January 2010

Salaried Primary Dental Care Services

Toolkit for Commissioners

Salaried Primary Dental Care Services: Toolkit for Commissioners: September 2009
Contents

Preface.......................................................................................................................................................... 3
Introduction............................................................................................................................................... 4
Purpose of this toolkit.............................................................................................................................. 6
What makes SPDCS different?................................................................................................................ 6
Accessing local needs.............................................................................................................................. 7
Mapping existing services....................................................................................................................... 8
  Capacity.................................................................................................................................................... 8
  Behaviour Management, Sedation and General Anaesthetic.............................................................. 9
  Commissioning GAs for special care patients.................................................................................... 11
Effectiveness and Safety................................................................................................................................ 11
Patient Experience........................................................................................................................................ 11
Premises and Patient Experience........................................................................................................... 15
Value for Money......................................................................................................................................... 15
Measuring and monitoring...................................................................................................................... 16
  Dental Access Centres............................................................................................................................ 16
  Activity.................................................................................................................................................... 17
  Finance................................................................................................................................................... 18
  Patient Charges..................................................................................................................................... 19
Shaping the market.................................................................................................................................... 21
Transforming community services......................................................................................................... 23
Appendix 1 Heart of Birmingham PCT................................................................................................. 25
Appendix 2 Case mix guidance for commissioners.......................................................................... 27
Appendix 3 SPDCS service specification framework....................................................................... 34
Appendix 4 Framework for NHS dental epidemiology for England............................................... 46
Appendix 5 NHS dental epidemiology programme for England...................................................... 47
Appendix 6 Protocol for an oral health survey of children attending special schools....................... 49
Appendix 7 Transforming community services and primary care dentistry.................................... 52
Appendix 8 resources........................................................................................................................... 54
Preface

Until recently, Salaried Primary Dental Care Services (SPDCS) have usually (although not exclusively) been directly provided by PCTs via their provider arms. With the advent of the Transforming Community Services agenda, this is likely to change.

In considering the appropriate organisational form for their SPDCS, PCTs will need to balance and reconcile several important factors:

- **Sustainability**: how to ensure the continued viability of the services provided, given their often specialist nature as well as the vulnerable sectors of the population served. PCTs may find it useful to work collaboratively with their neighbours to achieve economies of scale.

- **Equality Impact Assessment**: PCTs are legally required to commission NHS dentistry services for those who want to access them in their area. This requirement includes vulnerable groups of people who may be unable to access general dental services, and SPDCS have traditionally had an important role in enabling them to meet this obligation. In considering how to take forward Transforming Community Services, PCTs will need to ensure that they reduce, rather than widen, existing inequalities.

- **Compliance**: whatever organisational form is chosen must comply with the relevant Regulations and Directions (see the Section on Shaping the Market and Appendix 7). The requirement is specific to SPDCS. It applies regardless of whether the SPDCS is set up as a stand alone organisation, or forms part of a larger organisation providing other (non-dental) services.
Introduction

Salaried Primary Dental Care Services (SPDCS) are a small but important part of the dental services that PCTs commission. To differing degrees they provide a wide range of services [see diagram 1], including:

- a full range of treatment services to patients with special needs (both adults and children)
- a referral service for other health and social care practitioners
- dental care for patients who would have difficulties accessing ordinary “high street” dentistry
- specialist services, for example Special Care dentistry, Paediatric dentistry and Orthodontics
- access services eg out of hours (OOH) services and Dental Access Centres (DACs)
- public health - screening, health promotion and epidemiology
- access for vulnerable groups

PCTs are legally required to commission NHS dentistry services for those who want to access them in their area. This requirement extends to those sectors of the population who may be unable to access general dental services, and SPDCS have traditionally had an important role in enabling them to meet this obligation. However as directly provided services, SPDCS have not received the same level of attention from PCTs as general dental services for whom PCTs were required to implement local contracts and directly commission for the first time from 2006 onwards. Some SPDCS carry out what has been termed a “safety net” role, developed incrementally over a period of time within the provider side of the PCT and not actively commissioned. Hence more detailed commissioning knowledge of SPDCS may be lacking in some PCTs, as well as a clear understanding of how these fit into the overall pattern of dental services that they commission. This combination of factors has sometimes resulted in the SPDCS being perceived as inefficient and as the “Cinderella” of the dental world.

The majority of SPDCS are managed by PCT provider arms. There are some 1500 salaried dentists in England who are employed by about 120 organisations (some services cover more than one PCT).

New terms and conditions for SPDCS were introduced in 2008. These resulted from a national negotiation and were well supported by the profession with 86% of eligible members of the British Dental Association (BDA) supporting the proposals in a ballot held in November 2007. A new single pay spine was introduced, together with enhanced career development through the introduction of:

- job planning and objective setting
- appraisal and personal development planning
- specified competencies for each pay band

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2 Salaried Primary Dental Care Services, Summary Agreement, NHSE and BDA, November 2007
Purpose of this toolkit

The purpose of this toolkit is not to support re-negotiation of this contract but to assist PCTs in realising its benefits, by supporting commissioners to work with their providers to review and develop services.

In undertaking this work, PCTs will need to take account of the guidance contained in the Transforming Community Service series published by Department of Health (DH) and also the World Class Commissioning Competencies. To commission salaried primary dental services effectively, PCTs will need to develop and display each of the eleven competencies defined by the World Class Commissioning programme.

What makes SPDCS different?

The distinctive features of salaried primary dental services include:

- SPDCS are currently delivered within or by NHS organisations (in contrast with the majority of primary care dentistry which is provided by independent contractors), and operate within a primary/community setting but outside of the usual independent contractor models eg GDS, PDS, GMS, PMS and APMS.

- as NHS bodies, SPDCS have formal management, clinical leadership and governance structures – with the associated on-costs.

- SPDCS have professional links with other parts of the local NHS, and with related services (eg social services)

- the case mix handled by SPDCS is, by its very nature, quite varied. This means that appointment lengths are both highly variable and often longer than in normal primary care dentistry (30-60 minute slots are not uncommon). There is also a much higher “failed to attend” rate in SPDCS

- SPDCS undertake dental public health functions eg screening programmes in care homes and special schools, oral health promotion, oral health surveys

- most patients are seen on referral from other clinicians and other health care professionals

- services are often provided from multiple locations with low patient volumes - which means travelling time between locations may need to be factored into commissioning

- Indirect patient care - many patients require complex management which necessitates preparatory work before treatment is provided, eg contact with GPs/hospital consultants to ascertain medical histories, liaison with formal and informal carers about provision of care and consent issues. This work may be done when the patient is not present, and for this reason clinicians will have times when they are working but not directly treating patients.

- carry out a dental public health role as well as providing care and treatment
Assessing local needs

The first step in any commissioning cycle is a thorough assessment of local population needs. This will normally be through the Joint Strategic Needs Assessment (JSNA) carried out with the relevant local authority. This will entail having a clear understanding of:

• The different segments that make up the local population and how their needs differ, including patterns of oral health and service demand

• Specific communities or groups with unmet needs or comparatively greater health needs (eg those with learning or physical disabilities)

• How these needs compare (through benchmarking) with those in comparable populations elsewhere

See Oral Health Needs Assessment Toolkit at:

Those PCTs with a nearby dental teaching hospital should be aware that its proximity can impact on patient flows because of teaching requirements.
Mapping existing services

It is unlikely that a straight comparison with activity in high street dental services will be appropriate for the majority of SPDCS. Understanding the links between the different elements of primary care dentistry is important, bearing in mind the specialist nature of some of the services. The links between dentistry and other services are also key, eg between dentistry and the statutory and voluntary sectors providing residential care for vulnerable patients.

PCTs need to clear about their screening and epidemiological survey obligations and the arrangements they have put in place to commission this from the SPDCS. In particular they will need to ensure the service has sufficient staff available in the years where they have to undertake mandatory surveys. There is then potential to commission additional local surveys as part of an annual programme in those years where there is no central requirement.

Commissioners should familiarise themselves with the consent issues relating to screening and oral health surveys in schools when reviewing the dental public health aspects of the SPDCS.

Any benchmarking should be against comparable services elsewhere, taking into account the range, type and complexity of services being provided and the population served.

Capacity

PCTs need to focus on commissioning the capacity required – rather than continuing to commission services based on historic activity. To do this effectively oral health needs will require assessment and those which can not be met by normal GDS/PDS services identified. The results of the adult dental health survey and local registers, eg for people with learning disabilities are helpful sources of information though is should be borne in mind that normal protocols for the former exclude special needs patients.

Resources available to support this include:

- Projecting Adult Needs and Service Information system
- Projecting Older People Population Information system
  www.poppi.org.uk/index.php
- North West Public Health Observatory protocol – see appendix 5

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3 Statutory Instrument 2006 No 185
4 Direction to PCTs on Dental Public Health Functions 2008, Gateway 10639
5 Dental Screening (Inspection) in Schools and Consent for Undertaking Screening and Epidemiological Surveys, DH, 2007, Gateway 7698
Behaviour Management, Sedation and General Anaesthetic

- **Behaviour Management:** Behaviour management of patients who have a slight degree of dental anxiety and moderate treatment needs should be within the competency of the average general dental practitioner. All patients should be assessed for behaviour management first. The diagram below illustrates the relative proportions of patients with a clinical need for behaviour management, sedation or general anaesthetic.

  ![Diagram of behaviour management, sedation, and general anaesthetic proportions]

- **Sedation Services:** Conscious sedation may be defined as "A technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and techniques used to provide conscious sedation for dental treatment should carry a margin of safety wide enough to render loss of consciousness unlikely."

  - This is the same definition as that adopted by the General Dental Council in May 1999.

- **Many SPDCS provide services for people with severe dental anxiety often involving sedation, and where appropriate general anaesthetic services by arrangement with a site with critical care facilities.**

  It is important that the whole care pathway is considered when looking at sedation and General Anaesthetic (GA) services, as for all patients GA should be viewed as the last resort. To this end local referral protocols should relate to the needs of the patients and require referrals to be made for assessment, leading to a decision on whether sedation or GA is clinically indicated.


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6 This is the same definition as that adopted by the General Dental Council in May 1999
• **General Anaesthetic Services:** General anaesthesia is defined in “A Conscious Decision”\(^8\) as “Any technique using equipment or drugs which produces a loss of consciousness in specific situations associated with medical or surgical interventions.”

Only the most challenging patients should be treated using general anaesthesia. In this context, “challenging” includes pre-cooperative children as well as some severely medically compromised patients. Commissioners and providers should be mindful of the guidance regarding provision of such services produced by the General Dental Council and the Society for Advancement of Anaesthesia in Dentistry (SAAD).

