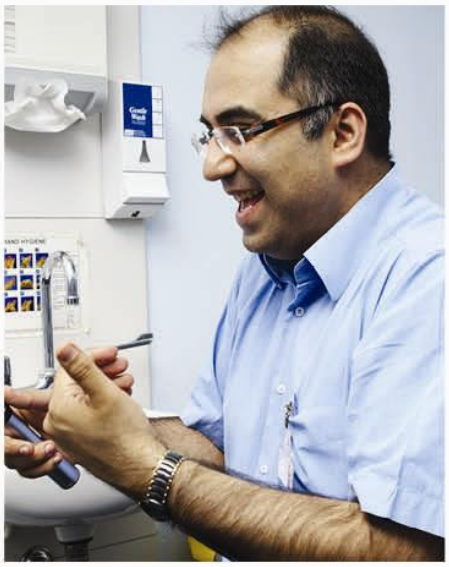
NHS Commissioning Board

Securing excellence in commissioning NHS dental services

February 2013



THE NHS CONSTITUTION
the NHS belongs to us all

Securing excellence in commissioning NHS dental services

NHS Commissioning Board

First published: February 2013

Prepared by: Sam Illingworth

Contents

Foreword

Dental services are valued highly by patients with over a million patient contacts per week occurring within NHS dental services alone.

The introduction of commissioned dental services enabled us to tackle longstanding access problems and we have made significant progress in this area. Many PCTs have been able to tackle previously intractable difficulties and access to NHS dental services continue to grow with over a million more people now visiting a NHS dentist compared to May 2010.

There have been major successes, the publication of Delivering Better Oral Health has enabled clinicians to adopt a more preventive approach to tackling dental disease within their practices, but the reconfiguration of the NHS now gives us an opportunity to bring greater consistency, greater clinical engagement and a more system wide approach to further improving NHS dental services and oral health.

From April 1 2013 all NHS dental services will be directly commissioned by the NHS Commissioning Board and this gives us opportunities to bring further improvement to the commissioning of routine dental care. We can achieve greater efficiency by doing some aspects of commissioning once as a single national organisation and not in 150 different ways by individual organisations. Commissioning the totality of dental care gives us the opportunity to better integrate primary and secondary services to provide better care and outcomes for patients and more rewarding careers for all clinicians.

A recurring theme over the last two to three years has been the engagement of clinicians and commissioners in the process of modernisation on which we are now embarked.

We are working hard to develop a new contract for NHS primary care dental services and the engagement and enthusiasm we have seen from clinicians involved in the pilot process has been unbelievably encouraging and we need to continue this.

We are working with clinicians and commissioners to develop care pathways for patients in need of an element of advanced care. We need to ensure that we utilise the skills of the whole dental team within a specialist led, but not necessarily delivered, service that provides high quality care regardless of setting.

Everyone understands that the current financial climate is tight but we are committed within the Board to develop a system which produces dental services for patients, based on the improving health outcomes, which are both cost effective and clinically effective offering patients a positive experience of care in a safe environment.

We owe that to our patients, ourselves, and taxpayers.

Change does not happen overnight and can certainly be unnerving, but within the Commissioning Board we are confident that we can respond to this challenge and I believe this document provides a sound basis on which we can build a 21st century dental service which everyone can be proud of.

Barry Cockcroft
Chief Dental Officer

This document, developed by commissioners and clinicians builds on the principles of "*Securing Excellence in Commissioning Primary Care"* published by the NHS Commissioning Board in June 1012.

"Securing Excellence in Commissioning NHS dental services" has created an opportunity for the NHS Commissioning Board to be an exemplar commissioner, commissioning patient focused, consistently high quality pathways for dentistry with a focus on outcomes.

Whilst services cannot change overnight, the development of Local Dental Networks will provide clinical leadership to support the implementation of the wider national primary care strategy, develop local patient engagement, and opportunities to work with the wider community of practitioners and providers to develop real change in how services are provided for patients.

The immediate challenge for us all is to achieve a safe transfer of all dental services from Primary Care Trusts to the NHS Commissioning Board in April 2013. However, whilst the initial focus is on maintaining a steady state in the transition, this document will enable the NHS CB and in particular the Area Teams and their Local Dental Networks, to maintain a line of sight for the development of dental services to ensure stability through transition and alignment to the NHS Commissioning Board's principles and values as models and frameworks are tested, refined and published.

I commend those clinical and commissioning colleagues who have helped to develop this document through this transitional period. We now have an opportunity to prepare ourselves to plan, prioritise and take this framework forward for the NHS.

Dr David Geddes
Head of Primary Care
NHS Commissioning Board

Executive summary

How the NHS Commissioning Board (NHS CB) will commission dental services is grounded in the NHS CB's primary care operating model – *Securing Excellence in commissioning primary Care* - published in June 2012 and will form a key part of the Board's primary care strategy.

Securing Excellence in commissioning NHS dental services focuses on commissioning the entire dental pathway as an integrated model of service delivery.

Scope

As part of its direct commissioning responsibilities, the Commissioning Board will commission all NHS dental services: primary, community and secondary care including dental hospitals and Out of Hours services. Clinical Commissioning Groups (CCGs) will have an interest in the delivery of dental services particularly for oral surgery and the interface with maxillofacial surgery but they will have no direct role in their commissioning from April 2013.

Operating Model

The NHS CB, as a single commissioner of all dental services, can achieve whole-England strategic planning and consistency in approach and direction. This single commissioner focus will offer dentistry a unique opportunity to share excellence across England.

The proposed operating model for commissioning specialist and community dental services has been led by a task group, incorporating expertise from NHS commissioners, clinicians and consultants in dental public health and includes collaboration with the Department of Health. A Minor Oral Surgery commissioning framework and care pathway is being developed as a model, components of which are now being tested as part of re-design projects across various locations.

A care pathway approach is proposed for all dental services to align with the NHS CB single operating model. This will ensure consistency in delivery of dental services both in the sequencing, effectiveness and quality of clinical care, the 'journey' that patients' experience, and a focus on patient outcomes.

Clinicians within Local Dental Networks will work within area teams to implement the national model pathways as they emerge and are validated. They will work with local partners, including patients, established wider dental networks and specialist groups to implement pathways to meet local needs.

