Classification: Official

Publication reference: PR1639

# Clinical guide for dentistry

Version 2, 28 October 2022

Updates to the previous version of this guide are highlighted in yellow.

# Contents

Foreword ... 3

1. Equality and health inequalities statement ... 4

2. Executive summary ... 4

3. NHS dental specialties ... 5

3.1 Getting serious about prevention ... 7

3.2 Managed clinical networks (MCNs) ... 7

3.3 The role of the MCN in developing the network ... 7

3.4 Establishing a Managed Clinical Network ... 8

3.5 Who will make sure the MCN is doing its job and hold it to account? ... 9

3.6 Improving referral pathways for MCN effectiveness and improved patient care ... 9

3.7 Supporting the profession ... 10

4. Factors to consider during implementation ... 11

4.1 Ethos ... 11

4.2 Context ... 11

4.3 Vulnerable and socially excluded patients ... 12

4.4 Domiciliary care ... 13

5. The patient journey ... 17

5.1 The summarised illustrative patient journey ... 17

5.2 Vision for the patient journey ... 17

5.3 Referral ... 18

5.4 Other issues ... 18

6. Workforce and training ... 19

6.1 Primary care providers ... 19

6.2 Foundation and postgraduate training ... 19

6.3 Patient Reported Outcome Measures (PROMs)/ Patient Reported Experience Measures (PREMs) ... 22

6.4 Data Compliance ... 23

7. Sustainability in dentistry ... 25

Appendix 1 – What is a health needs assessment? ... 26

Appendix 2: Relevant diseases and conditions ... 28

Appendix 3 ..... 29
Appendix 4: Glossary of terms ..... 30

# Foreword

In 2015 NHS England published the first of a series of Commissioning Guides and Commissioning Standards, which were produced following publication of Securing excellence in commissioning NHS dental services 2013.

The Commissioning Guides and Standards describe how dental care pathways should develop to deliver consistency and excellence in commissioning NHS dental services across the spectrum of providers to benefit patients.

Over the last 4 years NHS England has taken the opportunity to review the Commissioning Standard programme and reformat for online use, in order to provide a suite of Clinical Standards each linked to an overarching Commissioning Standard. This document is the revised and updated overarching Commissioning Standard which has evolved from the 2015 version.

This Overarching Standard includes associated appendices which will be derived from the current suite of Commissioning Standards and Commissioning Guides which look at specific dental specialties and areas of care. The move to an online platform will allow regular review and revision in line with current policy and practice; it will be necessary to review and update the standards regularly. Implementation will require energy and momentum, together with a willingness to share good practice, innovation and learning to enhance patient care.

# 1. Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have: Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and, regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

# 2. Executive summary

NHS England has developed a suite of Clinical Standards for Dental Specialties which intended offer a consistent and coherent qualitative approach for NHS commissioned services. This approach reflects the need and complexity of patient care and the competency of the clinician required to deliver the clinical intervention rather than by the setting within which the care is delivered. Care is delivered via a pathway approach which provides clarity and consistency for patients, the profession and commissioners. There are nationally agreed minimum specifications for each service, including how quality and outcomes are to be measured, which can be enhanced locally.

These standards describe the concept of clinical engagement and leadership to the Integrated Care System (ICS) through Managed Clinical Networks (MCNs) which will work closely with local commissioners.

Needs-led dental specialist care pathways (as in appendix 1) rely on maintaining and ensuring access to effective primary dental care services; particularly for those groups in the population who do not access care routinely or have additional needs. Commissioners who procure services should use these standards to complete needs assessments, set minimum standards and service direction and ensure that proposed outcomes and quality measures are included in service specifications.

The Standards including this overarching Commissioning Standard, should be made available to potential bidders.

# 3. NHS dental specialties

NHS England commissions all NHS dental services. The benefit of a single commissioner for dentistry is the ability to plan and produce more consistent standards of delivery and better health outcomes for patients across the whole of England.

A strong emphasis on prevention was underlined in the NHS England Long Term Plan and the production of these standards supports NHS England's pledge to improve prevention:

> "It does so while recognising that a comprehensive approach to preventing ill-health also depends on action that only individuals, companies, communities and national government can take to tackle wider threats to health, and ensure health is hardwired into social and economic policy."

These standards are intended to promote consistent quality of specialist dental care provided to patients. Methods to describe population need and current services, working jointly with the National Institute for Health Protection (NIHP), are modelled and shared for commissioners and clinicians to inform local needs assessment and the impact of existing services in meeting identified need. These Standards are about supporting commissioners and clinicians to work together to ensure that resources invested by the NHS in dental specialist care are used in the most effective way to provide the best possible quality and quantity of care for patients.

The levels of complexity do not describe contracts, or practitioners or settings. Levels 1, 2 and 3 care descriptors reflect a case in terms of procedural difficulty, patient modifying factors and competence required of a clinician to deliver care of that level of complexity. Each supporting appendix will detail the requirements of the three levels in regard to that specific clinical requirement.

The three levels of care are defined in table 1 below:

**Table 1: Three levels of care**

| Complexity | Description |
| --- | --- |
| Level 1 | Skillsets and competencies that are covered by teaching and training in the dental undergraduate and Dental Foundation (FD) programme. Such skills are enhanced and improved with experience, so the development of these skills is a career-long process. The provider is responsible for the delivery and quality of mandatory services. Treatments that are not specifically defined in Levels 2 or 3 are de facto Level 1 |
| Level 2 | Procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register. This care may require additional equipment or environment standards but can usually be provided in primary care. Level 2 case complexity may be delivered as part of the continuing care of a patient or may require onward referral. Providers of Level 2 care on referral will need a formal link to a specialist, to quality assure the outcome of pathway delivery. |
| Level 3a<br>Level 3b | Care that requires specialist practitioner or consultant led care due to complex clinical or patient factors. This care can be provided in a primary care, dental hospital or in a secondary care setting depending on the needs of the patient and/or local arrangements which may include current training commitments. |

These Standards are intended to inform and support Local Dental Networks and commissioners, working within the local context of Primary Care Networks and integrated care systems, to understand local need, impact of current investment and what would enable them to transform services in their area to build on any engagement work already undertaken with local partners such as Healthwatch and patients and the public. There will be a need to establish, strengthen or formalise clinical networks and specialist groups to implement system change which takes into account local needs and circumstances, including reviewing progress to date and required pace of change.