General anaesthetic services generally fall into 3 distinct groupings:

1. **GA exodontia services, which are:**
   - usually for very young children who are unable to cope with extraction
   - not special needs
   - provided by SPDCS in an acute setting

2. **Services for children with special care needs who are only able to receive dental care under GA:**
   - extractions
   - restorative dentistry will also be carried under GA
   - provided by SPDCS in an acute setting

3. **GA services for special care adults (predominantly adults with a learning disability):**
   - may include dental phobics
   - extractions
   - restorative
   - provided by SPDCS in a setting with appropriate critical care facilities

As a result of the need to deliver these services in an acute setting, patients will be linked to a nominated secondary care consultant though the SPDCS dentist will deliver the service. This means PCTs and SPDCS should work together to develop a mechanism for tracking patients through the service.

GA services may also be provided for adults who are unable to cope with extractions but these patients may not be identified separately.

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\(^8\) A Conscious Decision: A review of the use of general anaesthesia and conscious sedation in primary dental care, DH, 2000
Commissioning GAs for special care patients

Many SPDS provide dental care under general anaesthesia for those patients who are unable to accept dental treatment in the normal way. This requires access to a site with critical care and overnight stay facilities. There are several ways in which this secondary care service can be commissioned, and PCTs need to understand the implications, both in terms of costs and reporting:

- Tariff per patient with dentist and nurse provided by SPDS – acute trust responsibility to report under 18 week rules
- Rent paid to acute trust for use of secondary care facilities – PCT responsibility to report under 18 week rules

In both of the above scenarios, clinical responsibility rests with the named anaesthetist.

Tips

PCTs need to ensure that the funding streams for these services are clearly defined to reflect the respective contributions to the episode of care provided by the acute trust and SPDS. This is important to ensure that the PCT is not paying full tariff if the facilities are already paid for. To find out how GA access is being commissioned, and to check that there is no duplication in payments, PCTs can:

- Track patients and then check the minimum data set
- Seek information from their provider arm (GA work is often done under aegis of local nominated maxillo-facial consultant(s))

Take account of the whole care pathway when commissioning GAs

Referral protocols are important (remember the patient should be referred for assessment, not sedation or GA).


Effectiveness and Safety

Any commissioned service must meet all current quality requirements. Compliance with relevant NICE guidance is also required.

Patient Experience

The majority of patients seen by the service are referred by other clinicians. A PCT’s patient offer should take explicit account of the needs of vulnerable groups. To illustrate this, three scenarios are given in the text boxes below comparing standard and special care patients for each of the three treatment bands. Wherever possible, patients and carers should be involved in developing or reviewing services.
BAND 1 comparative scenario: 35 year old male attending for a recall examination

Patient 1 (Standard)
Mr A attends for a 10 minute recall appointment, where medical history is checked and full exam including routine X-Rays and a Basic Periodontal Examination (BPE) is undertaken. Presence of calculus is identified and a 15 minute appointment is booked with the hygienist for a scale and polish and to reinforce oral home care. A recall interval of one year is set. **Total time taken: Dentist 10-15 min; hygienist 15 min**

Patient 2 (Special Care)
Mr B has Downs syndrome and moderate learning difficulties. He lives in residential care and attends the service with a carer. On entering the surgery he is more interested in the people and equipment and it takes 5 minutes to encourage him to sit in the dental chair. A further 10 minutes is spent encouraging him with a toothbrush to open his mouth sufficiently to allow a visual dental examination. There is insufficient cooperation for either X-Rays or a BPE. No caries is noted but there is very marked reddening and swelling of gingivae, and some calculus present. A further 5 minutes is spent polishing his teeth with a rubber cup and corsodyl gel.

10 minutes is then spent discussing the proposed treatment plan with the carer, including best interests consent and current arrangements/responsibility for oral care at home.

The carer bringing the patient is not aware of the medical history. A letter is drafted to the GP to elicit the relevant information, and on response the dentist updates the dental records, and writes a prescription for corsodyl gel.

Three 30 minute appointments are made with the hygienist to acclimatise the patient; instruct carers how to assist in home care; ensuring the patients home care plan is up to date; monitoring improvement of the gingival condition, and subsequent to this completing the required scaling.

Due to the periodontal risk a recall interval of 3 months is set. **Total time taken: Dentist 30 min surgery; 10 minutes admin; Hygienist 1 hour 30 minutes combined clinical and administration**

BAND 2 comparative scenario: 78 year old female attending for a dental assessment at which it is found she requires 3 fillings, an extraction and a scale and polish

Patient 3 (standard)
Mrs C is fit and well with full mobility and mental faculty. She has a heavily restored dentition. Following a 15 minute assessment three further 20 minute appointments are made to complete this treatment. **Total time taken: 1 hour 15 minutes**

Patient 4 (special care)
Mrs D is a 78 year old lady living in a nursing home following a stroke 5 years ago. She was referred by her GP for routine dental care. Following assessment it was determined that she requires 3 fillings and an extraction. She is unaware of her benefit status and whether she would have to pay for dental charges. Her accompanying escort from the home is also uncertain of her benefits. The nursing home is contacted and they give the details of her next of kin who is her nephew. He confirms that his aunt will have to pay for dental treatment and an invoice be sent to him at the end of treatment.

Mrs D is seen on 3 further occasions to complete treatment. She is in a wheelchair and has to be hoisted from the wheelchair onto the dental chair. Due to pain from arthritis she then has to be supported by pillows and blankets to ease joint pain.
Each visit takes one hour due to hoisting and supporting patient. As she is high risk of developing further carious teeth she is placed on a short recall interval. A preventive regime is commenced. **Total time taken: 3 hours 30 minutes of surgery time plus 30 minutes of administration time.**

**BAND 3 comparative scenario: 55 year old female requiring new full upper and lower dentures**

**Patient 5 (standard)**
Miss E attends complaining that her old dentures are loose. After an oral exam and consent impressions are taken and special trays ordered. The dentist is assisted by having the previous dentures available and further appointments are made for second impressions, bite, try-in, fit, and final ease. **Total time taken: 1 hour 20 min**

**Patient 6 (special care)**
Miss F has mild learning difficulties and lives at home with her elderly mother. She is not eligible for free dental treatment. Mother reports that the previous dentures were lost at the day centre and she wants some new ones, but meanwhile Miss F is telling you that she can manage without and doesn't want them. The dentist spends 30 minutes trying to elicit how much the previous dentures were worn, and having determined that Miss F is capable of consenting for herself, some further time exploring why she is resisting new dentures. It transpires that Miss F wants dentures but is frightened of the impressions as last time they made her sick.

The dentist reassures Miss F that this won't happen, and makes a note to allow 30 minutes rather than standard 20 for the first impressions in anticipation that the patient may need to be prepared again to have the impressions at the next visit and they may have to deal with sick. A longer bite appointment is also anticipated as there are no previous dentures to act as a guide. 20 minute appointments are made for second impressions, try in, fit and 15 minutes for the ease.

Part way through treatment the patient moves into residential care. As a result one 30 minute appointment is failed to attend and the dental team spend 30 minutes tracing the patient and contacting the new carers. Treatment then continues as previously planned but the fit appointment is extended to give time to instruct the new carers on denture care. **Total time taken: 3 hours 15 minutes; dental team administration 30 min**

**Access and Choice**
Choice is defined to a large extent by the availability of specialist expertise. The British Society for Disability and Oral Health "Commissioning Tool for Special Care Dentistry" see:

[wwwbsdho.org.uk/misc/Commissioning_Tool_for_Special_Care_Dentistry_FINAL_MARCH_2007.pdf](http://wwwbsdho.org.uk/misc/Commissioning_Tool_for_Special_Care_Dentistry_FINAL_MARCH_2007.pdf)

lists the issues affecting access to dental services as including:

- Poor information regarding availability of dental services
- Access to services including transport
- Physical access to the premises and the surgery
- Access to appropriate oral health information
- The need to be accompanied / reliance on a third party
• Negative attitudes to the need to care – both individual patients and their carers
• Anxiety and fear
• Cost in emotional, psychological, social and financial terms
• Professionals’ attitudes to providing care
• Professionals’ lack of training or confidence
• Availability of means to transfer patient from wheelchair to dental chair

In terms of location of services, PCTs will need to weigh patient choice against need to ensure patient safety and access to expertise and specialist facilities/equipment (eg larger consulting rooms to take wheelchairs and special dental chairs). This applies equally to general practice as to SPDCS.

The majority of patients access SPDCS as a result of referral from elsewhere. Handling inappropriate referrals can present a dilemma for SPDCS [see examples of inappropriate referrals below] as often the last thing the patient needs is to be sent back to this type of dentist.

Example of an inappropriate referral to SPDS

An adult patient requires multiple fillings. On assessment by the salaried service, there is no anxiety, and the patient himself is unclear why he was referred. His GDS dentist referred as he felt unable to do the work.

Thus SPDCS needs to be able to say “no” in certain circumstances, which suggests it would be useful for commissioners to:
• Consider the patient pathway
• work with their provider to define what is (and isn’t) appropriate
• agree and publicise acceptance criteria (it might be helpful to involve the LDC in this work). Developing a referral proforma with scores for anxiety may also be useful. [See appendix 1 for example from Birmingham]
• have clear discharge route(s) out of the service
• set up a mechanism for the provider to feedback to them about compliance with referral criteria
• consider whether alternative approaches might be appropriate: for example, introducing counselling services for anxious dental patients as an alternative to commissioning costly sedation services.

What can reasonably be expected of a GDS dentist?
• s/he has responsibility to make an adequate referral
• behaviour management of patients who have a slight degree of dental anxiety and moderate treatment needs should be within the competency of the average general dental practitioner
• s/he should provide mandatory services eg multiple fillings.
Premises and Patient Environment

SPDS are provided in a range of settings which can include some or all of the following:

- Health centres/clinics
- Nursing and Residential Care Homes
- Day centres
- Patient homes
- Special Schools
- Prisons
- Walk In/Dental Access Centres
- Hospitals
- Mobile units in rural communities

NHS-provided premises and equipment must be maintained to agreed minimum standards, including:

- decontamination (compliance with minimum requirements is an urgent issue which may require access to capital – but commissioners should always ask whether the provider arm is able to use its own capital allocation)
- safety/security issues if OOH services are being provided
- compliance with the Disability Discrimination Act (DDA) together with PCT required standards

Other issues which commissioners may need to consider include:

- accessibility (ie location, car parking & transport links in relation to population served)
- utilisation levels at NHS provided premises
- acting on patient/carer feedback regarding patient environment eg access to water machine
- ownership & leasing of premises: whether PCT or provider, responsibilities need to be clearly documented to avoid confusion and possible duplication of costs. Co-location is often beneficial, as is having multi-surgery premises (eg joint training, cross fertilisation etc).