Dental care pathways will describe consistent national elements, regardless of setting, describing:

- Complexity and procedures across all levels of care, building on work led by the Department of Health
- Consistent clinical competencies for each level of care

- Consistent environment and equipment standards
- Consistent clinical outcomes, quality standards and patient reported outcome measures (PROMS)
- Consistent coding and pricing measures for each care pathway

Nationally the NHS CB will work with a range of stakeholders to determine the outcomes expected from all dental services and the main characteristics of high quality services.

The NHS CB will develop appropriate clinical information and intelligence across the whole system, to have oversight and assurance to plan, secure and monitor all dental services. This will include comparable and benchmarked data for activity, referrals and quality. The NHS CB will also aim to ensure that this information, in particular in relation to the quality of dental services, is made available in a meaningful and appropriate format for the public.

The NHS CB will work with Health Education England (HEE) to secure an effective and sustainable workforce for the future

Regions will have a key role in ensuring an overview of commissioning, maintaining a focus on tackling health inequalities and ensuring the right balance between consistency and adoption of national frameworks and localisation, and support the coordination of some of the NHS CBs national developments.

Area teams will be the interface for all dental services and stakeholders such as Local Dental Committees at a local level. This will initially be based on what the NHS CB 'inherits' from PCTs, however, with commissioners and clinicians working together through Local Dental Networks, the area teams will implement national frameworks, promoting innovation, best practice, and sharing expertise to get the best 'local fit'.

The partnership with dental public health is crucial to delivering the vision for NHS dental services. The NHS CB and Public Health England (PHE) will work together across the system to deliver excellence by establishing the new architecture and developing strategies to improve health outcomes.

In relation to the commissioning and contract management of secondary dental care it is proposed a scoping exercise is undertaken of the various options to establish the best fit for commissioning and managing secondary dental care. This will be undertaken in partnership with Directors of Commissioning in area teams

Next steps and early priorities

It is recommended that a national dental commissioning steering group is established that will enable central input across the NHS CB matrix, led by the Medical, Commissioning Development and Operations Directorates, to oversee the delivery of the NHS CBs operating model, establishing working groups across other specialist areas and feeding into the development of the Board's primary care strategy.

Key initial priorities identified to implement the operating model for dentistry are:-

- Establish **national dental care pathway commissioning frameworks**.
- Establish a working group for **workforce and dental schools** to develop frameworks for the NHS CB to commission services from dental schools and establish workforce alignments. This will need close partnership with HEE and LETBs.
- Develop a transition plan for oral surgery and maxillofacial surgery services.

The NHSCB will clearly articulate its commissioning intentions to the provider landscape. A steady state transfer is proposed from 1 April 2013. The NHS CB, will communicate via Area Teams to providers of community and secondary care, specialist dental services and dental schools:

- That the NHS CB will be the commissioner from 1 April 2013
- That the intention is for a steady state transfer but there is a clear intent to work with providers, clinicians and commissioners, collaboratively across the country to develop consistent high quality, evidence based care pathways
- This nationally consistent approach will involve the development of single operating procedures and policies.
- Improving access to NHS dental services will continue as will the drive to improve the cost effectiveness of dental services in order to play our part in the QIPP challenge.

Section 1

Introduction and purpose of the document

1.1 From April 2013, the NHS Commissioning Board (NHS CB) will take on its full commissioning responsibility from PCTs. As commissioner, the NHS CB has an overarching role to ensure that the NHS delivers better outcomes for patients, within its available resources, upholds and promotes the NHS Constitution and delivers the key objectives of the NHS Mandate. As a single national organisation, the Board will be responsible for ensuring that services are commissioned in ways that support consistency not centralisation; consistency in ensuring high standards of quality across the country. The NHS CB will work through its national, regional and area teams to discharge these responsibilities.

1.2 As part of its direct commissioning responsibilities, the Board will commission all NHS dental services: primary, community and secondary care and this will include dental out of hours and urgent care. Clinical Commissioning Groups (CCGs) will have an interest in the delivery of dental services, particularly for oral surgery and interface with maxillofacial surgery, but they will have not have a direct role in their commissioning.

1.3 The proposed operating model for specialist and community dental services has been led by a task group, incorporating the expertise from NHS commissioners, clinicians and consultants in dental public health, with support from the Department of Health. The operating model has not become a fixed concept, and the NHS CB will continue to use the same methodology to refine the operating model, defining and delivering priorities beyond the publication of this document, pre and post April 2013.

1.4 The over-arching principles of the operating model design work have been to:

- Articulate the NHS CB's proposed operating model for commissioning all dental services and early priorities to enable it to discharge this function
- Describe the care pathway approach to commissioning and the key components required to make this a reality
- Identify the enablers and levers required to deliver this and where in the system they need to be developed and delivered, aligning current levers and enablers where they exist
- Describe the key strategic and operational relationships that the NHS CB will need to deliver the model both across its directorates and with external stakeholders

1.5 In designing a commissioning system for dentistry, it is critical to ensure that the NHS CB will:

- Be effective in managing the safe transfer of responsibilities from PCTs for all dental services from April 2013

- Be capable of transforming and improving dental services beyond April 2013
- Ensure alignments with critical interdependencies that will be required to develop and deliver this model, such as national policy to reform the primary care dental contract and establish integrated end to end patient pathways.

1.6 The cornerstone for the NHS CBs operating model for the commissioning of dental services has been the NHS CB's primary care operating model. Although this document additionally focuses on requirements for commissioning secondary care and community services, it has been critical to the model for dental services not to distinguish between separate settings of care.

1.7 This operating model also outlines how the NHS CB will implement nationally developed care pathways across all specialties. This will provide the NHS CB with a vehicle to achieve dental commissioning that provides patients with a consistent NHS offer, no matter where they live, allowing the NHS CB to make best use of its commissioning resources, providing an effective and consistent national approach, but with local flexibility for local priorities.

Section 2

The Operating Model for NHS dental services

2.1 The NHS CB's vision is for a NHS that promotes health and wellbeing; which provides care that is centred on patients, is evidenced, informed and innovative, to achieve high quality, best outcomes for patients and value for money. The Board will focus on reducing unwarranted variation in the delivery of care and to reduce health and care inequalities by maintaining access and improving quality, particularly for children and disadvantaged groups.