## 3.1 Getting serious about prevention

The concept of needs-led, evidenced-based, prevention-focused care pathways is central to supporting change in dental service delivery. Specialist dental services can dovetail this approach as advocated in these commissioning standards. However, this relies on maintaining and continuing to improve access to primary care dentistry and investing in primary care.

The aim of adopting a care pathway approach is to shift dental service delivery from an interventional to a preventive focus with care based on individual need and risk; with the main emphasis on outcomes and effectiveness of clinical care. Additionally, the pathway model aims to encourage patients to take responsibility for protecting and maintaining their own oral health and committing to the demands of receiving specialist or advanced care, as part of a long-term continuing care relationship between themselves and their dental teams.

## 3.2 Managed clinical networks (MCNs)

MCNs have been defined as 'linked groups of health professionals and organisations from primary, secondary and tertiary care working in a coordinated manner, unconstrained by existing professional and organisational boundaries to ensure equitable provision of high quality, clinically effective services'.

An MCN should be led by a local consultant in the appropriate specialty, who commands the respect of the members and the LDN. Taking part in MCNs should be agreed as part of a consultant's job plan and a mechanism to fund the programmed activities (PAs) that have been agreed. This must be achieved within existing resources and is a matter for commissioners to facilitate using negotiations with secondary care providers during contract discussions and/or through efficiency savings. Clinicians, taking an active role in the MCN, need to be recognised and this work supported within the contractual framework.

All providers of Level 2 and Level 3 services should be members of the relevant local MCN. This should be stipulated in the service contracts.

## 3.3 The role of the MCN in developing the network

The role of the MCN in developing the network is illustrated in Table 2 below:

**Table 2: MCN role in developing the network**

| | |
|---|---|
| Developing its education and training | The educational and training potential for managed clinical networks should be used to the full, through exchanges between those working in primary care including specialist practices and those working in dental hospitals or secondary care settings. Networks' potential to contribute to the development of clinicians with enhanced skills and experience concept should also be kept in mind, and networks should develop appropriate affiliations to universities, the Royal Colleges and Workforce & Education (WT&E). |
| Have a CPD programme in place for all staff and ensure that staff are able to move within the network in ways to improve patient access and maintain professional skills | All networks must include arrangements for the effective delivery of training ensuring that those on specialist training pathways have sufficient experience and supervision with cases of clinical and patient complexity. The networks can also take an influential role in transforming undergraduate, postgraduate, remedial and training for clinicians with enhanced skills and experience, so that training opportunities follow patients receiving care rather than patients following established training arrangements. This will need to be influenced, implemented and monitored locally in an environment which supports ambitions and innovation. |
| Explore the potential | There must be evidence that networks allow professionals to come together to explore the potential to generate better value for money, service improvement and more interesting career opportunities for clinicians. |

## 3.4 Establishing a Managed Clinical Network

Commissioners must familiarise themselves with the National NHS England current core MCN job description and MCN terms of reference and liaise with the local dental network (LDN) to establish one.

MCNs will also link with LPN colleagues to ensure that the clinical voice of primary care is heard and that primary care is linked to specialist care providers giving a connection across historic boundaries to improve patient care. The group will interact with and be governed within the commissioning system and all providers of care on referral will require a formal link at least to submit and receive data but more importantly to contribute to the improving quality and service delivery agenda.

## 3.5 Who will make sure the MCN is doing its job and hold it to account?

Commissioners are responsible for establishing appropriate MCNs in their area and are responsible for ensuring that it does what it is supposed to do, and also that it is resourced appropriately. The MCN will provide reports to the LPN or dental system leadership team. Commissioners and MCNs will together ensure that the correct level of competence, quality (including equipment) and outcomes are being achieved for patients, regardless of the setting.

There will need to be fair access to all aspects of specialist dentistry care and as is the case now, patient choice and awareness of all options available to them will be key features of the service.

## 3.6 Improving referral pathways for MCN effectiveness and improved patient care

There should be a robust referral management process that recognises the needs of the patient, the referring practitioner and the accepting dentist/specialist. The Commissioners will also have requirements to ensure that referrals are appropriate and that the care is being provided by those contracted to deliver that care.

At the point of making the decision to refer, the patient needs to know why they are being referred and what is likely to happen at the first appointment. The referral ideally needs to be as local as possible to the patient, however patient choice should be considered. The patient needs to know how long they may have to wait for an appointment following referral, how they will be contacted and how they can change any given appointment.

If possible, patients should be given a choice of specialist provider, however this may not always be possible particularly in the shorter term. The benefits and risks

of treatment together with information on the time needed and the number of appointments should also be provided.

An RMS should assist the referring practitioner to know who to refer to and how. The system should also have clear acceptance criteria. The RMS needs to acknowledge receipt of the referral and the referrer ideally needs to be informed of the patient's appointment. Once the patient has been assessed, should this just be for advice and support, there needs to be prompt reply / treatment plan to the referrer with a clear treatment pathway for the patient.

The receiving practitioner/specialist needs clear and concise referral data that meets the agreed acceptance criteria and contains all the information required. Standardised pro-formas will assist in this. Transmission of all relevant information, including x-rays must be secure utilising the nhs.net system.

The referral data needs to be auditable and available to the MCN. This will help to improve the referral process, to better understand the needs of the patient base and will help commissioners plan for future service delivery.

