

7.4 Waiting Times

The definition of a treatment waiting list is the period of time when the patient is assessed and judged to meet NHS criteria, accepts the offer of NHS orthodontic treatment and is ready to commence orthodontic treatment.

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

- review of referral – 10 working days, apart from exceptional circumstances such as unplanned sickness;
- receipt of referral to assessment appointment – 12 weeks from date of receipt of referral (not date of review of referral);
- assessment to treatment start (see above definition) – prioritised according to clinical need.

7.5 Discharge Criteria and Planning

Providers are expected to follow British Orthodontic Society (BOS) guidance on continuing care after completion of active treatment.

7.6 Discharge Information Standards

Discharge information upon the completion of active treatment, at the point retainers are fitted will:

- include the unique reference number (URN) (where referral management arrangements are in operation) and the NHS Number (where known);
- contain clear instructions for the patient's GDP for any on-going care;
- contain a summary of the treatment provided;
- contain details of the continued treatment to be given by the service;
- contain clear instructions to the patient regarding the use of any retainers and the consequences of non-compliance;
- be sent to the referring GDP within 10 working days of completion of active treatment, at the point retainers are fitted;
- an FP17O completion form must be submitted within 62 days of the completion of active treatment, at the point retainers are fitted.

Taking into account local safeguarding protocols, procedures on discharge, patients whose active treatment is complete:

- where appropriate, other agencies will be informed within 10 working days of completion of active treatment, at the point retainers are fitted.

Following the period of retention:

- a final discharge letter to be sent to the referring GDP within 10 working days of final discharge;
- where appropriate, other agencies will be informed within 10 working days of final discharge.

Patients whose treatment is not complete:

- patients who do not attend for appointments (DNA) will be discharged according to the provider's DNA protocol following suitable efforts to contact the patient/carer to complete treatment, with discharge information provided in line with above requirements. The provider must be able to demonstrate they have made reasonable efforts to contact the patient/carer and inform them what will happen if they DNA;
- where appropriate, other agencies will be informed as outline above;
- where patients are discharged due to non-compliance with treatment requirements, the provider will need to be able to demonstrate that they have explained the consequences of the non-compliance to the patient;
- an FP17O completion form must be submitted within 62 days of the decision to discontinue or abandon a course of treatment.

Patients who do not commence treatment:

- if a patient DNAs their initial assessment, they will be discharged back to the referring clinician, with notification sent within 10 working days;
- no FP170 form will be submitted in these instances.

7.7 Prevention, Self-Care and Patient Carer Information

Each performer must ensure that the patient and/or carer has a clear understanding in advance of treatment what will happen to them during the treatment, who will be

responsible for delivering each element of care and why, eg the patient may be returned to their GDP for extractions.

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

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

Providers will be required to:

- ensure valid consent is gained for all patients prior to initiating assessment and/or treatment;
- have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults;
- have in place a policy that meets the commissioner's and CQC requirements for safeguarding children/young persons;
- evidence that all patient information and consent processes have involved patients/carers in its development and that it is regularly reviewed and updated.

8. Activity

The provider will be required to deliver the contracted number of UOAs from year 1. The provider may not take over care for a cohort of patients currently in treatment and retention. Until the outcome of the procurement is established it will not be possible to confirm which contracts will accept a cohort of patient transfers to continue treatment in addition to the new patients they will accept that will deliver the contracted UOA baseline. This will need to be negotiated on a case by case basis dependent upon local circumstances and the pricing structure in section 9 will be applied.

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

8.1 Ongoing Patient Transfer Arrangements, Not Associated with the Procurement of New Contracts

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.

8.1.1 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, 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.

8.1.2 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 (ie the treatment is not almost complete or the distance is not considered great when considering this is for specialist treatment and changing orthodontist during a course of treatment can extend the duration of treatment) once the patient has chosen their preferred new orthodontist the GDS practice should contact the original orthodontist and obtain details of the treatment (see below) to refer to a new orthodontist.

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

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

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

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

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

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

9. Currency and Pricing

- A national methodology has been used to establish a viable UOA price for a "stable" practice that has a cohort of patients already in treatment, in retention as well as taking on new patients. This will be a benchmark price of £56.89 with the bidder considering local market factors such as contract size and location when submitting their contract price. The benchmark price is at 2017/18 rates and will attract Doctors and Dentists Remuneration Body (DDRB) uplifts each year thereafter.
- A stepped contract value may be necessary for years 1 and 2 where a new contractor does not take over a caseload of patients currently in treatment or retention; where this applies providers will not be expected to have a full staffing establishment on day 1 and can build staffing levels as caseloads increase. Details of this are below in 9.1.

9.1 Pricing of Orthodontic contracts post 2019

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

- Bid price * number of UOAs commissioned.
- Complete all treatments commenced pre 31st March 2019 with no additional payments.