2.2 The NHS CB, as a single commissioner of all dental services, can offer whole-England strategic planning and consistency in approach and direction. This single commissioner focus will offer dentistry the opportunity to achieve and share excellence across England which is clinically driven.

2.3 The NHS CB will operate as part of a wider system and will have clinical leadership at the heart of planning, with a chief dental officer who will work at national level in partnership with DH and a wider range of organisations within and beyond the NHS such as NICE, Health Education England, Public Health England (PHE), Care Quality Commission and Health Watch England. This clinical leadership will build on productive relationships with national dental organisations such as the British Dental Association, the Royal Colleges, learned specialist societies and opinion leaders to socialise the commissioning direction of the NHS CB and to form productive relationships for dentistry.

2.4 Through this mechanism the NHS CB will work through and respond to its commissioning teams, engaging the wider clinical and professional community via local dental networks within the area teams. It will do this in partnership with the PHE, the deputy chief dental officer providing national dental public health leadership and Consultants in Dental Public Health, working out of PHE, at regional and local level. These key strategic and operational partnerships are described in more detail later in this document.

2.5 At a national level, the NHS CB will work with a range of stakeholders, to determine the outcomes expected from all dental services and the main characteristics of high quality services, taking into account national priorities for improving NHS and Public Health outcomes, evidence from patient experience and insight, evidence from local experiences, and innovative practice from across the NHS.

2.6 Clinicians within local dental networks will work in an integrated way within their area team and with local authorities (LAs) and Health and Wellbeing Boards (HWBs). This will ensure that decision making will be clinically led and

strategically fit with public health and social care. Local dental networks will have a responsibility to involve patients and the public, to work with local stakeholders such as other established dental networks, specialist groups, the wider dental community, HWBs, LAs and CCGs to meet local needs.

2.7 To date, the work to develop a cohesive operating model for the NHS CB has concluded that to be an exemplar commissioner of dental services, we will require:

- National consistent **care pathway commissioning frameworks** across all specialties encompassing; consistent procedures/levels of complexity
- Consistent standards and criteria, comparable costs and coding, consistent specifications and clinical and patient outcome
- A consistent method to capture need/diagnosis and level of complexity for all specialties, referrals and treatments
- Consistent information, and commissioning intelligence for service planning, performance management and financial control
- Sharing of meaningful information about patient outcomes and commissioned services with the public to allow patients to make informed choices
- The capacity and capability within the commissioning system to deliver this agenda in a consistent and efficient way
- A national package of 'tools' to enable a consistent care pathway approach to commissioning for each specialty
- National (clinical and commissioner) consensus on these elements, for local translation into implementation

2.8 These will be developed over time, coordinated at national level, but using the expertise of dental commissioners, clinicians and public health from area teams to ensure it is grounded in the needs of local health and care services.

Section 3

Care pathway commissioning frameworks

3.1 A care pathway approach supports evidence based informed decision making and the organising of care for patients during a defined period. The use of a care pathway approach has been shown to improve the quality of care and aid the continuity of care between clinicians and settings; in short the use of care pathways will underpin the consistency and effectiveness of commissioning in dentistry.

3.2 **Primary Dental Contract Pilots**: a care pathway approach to commissioning of primary care dental services is currently being piloted. The underlying principle is of a clinical pathway which promotes a standard oral health assessment, identification of need and disease risk and evidence based prevention for patients.

3.3 Care pathways are also being used to achieve continuity of care across care settings for each dental specialty and as a tool relating to clinical governance in intermediate and secondary care dental services and have demonstrated improved quality and efficiency of care by specifying steps in the care process. This approach will therefore align with the NHS CB single operating model, promoting consistency in dentistry across two trajectories: the sequencing and quality of clinical care, and the 'journey' that patients experience including an assessment of outcomes.

3.4 Dental care pathways will be developed to describe consistent national elements in the following areas;

- Levels of care, complexity and procedures (e.g. building on advanced care work currently being led by the DH)
- Consistent competencies for each level of care (building on advanced care work)
- Consistent environment/equipment standards for each level of care
- Consistent clinical outcomes, quality standards and/or patient reported outcome measures (PROMS) for each level of care
- Consistent approach to coding and costing measures for the care pathway across all settings
- Access to services across each pathway to ensure that people with disabilities and all other "hard to reach" groups of people have equitable access to good oral health outcomes.

3.5 Ensuring that hard to reach groups are able to access services across each pathway will be a priority for the NHS CB. The special care dentistry specialty and the development of a pathway in relation to it offers an opportunity to address this systematically across all providers; including prison dentistry. Pathways will require focus not only upon the development and potential redesign of services provided in a special care setting, but also on how all providers can make “reasonable adjustments” where appropriate to facilitate access.

3.6 In developing care pathways, the NHS CB will need to make strategic alignments to existing critical components (and influence where needed), including the dental contract pilots and advanced care pathway currently being led by the DH.

3.7 For the purpose of demonstrating this approach, a Minor Oral Surgery commissioning framework and care pathway is being been developed and tested in Greater Manchester, as part of a pathway re-design project led by clinicians, commissioners and dental public health. Appendix 2 sets out the proposed pathways for development. These will be developed over the coming months and in partnership with colleagues in the NHS CB, the DH and other key stakeholders. The operating model for the NHS CB to commission dental services is grounded in developing commissioning packages for all dental specialties at national level for use by area teams to support the transition to a consistent and quality driven care pathway approach to commissioning that covers the entire dental space.

3.8 Further testing and refinement of these commissioning frameworks will be established and aligned to national developments as they come on stream, in particular the new dental contract and associated clinical pathways, which are crucial enablers to delivering this approach.

3.9 Area teams, working with dental public health and clinicians through local dental networks will be enabled through a training programme, to use these frameworks to support local commissioning in response to local needs. In doing so, the NHS CB will have a managed transition to delivering consistency, grounded in best practice and national consensus aligned to its operating model.

Section 4

Scope of NHS dental services

4.1 There is variation in how PCTs have historically commissioned and managed primary, community care and secondary care services. Some PCTs have made good progress in re-designing some secondary care services and associated pathways, such as the work in Croydon and Lancashire, while others have focussed on managing demand, particularly for oral surgery. What is delivered in dental hospitals, dental teaching hospitals and district general hospitals, in terms of specialist dental services and teaching, in particular, varies widely and currently the national picture is still little understood.