## 3.7 Supporting the profession

The MCN can provide an effective role in being able to support those professionals undertaking care. There may be some tell-tale signs that practitioners are experiencing problems or difficulties through the referrals that are being received. An above average number of referrals or a continued number of referrals not meeting acceptance criteria could be such triggers. A complete absence of any referrals from a practice may also be a trigger.

The MCN with commissioners and Health Education England (WT&E) should consider how they can best support these individuals and how services might offer opportunities to ensure continued sustainability of care to patients.

# 4. Factors to consider during implementation

## 4.1 Ethos

England is too diverse for a 'one size fits all' care model to apply everywhere. These clinical standards provide a national framework for care delivery models. Regional teams have flexibility over pace and scale of change to reflect local circumstances and needs, but are expected to adhere to standards, measures and vision.

Transformational and transactional change is required in the delivery of dental specialist services and commissioners must regularly review population need, investment and impact of existing local services in meeting that need, using the enablers set out in the patient journeys within these standards as a benchmark.

## 4.2 Context

An emphasis on improving outcomes and effectiveness, consistency and clarity, regardless of setting, is needed in several areas and the individual specialist standards provide a framework and some detail for clinicians to achieve that by offering:

- clarity of what is expected as a minimum by primary care providers treating patients with Level 1 complexity, dentists with enhanced skills and experience or specialists treating patients with Level 2 complexities on referral and specialist and consultant-led care treating patients with Level 3 complexity
- expected clinical competencies and outcomes at each level of care
- consistent environment and equipment standards within outline model specifications
- generic and specialty specific clinical outcomes, quality standards and patient reported outcome and experience measures (PROMS) (PREMS) for England
- consistent referral core data set, coding and tariff expectations for care pathways

- access to services across each pathway to ensure that people with disabilities and all other 'hard to hear' groups of people have equitable access to specialist dental care when required.

For each clinical standard a common format has been used. The individual standards include the following:

- Brief description of the speciality
- Brief overview of workforce and training
- Specific population need and delivery at a national and regional level, (giving commissioners a method) to collate and understand local need and to assess the impact of current services in meeting that need
- Quality standards and metrics for competency of clinicians, environment including equipment
- Generic and specialty-specific PROMs and PREMs. Commissioners, clinicians and service leads can add additional measures, if capacity to measure and report on more exists.

## 4.3 Vulnerable and socially excluded patients

The NHS typically defines at-risk adults as:

> "A **person** who is 18 years of age or over, and who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him/herself, or unable to protect him/herself against significant harm or serious exploitation."

Section 59 of the Safeguarding At Risk Groups Act 2006 states that:

A person is an at-risk adult if, having attained the age of 18, s/he:

1. is in residential accommodation
2. is in sheltered housing
3. receives domiciliary care
4. receives any form of health care
5. is detained in lawful custody

6. by virtue of an order of a court, is under supervision per Criminal Justice Act 2003 sections regarding community sentences
7. receives a welfare service of a prescribed description
8. receives any service or participates in any activity provided specifically for persons who has particular needs because of his/her age, has any form of disability or has a prescribed physical or mental problem. (Dyslexia, dyscalculia and dyspraxia are excluded disabilities)
9. has payments made to him/her or to an accepted representative in pursuance of arrangements under Health and Social Care Act 2012, and/or
10. requires assistance in the conduct of own affairs.

While these definitions are helpful, they are not comprehensive, and further groups can be found within The national framework for NHS – action on inclusion health 2023, which describes inclusion healthcare for patients who are within the vulnerable and socially excluded groups.

## 4.4 Domiciliary care

There will always be a requirement for a level of domiciliary care for those patients who are housebound. This is a growing area due to an aging population many of whom are dentate but with complex health needs.

Undertaking care and treatment for these patients can be difficult and therefore, wherever possible, dental care should be provided in an appropriate clinical environment where comprehensive treatment can be provided. Commissioners could consider options such as transport provision which would minimise the need for some domiciliary care.

Commissioners should work with their special care dentistry MCN and general dental practitioners to develop care pathways together with a clear set of guidelines for accessing domiciliary care services and similarly a clear set of expectations of the care that should be provided for those practitioners and services whose contracts contain domiciliary care services. These guidelines should take account of factors such as:

- equipment to manage medical emergencies,

- maintenance of infection control standards,
- management of clinical records.

It is likely that two sets of locally commissioned pathways will exist. One for general dental services providers who may see particular groups of patients and another for specialist service providers addressing the more specific needs of their patients. These local guidelines should be widely shared to ensure that everyone understands for who these services exist, how they can be accessed and the treatments that might be available.

There may be practitioners who have domiciliary care elements within their contracts but who do not undertake these or undertake them to the levels specified within their contracts. Commissioners should ensure that where practitioners wish to continue delivery of these services, that referrals for such services are appropriately directed to these practices so that delivery of care can take place.

By working in collaboration local information packs and resources could be developed to better ensure that individuals and their carers, such as residential and nursing homes, can ensure that good oral healthcare is maintained or improved.

### 4.4.1 Better resources available to practices

While there is a large amount of information available regarding patient charges and how to claim for exemption against payment, much of this information is not in a format that is easily understood by many vulnerable patients. Consideration should be given to the provision of easy to interpret information for these patients.

### 4.4.2 Solutions for patients

There are a wider number of ways that commissioners could consider working with their partners and practices to improve access to services for vulnerable patients:

- Autistic adults, children and young people and/or those with a learning disability: practices should consider appropriate appointment times for these patients. It may be better to offer appointments to these patients at the start of a treatment session to minimise their waiting times and the number of additional patients who may be in the practice which may cause them additional anxiety.