Value for Money

SPDCS is often perceived to be a costly service. As previously mentioned, SPDCS can include a wide range of different elements, with a correspondingly varied price range. The important thing is for PCTs to be clear that the service that they are commissioning represents value for money, and does not duplicate services that they are already buying through their routine GDS and PDS contracts.

Benchmarking should be done against appropriate/similar services in terms of activity, pay and non-pay costs (eg staffing, travel costs, staff training, premises, equipment & overheads). Dental public health programmes are not an overhead, and should be commissioned separately in accordance with the Directions to Primary Care Trusts concerning the exercise of dental public health functions 2008 (Gateway No 10639). Similarly, advice on teaching costs should be sought from local educational establishments.

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9 HTM 01-05, Decontamination in Dental Practice
Measuring and monitoring

Access
SPDCS is about ensuring access to vulnerable groups, so the access metric does not apply in the same way as it does for general dentistry. Although SPDCS will feature in the PCT’s access figures, re-attendance rates are likely to be higher than for general dentistry. It is suggested that each element of the service is considered on an individual basis because of the higher needs of the vulnerable groups served.

Dental Access Centres
Many SPDCS manage Dental Access Centres (DACs) which provide an urgent access service and do not deliver full courses of treatment. Many DACs provide an urgent access service and do not deliver full courses of treatment. The need for, and use of, DACs should be considered in the context of the wider commissioning of primary dental services. If the services that are commissioned from DACs are changed then the cost base may need to be reviewed in light of the new case mix.

DACs normally have a higher percentage of charge payers than other SPDCS who do not provide this function, but less than GDS. In one service the proportion of charge paying patients attending the DAC was 46% compared with 26% for specialist services.

A good comparator for DAC activity is the activity carried out in dental access slots commissioned from high street dentists. If PCTs do not have these they may want to consider benchmarking with services commissioned by other PCTs. Recent work by one PCT has show that 15% of the DAC patients were using it on a repeat basis. Other work has shown that a number of DAC patients had attended a practice in the area within the last 24 months.

Case study: NHS Leicester City PCT has piloted alternative provision for urgent dental care. This is being delivered by GDPs (not the DAC) who offer unsociable hours including early mornings, lunch times, evenings and weekends. Many of the patients have not accessed regular dentistry for several years.

The practices have been paid an enhanced UDA rate based on a sum of money per hour with an average of 6 UDAs/hour. Referrals are made directly from the DAC, NHS Direct and PALS. Patients have the opportunity to choose a dentist in various geographical locations. The PCT has made provision for 1000 patient slots per month, and in the first 2 weeks of this scheme, 445 patients accessed the service. The pilot will be completed in June 2009 but early indications suggest it has been widely used and patient feedback has been very positive.

Some PCTs have commissioned a "transitional" service which completes follow on treatment after the DAC has finished the urgent access treatment. This transitional service:

- can be located at another dental practice (in which case the DAC provides the telephone number and address to the patient). The patient also consents to the transfer of dental records where appropriate.
- completes the follow up treatment
- advises the PCT of the course of treatment provided
- submits the FP17 and completes the clinical data set.

In some circumstance the UDA rate agreed can be varied dependent upon the complexity of the treatment, however UDA costs are "smoothed" or averaged-out to anticipate those courses of treatment.
Activity

PCTs often complain that they lack sufficient information to monitor the performance of their SPDCS robustly.

Units of Dental Activity (UDAs) are the activity measure for clinical work undertaken by SPDCS, in the same way as for GDS/PDS (see table below).

<table>
<thead>
<tr>
<th>Charge Band</th>
<th>Summary of Care Provided</th>
<th>UDA value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Examination, diagnosis and prevention</td>
<td>1 UDA</td>
</tr>
<tr>
<td>2</td>
<td>All in Band 1 plus fillings, extractions, endodontic treatment</td>
<td>3 UDAs</td>
</tr>
<tr>
<td>3</td>
<td>All in Bands 1 and 2 plus dentures, crowns, bridges – treatment requiring laboratory work</td>
<td>12 UDAs</td>
</tr>
<tr>
<td></td>
<td>Urgent Course of treatment</td>
<td>1.2 UDAs</td>
</tr>
</tbody>
</table>

Given the specialist nature of many of the services that are provided it is important to take into account a wider range of factors. Many of the patients seen in SPDCS have high levels of dental care and/or complex needs. It follows that the outcome measures used to monitor the service need to reflect this - the use of a number of UDAs alone does not sufficiently describe the range and weight of work being undertaken. The cost per UDA for SPDCS is likely to be higher than for general practice.

The enhanced clinical data set, collected on form FP17 introduced from 2008 enables more detailed understanding of the range of treatments being provided. However, it does not give any indication of the degree of difficulty in carrying out dental treatment, for example if the patient has a learning disability or is medically compromised and suffers an epileptic fit during the appointment.

It is suggested therefore that PCTs will want to consider also using a mix of qualitative and quantitative measures, for example:

**Suggested qualitative & quantitative measures**

<table>
<thead>
<tr>
<th>Case mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers of unique patients</td>
</tr>
<tr>
<td>For Dental Access centres numbers not able to get an appointment on day of contacting service</td>
</tr>
<tr>
<td>Number and type of referrals</td>
</tr>
<tr>
<td>Difficulties in obtaining consent</td>
</tr>
<tr>
<td>Waiting times (will vary according to case mix)</td>
</tr>
<tr>
<td>Outcomes</td>
</tr>
<tr>
<td>Clinical vs non clinical time (eg need to take account of travelling between clinic locations, and indirect patient care)</td>
</tr>
<tr>
<td>DNAs &amp; short notice cancellations</td>
</tr>
<tr>
<td>18 week pathways [for GA and orthodontics]</td>
</tr>
<tr>
<td>Episodes of care (a measure of throughput)</td>
</tr>
</tbody>
</table>
Public health

- screening programmes:
  a. numbers screened in comparison with agreed sample size
  b. information and support provided
  c. other programmes – type, location, protocols, carer/staff awareness & support/follow up action, contacts

- epidemiology – follows national guidance (see Appendix 4); agree sample size; need to consider what is commissioned in the years where there is no national requirement to ensure service continuity

- health promotion – will follow from local OHNA and priorities (see examples below)
  a. interventions & outcomes by care group

The BDA case mix model, which measures the complexity of the patient based on a single course of treatment against 6 criteria, may be useful (see Appendix 2).

Croydon PCT “Don’t leave it to the tooth fairy!” – an example of SPDCS providing health promotion

In 2006 33% of Croydon’s 5 year olds had experience of tooth decay, 28% had untreated cavities, and there was also very low uptake of available dental services by younger children. In response, as part of Croydon’s Oral Health Promotion strategy, a Birthday Card scheme was developed focussed on young children aiming to improve their access to dental services and reduce incidence of dental caries.

A DVD “Don’t leave it to the tooth fairy!” was produced aimed at young children containing prevention messages and encouraging visiting a dentist. This was sent to all 3 and 4 year old children on their Birthday in 2008/09 accompanying an individual Birthday Card for the child. A list of dental practices participating in the scheme and accepting new NHS child patients was also enclosed. The family was incentivised to attend one of the practices receiving a ‘Brushing for life’ pack in return.

The programme will roll forward sending a Birthday Card and oral health promotional DVD to all 3 year old children in Croydon.

Finance

When reviewing the costs of SPDCS there are a range of factors that should considered. Financial monitoring should:

- take account of the issues relating to the location of services (eg multiple locations)
- treat public health functions as an element of the service not as an overhead
- take account of the fact that specific health promotion initiatives may need to be funded – for example, a campaign to improve children’s oral health.
- teaching commitments
Tip

• Commissioners and their SPDCS jointly need to identify how many different services they provide, including where different services are delivered on the same site

• NHS Dental Services should be asked to assign new contract numbers to each element identified

• SPDCS staff need to ensure that they report FP17 activity to the appropriate contract numbers and location (this may require internal training)

• This will assist both parties: SPDCS to performance manage their own activity internally, and for the commissioners to be able to monitor activity relating to the different elements of the service they are commissioning.

• This information will help both parties - at a local level - to compare similar services for value for money

Patient charges

Patient Charges: Collecting patient charges can present some challenges, for example:

• home visits: carrying large amounts of cash presents security issues for staff

• carers often do not know about a patient’s exemption status (see text box scenario below)

• elderly patient living in nursing or residential care home – at point of patient contact, the patient is often unaware of his/her financial circumstances. It may be difficult to obtain details about exemption status prior to the visit.

• younger patients with learning difficulties – patients may be in full time education, but aged over 18. Or, patients may be living independently, but are unable to show proof of qualifying benefit (or it is impossible to ascertain whether they are on qualifying benefit)

Services that are provided by the SPDCS in a primary care setting attract a patient charge whilst there is no patients charge attached to those that take place in an acute setting.

Scenario: Elderly and/or confused patient with carers

“An elderly confused patient came to see me last week with her new carer from her care home. The patient lacked the mental capacity to sign the FP17 form, and the carer did not have a clue about her exemption status. Nor did the carer wish to sign the FP17 or any other form on the patient’s behalf; she felt this was not her job.”

Scenario: Patient attending special school aged 19

“Parents brought their son thinking he is exempt from charges because he is still at school – however he is over 18. Once they are advised to complete a HC1 form they can obtain a HC2 certificate, but this involves quite a lot of explaining at the clinic.”
Quality

Factors that PCTs may wish to consider include:

- opening hours, appointment systems, waiting times, failed appointment rates (see box)
- complaints procedure
- accessibility for people whose first language is not English
- information for patients (see below)
- findings from clinical governance, clinical audit and peer review
- clinically led appraisal system
- delivery and evaluation of oral health programmes
- use of patient (and carer) satisfaction surveys; PCTs may want to focus on specific patient groups as part of rolling programme
- external review (see below)

Failed Appointments

Failed appointments (FTAs) are a significant issue for SPDCS. PCTs commissioners need to recognise that there are valid reasons for some of these, for example if patient transport fails, a carer is sick and unable to bring the patient for treatment, or the patient has unstable epilepsy and suffers a seizure. Equally, commissioners need to work with providers to look at ways of minimising FTAs eg SMS text reminders (see briefing note on Managing and Minimising FTAs at www.pcc.nhs.uk/uploads/Dentistry/march_uploads/managing_ftas.pdf)

- **Information for Patients:** Information for patients, carers and the public needs to be carefully considered:
  - use template leaflet
  - providing condition specific information may be useful
  - impact of general publicity on demand – there is a risk that the service might get swamped with patients from the “anxious” group

- **External Review:** PCTs are able to work with the Dental Reference Service (DRS) to review the clinical services delivered to patients. The DRS can provide PCTs with direct clinical evidence of the quality of patient care and record keeping by examination of patients and records at practice visits.