Primary care

4.2 The NHS CB will inherit over 10,000 primary care dental contracts with a budget of **£2.8 billion** including associated patient charge revenue (PCR). The combined budgets are used to commission primary care dental services.

4.3 Since April 2006, the following contracting routes have been available to enable commissioning of primary dental services:

- General Dental Services contracts (GDS)
- Personal Dental Service agreements (PDS) which community dental services and non-mandatory services such as orthodontics and sedation.

4.4 The contract transition programme and guidance has also identified other SLA based primary care dental services, including orthodontics, some community services and triage or referral management services which may not be under PDS and GDS arrangements.

Community dental services

4.5 The NHS CB will inherit responsibility for commissioning community dental services, which primarily provide specialist-led special care and paediatric dental services for people with additional care needs. Previously known as Salaried Dental Services, prior to April 2011 the majority of these services had been provided by PCTs. However, the Department for Health's Transforming Community Services Programme meant that new hosting arrangements were required for these services.

4.6 There has been significant national variation in how community dental services have been specified and contracted and there is opportunity under the NHS CB for national benchmarking and specification, and for these important services to be included in the care pathway work. A care pathway approach for community dentistry is soon to be piloted as part of the dental contract reform programme.

Secondary dental services

4.7 The NHS CB will also inherit the responsibility for commissioning secondary dental services with a budget of £600m.

4.8 Defining the 'pure' dental specialties is relatively straightforward, covering all general and dental hospital, and dental teaching hospital based services that will be commissioned by the NHS CB (Annex A provides full details and definitions). These specialties are in line with GDC recognised definitions. Within each specialty however there are a small number of procedures that involve multidisciplinary care with medical specialties which would not be recognised as primarily a dental care pathway. These pathways represent the complex end of a spectrum.

4.9 It is not possible without defining clear pathways to robustly separate the delivery of oral surgery and many elements of oral and maxillofacial (OMFS) surgery procedures and therefore to define the resources that flow with them. Many of the consultants in OMFS perform procedures that fall within the oral surgery remit, and junior staff and trainees perform oral surgery procedures as part of long established training schemes. A significant proportion of the procedures currently carried out in many secondary care services can and should be delivered by specialists and dentists in a primary care setting. Oral surgery is of particular note, where there is scope for a strategic approach to redesign. Approximately 80% of referrals to an OMFS unit are for oral surgery and about 20% specifically require the services of a maxillofacial surgeon. Whilst this means accessibility for specific OMFS services remains good, the pressure for oral surgery is much greater and access poorer. This pressure would be greatly alleviated by the development of a consultant led, locally delivered, service with hospital based consultants running a managed clinical network of suitably qualified providers in primary care. Such a model would align closely with the piloting of the new primary care dental contract.

4.10 For these reasons the oral and maxillofacial surgery will initially be commissioned by the NHS CB, whilst working collaboratively with CCGs during a transition period. Maxillofacial surgery, as a medical specialty, will later be transferred to CCGs as part of their remit to commission all medical services. Guidance to support the contract and financial transition programmes has already outlined this for PCTs as part of the transition process.

Dental schools

4.11 Dental hospitals provide specialist NHS dental services and act as hosts to university dental schools. The host trusts receive service increment for teaching (SIFT) funding to cover the additional costs to the service of supporting undergraduate teaching. Health Education England will have the responsibility for allocating SIFT funding, via Local Education and Training Boards in the future.

4.12 SIFT allocations are based on historical numbers of students already in training, and by a fixed placement rate of £25k per student commencing study in Autumn 2005, all uplifted by inflation.

4.13 Currently, PCTs also commission specialist NHS dental services, as well as general dental services (primary care) for the purposes of teaching from Dental Hospitals. Some schools have also been used by commissioners as a means to provide urgent access clinics. These specialist services include the larger specialties of oral surgery and orthodontics, which are also provided in most district general hospitals, but also smaller specialist services such as restorative dentistry, paediatrics, oral medicine, oral and maxillofacial pathology, oral and maxillofacial radiology, which are largely confined to dental hospitals. Dental hospitals have a significant role in providing specialist NHS training, especially for these more specialist areas.

4.14 Collaborative commissioning arrangements for NHS services provided by dental hospitals and for SIFT funding from HEE, provide scope for development opportunities for a collaboratively approach between LETBs and the NHS CB in the future. This is important, as there is significant co-dependency between these two sources of revenue for dental hospitals and the delivery of services for patients.

Section 5

Delivering the Operating Model

5.1 The Department of Health will continue to be responsible for policy on patient charges including the setting of patient charges. More broadly speaking, the following functions underpin the NHS CBs commissioning operating model, and the respective roles across national support centre, regions and area teams are highlighted in the diagram below:

5.2 **Planning** the optimum services that meet national standards and local needs and ambitions, ensuring that patients, carers and the public are involved in the process alongside other key stakeholders and the range of health professionals who contribute to patient care;

5.3 **Securing** services, using the contracting routes and national consistent frameworks and dental care pathways that will deliver the best quality and outcomes and promote shared decision-making, patient choice and integration; and

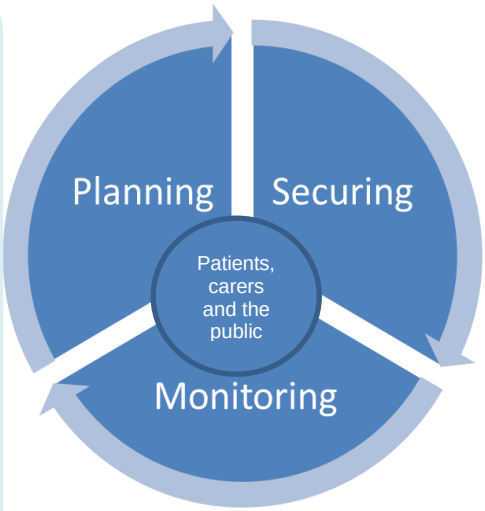
5.4 **Monitoring,** assessing and, where necessary, challenging the quality of services; and using this intelligence at national, regional and local level to design and plan continuously improving services for the future.