- Extended/alternative hours will provide greater flexibility for those patients who may have difficulty accessing services within 'normal operating hours'
- Continuity of care with the same dentist could help some patients overcome additional anxieties and problems caused merely by attending the dentist.
- Provision of easily accessible information for patients that explains how the services work, how to access them and explains more about treatment and how any potential referral pathways work. It would be beneficial to ensure that this information was more widely available and if the overarching principles above were adopted then it should be relatively easy for this information to be available where it could best be accessed.
- Improving signage both outside and inside the practice can help many patients particularly where this is a larger practice or perhaps a practice located within a large health facility.
- Having support for individuals who may require additional help in completing 'paperwork' such as medical and social histories.

Homeless people should not be denied treatment on the basis that they do not have an address which is a requirement for completion of an FP17 claim form which dental practices need to complete following treatment. If the patient is of 'No fixed abode' the dentist can use their dental surgery address. A note regarding this should be made on the patients' dental records for reference.

### 4.4.3 General legislation and guidance

General legislation and guidance will cover elements such as:

- Health Technical Memorandum 01-05: Decontamination in primary care dental practices
- Ionising Radiation (Medical Exposure) Regulations (IRMER),
- HIV-infected health care workers: Guidance on management and patient notification – no the original document (which was withdrawn in February 2021) but a more generic document regarding bloodborne illnesses
- Equality Act
- Dental Practitioners' Formulary
- GDC Scope of Practice guidance

- GDC Fitness to Practice advice
- GDC Standards for the Dental Team guidance
- General Data Protection Regulations
- Compliance with Health and Safety at Work etc. Act,
- Compliance with Employers' Liability (Compulsory Insurance) Act,
- Compliance with Electrical safety at work regulations
- Compliance with safety requirements for autoclaves
- Compliance with Control of Substances Hazardous to Health (COSHH)
- Compliance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- Compliance with Water Supply (Water Fittings) Regulations, 1999
- Disability access requirements
- CQC registration

### 4.4.4 Continuity of care

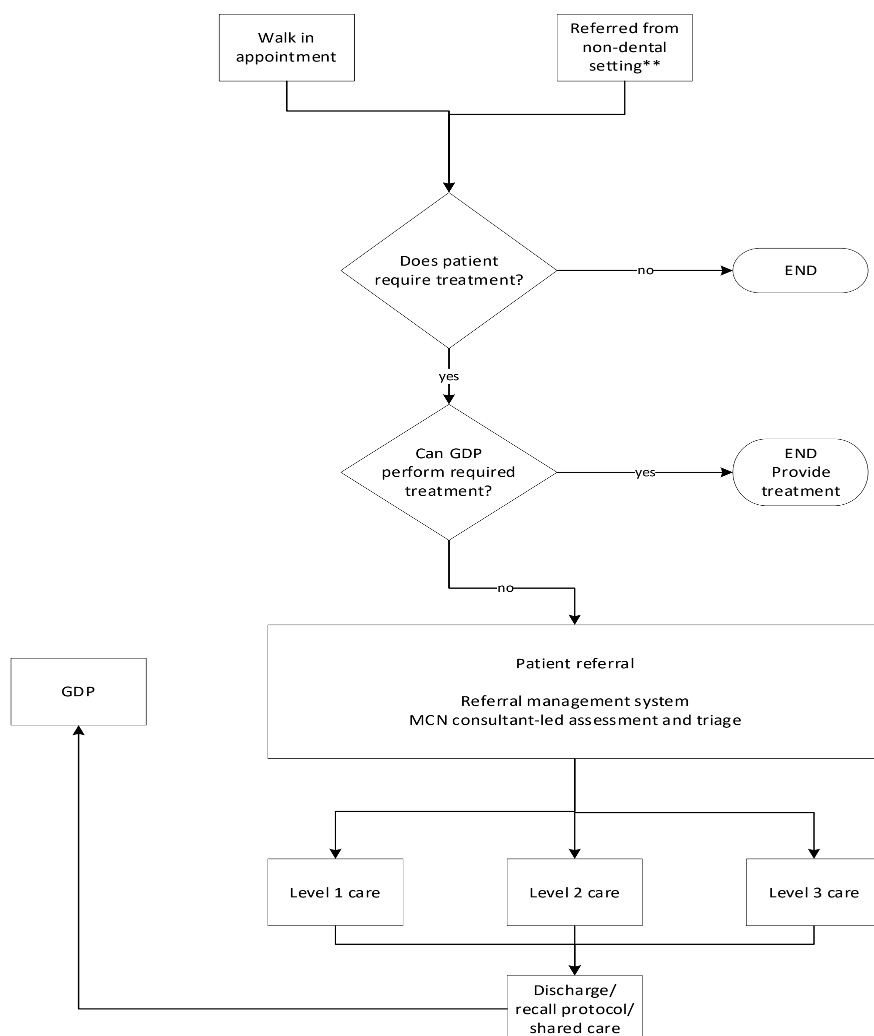
For some patients seeing the same practitioner can make a difference to their experience of attending the dental surgery. They are able to build a level of trust and there is the opportunity to develop an ongoing relationship which can help overcome fears and anxieties. There will always be a level of staff turnover in practices but it may be possible within some practices to make minor adjustments which could allow for better continuity of care. Long term planning for these patients is also important, particularly if they have a progressive disease such as dementia.

### 4.4.5 Developing partnerships with key stakeholders

Better working relationships with key stakeholders and advocacy groups could help improve access to dental services for all vulnerable adults through ensuring accessible, up to date and accurate information on how to access care is available. Some of these groups would also be able to provide information and support for transport systems to enable patients, who otherwise might expect domiciliary care, to access more appropriate services within a practice environment where a greater range of treatment options are available.

# 5. The patient journey

## 5.1 The summarised illustrative patient journey




**** Examples of where referrals into GDPs may come from:**

- Healthcare professionals
- Relatives and carers
- Learning disability teams
- Day centre and residential/ care home staff
- Community mental health teams
- Social services
- Tertiary referral
- GMPs
- 111

## 5.2 Vision for the patient journey

Every patient journey to specialist dental care should begin with a visit to a primary dental care practitioner (GDS or CDS) from whom they receive regular care; this may be an NHS or private primary care provider.