Where there are particular clinical concerns the DRS can provide advice and support with additional clinical monitoring activities where appropriate.

Further information on the DRS can be found at [www.nhsbsa.nhs.uk/DentalServices/848.aspx](http://www.nhsbsa.nhs.uk/DentalServices/848.aspx)
Shaping the market

Given the range and complexity of SPDCS, commissioners need to balance issues of viability and monopoly quite carefully:

- joint commissioning (whether by more than one PCT, or including a Local Authority) may be appropriate in a number of circumstances, including across large urban areas such as London and Birmingham.

- broadly speaking, the more specialist the service, the larger the population base needed to sustain it. PCTs should work with their immediate neighbours to determine the need for SPDCS services and, if so to ascertain the minimum viable size for the service they want to commission. A specialist [consultant] might, for example, be appointed to work jointly across 2-3 PCTs.

- where recruitment in SPDCS is an issue in a particular locality should be given to commissioning the service in different ways e.g. across boundaries to increase the size of the area covered (– the larger the service, the more attractive the opportunities it is likely to be able to offer for skill mix and career progression) or commissioning through GDS

- If PCTs wish to establish a Dentists with Special Interests (DwSI) in Special Care Dentistry as part of their commissioning strategy, a guide is available which covers the process of assessing whether the commissioning of dental services from a DwSI would be appropriate, how such practitioners should be accredited and how a service might operate.

Resources include:

- PCT procurement guide (Gateway 9915, May 2008)  

- Principles and Rules for Cooperation and Competition (Gateway 9244, December 2007)  

- Framework for Managing Choice, Cooperation and Competition (Gateway 9914, May 2008)  

- Code of Practice for Promotion of NHS funded services (Gateway 9580, March 2008)  

- National Guidelines for the appointment of dentists with a special interest in special care dentistry  
Workforce issues: recruitment and retention

One of the factors which may influence the career choice of a newly qualified dentist is the need to repay the debt s/he may have incurred during training. The increase in PCT dental budgets in 2008/9 and 2009/10 has made it harder to attract young dentists into SPDCS. In order for a career in SPDCS to appear attractive, commissioners and providers may need to consider:

- succession planning – rotations may be useful (although it is usually necessary to convert a service post into a training post)
- developing links with universities and establishing an undergraduate outreach programme involving placements in SPDCS and/or learning agreements
- funding/offering undergraduate and vocation (Foundation) training posts in SPDCS (NB this may affect the amount of surgery accommodation required; also the type of patients required for teaching purposes may have an impact on referral criteria)
- offering specialist training posts (e.g. paediatrics, endodontics, special care dentistry and periodontics)
- innovative use of skill mix
Transforming community services

The diagram below shows the three types of contract which PCTs may use to commission primary dental care: GDS, PDS and Primary Care Dental Services. These three routes are the only legal ways a PCT may commission primary dental care. Each has its own set of Regulations (in the case of primary dental care services, which cover SPDCS, this is the PCT Dental Services Directions 2006).

GDS - General dental Services
• local contracts commissioned by PCT

PDS - Personal Dental Services
• local contracts commissioned by PCT

PCT dental services
• new national contract (terms and conditions) for salaried dentists April 2008

As the transforming Community Services agenda progresses, the number of directly provided SPDCS is likely to reduce

The PCT Dental Directions 2006 enable PCTs to provide primary care dentistry themselves and set out how this must be done – usually via the PCT’s provider arm. No formal contract is necessary where the provider arm is still legally part of the PCT. (There may be a Service Level Agreement in place, but this is not a legal contract.)

The document Transforming Community Services10 makes it clear that by April 2009 all PCT direct provider organisations are expected to have moved into a contractual relationship with their PCT commissioning function, using the national contract for community services in 2009/10.2

Where the PCT’s provider arm becomes a separate organisation and is no longer legally part of the PCT (e.g. if it becomes a social enterprise organisation) then a contract would be necessary.

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10 Transforming Community Services: Enabling new patterns of provision, Department of Health January 2009, Gateway Reference 10850
Subject to the requirements of the Transforming Community Services document, it is up to the PCT to decide what organisational form is appropriate for its provider arm. Providers of NHS primary care dental services must however comply with the relevant legislation, Regulations and Directions, specifically:

- the Dentists Act 1984 (which states that, to carry out the business of dentistry, a majority of the Directors on the Board must be dentists or dental care professionals)
- NHS Act 2006
- GDS & PDS Regulations
- SPDCS Directions 2006
- The National Health Service (Performers Lists) Regulations 2004
- The National Health Service Dental Charges Regulations 2005

This means that the standard community contract is not appropriate; and in order to collect Patient Charge Revenue, either a GDS or PDS contract has to be used (since the PCT is no longer directly providing dentistry itself, the SPDCS option does not apply).

See also appendix 6.
Appendix 1  Heart of Birmingham PCT (Birmingham Personal Dental Service) Referral Criteria and Referral Form

The PDS provides routine NHS primary dental care, using Relative Analgesia (RA) where appropriate. It does not directly provide GA.

We accept referrals for people of any age, who are unable to have routine treatment in a general dental surgery due to conditions which would influence dental management, such as:

- Complex medical history
- Intellectual impairment (for example, learning disability or mental health problem)
- Physical disability

In addition we are able to accept referrals for children who have:

- Caries and limited co-operation
- Behavioural problems

In all cases the first appointment will be an assessment visit, when the patient will be assessed for suitability before treatment. Standard NHS charges and exemptions apply.

Contact Details

Name of service lead

Address
<table>
<thead>
<tr>
<th>Patient Details</th>
<th>Referring Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
<td>Name of Dentist / GP / Nurse</td>
</tr>
<tr>
<td>Forename</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>Postcode</td>
<td>Tel No</td>
</tr>
<tr>
<td>Tel No</td>
<td></td>
</tr>
<tr>
<td>Name of GP</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Date of Referral</td>
<td></td>
</tr>
<tr>
<td>Treatment Required/Reason for Referral</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Treatment</th>
<th>Urgent</th>
<th>Non urgent (please circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is A Home Visit Necessary?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Problem</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sensory Impairment</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Wheelchair User</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is an Interpreter Required?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Any other Information

**OFFICE ONLY**

Date Referral Form Received

Clinicians Name / Clinic

First Appointment Date Offered

Return to: Name of service lead

Address
Appendix 2 Case Mix Guidance for commissioners

Commissioners of health care services are required to ensure that services are provided to meet the needs of all the population for whom they have responsibility. The Department of Health in England recently published 'Valuing People's Oral health'; a good practice guide for improving the oral health of disabled children and adults. This guide highlights the importance of incorporating oral care into all healthcare plans. It acknowledges that some disabled children and adults present barriers and challenges to primary and secondary care providers when providing dental care.

In the British Society for Disability and Oral Health document 'Commissioning tool for special care dentistry' it is recommended that 'commissioners appraise themselves of the complex needs of many patients accessing special care dentistry. As such contracts must reflect the additional time and resources required to provide care for this group of patients'.

One piece of information recommended in Valuing Peoples Oral Health is 'an assessment of the degree of difficulty in carrying out dental treatment, based on the individual's impairment or disability and the impact this has on providing a responsive service.' The case mix model is designed to measure this additional complexity of providing dental care for disabled children and adults, in comparison to providing equivalent care for the 'average' patient. The model has been developed at the British Dental Association by clinicians with many years experience in providing special care dentistry. The model has been widely field tested, and consulted with other societies with a specific interest in special care dentistry.

The model describes the complexities presented by the patient across six parameters. The complexities measured are those of the patient in respect of dental care provision and not of the actual dentistry to be provided. Each individual episode of care is measured separately, thus the model reflects the actual complexity experienced in providing a specific course of treatment. This ensures the model is realistic in describing resource needs - for example a patient requiring full operating general anaesthetic facilities for a simple dental filling may not require such facilities for those courses of treatment when only dental hygiene is undertaken.

The model is not a contract currency per se, but is intended to be one of a number of indicators to be used to monitor and ensure adequate provision of dental services for disabled children and adults. A provisional weighting system has been applied to the criteria (see case mix scenarios below), and this can be used to ensure comparison between, for example, different operator's caseloads or different clinics. It is anticipated that as usage increases benchmarking between different services will be undertaken. Additionally in some parts of the country the criteria contained within the model are being used to determine whether specific patients are eligible to be accepted for referral by special care dentistry services, or should be retained for continuing care by these services once the initial course of treatment is completed.

Further information about the model is available at www.bda.org.uk
Case Mix Scenarios

The narrative is written as a series of examples, which may or may not all be applicable for any specific patient. A particular patient will score differently for different courses of treatment – this is deliberate as the model is intended to measure the complexity of a specific episode of care and not be a permanent label attached to the patient. This complexity is reflected in six independent criteria, each of which covers both actual provision of clinical care for the patient, and the many additional pieces of work necessary to facilitate care for many of these patients. The criteria are

• ability to communicate
• ability to co-operate
• medical status
• oral risk factors
• access to oral care
• legal and ethical barriers to care

All criteria are independently measured on a 4 point scale where 0 represents an average fit and well child or adult attending for dental care, and A, B and C represent increasing levels of complexity.

Each point on a scale is supported by a narrative against which the clinician determines a ‘best fit’.

Scenario 1

Peter W is a 32 year old who has severe learning disabilities. He lives in a unit with 24 hour nursing/support care. Peter does not communicate verbally spending all his time colouring in pictures. Any communication is by vague gestures. It is impossible to examine his teeth except, visually, the anteriors where it is noticed he has copious amounts of calculus on lower incisors. Medically he has epilepsy with seizures weekly, the majority of which are self limiting but occasionally require use of buccal midazolam to control. It is agreed to examine Peter with use of IV sedation in order to examine his posterior teeth and undertake scale and polish. On examination it is noted Peter is caries free with only scaling required.