9.1.2 New contracts (contracts not in place pre 31st March 2019, commencing on 1st April 2019; no pre-existing caseload)

- Bid price * number of UOAs commissioned *85% Year 1
- Bid price * number of UOAs commissioned *96% Year 2
- Bid price * number of UOAs commissioned *100% Year 3 onwards

Payment to complete treatments if applicable

- Payment of £662 to complete treatments for patients who commenced treatment pre 31st March 2019, still in active treatment and transferred to the provider for treatment completion. *Monies paid over 2 financial years – 70% in year 1 (2019/20); £463: 30% in year 2 (2020/21) £199*
- Retention payment for patients who completed treatment n 2018/19 and transferred to the provider - £25. *Monies paid in year 1*

9.1.3 Scale down contracts (reduced number of UOAs commissioned when compared to numbers commissioned up to 31st March 2019)

- Bid price * number of UOAs commissioned

Payment to complete treatments

- Payment of £662 to complete treatments for patients ***above*** contracted activity post 1st April 2019 and still in active treatment. *Monies paid over 2 financial years – 70% in year 1 (2019/20); £463: 30% in year 2 (2020/21) £199*

- Retention payment for patients ***above*** contracted activity post 1st April 2019 completing treatment in 2018/19 - £25. *Monies paid in year 1*

*N.B. In order to calculate the number of patients for whom 'payments to complete treatment' can be made, the number of patients in treatment at 31st March 2019 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 post 1st April 2019 and divide by 22.5. Providers can then achieve 'payment to complete treatments' by subtracting the number of patients to be treated post 1st April from the numbers in treatment on 31st March 2019.*

9.1.4 **Scale up contracts (increased number of UOAs commissioned when compared to numbers commissioned up to 31st March 2019)**

- Bid price * number of UOAs commissioned for number of UOAs commissioned from provider pre 31st March 2019
- Complete all treatments commenced pre 31st March 2019 with no additional payments.

Additional contracted activity

- Bid price * number of UOAs commissioned ***above*** number of UOAs commissioned pre 31st March 2019 *85% Year 1
- Bid price * number of UOAs commissioned ***above*** number of UOAs commissioned pre 31st March 2019 *96% Year 2
- Bid price * number of UOAs commissioned ***above*** number of UOAs commissioned pre 31st March 2019 *100% Year 3 onwards

Payment to complete treatments

- Payment of £662 to complete treatments for patients who commenced treatment pre 31st March 2019, still in active treatment and transferred to the provider for treatment completion. *Monies paid over 2 financial years – 70% in year 1 (2019/20); £463: 30% in year 2 (2020/21) £199*
- Retention payment for patients completing treatment in 2018/19 and transferred to the provider - £25. *Monies paid in year 1*

10. Baseline Performance Targets – Quality, Performance and Productivity

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*
Control of Infection	Premises to confirm to HTM01-05 best practice (as opposed to essential) and other relevant standards	100%	CQC report/other national quality assurance reports IPS 6 monthly audit tool
Premises and Equipment Compliance	Premises to conform to relevant national standards	100%	CQC report/other national quality assurance reports