The dentist will complete a comprehensive examination to assess risk and need. If a patient needs dental treatment, the primary care provider delivers comprehensive primary dental care. If a patient requires a complex procedure, has modifying factors that make routine dental care complex, or requires additional equipment or facilities to deliver care then a referral to a specialist service maybe required.

In many cases the dentist may be competent to provide level 2 care complexity and will do so for their own patients; however, some may need to make a referral to a specialist provider in a primary or a secondary care setting.

It is important the referral process, at the beginning of the patient journey to specialist dental care, captures GP referrals, those from private dental providers and patients who attend A&E to ensure that these patients have access to an appropriate primary or specialist care to meet their needs. Reporting on these and working with the relevant MCN enables commissioners to identify variances which may need to be discussed with providers.

## 5.3 Referral

The referral will be made by a primary care dentist within one week of a decision to refer a patient. Other sources of referrals to dental specialties will be identified and managed. A core data set will be provided by the referrer (as detailed in individual specialty standards). It will allow an appropriate triage decision within specified timescales. Referrals are then directed to an appropriate level of specialist service taking account of any local arrangements and patient choice.

Dentistry must legally use NHS numbers as this underpins robust data collection and reporting to enable integration of dental services within NHS England. The patient may also have a unique reference number to track progress of their referral. In anonymised form this data set will also allow commissioners to understand the complexity of referred cases to support needs assessment.

## 5.4 Other issues

Patients often prefer more familiar surroundings. It is not the intention of these standards to change this care delivery model but with the advent of the ICS patients may go to a different practice to receive their treatment where appropriate.

# 6. Workforce and training

## 6.1 Primary care providers

NHS and private primary care providers deliver most of the dental care in England. Many NHS practices provide both to their patients. Most dental practices will employ dental care professionals who will include nurses, hygienists, and therapists. Occasionally services may also be provided by clinical dental technicians and dental technicians.

### 6.1.1 Greater use of skill mix

Practices could look to employ their skill mix to support oral health improvements for patients. As well as providing services within the practice environment practices could also:

- Work with groups within the community to identify the best ways for them to interact with dental services
- Build relationships with organisations and individuals within the community
- Organise visits, events and promotions in the community designed to raise awareness of good oral health and access to dental treatment

The Scope of Practice for Dental Care Professionals sets out their individual skills and abilities which can change over the course of their respective careers and can be found on the GDC website. It is recommended that the service specifications that are developed that allow DCPs to use the full scope of their practice. This will improve skill mix and enable dentists to also utilise their full range of skills and competences.

## 6.2 Foundation and postgraduate training

Dental training at all levels requires trainees to carry out regular direct patient care under supervision. All dental service contracts should clarify that trainees can be involved in service delivery where the training post has been approved by the Postgraduate Dental Dean. WT&E and its constituent Local Education and Training Boards (LETBs) are responsible for workforce development and commissioning of education and training for the healthcare workforce and need to reflect the requirements of NHS England.

They ensure that the workforce has the right numbers, skills, values, and behaviours to support patients and thus enhance patient care by providing guidance, education, and training to the healthcare workforce. This includes developing a multi-professional primary dental care workforce that can meet the needs of current and future service requirements.

WT&E can provide an integrated approach to educating clinicians to address the needs of vulnerable patients and to plan for changing population demographics.

Commissioners should therefore work with Health Education England (WT&E) and teaching hospitals to identify the training requirements for local service delivery. Then ensure that education on delivery of services to vulnerable groups forms part of any outreach during foundation training and dental workforce development opportunities.

Commissioners should ensure they have formal arrangements to share dental service commissioning plans with their LETB dental lead (usually the Postgraduate Dental Dean or Director) and should be aware of the training needs and delivery in place. Changes to service commissioning and delivery can have a significant impact on training provision and the best outcomes for all concerned are achieved when training is considered at the outline planning stage.

Completion of dental foundation training in primary dental care is compulsory to enable UK trained dentists to join the NHS Performers List without conditions. This allows practitioners to deliver primary care dental services to Level 1 complexity, as a minimum competency.

Dental specialty training lasts between 3 and 5 years and is undertaken by dentists who will join a GDC Specialist Register on completion of the programme.

| | |
|---|---|
| 1. Mental Capacity Act training | This training will ensure that staff understand and can navigate the process for obtaining consent for treatment. |
| 2. Communication training | This type of training facilitates service provision for all vulnerable adults and particularly those with dementia. The General Dental Council highlights the importance of effective communication with patients, the dental team, and others across dentistry, including when obtaining consent, dealing with complaints, and raising concerns when patients are at risk. It recommends that all dental registrants undertake training in communication as part of their Enhanced Continuing Professional Development. |
| 3. Dementia friendly training | People living with dementia will encounter a range of people on a day to day basis as they go about their business. They may experience a range of problems associated with dementia that have the potential to impact on their ability to interact with those they encounter. Similarly, those they encounter may be unsure how and whether to help people who appear to be experiencing difficulties.<br><br>People with dementia all differ in the way they experience their dementia, but generally speaking in public situations people with dementia may have a range of difficulties, including:<br><br>Have problems remembering what they are doing<br><br>Have difficulties in communicating clearly<br><br>Have problems handling money<br><br>Have problems navigating in complex or confusing environments<br><br>How others respond to people who may be experiencing these kinds of problems can make a real difference.<br><br>The College of General Dentistry has developed Dementia-Friendly Dentistry: Good Practice Guidelines which enables dental professionals to understand dementia and its implications for dental practice, and adapt their patient management and clinical decisions accordingly |