5.5 There are three elements to the operating model for dental commissioning:-

- What happens locally (including regions) within the Operations Directorate
- What happens nationally and across the NHS CB Directorates to develop consistent commissioning frameworks, using the expertise from across the system as part of the wider primary care strategy.
- The interface and relationships between the two and how best the NHS CB can use its clinical and commissioning expertise throughout to drive improvements.

National/Regional: Plan on basis of aggregation of local need, NHS CB priorities, patient insight, DH mandate; works with partners and stakeholders, such as PHE, professions, to develop and agree outcomes and develops commissioning frameworks.

Area team: Engage via local professionals and patients to identify priority areas for improvements, contributes expertise to national and regional to develop commissioning frameworks; feed into local assessments; respond to performance; agree commissioning plans locally, implement national frameworks.



National: With PHE, collate, aggregate, analyse information; on quality standards and outcomes and provides information and intelligence to ATs. Local with CSUs: Contract monitoring and performance management within context of national framework; exercise

National: Develop and negotiate contracts; policies, procedures, guidance and processes.

Regional: brings together clinical and commissioning expertise to enable development of national refinements and testing of frameworks, 'custodians of consistency'; expedites fast track adoption and spread of innovation.

Area team: Use standard commissioning frameworks to secure services and ensure good value for money; facilitate innovation and getting the best return on investment; support providers to ensure optimum delivery.

National support centre

5.6 At national level, as part of the development of the primary care strategy the NHS CB will work with a range of stakeholders to determine the outcomes expected from all dental services and the main characteristics of high quality services, taking into account national priorities for improving NHS outcomes, evidence from patient experience and insight, evidence from local experiences from area teams and regions, and innovative practice from across the NHS.

5.7 Importantly, the components of commissioning frameworks are developed with the input and ownership across the NHS CB's directorates and through a two way exchange of expertise, knowledge and innovation across area teams, regions, and central support teams. The Chief Dental Officer (CDO), working with other clinical leaders throughout the commissioning system will describe quality and outcomes and set the ambitions for dental services. The CDO, working at national level across the NHS CB matrix structure, and drawing in expertise from local and regional level to support this will provide senior clinical oversight and ownership to the development of consistent quality frameworks, dental care pathways and dental specialty based commissioning packages to be adopted across the NHS CB.

5.8 Some components, the NHS CB will ‘take and drop’ into its commissioning system, such as current national and local reporting systems, but will need to adapt and enhance them over time to meet the challenges of this model.

5.9 The NHS CB central support team will secure appropriate information and intelligence needs for area teams to enable them to have oversight and assurance to plan, secure and monitor secondary care dental services. This will include comparable and benchmarked data for activity and referrals where this currently exists at national level.

5.10 It will provide area teams with the means to determine and address unwarranted variation, enabling clinically led discussions, via local professional networks, to support quality and service improvements.

Regions

5.11 Regions will have a key role in ensuring an overview of commissioning, they will have a focus on health inequality, and ensuring the right balance between consistency and adoption of national frameworks and localisation. Regional teams will provide co-ordination to some of the NHS CBs national developments.

5.12 As regional teams will have a role in supporting the work of the national clinical senates, so too will they support the role of clinical leadership for dentistry to contribute to national level developments.

Area teams

5.13 Area teams will contribute to the development of national frameworks for dental commissioning using the expertise of clinical and managerial commissioners. They will take nationally developed resources and commissioning enablers for alignment to meet local need, working closely with Consultants in Dental Public Health employed by PHE, patients and other key partners, via their local dental networks, to implement care pathways, innovation and quality improvement.

5.14 Area teams will plan, secure and monitor all dental services at local level, initially based on what the NHS CB ‘inherits’ from PCTs, but as part of a move to consistency, tackling inequality and sharing expertise, innovation and adopting best practice, work towards implementing national frameworks. In many parts of the country regional dental leads meetings have proven an invaluable mechanism to do this. The continuation and extension of these regional forums will therefore be encouraged. As new teams are established these will also provide a forum for staff new to dentistry to develop key skills and knowledge necessary to become effective dental commissioners through training.

5.15 Area teams will build strong relationships with all partners and stakeholders such as LDCs across the commissioning system. They will work closely with CCGs on commissioning areas of care that have interdependencies and

where CCGs will have an interest in the outcomes, such as urgent dental care and oral and maxillofacial surgery.

5.16 The NHS CB can make greater economies of scale by area teams working with each other across health economies to commission services that have benefits for wider populations. This is particularly relevant to the commissioning of secondary care dental services where resources can and should be configured to provide oversight of pathways of care that extend beyond area team boundaries, such as smaller specialties provided by dental hospitals.

5.17 It is proposed therefore that in order to find the best fit for commissioning secondary / tertiary dental care, that a scoping exercise is undertaken of the various options. The direct commissioning function within an area team spans primary dental services as well as specialised services. Therefore, one option is that the ten area teams hosting specialised commissioning can host contracts for secondary care dentistry. Although not all secondary care dentistry, apart from specialisms such as cleft lip and palate, would constitute what would be considered as specialised, these teams possess the necessary skills and experience to manage contracts in an acute setting. Also, some of the small non clinical specialties such as oral pathology and microbiology may also be better aligned with specialised commissioning teams.

5.18 Whichever option is selected it will be imperative that there is a clear line of sight on complete dental pathways across regions and that the operating model supports a clear working relationship between the area teams, regions and the national support centre.

5.19 As explained above (ref 4.10), once the 20% of OMFS activity that does not relate to the dental pathway has been accurately identified this will be transferred to CCGs. Specialised commissioning teams will be well placed to conduct this exercise and ensure that those services within OMFS that do constitute specialised services remain within their remit.

5.20 Broadly speaking area teams will;

- Manage relationships with all providers.
- Seek to develop the provider landscape.
- Implement nationally developed care pathways and frameworks in the context of local health economy, with support from CSUs
- Use commissioning intelligence (not produce it)
- Use standard policies/procedures (not develop them)

5.21 As a national organisation, NHS CB has the opportunity as part of the primary care strategy to have an operating model, tested out and informed by grassroots experience, reflecting local need and best practice. As a national system, the NHS CB can benefit from economies of scale and use the best expertise and innovation from a local level for the basis of developments of national levers and enablers (contractual, financial and regulatory).