- Ability to communicate C. (No ability)
- Ability to cooperate C. (Sedation required)
- Medical status B. (Epilepsy unstable)
- Oral risk factor B. (OH 3rd party needed)
- Access A. (Relies on carer)
- Legal & Ethical B. (Best interests with consultation)
Scenario 2

Mrs B is 86 and lives in a nursing home. She was diagnosed with dementia 8 years ago. Medically she is fit and well, but has been prescribed aspirin, statin and antipsychotic medication. She has had difficulty eating recently and the nursing home has asked for a visit. Mrs B is difficult to examine as she does not open her mouth for very long. Communication is extremely difficult. With encouragement from nursing staff it is possible to determine that she is dentate with no caries but has acute gingivitis and poor oral hygiene. She also has a very mobile lower molar that was extracted on a subsequent visit with some difficulty. Arrangements have been made for the hygienist to visit and work with carers to improve oral hygiene.

- Ability to communicate C. (communication via 3rd party)
- Ability to cooperate B. (considerable difficulty)
- Medical status A. (some treatment modification)
- Oral risk factor B. (OH poor)
- Access C. (domiciliary)
- Legal & Ethical B. (best interests with consultation)

Scenario 3

Rebecca is an 8 year old who fell in the playground and fractured her upper central incisor suffering pulpal damage. Although attending her GDP she was referred to the salaried service 3 weeks later for management of a non-vital open apex tooth. Rebecca attends with her mother, and is a cooperative child and once treatment of the incisor was completed she returned to her GDP

- Ability to communicate 0
- Ability to cooperate 0
- Medical status 0
- Oral risk factor 0 (trauma not a risk factor)
- Access 0 (adult with child code 0)
- Legal & Ethical 0 (parental consent code 0)

Scenario 4

Miss A is a 40 year old lady who has cerebral palsy and is profoundly deaf. She lives in supported housing and has use of a British sign language interpreter. She is able to consent to treatment herself and makes a cross on the consent form to indicate this. She undergoes a course of treatment including fillings and extractions with sedation.

- Ability to communicate B. (sign language)
- Ability to cooperate C. (sedation)
- Medical status 0
- Oral risk factor A. (course following neglect)
- Access A. (access with support)
- Legal & Ethical 0
Scenario 5

John is a 44 year old male patient with advanced Huntingdon’s disease, and has considerable involuntary movement. He has limited understanding and is unable to communicate directly. His mother assists with communication and also tries hard to brush his teeth with limited success. He frequently has 3 or 4 new carious lesions annually, and in this course of treatment it has been possible to restore 3 buccal cavities over 4 visits using moderate restraint in the dental chair.

- Ability to communicate: C. (communication via 3rd party)
- Ability to cooperate: B. (moderate restraint)
- Medical status: 0 (no impact on dental care provided)
- Oral risk factor: B. (OH relies on 3rd party)
- Access: A. (access with support)
- Legal & Ethical: A. (best interests with no 2nd opinion)

Scenario 6

Anne is 32, is HIV positive and is on combination therapy. She has had a recent haematological investigation and you write to her consultant for the results. She is anxious about dental treatment, and has three carious teeth, one of which can be restored and three require extraction. At the first visit she consents to this plan, but DNAs the next two visits, and you discontinue treatment.

- Ability to communicate: 0
- Ability to cooperate: 0
- Medical status: B. (complex/ additional enquiries)
- Oral risk factor: A. (course following neglect)
- Access: A. (DNA)
- Legal & Ethical: 0

Scenario 7

James is 36 and has learning disabilities. His communication is limited and you obtain a partial medical history from the carer. The carer does not have the details of James’ medication and you write to the GP for this. In fact he is just on medication for asthma and epilepsy. The carer is asked to investigate further responsibility for patient charges.

With much persuasion and behaviour management you manage a simple visual examination of James’ mouth. The only findings are poor oral hygiene and generalised periodontitis, which will be managed with scaling and root planing. You refer him to the hygienist.

- Ability to communicate: B. (limited communication)
- Ability to cooperate: B. (limited examination)
- Medical status: B. (additional enquiry)
- Oral risk factor: B. (poor OH)
- Access: A. (access with support)
- Legal & Ethical: A. (self consent with further clarification)
Scenario 8
Trevor is 65 and lives in a care home. He is communicative and cooperative and has an uncomplicated medical history. His carer brings him to your mobile surgery and on examination you find moderately good oral hygiene with little evidence that he is periodontally susceptible. One filling requires replacement in addition to a minor scaling. Previously Trevor has been assessed as lacking capacity to consent, and an advocate has been appointed. The advocate does not live locally and consultation is required before treatment can commence. This is done over the telephone before the next appointment, and treatment is completed without incident.

- Ability to communicate: 0 (Lacks capacity but communication OK)
- Ability to cooperate: 0
- Medical status: 0 (no impact on dental care provided)
- Oral risk factor: 0
- Access: A. (mobile clinic)
- Legal & Ethical: B. (consultation with advocate)

Scenario 9
Tom has profound learning disabilities and attends the surgery in a wheelchair. He arrives at the surgery in a taxi arranged by his mother. You use the hoist to transfer him to the dental chair for examination. His medical history, obtained from his mother indicates cerebral palsy, and medication for epilepsy. His mother does not report any behaviour indicating a dental problem. Examination is very difficult, and you only manage to see the anterior teeth. A small and possibly carious buccal lesion is seen on an incisor and but many surfaces are obscured by calculus. You arrange a case conference with your colleagues and agree that as it is many years since he had a full examination you will arrange a GA for full exam, and to treat the cavity identified plus anything else found.

- Ability to communicate: C. (no communication)
- Ability to cooperate: C. (GA used)
- Medical status: A. (medication / patient management)
- Oral risk factor: B. (restricted access)
- Access: B. (hoist)
- Legal & Ethical: C. (case conference)

Scenario 10
Natalie, aged 7 attends with her mother who provides medical details. (nil relevant) Natalie is anxious and requires considerable persuasion for examination. She is caries free but oral hygiene needs improvement with support from the parents. You arrange for a couple of visits with the hygienist to acclimatise her to the dental surgery.

- Ability to communicate: 0
- Ability to cooperate: A. (exam with difficulty)
- Medical status: 0
- Oral risk factor: A. (OH fair support needed)
- Access: 0 (adult with child code 0)
- Legal & Ethical: 0
Scenario 11

Ernest is 76 and is cared for by his partner with social services input. He has early signs of dementia, and recently had a stroke. He also has had severe arthritis for many years resulting in poor mobility. The referral letter from his GP indicates current medication of a total of 14 different drugs. He is referred because he has lost his dentures and is having difficulty eating. You see him on a domiciliary basis and initially there is some resistance to examination. Ernest indicates he does not want new teeth. After conferring with his partner regarding your concerns about his being able to cope with new dentures, you decide not to proceed and write back to his GP reporting this.

- Ability to communicate  A. (some difficulty)
- Ability to cooperate  A. (completed exam with some difficulty)
- Medical status  B. (complex multipharmacy)
- Oral risk factor  0
- Access  C. (domiciliary)
- Legal & Ethical  0

Scenario 12

Mavis is 70 and lives in a care home following a stroke. Her blood pressure is controlled by medication and she is on statins and a low cholesterol diet to prevent recurrence. The clinic arranges transport for the patient to attend the surgery, where you find she is cooperative for examination. Clinically she requires one extraction of a very mobile tooth and replacement dentures. During the examination you find some inconsistency in the things she is telling you, and following discussion with the carers you agree that there is some uncertainty regarding her capacity to consent. You arrange for a mental capacity assessment to be done, which indicates she is competent for all but the most complex decisions.

- Ability to communicate  0 (communication OK)
- Ability to cooperate  0
- Medical status  A. (slight modification)
- Oral risk factor  0
- Access  B. (clinic arranges transport)
- Legal & Ethical  C. (multi-professional consultation)
Scenario 13

Maud is 82 and wheelchair bound. She is brought into the surgery by her active husband. Maud is dominant and will not allow you to speak to her husband. He manages to communicate with the nurse that she has been to see a dentist several times without receiving any treatment. She says that she is younger than him and to speak to her. She manages to transfer to the dental chair with difficulty. There appears to be little of relevance in the medical history other than arthritis and hypertension for which she is taking appropriate medication.

Examination reveals a few standing upper anterior teeth with a pointing sinus above the UL2, 2 lower standing teeth of which one is grade 3 mobile and a very ill fitting lower denture which she is unable to wear. Her oral hygiene is poor and she will not allow anyone to assist her with it.

Following examination the patient is informed of the findings and offered treatment alternatives. The patient seems confused about the options and they are repeated to her on several occasions. A treatment plan is eventually agreed. However at the next visit the patient is not happy to have treatment without the explanation and the whole appointment is spent going through her options.

The dentist then decides to confirm the medical history with her GP. The GP writes that she has been diagnosed with Obsessive-Compulsive Disorder but that she refuses to acknowledge the problem or receive any treatment for it. It also appears that she has memory problems. You agree with the patient that you will write to her with all the findings and her options for treatment, which she will return to you with a tick list of which option she wants. Over several prolonged visits with reference each time to her tick list you are able to finally extract the UL2 and the grade 3 mobile tooth and provide her with new partial dentures. She ignores your preventive advice.

- Ability to communicate
  - B. (in writing)
- Ability to cooperate
  - B. (considerable interruption)
- Medical status
  - B. (additional enquiries)
- Oral risk factor
  - B. (poor OH)
- Access
  - A. (access with support)
- Legal & Ethical
  - A. (self consent after further clarification)
Appendix 3 SPDCS Service Specification Framework

1. Purpose

For example to:

- Improve the oral health of the local population;
- Reduce inequalities in oral health and dental treatment;
- Improve the quality of people’s experiences of oral healthcare services;
- Ensure service delivery is prioritised to meet the current national strategy ‘Choosing Better Oral Health. An oral health plan for England’ (DH, 2005);
- Deliver and develop services for PCT residents who require SPDCS.

Also include:

- Details of the evidence base – national and local
- Strategic policy direction
- Key national and local targets/priorities
- Current commitment of resources

A summary of local health and social care service needs drawn from a joint strategic needs assessment, done with Local Authority partners

2. Definition and Scope

2.1. Service Description

For example:

Special care dentistry is concerned with providing and enabling the “improvement of 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 a number of these factors”.

The SPDCS will provide a comprehensive range of dental care including Special Care Dentistry to priority groups within XXX who would not otherwise access dental care, screening of the local population as required by the commissioner, oral health promotion services and the collection of epidemiological information on dental needs and patterns of disease within the local population.