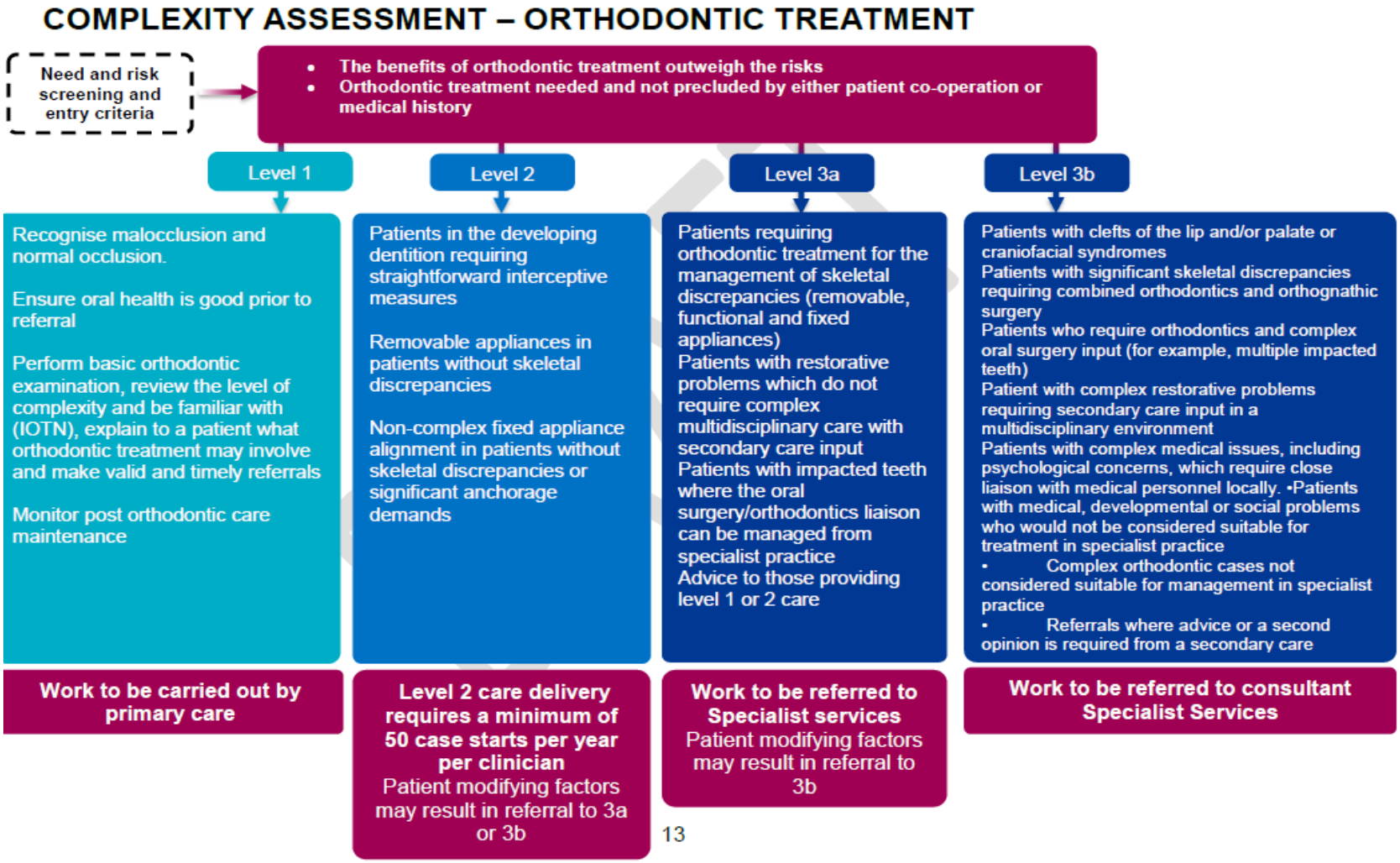
Personalised Care	Referrals are reviewed within 10 working days of receipt	100%	Audit
	Patients are assessed within 12 weeks of receipt of fully completed referral	100%	Audit
	Patients are provided with a written orthodontic treatment plan, FP17DCO and Patient/Orthodontist Agreement	100%	Audit
Clinical outcomes	The provider will undertake a minimum of one clinical audit in addition to PAR scoring per annum agreed with the MCN plus regional audits as agreed	100%	Annual report
Service User Experience	A patient and carer experience survey is offered to all patients upon discharge or completion of their treatment that incorporates the Friends and Family test (NHSFFT)	15% return rate and 80% of the response is good or better according to MCN agreed standards	Quarterly returns via MCN and NHSFFT
	Did you feel sufficiently involved in the decisions about your care?		
	How satisfied are you with the NHS dentistry received?		

11. Key Performance Indicators

National Key Performance Indicators (KPI's)	Excellent OR Band A[1]	Acceptable OR Band B[2]	Unacceptable OR Band C[3]
Number of Case Starts (total number of commissioned UOAs 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, six monthly between April and September and October and March, 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] (annual)	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	Engagement with 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.