Local Dental Networks (LDNs)

5.22 Area teams will have a focused team of clinicians, working with and alongside the area team with co–located consultants in dental public health from PHE to enable clinically led decisions for dentistry across commissioning and quality improvement. Feeding grass roots experience and innovation through to the CDO, they will influence policy decisions at a national level to enable cohesion across the commissioning system. There will need to be a clear line of communication from clinicians and commissioners via the LDN to the central support team as well as tactical and strategic implementation of national commissioning frameworks, via LDNs at local level. Local dental networks are crucial to enabling the delivery of the model for commissioning dental services as they will provide the vehicle by which local engagement across all specialties and sectors will be enabled for the NHS CB.

Local Dental Network and Dental Clinical Commissioning Case Studies

5.23 Birmingham and Solihull Local Dental Network Pilot

In Birmingham and Solihull a Local Dental Network has been established which has representation from clinicians in primary care, community dental services and acute hospital services and dental hospital services and a senior commissioning manager. Although it has only been in operation for a short time it is supported by Managed Clinical Networks across all specialties some of which have been in place for significantly longer. This has enabled the LDN to start to tackle issues such as lengthy waiting lists for Oral Medicine services, in a way which would previously been impossible, by engaging clinicians commissioners and managers in a productive dialogue. By commissioners engaging with clinicians through the LDN it has provided a meaningful expression of clinical commissioning for dentistry and if continued aims to break down barriers and create a culture of trust and confidence in the system

5.24 Greater Manchester Local Dental Network Pilot

In Greater Manchester a pilot LDN included a Consultant in Dental Public Health, GDPs a DPA, LDC rep, patient rep and SHA project/admin. We used existing clinical networks to strengthen consistency and influence direction but have also had to establish more.
A number of wider engagement meetings have been held with over 400 dentists attending in total to hear about the work and how they can get involved. Sitting under the core LDN group is a number of specific specialist sub groups.

To test the structure we have chosen an initiative for very young children that will involve the core LDN and sub paediatric group. The specialist group is drawing up a toolkit for practices to support evidence informed management of dental treatment in children. We took a paper to GM Cluster board in Oct Sept and £200K was released from dental underspends to support the initiative. This money is being used for resources to support participating practices and to fund 10 clinical champions a session a fortnight - one from each of the 10 PCTs localities that make up GM.

There is a buzz about what they are achieving (almost 50% of the 400 practices have signed up to the SLA) and this level of clinical involvement and leadership is having an impact over and above what we in dental public health and commissioning have experienced in the past despite a good track record of engagement

5.25 NHS Cumbria Managed Clinical Network

In July 2008, an Oral Surgery review concluded that there were a significant proportion of patients whose care could be provided in a primary care setting by appropriately trained clinicians. The review was signed off by the Elective Care Board of the PCT and a decision taken to work with local clinicians to develop a good quality accessible minor oral surgery service. Critical to the success of the creation of this service was the establishment of the Oral Surgery Clinical Network. The Network was established in 2009 when clinicians from four dental practices and two Salaried Primary Dental Care clinics met with Oral Surgery staff and Consultants from the Morecambe Bay and Carlisle Hospitals. In addition commissioners from NHS Cumbria and the Consultant in Dental Public Health were involved at the outset of the process. The network considered:

- *the complexities in Oral Surgery procedures and who should provide them, the competencies that would be required for an MOS service provider, how these related to routine general practice and how they would be assessed*
- *the development of a single clinical pathway and associated referral pack*
- *the identification of training needs and plans to address these*
- *the establishment of a review process to include audit and lessons learn*

Having agreed an outline clinical pathway, the Network agreed to develop a referral pack to support dentists making referrals to the Oral Surgery services. This referral pack included the care pathways and guidelines, the responsibilities of referring dentists, the responsibilities of service providers, patient information, specific information about the MOS providers and a single Oral Surgery referral form to be used for all referrals. The referral form was also made available electronically.

The clinical pathway became operational in 2010 when the referral guidelines were published and sent to all local practices. The pathway was also promoted at locality engagement events with local GDPs and at contract monitoring reviews. By following the agreed guidelines and using the referral form, patients are directed to the most appropriate provider, be that the MOS provider or Hospital Consultant care. Capture of data about the source and quality of referrals enabled the creation of a feedback loop to GDS providers who were not following the guidelines or were deemed to be outliers. This has resulted in feedback to referrers via the commissioning process and has improved the quality and scope of care within general dental services contracts.

The importance of the clinically led approach to the development and continuous improvement of this local system cannot be underestimated.

Section 6

Key strategic and operational partners

6.1 The following organisations will play a key role in the commissioning of NHS dental services from April 2013:

Department of Health (DH)

6.2 The DH will set out the Secretary of State's expectations and requirements for the NHS in the annual NHS Mandate, agreed with the NHS CB, which will accompany the resources allocated by government to the NHS. The Secretary of State retains responsibility for public health services and will enter into agreements for these responsibilities to be discharged by Local Authorities and Public Health England.

6.3 Specific to the current policy direction for NHS dental services, the DH will retain responsibility for the primary care dental contract reform programme and associated advanced care programme. The NHS CB will want to ensure it can influence, support and steer developments in these areas to ensure they align to delivery at operational level, for example, supporting the continued piloting of elements of a new dental contract. The DH and NHS CB will need to agree an appropriate process and timescale for the transfer of any dental contract reform programme and care pathway work in due course.

Public Health England (PHE)

6.4 Close collaboration will be required for the NHS CB and PHE to deliver our individual functions and our common goals. The partnership with dental public health and the leadership it provides is crucial to delivering the operating model for NHS dental services. The NHS CB and PHE will work together across the system to deliver excellence in dental services in two broad areas:

- Establishing the new architecture – at national, regional and local areas, the NHS CB and PHE will establish effective joint working with a focus on delivering the model for dental services. Consultants in dental public health will provide key leadership, advice and direction to local commissioning teams and local professional networks to support timely and accurate decisions to support and enable improvements in dental services and ensure the safe transfer of steady state dental services in the first instance.