2.2. Whole System relationships

For example:

The SPDCS cannot work in isolation and must work with partners to address the needs of priority groups to attain optimum outcomes. Partners will include:

- Education /special schools
- Social Care
- GDPs
2.3. Interdependencies

For example:

The SPDCS will work together with General Dental Practitioners (GDPs) and hospital dental and maxillofacial services to ensure seamless provision of care.

2.3.1 Safeguarding

The service must ensure that policies and procedures relating to safeguarding are adhered to, that staff have undertaken training appropriate for their professional role and should be represented on the local safeguarding children's board. All staff working with children and young people will have undertaken an enhanced Criminal Records Bureau check (for dentists this will be in accordance with the NHS Performers List Regulations). Reference should be made to the safeguarding clauses within the National Community Contracts.

2.4. Patients/client groups included

For example:

- Children and adults with severe learning disabilities;
- Children and adults with severe mental health problems, who cannot be managed by a General Dental Practitioner (GDP). This includes people who exhibit challenging behavior;
- Children and adults, who are severely physically and/or medically compromised and cannot be treated by a GDP;
- Looked after children
- Children referred to the SPDCS by a GDP, who are very difficult to treat due to a severe phobia towards dental treatment;
- Phobic adult and housebound patients
- Frail elderly
- Young offenders, prisoners and those detailed in other secure institutions
- Socially excluded groups eg migrants and homeless people

2.5. Relevant networks & screening programmes

For example:

The SPDCS will deliver dental public health programmes in line with the PCT’s responsibilities under the Dental Public Health Regulations 2005 and SPDCS Directions 2006.
3. Service Delivery

3.1 Service Model

A statement or diagram which shows the various elements of the service and the key linkages with other service providers including sub-contractors.

The SPDCS will provide specific clinical primary care dental services and dental public health programmes and to the PCT’s population, as specified below.

3.1.1 Special Care Dentistry (Mandatory and Advanced Services)

The SPDCS will provide a comprehensive and proactive oral health care service for people of all ages resident in XXX, who have special needs according to the XXX SPDCS referral protocol.

3.1.1.2 Mandatory Services

The SPDCS must provide for its patients all proper and necessary dental care and treatment which includes the following:
- The care which a dental practitioner usually undertakes for a patient, and which the patient is willing to undergo;
- Treatment, including urgent treatment;
- Where appropriate, the referral of the patient for advanced mandatory services such as Orthodontics or Consultant led secondary care services.

The dental care and treatment referred to above includes the following treatments:
- Examination;
- Diagnosis;
- Advice and planning of treatment;
- Preventative care and advice;
- Periodontal treatment;
- Conservative treatment;
- Surgical treatment;
- Supply and repair of dental appliances;
- The taking of radiographs;
- The supply of listed drugs and listed appliances;
- The issue of prescriptions.

3.1.1.3 Advanced Mandatory Services

- Services under general anaesthesia;
- Domiciliary services, for people who are housebound;
- Sedation services. Dental treatment under relative analgesia for children and [dental phobic] adults, where sedation is necessary to enable the patient to access primary care dental treatment.
3.1.2 Treatment under General Anaesthesia

For example:

The SPDCS will provide a full range of appropriate mandatory services / treatment under general anaesthesia for children and adults who have disabilities, providing they can fulfil the criteria set out in A Conscious Decision and those for treating people as day-care patients. This includes ensuring that overnight stay and critical care facilities are available.

Treatment under general anaesthesia will only be provided if other options are not possible. The SPDCS will agree written protocols with the PCT describing the patient pathway to treatment under general anaesthesia.

3.1.3 Domiciliary dental services

For example:

The SPDCS will provide domiciliary dental care to those patients who are unable to obtain care from their GDP and who are genuinely housebound and unable to access fixed clinics. A protocol for the delivery of domiciliary dental care services will be developed jointly.

3.1.4 Unscheduled and Out of Hours dental care

For example:

The SPDCS is expected to see regular patients 'of their practice' who contact or present in an emergency during normal working hours, on the same day. The unscheduled appointment need not necessarily be offered at the clinic of the patient’s usual attendance.

A daily rota of 'access slots' will be maintained and available for unscheduled housebound patients requiring emergency domiciliary dental care.

It is essential that patients receiving care under general anaesthesia (GA) are informed of the process of obtaining emergency care post-operatively Out of Hours (OOHs).

Patients will be subject to payment inline with the NHS (Dental Charges) Regulations 2005 (unless exempt).

Insert details of arrangements for OOH and weekend services

3.1.5 Dental Public Health Functions

3.1.5.1 Oral Health Promotion

For example:

The SPDCS will provide oral health promotion programmes to groups and individuals in XXX.

Delivery of oral health promotion programmes will be at the locations where the particular targeted groups usually meet. However, use of SPDCS clinical bases will also be considered as and when these may be more appropriate.
3.1.5.2 Oral Health Screening

DH guidance on consent (May 2006) indicated that positive consent is required in accordance with DH “Good practice in consent” for dental screening and epidemiology. “Dental screening (inspection) in schools and consent for undertaking screening and epidemiological surveys.” (DH 2007, Gateway 7698) presented UK National Screening Committee recommendations questioning the aims and effectiveness of school dental screening, advising PCTs:

- To review screening programmes;
- Consider the discontinuation of screening and re-direction the resources to address inequalities more effectively

3.1.5.3 Epidemiology

For example:

Every Primary Care Trust is required to engage in the activities required by the NHS Dental Epidemiology Programme (NHS DEP)11. This facilitates the production of standardised, quality assured information about the dental health of population sub-groups, which is required by commissioners when planning services and addressing health inequalities. The PCT Dental Service has the experience and skills required to undertake the required surveys.

As a minimum contribution to the production of relevant dental health information the PCT Dental Service (SPDCS) will undertake the necessary surveys required by Statutory Instrument and related Directions12. This will ensure compliance with the Health and Social Care (Community Health and Standards) Act 2003, Choosing Health (2004), Choosing Better Oral Health (2005) and the Water Act (2003) which requires that Strategic Health Authorities monitor health on a four-yearly basis starting in 2007/08.

The selection of personnel for the range of tasks involved in the nationally coordinated surveys will be undertaken with due recognition of the importance of continuity and the ability to compare results from one year with another.

Suitable clinical examiner(s) will be identified from among the SPDCS Dental Officers or Senior Dental Officers, along with sufficient support staff for administration, recording and data entry, and relieved of clinical duties to allow for all activities to be undertaken within the prescribed timescale. Relevant members of the fieldwork team will be supported to attend all necessary training and calibration events provided at SHA level. The SPDCS will only use a clinical examiner who has successfully calibrated at the relevant regional calibration session, using guidance provided by the Dental Public Health Observatory/ BASCD13.

The fieldwork team will be familiar with, and comply with, the standards and procedures laid down in the relevant National Protocol. This includes compliance with the sampling process, approach to specified target populations, gaining of consent, application of measures and storage, back-up and handling of data. The team will make the anonymised survey data available to the SHA NHS DEP Regional Coordinator. The process will be planned, executed and completed in the nationally agreed required timeframes.

The SPDCS will ensure that the results, once verified centrally, are made available in suitable format to the Consultant in Dental Public Health or other advisor to the PCT, and to commissioners to assist with service planning. The raw, anonymised, data will be securely retained for potential later analysis.

11 Statutory Instrument 2006 No 185
12 Directions to PCTs concerning the exercise of Dental Public Health functions 2008. DH Gateway 10639
3.1.5 Teaching & Research [If there is a nearby Dental School]

The SPDCS will provide out-reach teaching sessions for dental students, dental hygienists and dental therapist students from XXX Dental School. Out-reach teaching sessions may contribute to the service output of the department during times of difficulties in recruitment and retention of professional personnel.

3.2 Care pathways

The SPDCS will agree written protocols with the PCT describing the patient pathways into and out of the service.

4. Referral, access & acceptance criteria

4.1. Geographic coverage/boundaries

4.2. Referral criteria & sources

Patients will only be accepted for SPDCS dental care by written referral from an appropriate health professional, including:

- GDPs;
- General Medical Practitioners (GPs);
- Hospital Consultants;
- Community Psychiatric Nurses (CPNs);
- Health Visitors;
- District Nurses;
- School Nurses;

Referrals may also be received from:

- Social Services (in the case of patients with severe learning disabilities);
- Direct access referrals (such as care-staff in care institutions);
- Limited self referral for people with severe disability

4.3. Locations & opening times

For example

- Clinic locations, opening times & types of service provided at each.
- Any changes to opening times and clinic locations will be agreed with the commissioner prior to changes taking place
- Domiciliary visits will be at a variety of settings including patients own home, nursing and residential care homes etc.
- General anaesthesia will only be available as in-reach to secondary care at XXX Hospital in accordance with recommendations of ‘A conscious decision’ (DH 2000)
4.4. Exclusion Criteria

For example:

The SPDCS is able to refuse dental treatment for the following reasons:

- Non-attendance (DNAs). This will be dealt with using the protocol agreed by XXX PCT and XXX Local Dental Committee (LDC);
- Persistent non-payment of dental charges by fee-paying adults;
- Threatening behaviour/violence.

5. Discharge criteria & planning

The intention of this section is to make clear what the service’s exit plan with a service user is and when this would be reached.

6. Self Care & Service User/Carer information

7. Quality & Performance

PCTs may wish to consider incorporating the relevant mandated areas in the standard community contract along with those below:

The SPDCS will produce an annual quality report summarising the findings and action taken in relation to its quality assurance process.

7.1 General Quality Standards

The SPDCS will provide a safe environment for staff and clients. In particular, the SPDCS will abide by the standards below, as well as PCT policies:

- SPDCS Directions 2006;
- Compliance with all Health and Safety legislation;
- Infection Control Policy (British Dental Association A12 [under review]);
- Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000;
- EL((93)24 AIDS/HIV Infected Health Care Workers Guidelines
- Implementation of a Hepatitis working activity group to protect health care workers and clients from Hepatitis B.
- Sedation standards will fully adhere to the expectations of the GDC and the guidelines in Standing Dental Advisory Committee document ‘Conscious sedation in the provision of dental care’ (DH 2003)
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- Dental records are properly completed and notes are legible.

7.2 Clinical Governance

The SPDCS will fully comply with the following:

- Co-operate with such clinical governance arrangements as the PCT
- Comply with the Standards for Better Health (core and developmental) as defined by the DH, and applied under the aegis of the Care Quality Commission.
- Produce evidence to demonstrate compliance with the Standards for Better Health, as well as producing an annual clinical governance action plan;
- Maintain strong internal governance systems;
- Ensure that all staff undertake regular continuing professional development relevant to their function to meet GDC registration requirements.