| | |
|---|---|
| 4. Safeguarding training | Working with vulnerable adults can be incredibly rewarding but it also comes with responsibilities. Safeguarding training can help improve the dental teams' communication ability.<br><br>The ability to communicate to vulnerable adults about their needs and well-being lies at the core of safeguarding. Therefore, safeguarding training has a serious focus on the different ways in which staff can talk to vulnerable adults about abuse and neglect.<br><br>Abuse and neglect of any type may happen to anyone, however vulnerable adults may be more likely to suffer neglect and harm, therefore it is important for all dental professionals to be aware of the issues related to safeguarding.<br><br>Every dental professional should be trained in safeguarding. The practice should have a safeguarding lead and a straightforward policy when concerns arise. It may be that an individual's only external contact is with a dental professional; in turn it becomes their duty of care that the matter is reported as deemed appropriate. |
| 5. Equality and diversity training | This training demonstrates commitment to ensuring a fully inclusive patient centered service. It can help practices ensure that their service users can feel confident that their dental practice understands and can respond to specific patient need. Quality assurance services such as the LGBT Foundation Pride in Practice initiative provides useful training for primary care providers. |

## 6.3 Patient Reported Outcome Measures (PROMs)/ Patient Reported Experience Measures (PREMs)

The Core set of PROMS and PREMs below should be included in all service specifications with additional specialty specific PROMS and PREMs added as appropriate.

Patient Reported Outcome Measures

| Question | How much of a problem are your teeth for you? |
| --- | --- |
| **Responses** | A lot |
| | A bit |
| | Not at all |

**Global rating of oral health (Gilchrist 2015)**

| Question | Since your last treatment, do you think your teeth are: |
| --- | --- |
| **Responses** | Better |
| | The same |
| | Worse? |

**Global change in oral health condition (following treatment) (Gilchrist 2015)**

### 6.3.1 Patient Reported Experience Measures

| Question | Did the clinical team (clinician) involve you in your treatment decision in terms that you understood? |
| --- | --- |
| **Responses** | Yes |
| | No |
| | Not sure |

| Question | Were you given the opportunity to ask questions? |
| --- | --- |
| **Responses** | Yes |
| | No |
| | Not sure |

## 6.4 Data Compliance

Following recommendation by the Standardisation Committee for Care Information (SCCI), the Department of Health and Social Care approved a change to an

existing information standard which states that systems used within Dentistry and all other providers of health and social care - for the direct management of care of an individual - must use the International standard of Systematised Nomenclature of Medicine - Clinical Terms (SNOMED CT) as the clinical terminology standard within all electronic patient level recording and communications by 1 April 2020.

Commissioners must ensure that all data is recorded in SNOMED terminology and that the information systems utilised in the input, storage and transmission of electronic patient data comply with extant NHS standards.

The registration of a dental practice and its team members to the NHSmail system must be a pre-requisite to the issuing of an NHS contract to ensure integrity of the transmission of patient clinical information.

# 7. Sustainability in dentistry

As of April 2023, every Integrated Care System (ICS) in England has a Green Plan, borne of NHS England's response to the UK Climate Change Act 2008. The Clinical guidelines for environmental sustainability in dentistry provides a set of guidelines, accompanied by indications for the costs and time taken to implement in Primary Care settings. Sustainability in dentistry: Leading for change provides a scoping review to facilitate discussions and relationships between the dental profession, dental industry, and wider oral health and dental care infrastructure.

# Appendix 1 – What is a health needs assessment?

A health need can only exist when an individual has an illness or disability for which there is an acceptable cure (Matthew, 1971). Health needs may be described from the perspective of the service recipient or that of the service provider (Chestnutt *et al.,* 2013). Different types of health need exist, including need defined by health professionals (normative need), needs defined by service users (felt need), actions taken by service recipients to utilise health services (expressed need or demand), need between similar groups of people (comparative need) and the difference between need for health services and service provision (unmet need) (Bradshaw, 1972; Carr and Wolfe, 1976). A health needs assessment usually aims to identify the unmet health needs of a defined population to enable targeting of resources to improve health and reduce health inequalities.

Commissioning of healthcare comprises a range of activities [1] including:

- planning services
- procuring services
- monitoring quality

Planning oral healthcare services should be underpinned by a needs assessment. Oral health needs assessment (OHNA) should be used to determine if current oral healthcare services for patients are meeting local oral health needs. The method utilised should aim to answer the following questions:

- What is the health problem?
- What is the size and nature of the problem of the population?
- What are the current services available?
- What do professionals, patients and the public and other stakeholders want/need?
- What are the most appropriate and cost-effective interventions?
- What are the resource implications?

An oral health needs assessment (OHNA) therefore involves establishing and describing the oral health of a population, ascertaining their needs, measuring the capacity of existing services to meet these needs. Where these gaps exist, identifying new or alternative ways in which such gaps can be prioritised and filled (Chestnutt *et al.,* 2013). Consultants in dental public health as public health advisors to the NHS have the expertise to undertake oral health needs assessments and support NHS England to commission high quality, safe and effective oral healthcare services, leading to improved access, patient outcomes and experience. However, there are difficulties in determining need, uptake and demand for oral healthcare services due to limited information sources. Commissioning services that meet the needs of the population within available resources remains challenging.

A recent review (Chestnutt *et al.*, 2013) [1] of existing methods for undertaking oral health needs assessments found that there was no one format for an OHNA and no evidence was available on how to conduct an ideal OHNA that results in changes that are clinically- and cost- effective. Chestnutt *et al.* proposed a 10 step approach for carrying out an OHNA (Figure 1).

The needs assessment undertaken as part of the process to implement this commissioning guide should include:

- A description of the oral health needs of the local population;
- A description of the special care groups in the local population;
- A description of the current oral healthcare service provision for special care groups;
- Identification of gaps in service provision against local needs; and

- Recommendations for the future development of special care dental services in line with the commissioning guide.