- Develop common strategies to improve health outcomes – as previously described, PHE is a key partner to developing the consistent patient care pathways and commissioning frameworks across all dental services described in this document. This will happen at national, regional and local level and dental public health will be a crucial source of clinical expertise and leadership to the NHS CB to delivering this aim.

Local authorities (LAs)

6.5 Local authorities will be responsible for commissioning the majority of public health services for people in their area, including dental and oral health programmes and oral health promotion services. It will be crucial that the NHS CB and LAs work closely together to ensure a cohesive approach to delivering integrated models of dental services. Dental public health colleagues will be an important resource in ensuring this happens collaboratively and with consistency.

Clinical commissioning groups (CCGs)

6.6 Although CCGs will have no direct role in commissioning NHS dental services, the positioning of commissioning of maxillofacial services, initially to be undertaken by the Board, means that collaborative working with area teams is crucial to delivering a managed transition of these services to CCGs. Area teams and CCGs will determine locally when this is most appropriate to take place, dependent on local progress in care pathway implementation associated with oral and maxillofacial services. In addition, CCGs will have an interest in the quality and delivery of dental services, particularly for specific groups of patients with long term conditions. CCGs are likely to commission referral management systems and look to re-design whole packages of care and there may be opportunities to integrate dental pathways within these structures and developments to avoid costly duplication.

Commissioning support units (CSUs)

6.7 In relation to secondary dental care, the NHS CB will look to CSUs to provide a supporting role in the same way that it provides support for specialised commissioning to enable the transition towards proposed care pathway models and the single operating model.

6.9 Below is an outline of the CSU services that will be required by the NHS CB for managing secondary care contracting and monitoring arrangements:

Business Intelligence

- Information collection
- Information analysis – contract analysis
- Information analysis – clinical outcomes
- Information analysis – patient experience
- Capacity planning and modelling
- Data validation
- Database management
- Monitoring of KPIs and service standards

Procurement and market management

- Market analysis
- Tendering to point of contract award

Provider Management

- Provider management – ensuring contract delivery
- Contract reporting and forecasting
- Formal contract management, including dispute

Section 7

Initial priorities

7.1 The NHS CB will approach the development of commissioning dental services by generating commissioning guides for each dental pathway. Appendix 2 provides a summary of the relevant pathways. A commissioning guide for Oral Surgery is currently in development and following further consultation is planned for release prior to 1 April 2013. The principles and approach of developing this document will be the methodology by which the NHS CB will further refine and deliver commissioning of all other dental services in the future. Effective co-production between those working at grass roots level and nationally are a critical part of ensuring that we build, test, adapt and adopt evidence-based, best practice to achieve quality improvement and drive cost efficiency nationally, using the skills and expertise across the NHS CB's structures.

7.2 A national dental commissioning steering group will be established (transitioning from the task group that designed this operating model) that will enable central input across the NHS CB matrix, led by the Medical Directorate, supported by the Commissioning Development and Operations Directorate, to oversee the delivery of the NHS CB's operating model, establishing working groups across the areas highlighted above and any future issues which arise from the primary care strategy.

7.3 The NHS CB will influence and ensure alignment to current national developments and policy that will be key enablers in the future commissioning agenda, such as the dental contract pilot reform programme and outcomes, and the advanced care pathway developments, currently being led by the Department of Health.

7.4 **Key initial priorities** identified to deliver the model for dentistry are:-

- Establish **national dental care pathway commissioning frameworks** across the entire dental space. By providing a consistent approach to commissioning, capturing best practice and enabling work by provision of area team, guides, standard forms and key quality measures, the frameworks will embed robust commissioning practices and assist in maintaining and enhancing quality. These will be developed by lead area teams, supported by the national dental commissioning steering group.

- Establish a working group for **workforce and dental schools** to develop frameworks for the NHS CB to use to collaboratively commission services from dental schools and establish robust workforce alignments to the future commissioning ambitions of the NHS CB.

- Following on from the testing of the Minor Oral Surgery care pathway in Greater Manchester, and working closely with CCGs; to develop a

transition plan for describing oral surgery and maxillofacial surgery pathways, allowing them to be clearly distinguished. This work will need to consider workforce and training implications and require close partnership with HEE and LETBs.

- The national group will oversee a number of specific projects aligned to the national framework outlined in this document. The minor oral surgery commissioning framework being developed alongside the production of this document is one example of this. Similar guides will be developed nationally to act as the vehicle for the NHS CB to describe and implement a single operating model, built on excellence and best practice to deliver efficiency in effort, consistent quality improvements and best use of resources.

7.5 Some commissioners are already underway with developing care pathway approaches, and it is sensible and efficient for the NHS CB to tap into the local energy of these groups, working with them to align and steer the national delivery of the NHS CBs operating model for dental services. For example, a pan-London approach to orthodontic commissioning is underway and using the commissioning framework outlined in this document, could be delivered as a proposal for a national commissioning framework. Likewise, work underway in South Yorkshire on developing a special care dentistry pathway could be used to deliver a national framework to be adopted across the NHS CB.

Section 8

Transition from PCTs to the NHS Commissioning Board

8.1 The NHS CB will ‘inherit’ a range of contractual arrangements for dental services from PCTs on 1 April 2013. The contract transition programme has now entered the ‘shift’ phase of the process and all dental services will need to be clearly identified and contracts established as per the contract transition guidance.

8.2 This is comparatively straightforward for dental services under GDS and PDS arrangements, including those for community dental services, which are contracted PDS agreements as per PCT transition guidance. For secondary care services, this is far more complex and it is important that area team Directors of Commissioning have a clear line of sight for these services as part of the planning rounds for 2013/14.

8.3 Transfer of the responsibility for secondary care dental services to the NHS CB will be as a steady state transfer on 1 April, ensuring that current local agreements on planned activity, any local tariff agreements and CQUIN arrangements are not destabilised. Post April, the NHS CB will work across its system to develop care pathways as outlined in this document, across all dental specialties to achieve managed transition to commissioning within a single operating model.

Section 9

Next steps

Central work

9.1 The NHS CB will work with area teams in the coming weeks and months to manage the safe, steady state transfer of all dental services to the NHS CB as part of the 'shift' phase of the contract transition programme.