The SPDCS will nominate a lead person who will have responsibility for ensuring co-operation with clinical governance arrangements and provision of reports to the PCT.
7.3 Workforce

- All SPDCS practitioners must be on a performers’ list, in accordance with the NHS (Performers’ List) Amendment Regulations 2005.
- The staff of the SPDCS will fully adhere to the General Dental Council’s (GDC) guidance ‘Standards for Dental Professionals’.
- Clinical staff have a special interest in the procedures covered by their contracts, and the opportunity to treat a sufficient number of patients to maintain their skills.
- A staff training and investment plan is produced and updated annually.
- Appropriate procedures are followed for the appointment of locums and fixed term staff and adequate supervision is given trainees.
- While working in the employment of an NHS body all SPDCS practitioners are covered for insurance purposes under standard (NHSLA) arrangements arranged by the employing organisation. While not mandatory it is recommended that they also have personal professional indemnity insurance in place, through an appropriate professional defence organisation.
- A 3-year workforce plan is developed and reviewed annually.

7.4 Evidence Based Dentistry Programmes

The SPDCS will provide clinical services based on best available evidence, and will work to relevant clinical guidelines published by professional bodies, incorporating relevant best-practice principles. The service will keep up to date policies and local clinical guidelines incorporating recommendations from (as a minimum):

- Department of Health;
- Royal College of Surgeons (RCS);
- Faculty of General Dental Practice UK (FGDP(UK));
- Faculty of Dental Surgery (FDS);
- British Society for Disability and Oral Health (BSDOH);
- British Dental Association (BDA);
- British Society of Paediatric Dentistry (BSPD).

New treatment modalities will be incorporated into SPDCS clinical service provision as and when appropriate. Any new treatments will be based on demand management, and with agreement from the commissioner.

The National Institute for Health and Clinical Excellence (NICE) guidelines on dental recall entitled will be fully adhered to. Patient records should show that appropriate recall intervals have been identified by the SPDCS, based on the assessment of risk in discussion with the patient.

7.5 Professional Leadership

The SPDCS will be led by a suitably qualified clinician who will provide clinical supervision when needed, and will ensure and develop clinical effectiveness in professional practice. In particular this will be delivered through:

- Clinical Leadership (particularly in Special Care Dentistry);
- Clinical Governance/Quality Leadership;
- Mentoring clinical staff;
7.6 Practice Leaflet

The SPDCS will provide to its patients a suitable patient information leaflet.

7.7 Complaints Procedure

A complaints procedure will be operated by the SPDCS, to deal with matters connected with the provision of services under the service specification. A nominated person will act as the complaints manager for the service. All reasonable efforts will be made to effectively deal with the complaint.

If the patient feels unable to resolve the matter in a manner satisfactory to them, they will be able to invoke the PCT’s standard complaints procedure.

8. Activity

Only activity relating to patients resident in XXX, or with a XXX GDP, is to be counted in this agreement.

Units of Dental Activity (UDAs) are the activity measure for clinical work undertaken (see table below).

<table>
<thead>
<tr>
<th>Charge Band</th>
<th>Summary of Care Provided</th>
<th>UDA value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Examination, diagnosis and prevention</td>
<td>1 UDA</td>
</tr>
<tr>
<td>2</td>
<td>All in Band 1 plus fillings, extractions, endodontic treatment</td>
<td>3 UDAs</td>
</tr>
<tr>
<td>3</td>
<td>All in Bands 1 and 2 plus dentures, crowns, bridges – treatment requiring laboratory work</td>
<td>12 UDAs</td>
</tr>
</tbody>
</table>

Given the specialist nature of many of the services, the following qualitative and quantitative measures will also be used:

For example:

Case mix
- Numbers of unique patients seen
- Total number of patient contacts
- Numbers of domiciliary visits
- Number, type and source of referrals
- Difficulties in obtaining consent
- Waiting times (will vary according to case mix)

Outcomes
- Clinical vs non clinical time
- DNAs & short notice cancellations
- 18 week pathways [for GA and orthodontics]
- Episodes of care by age range
Episodes of care containing:

- Sedation
- General anaesthesia
- Orthodontics

Public health

- screening programmes:
  a. annual programmes
  b. other programmes – type, location, protocols, carer/staff awareness & support/follow up action, contacts
- epidemiology
- health promotion
  b. interventions & outcomes by care group

<table>
<thead>
<tr>
<th>Workforce Profile</th>
<th>WTE &amp; grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Director Managerial Band C</td>
<td></td>
</tr>
<tr>
<td>Senior Dentist Band B</td>
<td></td>
</tr>
<tr>
<td>Dentist Band A</td>
<td></td>
</tr>
<tr>
<td>Clinical Specialist Band C</td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
</tr>
<tr>
<td>Principal Dental Nurse</td>
<td></td>
</tr>
<tr>
<td>Senior Dental Nurse</td>
<td></td>
</tr>
<tr>
<td>Dental Nurse</td>
<td></td>
</tr>
<tr>
<td>Dental Therapist</td>
<td></td>
</tr>
<tr>
<td>Administrative &amp; Clerical Staff</td>
<td></td>
</tr>
<tr>
<td>Oral Health Promotion</td>
<td></td>
</tr>
</tbody>
</table>

8.2 Courses of Treatment and Patient Charge Income

For example:

SPDCS Part 7 (Fees and Charges) directions require the SPDCS to collect patient charges from eligible patients, for those services that attract charges and remit the charges to the PCT. The SPDCS will be required to submit claims to NHS Dental Services, by FP17 form electronically.

The PCT will monitor patient charge collection quarterly

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14 It is for the provider to determine how they will deliver the contract; however, the SPDCS national contract clearly defines the need for clinical leadership and a clinical director, and it would be reasonable for commissioners to specify that this is in place.
9. Continual Service Improvement

As part of the monitoring and evaluation procedures, each service will identify a plan and method to agree measurements for continuously improving the service being offered and work to ensure unmet need is both identified and brought to the attention of commissioners.

10. Prices & Costs

11. Period of Service

For example:

This service will run for a period of three years from 1st April 2009 – 31st March 2012 (extendable for a further 2 years subject to satisfactory performance).

12. Type of contract

[See appendix 6]
## Appendix 4 SPDCS Service Specification Framework

Proposed framework for NHS Dental Epidemiology for England

<table>
<thead>
<tr>
<th>Academic year</th>
<th>Proposed plan</th>
<th>Reasons</th>
<th>Other surveys in England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007/08</td>
<td>5 yr olds</td>
<td>Links with Wales Yr 1 and Scotland P1 Supports first St HA water fluoridation reports</td>
<td>APHO profiles Health Survey for England Child height and weight measurement Local health and lifestyle surveys</td>
</tr>
<tr>
<td>2008/09</td>
<td>12 yr old caries, ortho and perceptions of enamel mottling Bringing together of existing data for PCTS: TDO/NWPHO P7</td>
<td>End of transitional commissioning - richer data required Maximising yield from existing data sources Wales Y7 and Scotland</td>
<td>APHO profiles Health Survey for England Child height and weight measurement Local health and lifestyle surveys</td>
</tr>
<tr>
<td>2009/10</td>
<td>Collaboration work with ADHS eg, Local ADH surveys</td>
<td>Links with ADHS Wales - planning survey of adults Scotland P1</td>
<td>APHO profiles Health Survey for England Child height and weight measurement Local health and lifestyle surveys Decennial ADHS</td>
</tr>
<tr>
<td>2010/11</td>
<td>SHA defined activities Activities and some core protocols to be provided by NWPHO/ TDO</td>
<td>Links with WHO international comparison. Supports St HA water fluoridation reports - measurement of fluorosis Scotland P7</td>
<td>APHO profiles Health Survey for England Child height and weight measurement Local health and lifestyle surveys</td>
</tr>
<tr>
<td>2011/12</td>
<td>5 yr olds</td>
<td>Supports St HA water fluoridation reports links with Wales Y1 and Scotland P1</td>
<td>APHO profiles Health Survey for England Child height and weight measurement Local health and lifestyle surveys</td>
</tr>
<tr>
<td>2012/13</td>
<td>12 yr old caries, (ortho and) enamel mottling</td>
<td>Links with CDHS</td>
<td>APHO profiles Health Survey for England Child height and weight measurement Local health and lifestyle surveys Decennial CDHS</td>
</tr>
</tbody>
</table>
Appendix 5 NHS Dental Epidemiology programme for England (NHS dep): Roles and Responsibilities of regional epidemiology co-ordinators

Each SHA should ensure a NHS DEP Regional Coordinator is appointed and provided with the necessary support so that all PCTs in the region are able to fulfil their obligations to provide and use local information on which to base commissioning decisions.

The Regional Epidemiology Co-ordinator will be an experienced dental epidemiologist or an individual with working knowledge of the relevant Dental Public Health competencies who is able to lead relevant activities within the Region. The main purpose will be to assure, on behalf of Region and commissioners, that the quality standards for dental epidemiology are maintained and that compliance by PCTs within the Region is maximised.

The responsibilities are to encourage all Primary Care Trusts to participate in programmes and to ensure that agreed protocols are followed with the support of SHA Dental Public Health leads.

The NHS DEP for England will be overseen by North West Public Health Observatory with The Dental Observatory.

The UK dental epidemiology programme will be co-ordinated between England, Scotland, Wales and Northern Ireland by the British Association for the Study of Community Dentistry (BASCD), who will also establish and maintain guidelines for agreed standards with support for training and calibration as necessary.

Roles and responsibilities include:

1. Attendance at meetings of Regional Epidemiology Co-ordinators arranged by BASCD or TDO/NWPHO
2. Liaison with SHA Dental Public Health leads and the relevant Regional Public Health Observatory
3. Informing PCTs of NHS DEP forward plan and other relevant information
4. Taking the lead in the implementation of agreed regional programmes, with reviews of the procedures and progress.
5. Being familiar with the national protocol and guidance for data handling.
6. Being aware of current geographies within the region for Local Authorities and health economies.
7. Provision of advice and assistance on epidemiological pro-grammes, as needed, to all CsDPH and PCTs.
8. Ensuring that training and calibration exercises for examiners and recorders are provided within the Region for each NHS DEP survey with regard to the National Protocol.
9. Ensuring that measures of comparability between PCT clinical examiners, the Regional Standard examiner and the group mean are calculated according to guidelines set down by BASCD.
10. Ensuring that PCT clinical examiners are notified of their success, or otherwise, arising from Regional calibration exercise.
11. Liaison with designated Regional trainers and Regional Standard examiner as necessary.