# Appendix 2: Relevant diseases and conditions

| Condition | Description and Data Source |
|---|---|
| Dental caries (teeth) | Destruction of tooth tissue by toxins produced by bacteria living in the mouth reacting with sugars in the diet. https://fingertips.phe.org.uk/search/caries#page/0/gid/1/pat/6/par/E12000005/ati/102/are/E08000025 |
| Periodontal disease (gums) | Periodontal disease affects the gums, ligaments and bone that support teeth. https://files.digital.nhs.uk/publicationimport/pub01xxx/pub01086/adul-dent-heal-surv-summ-them-the2-2009-rep4.pdf |
| Oral Cancer | The main risk factors for oral cancer are tobacco and alcohol usage and these have a synergistic effect. https://fingertips.phe.org.uk/search/oral%20cancer |
| Tooth wear | Tooth tissue can dissolve because of exposure to dietary or other acids, it can be worn away by contact with something else (such as a toothbrush and abrasive paste) or the two arches of teeth can grind against each other and be worn away. https://files.digital.nhs.uk/publicationimport/pub01xxx/pub01086/adul-dent-heal-surv-summ-them-the2-2009-rep4.pdf |
| Cleft Lip and Palate | This condition often results in orthodontic and restorative specialist care and impacts on oral and maxillofacial surgery. https://www.clapa.com/treatment/research/the-crane-database/ |
| Orthodontics | Orthodontic treatment is treatment to correct irregularities of the teeth or developing jaws and to improve the function and appearance of the mouth and face. https://files.digital.nhs.uk/publicationimport/pub17xxx/pub17137/cdhs2013-report4-burden-of-dental-disease.pdf |
| Dental Anxiety | The control of pain and anxiety means that some patients clearly need sedation for routine dental treatment while others do not. The services provided should integrate the use of behavioural management techniques including Cognitive Behavioural Therapy (CBT) with conscious sedation and, if necessary, General Anaesthesia. https://files.digital.nhs.uk/publicationimport/pub17xxx/pub17137/cdhs2013-report1-attitudes-and-behaviours.pdf https://files.digital.nhs.uk/publicationimport/pub01xxx/pub01086/adul-dent-heal-surv-summ-them-the8-2009-re10.pdf |

# Appendix 3

**Acknowledgement**
Membership of the production of the clinical standards, collective endeavour.

| Clinical Guide for Dentistry (Overarching document | Revised October 2022 | OCDO |
|---|---|---|
| Clinical standard for Anxiety Management | Revised January 2023 | David Craig |
| Clinical standard: Special care dentistry | Revised October 2022 | Deborah Manger |
| Clinical standard: Restorative dentistry | Revised October 2022 | Avi Banerjee |
| Clinical standard for Urgent Dental Care | Revised January 2023 | Divyash Patel |
| Clinical standard: Oral Surgery | Revised May 2023 | Paul Coulthard |
| Clinical standard: Oral Medicine | Revised May 2023 | Pepe Shirlaw |
| Clinical standard : Paediatric Dentistry | Revised May 2023 | Deborah Manger |

The information in the clinical standards can be made available in alternative formats, such as easy read or large print, upon request. Please contact england.ocdo-cdo-england@nhs.net for any enquires regarding the documents.

# Appendix 4: Glossary of terms

| | |
|---|---|
| A&E | Accident & Emergency |
| ADHD | Attention Deficit Hyperactivity Disorder |
| AoMRC | Academy of Medical Royal Colleges |
| ARCP | Annual Review of Competence Progression |
| ASA3 | American Society of Anesthesiology Classification – A Patient with server systemic disease |
| ASA4 | American Society of Anesthesiology Classification – A Patient with server systemic disease that is a constant threat to life |
| ASD | Autism Spectrum Disorders |
| BDA | British Dental Association – A national professional association for dentists |
| ASD | Autism Spectrum Disorders |
| BDA | British Society of Paediatric Dentistry |
| BSA | NHS Business Services Authority – http://www.nhsbsa.nhs.uk/ |
| BPSD | British Society of Paediatric Dentistry |
| BPE | Basic Periodontal Examination |
| BSP | British Society of Periodontology |
| CBT | Cognitive Behaviour Therapy – A talking therapy that can help manage problems by changing the way one thinks and behaves. |
| CCG | Clinical commissioning groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England |
| CCST | Certificate of Completion of Training |
| CDS | Community Dental Services |
| CDGA | Comprehensive Dental Care Under GA |
| CsDPH | Consultants in Dental Public Health |
| Commissioning | The Department of Health defines commissioning as the means to secure the best value health care for the local population and taxpayers |
| CPD | Continuing professional development |
| CPQ | Child Perceptions Questionnaire |
| CSUs | Commissioning Support Units |
| CQC | Care Quality Commission is the independent regulator of health and social care in England. |
| CQUIN | The Commissioning for Quality and Innovation payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. |
| CYP | Children and Young People |
| DBOH | Delivering Better Oral Health |
| DCP | Dental Care Professional – Dental nurses, dental hygienists, dental therapists, orthodontic therapists, dental technicians |