9.2 In establishing a clear plan to deliver the over-arching operating model in this document, we will work with area teams, the DH, PHE and wider stakeholders to develop a critical path for the development of commissioning guides and end to end care pathways, building on and utilising the skills within area teams and our partners to do so. As part of this, we will further engage the system and stakeholders in consultation on the draft Minor Oral Surgery Commissioning Guide and patient pathway to test and refine it further where needed.

9.3 In order to ensure dental contractors are treated in a fair, consistent and transparent way a key set of policies are currently being developed for area teams to use as part of their contract management function. An eight stage process has been developed which includes consultation with professional groups.

9.4 A national dental commissioning steering group will be established as described above (Ref 7.2) along with a working group for workforce and dental schools (Ref 7.4).

Secondary care dental commissioning expertise

9.5 As outlined in section 5.17, it is proposed a scoping exercise is undertaken of the various options to establish the best fit for commissioning and managing secondary dental care. This will be undertaken in partnership with Directors of Commissioning in area teams.

Local work

9.6 Area teams should discuss this document with local stakeholders, including the local authority and public health, local representative committees, and all providers of dental services. Once established, local dental networks are a good forum for these provider level discussions. They should consider how they might contribute to the delivery during transition and beyond to make this operating model a success.

9.7 As part of the contract transition programme, area teams will have a clear view of the secondary care dental service elements currently in acute contracts and the financial resource for these services will have been identified via the contract financial reconciliation processes currently

underway. Area team Directors will need to ensure that this is clear for the services provided in their areas with secondary care providers for each acute contract. This needs to include any specialist primary care based services, such as referral management and triage services currently under contracts. A consolidation using dental commissioning teams at local level will support this.

NHS CB commissioning intentions

9.8 The NHS CB will need to articulate any early priorities for its commissioning intentions and ensure these are articulated in the planning framework. As a steady state transfer is proposed from 1 April, this will be grounded in the future proposal of a managed transition to a national care pathway operating model. The NHS CB's area teams should communicate the following assumptions to providers of primary and secondary dental services and dental schools;

- That the NHS CB will be the commissioner of these services from 1 April 2013.
- That the intention is for a steady state transfer but there is a clear intent to work with providers, clinicians and commissioners, collaboratively across the country to develop consistent care pathways.
- This nationally consistent approach will involve the development and introduction of some single operating procedures and policies that local dental networks via the area teams, will want to work with local providers to implement in the future, for example, single national referral forms.
- Improving access to NHS dental services will continue as will the drive to improve the cost effectiveness of dental services in order to play our part in the QIPP challenge.

Acknowledgements

We are very grateful to the dental commissioning community, clinical and managerial, for their commitment and hard work in helping to develop the NHS CB's vision for the commissioning of dental services; and to national and local stakeholders representing patients, clinicians and others for their feedback and practical support.

We would like to extend particular thanks to members listed below of the task group which has worked on the development of the operating model over the last year: Samantha Illingworth, Colette Bridgman, Eric Rooney, Jenny Godson, Nick Kendall, Uriana Boye, Iain Pretty, Paul Coulthard, Paul Brunton, Ben Cochrane, James Butcher, Kate Jones, Amanda Borland and Zaneta Arthur.

Annex A

Scope of NHS Commissioning Board's responsibilities

GDC definitions of dental specialties

Special care dentistry: This is concerned with the improvement of the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors. It pertains to adolescents and adults.

Oral surgery: This deals with the treatment and ongoing management of irregularities and pathology of the jaw and mouth that require surgical intervention. This includes the specialty previously called Surgical Dentistry.

Orthodontics: This is the development, prevention, and correction of irregularities of the teeth, bite and jaw.

Paediatric dentistry: This is concerned with comprehensive therapeutic oral health care for children from birth through adolescence, including care for those who demonstrate intellectual, medical, physical, psychological and/or emotional problems.

Endodontics: This is concerned with the cause, diagnosis, prevention and treatment of diseases and injuries of the tooth root, dental pulp, and surrounding tissue.

Periodontics: The diagnosis, treatment and prevention of diseases and disorders (infections and inflammatory) of the gums and other structures around the teeth

Prosthodontics: The replacement of missing teeth and the associated soft and hard tissues by prostheses (crowns, bridges, dentures) which may be fixed or removable, or may be supported and retained by implants.

Restorative dentistry: This deals with the restoration of diseased, injured, or abnormal teeth to normal function. This includes all aspects of Endodontics, Periodontics and Prosthodontics.

Oral medicine: Concerned with the oral health care of patients with chronic recurrent and medically related disorders of the mouth and with their diagnosis and non-surgical management.

Oral microbiology: Diagnosis and assessment of facial infection - typically bacterial and fungal disease. This is a clinical specialty undertaken by laboratory based personnel who provide reports and advice based on interpretation of microbiological samples.

Oral and maxillofacial pathology: Diagnosis and assessment made from tissue changes characteristic of disease of the oral cavity, jaws and salivary glands. This is a clinical specialty undertaken by laboratory based personnel.

Dental and maxillofacial radiology: Involves all aspects of medical imaging which provide information about anatomy, function and diseased states of the teeth and jaws.

Oral and maxillofacial surgery: Involves the diagnosis and treatment of any disease affecting the mouth, jaws, face and neck. This includes surgical dentistry (impacted teeth, dental cysts, dental implants etc.), injuries to the face, salivary gland problems, cancers of the head and neck, facial deformity, oral medicine, (ulcers, red/white patches, mouth cancer), facial pain and temporomandibular joint disorders. **Not considered a dental specialty, but encompasses significant oral surgery elements that would be considered NHS CB remit. NHS CB will work in collaboration with CCGs to commission these services from April 2013 aligned to oral surgery services, for a transitional period to enable 'unravelling' of procedures, coding and pathways, after which it will transfer to CCG**

Annex B

List of proposed dental specialty pathway guides

• **Oral surgery**

• **Restorative dentistry**
  • Periodontology
  • Endodontics
  • Prosthodontics
  • Implant Dentistry

• **Paediatric dentistry**
• **Special care dentistry**
• **Orthodontics**
• **Oral medicine**

• **Smaller specialties**
  • Oral microbiology
  • Oral and maxillofacial pathology
  • Dental and maxillofacial radiology

• **Oral and maxillofacial surgery**   • Oral cancer and two week wait