12. Appendix A: Complexity Assessment – Orthodontic Treatment

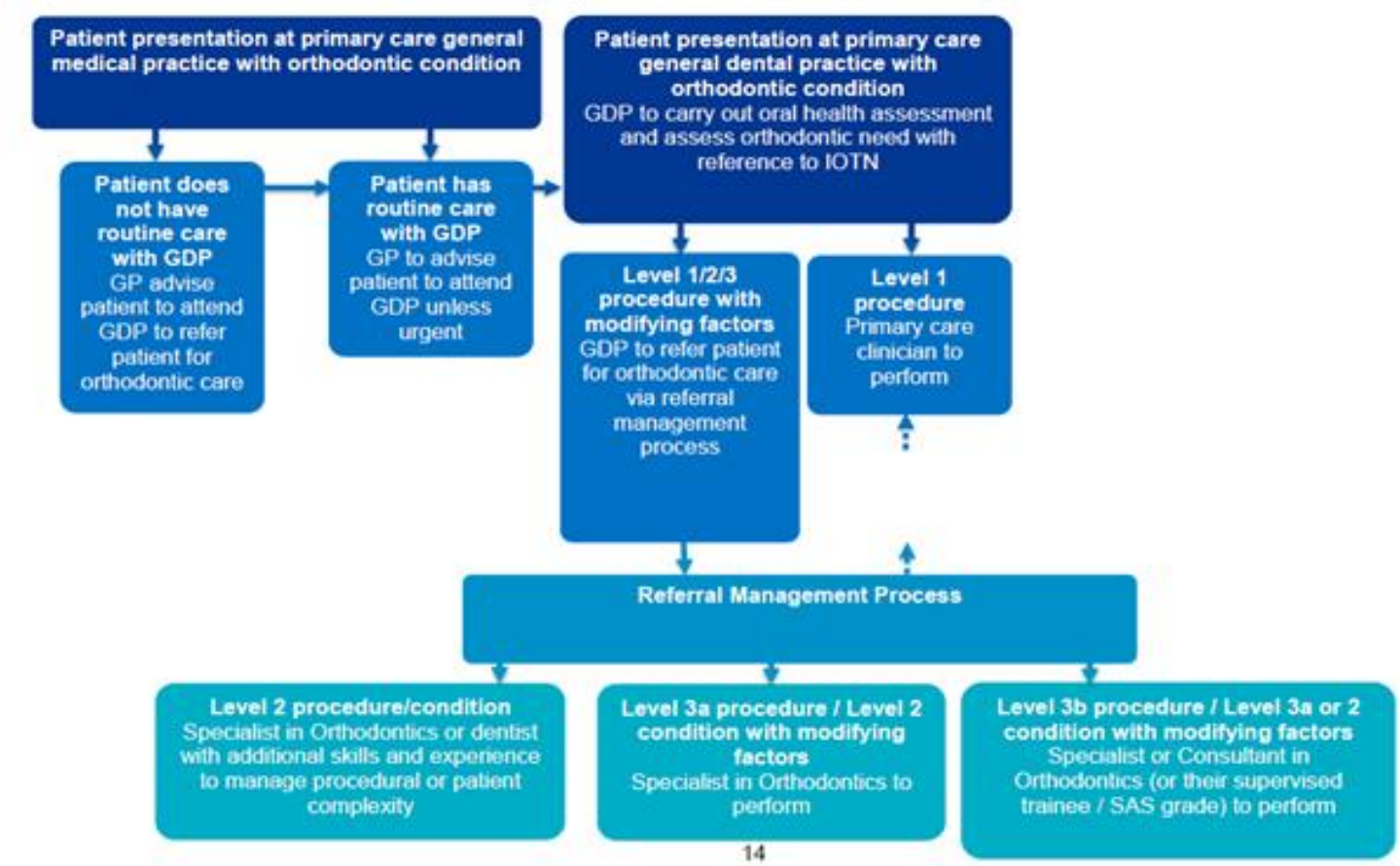


13. Appendix B: Provider Specification

	Requirement
Clinical skills and competencies: performer (s)	1. Registered with General Dental Council. 2. Currently on, or eligible for inclusion, on Performer List. 3. Specialist in Orthodontics on the register held by the General Dental Council.
Clinical skills and competencies: Chairside Dental Care Professionals	*GDC Registered Orthodontic Therapist* Current skills outlined in the GDC Scope of Practice 2013 and work under the supervision of GDC registered dental practitioner as outlined in the British Orthodontic Society publication 'Guidelines on Supervision of Qualified Orthodontic Therapists'. *GDC Registered dental nurse* Current skills in chairside dental nursing for orthodontic procedures (where provided) and expanded duties subject to suitable training.
Facilities	Accessible, appropriately equipped and CQC registered clinical setting for the provision of orthodontic services. To have in-contract access to: • Digital OPG/lateral CEPH radiology equipment.
Record keeping	Evidence of adequate clinical records keeping and a document management/data governance as well as compliance with relevant legislation/standards. Use of contemporary and secure practice/records management software.
Medical emergencies	Evidence of training within last 12 months for all clinical staff.
Management of service: (interface with other clinical service providers and referral management arrangements)	Appropriate IT to receive patient referrals safely and compliance with information governance standards. All providers will have an nhs.net email account. Able to communicate effectively (written and verbal) with primary and secondary care clinicians with primary and secondary care clinicians.
Management of service: interface with patients	Systems in place for receiving patient feedback and management of complaints/incidents.

	A Patient/Orthodontist Agreement; FP17DCO; written treatment plan. Appropriate verbal and written information for patients in a variety of formats/media. Robust appointment and reminder systems. Minimum of 30% of appointments outside of school times (during term time). Policy for minimising wasted appointment times due to failed appointments and cancellations. Flexible and responsive service able to adapt to patients' needs including those with physical or learning disabilities and different cultural needs, ethnicity, language.
Management of service: interface with commissioners	Able to demonstrate systems in place for reporting on performance, activity and quality of service.

14. Appendix C: Summarised Illustrative Patient Journey



15. Appendix D: NHS England – Location(s) of Services

It is expected that activity will be delivered within the location(s) identified for each of the Orthodontic Planning Areas (OPAs):

Individual lot data sheet.