|  |  |
|---|---|
|  | and clinical dental technicians. |
| DGA | General Anaesthesia for Dental Care |
| DGI | Dentinogenesis Imperfecta |
| DHSC | The Department of Health and Social Care |
| Dt/DT | Decayed Teeth |
| Dental WT&E AG | Dental Health Education England Advisory Group |
| DNA | Did Not Attend |
| DSTG | Dental Sedation Teachers Group GA |
| ECOHIS | Early Childhood Oral Health Impact Scale |
| EHCP | Education, Health and Care Plan |
| FFT | Friends and Family Test |
| FP17 | Form Processing 17 - Providers submit forms (FP17) to us detailing dental activity data. The data recorded on the FP17 show the patient charge collected, the number of units of activity performed and treatment banding information |
| FTs | Dental Sedation Teachers Group GA |
| FYFT | Five Year Forward View |
| GA | A medication used to cause a loss of consciousness rendering the patient unaware of the surgery |
| GDC | General Dental Council – Organisation that regulates dental professionals in the UK www.gdc-uk.org/ |
| GDS Contracts | General Dental Services Contracts. |
| GDP | General Dental Practitioner – Dentist |
| GMP | General Medical Practitioner |
| GMC | General Medical Council |
| GPs | General Practitioners |
| HbA1c | Glyceated Haemoglobin Index |
| HEA | The Higher Education Academy (HEA) is the national body for enhancing learning and teaching in higher education (HE) |
| WT&E | Workforce Training and Education - Its function is to provide national leadership and coordination for the education and training within the health and public health workforce within England. |
| WT&E (SIFT) | Health Education England Service Increment for Training |
| HEFCE | The Higher Education Funding Council for England promotes and funds high quality, cost-effective teaching and research, meeting the diverse needs of students, the economy and society. |
| HES | Hospital Episodes Statistics contains details of all admissions to NHS hospitals and all NHS outpatient appointments in England |
| HNA | Health Needs Assessment |
| HSCIC | Health and Social Care Information Centre |
| HTM 01-05 | Health Technical Memoranda are guidance documents providing comprehensive advice and guidance on the design, installation, and operation, of specialised building and engineering technology used in the delivery of healthcare. HTM01-05 is focuses on the quality of decontamination |

| | |
|---|---|
| IACSD | Intercollegiate Advisory Committee for Sedation in Dentistry |
| ICO | Information Commissioners Office |
| ICS | Integrated Care System |
| ILS | Intermediate Life Support – Management of a patient in cardiac arrest until the arrival of a cardiac team |
| IMOS | Intermediate Minor Oral Surgery |
| IOPDN | Index of Paediatric Dental Need |
| IOSN | Indicator of Sedation Need |
| IOTN | Index of Orthodontic Treatment Need |
| ISFE | Intercollegiate Specialty Fellowship Examination |
| LA | Local Anaesthesia |
| LD | Learning Difficulties |
| LDC | Local Dental Committee – statutory bodies which are the professional organisations representing GDPs |
| LDN | Local Dental Network |
| LETBs | Local and Education Training Boards |
| Level 1 | Care/procedures/conditions to be performed or managed by a dentist commensurate with level of competence as defined by the Curriculum for Dental Foundation Training or its equivalent |
| Level 2 | Care is defined as procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register |
| Level 3a | Care and procedures/conditions to be performed or managed by a dentist recognised as a specialist in Paediatric Dentistry by the GDC |
| Level 3b | Complex level of care and should be delivered by a dentist recognised as consultant in Paediatric Dentistry |
| LPN | Local Professional Network – Dental LPNs cover dentistry, pharmacy and eye health, and help drive service improvements and reduce health inequalities. |
| MCN | Managed Clinical Networks. See *Guide for Commissioning Dental Specialty Services* |
| MDAS | Modified Dental Anxiety Scale |
| MDT | Multi-disciplinary Team |
| MSc | Master's Degree |
| NDH | **Non-diabetic Hyperglycaemia** |
| NICE | National Institute of Health and Care Excellence PDS |
| NSPCC | National Society for the Prevention of Cruelty to Children |
| OHNA | Oral Health Needs Assessment |
| ONS | Office for National Statistics – https://www.ons.gov.uk/ |
| OPCS Codes | The Office of Population Censuses and Surveys (OPCS). This is a published procedural classification and coding of operations, procedures and interventions. This is a 4-character code system. The first character is always a letter and the other three are numbers. All codes beginning with "F" are related to the mouth. |
| OPG | Orthopantomogram |

| | |
|---|---|
| PANSI | Projecting Adult Needs and Information Systems – Programme to explore the possible impact that demography and certain conditions may have on populations aged 18 to 64. |
| PAR | Peer Assessment Review |
| PbR | Payment by Results – A set of prices and rules to help local NHS providers and Commissioners provide best value to their patients |
| P-CQP | Parental Caregivers Perception Questionnaire |
| PCR | Patient Charge Revenue is generated by the fees charged for |
| PDS | Personal Dental Services |
| PDS Contracts | Personal Dental Services Contracts |
| Performer | A qualified clinician who is contracted to perform the service |
| OHID | Office for Health Improvement and Disparities |
| PIA | Privacy Impact Assessment |
| PREMs | Patient Reported Experience Measures |
| PROMs | Patient Reported Outcome Measures |
| Provider | The contract holder to provide a service. |
| RCS | Royal College of Surgeons |
| RCOA | Royal College of Anaesthetists |
| RMS | Referral Management System |
| SAAD | Society for the Advancement of Anaesthesia in Dentistry |
| SCD | Special Care Dentistry |
| SDCEP | Scottish Dental Clinical Effectiveness Programme |
| SDEB | Specialist Dental Education Board Securing Excellence in Commissioning NHS Dental Services. |
| SEICD | Securing Excellence in Commissioning NHS Dental Services. |
| SEN | Special Educational Need |
| SEND | Special Educational Needs and/or Disability |
| SNOMED CT | Systematized Nomenclature of Medicine - Clinical Terms |
| SOHO | Scale of Oral Health Outcomes |
| SLA | Service Level Agreement - Agreement between service provider and user on scope, quality, and responsibilities Sedation Training Accreditation Committee of the Faculty of Dental Surgery of the Royal Surgeons of England |
| STAC | Sedation Training Accreditation Committee of the Faculty of Dental Surgery of the Royal Surgeons of England |
| UDA | Units of Dental Activity - Units of measure by which GDPs are paid and, against which, performance is measured |
| UOA | Units of Orthodontic Activity |
| WHO | World Health Organisation - www.who.int/ |
| WNB | Was Not Brought |
| XGA | Exodontia with General Anaesthetic |

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

This publication can be made available in a number of alternative formats on request.

© NHS England 2022 | PR1639