12. Receive proposed sampling methodologies from PCT teams, check, agree or amend as necessary.

13. Ensure from a Regional perspective that the appropriate quality standards for NHS DEP surveys are maintained in line with the National protocols and guidance, in consultation with the Consultants in Dental Public Health or other dental public health advisers responsible to Primary Care Trusts, who may wish to apply their own additional quality standards in line with local policy.

14. Provision of advice on the collection and analysis of data and completion of standard reporting forms in line with the National protocols and guidance.

15. Collection and quality checking of data submitted for inclusion in the programme in each Region to ensure that data has been collected in accordance with NHS DEP guidance and BASCD standards.

16. Submit to NHS DEP national convenors the completed PCT results, together with relevant details on calibration and sampling in the agreed format; also any additional information which may be requested from time to time.

17. Ensure local distribution within the Region of information and results supplied by NHS DEP convenors.

18. Ensure an annual regional report on the NHS dental epidemiology programmes is produced.

19. Ensure that all relevant information is passed on to the successor to the post.

Revised from - BASCD / DoH July 1993
Revised April 2009
Appendix 6 Protocol for an Oral Health Survey of Children Attending Special Schools

1. Introduction

Children from mainstream state-funded schools are included in the Department of Health annual surveys, co-ordinated by BASCD. However, the dental health status of children attending special schools is not usually known.

Policies about provision of education for children with moderate physical, learning, communication, behavioural or emotional difficulties vary from one local education authority to another. Most authorities will have some special educational provision for children with severe problems. These children may make greater demands on specialist dental treatment services in the short or long term which need to be estimated for planning purposes. In addition, their oral health promotion needs should be measured. For these reasons surveys of children in special needs schools should be undertaken.

2. Aims

To measure the prevalence and severity of dental caries among children attending special schools within a defined health economy area.

This information can be used to:

6.2.1 Provide comparisons with children of the same age attending mainstream schools in the same area

6.2.2 Inform part of a health needs assessment

6.2.3 Inform the local oral health promotion strategy

It is recognised that full examination of some children will not be possible but at the very least the following will be established:

- The number of primary and secondary special schools in the area
- The number of children attending these schools
- The number and types of disabilities experienced by the age group in question
- The number of children who are fully or partially examinable and those who are not
- The number of examinable children who have extraction or caries experience.

3. Sample

Relatively few children have severe special needs so sampling of schools or individuals is not required. In order that comparisons can be made with mainstream educated children the same age groups should be surveyed.

Children may not be grouped by age as in mainstream schools so care must be taken when specifying the subset of children to be included. For example, to compare with Year 6 children the intention should be to examine all Special Needs children whose date of birth falls within the limits of the current mainstream Year 6.

Please note: this is the protocol established for the North West by the North West Public Health Observatory (http://www.nwph.net/nwpho/default_lead.aspx). Anyone wanting to use this should contact The Dental Observatory http://www.nwph.net/dentalhealth/ for assistance with a tailored format and data collection sheet to align with the current NHS DEP survey.
This allows for the spread of age groups through various ‘classes’ in a special needs school.

**Consent**

The procedure for obtaining consent should be the same as that for the survey in mainstream schools (Protocol section 4.4). However, in view of the special needs of the children the PCT may wish to supplement this providing access to someone who can answer questions and provide adequate opportunities to allow withdrawal.

Use could also be made of the home-school diary system that some schools use to communicate with parents. Letters or additional notices about the survey can be inserted into these.

**5. Personnel**

The survey examiner requires the skills of a dental epidemiologist and those of a clinician who is used to working with special needs children. He/she must be able to undertake a standardised examination of as many children as possible and maximum co-operation is best achieved by an experienced clinician. Experience allows the clinician to cope with unpredictable responses and helps with patience and persistence. A flexible approach is necessary and all efforts should be made to avoid distress.

Whoever carries out the examination must be trained and calibrated. This should be carried out at the time of the regionally organised, annual calibration. If this is not possible the Regional Coordinator must be contacted and alternative arrangements made. The Dental Observatory will review agreement between examiners.

Two support workers are required and one of these should be familiar with the school or the children. The school nurse can be invaluable in providing advice which may help with children’s co-operation.

**6. Conduct**

The survey should, as far as possible, follow the guidelines for mainstream surveys. Any deviations should be documented. Head teachers and school nurses at schools that have not been surveyed before may need more explanation, as they are unfamiliar with the purpose, process and practical issues. As disturbance to classes is likely to be higher than in mainstream it is beneficial if all affected class teachers are fully informed.

It is likely that the process will take longer than in mainstream schools. The children may be brought for examination one by one and examination will take longer. Consideration for reducing disturbance may necessitate specific children being brought in an order decided by the school. The dignity and right to privacy of the children should be respected.

**7. Equipment**

The disabilities of some children will prevent a supine examination with a Daray lamp. It has to be accepted that a variety of examining approaches will be required and in some cases only a partial examination will be possible. This should be documented and teeth and surfaces that cannot be fully seen coded accordingly (Code 9).

Schools will have a variety of equipment to assist with positioning for eating, learning, standing and relaxation. These may include standing frames, supportive chairs, beanbags, pre-formed foam chairs and tilting wheelchairs. The examining team should use whatever position gives the highest level of co-operation along with the best access while the child’s safety and comfort is the overriding consideration.

A directionable head lamp, such as that worn by cavers, can be used instead of the fixed Daray lamp. It is acknowledged that this may not provide the same light levels as the standard examining lamp but some directional light, which leaves both hands free, is the next best option. A pen torch may be used to provide additional light.
All equipment must be robust and reliable. Thorough testing, before taking it into schools, is strongly advised.

It may not be possible to use cotton wool rolls, cotton buds or pledgets to clear the teeth of debris and moisture. This should be recorded as a ‘partial’ examination.

A toothbrush may be used to encourage initial mouth opening as this is more familiar than a mouth mirror. It may be necessary to leave the brush in place as a prop while the arches are examined with a mouth mirror.

It may not be possible to examine in a set order, nor, in some cases to complete the examination. In these cases a ‘partial’ examination should be recorded and all unexamined surfaces coded ‘9’.

If detailed feedback is provided for parents it should be couched in terms which respect any existing patient-clinician relationships.

8. **Survey Plus 2 Format**

The Dental Observatory will supply a format which allows collection of data in addition to that collected for mainstream surveys. This will include:

- major disability
- level of examination possible; full, partial or none because of poor co-operation
- presence of significant plaque
- standardised collection of data about which carious surfaces should be coded as involving the pulp
- presence of sepsis
- primary upper incisors that have probably been extracted for caries*

9. **Further information**

This can be obtained from Dr Gill Davies, who can be contacted by telephone on 0161-881 3368 or by e-mailing gill.davies@manchester.nhs.uk.

* In the Manchester survey of Special Needs 5-yr-olds there was a high level of ECC. The application of the BASCD convention, which assumes that all missing upper incisors have exfoliated, depresses the dmft by 13% in this group. The facility to record separately which incisors have, in all probability, been extracted for caries enables the collection of important data for this group and gives indication about the timing and types of intervention that may be required.
Appendix 7 Transforming Community Services & Primary Care Dentistry

The NHS Operating Framework for 2008/09 included a requirement for PCTs to ‘create an internal separation of their operational provider services, agree Service Level Agreements, based on the same business and financial rules as applied to all other providers.’

By October 2009, PCTs are expected to have developed a detailed plan for transforming their community services and to have moved into a contractual relationship with their provider arm, using the national contract for community services.

Commissioning primary care dentistry

Currently PCTs are legally required to commission NHS primary care dentistry for those people who want to access it in their area, and the dental Regulations and Directions provide three ways in which they may do this, as follows:

- via local GDS contracts
- via local PDS agreements
- via the Primary Care Trust Dental Directions

The NHS Act 2006 sets out who may hold dental contracts/agreements. GDS contracts may be with an individual dental contractor, a dental body corporate or a partnership. The range of eligible persons/organisations is somewhat wider for PDS agreements, which may be entered into by any one or more of the following:

- PCT, NHS Trust or Foundation Trust
- medical or dental practitioner
- dental corporation (a qualifying body)
- NHS employee
- health care professional
- individual providing services under a GMS/PMS or GDS/PDS contract or agreement

The PCT Dental Services Directions enable PCTs to provide primary care dentistry themselves and specify how this must be done. Such directly provided services are commonly referred to as the “Salaried Primary Care Dental Services” (SPDCS) and typically deliver a diverse range of services, including specialist dentistry and services for those with special needs.

Implications for Salaried Primary Care Dental Services

In practice SPDCS are usually, but not exclusively, provided via the PCT’s provider arm. In some cases, a PCT will host the SPDCS on behalf of its neighbours as well; or an acute or mental health trust may provide the service.

Where SPDCS is provided by the PCT’s own provider arm, no formal (ie legal) contract has been necessary to date – as the provider arm is not a separate legal entity but was part of the PCT, and the PCT cannot contract with itself. (There might be a Service Level Agreement in place, but this is not a legal contract.)

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16 Transforming Community Services: Enabling New Patterns of Provision” (Gateway 10850)
17 The NHS (General Dental Services) Regulations 2006
18 The NHS (Personal Dental Services) Regulations 2006
19 See Appendix
Chapter 7 of Transforming Community Services outlines several possible organisational forms for PCT provider arms, including:

- provision of the services remain with the PCT but with separate governance arrangements
- vertical integration with another NHS provider organisation (e.g., an acute or mental health trust)
- horizontal integration with the relevant local authority
- Community Foundation Trust
- one of the social enterprise types

Where the PCT’s provider arm does become a separate legal entity (e.g., a social enterprise organisation) then a contract would be necessary. For the non-dental service elements such as community nursing and therapies, the new standard community contract will be used— but for SPDCS this is not appropriate for the following reasons.

- dental contracts can only be entered into by the persons/organisations specified in the NHS Act 2006 (this does not include social enterprise organisations unless it has the same legal status as a dental corporation, nor local authorities)
- the NHS Act 2006 and the dental Regulations/Directions do not permit the standard community contract to be used for commissioning primary dental care (including SPDCS)
- ability to collect patient charges in accordance with the NHS Charges Regulations is tied to provision under a GDS contract, PDS agreement or SPDCS
Appendix 8 Resources


Creating the Future, Modernising Careers for Salaried Dentists in Primary Care, Department of Health, December 2004


Mental Capacity Act 2005 Deprivation of Liberty Safeguards (Gateway reference number: 11468)
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_095827

Primary Care Trust Dental Services Directions 2006