Worcestershire County Council

Item 5 Dental Services (Appendices 2 – 5)

Agenda

Health Overview and Scrutiny Committee

Wednesday, 18 September 2019, 10.00 am
County Hall, Worcester

All County Councillors are invited to attend and participate

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DISCLOSING INTERESTS

There are now 2 types of interests:
'Disclosable pecuniary interests' and 'other disclosable interests'

WHAT IS A 'DISCLOSABLE PECUNIARY INTEREST' (DPI)?

- Any **employment**, office, trade or vocation carried on for profit or gain
- **Sponsorship** by a 3rd party of your member or election expenses
- Any **contract** for goods, services or works between the Council and you, a firm where you are a partner/director, or company in which you hold shares
- Interests in **land** in Worcestershire (including licence to occupy for a month or longer)
- **Shares** etc (with either a total nominal value above £25,000 or 1% of the total issued share capital) in companies with a place of business or land in Worcestershire.

NB Your DPIs include the interests of your spouse/partner as well as you

WHAT MUST I DO WITH A DPI?

- **Register** it within 28 days and
- **Declare** it where you have a DPI in a matter at a particular meeting
  - you must **not participate** and you **must withdraw**.

NB It is a criminal offence to participate in matters in which you have a DPI

WHAT ABOUT 'OTHER DISCLOSABLE INTERESTS'?

- No need to register them but
- You must **declare** them at a particular meeting where:
  You/your family/person or body with whom you are associated have a **pecuniary interest** in or **close connection** with the matter under discussion.

WHAT ABOUT MEMBERSHIP OF ANOTHER AUTHORITY OR PUBLIC BODY?

You will not normally even need to declare this as an interest. The only exception is where the conflict of interest is so significant it is seen as likely to prejudice your judgement of the public interest.

DO I HAVE TO WITHDRAW IF I HAVE A DISCLOSABLE INTEREST WHICH ISN'T A DPI?

Not normally. You must withdraw only if it:

- affects your **pecuniary interests OR**
  relates to a **planning or regulatory** matter
- **AND** it is seen as likely to **prejudice your judgement** of the public interest.

DON'T FORGET

- If you have a disclosable interest at a meeting you must **disclose both its existence and nature** – 'as noted/recorded' is insufficient
- **Declarations must relate to specific business** on the agenda
  - General scattergun declarations are not needed and achieve little
- Breaches of most of the **DPI provisions** are now **criminal offences** which may be referred to the police which can on conviction by a court lead to fines up to £5,000 and disqualification up to 5 years
- Formal **dispensation** in respect of interests can be sought in appropriate cases.

Simon Mallinson Head of Legal and Democratic Services July 2012 WCC/SPM summary/f

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Health Overview and Scrutiny Committee
Wednesday, 18 September 2019, 10.00 am, County Hall

Membership

Worcestershire County Council	Mr P A Tuthill (Chairman), Ms P Agar, Mr G R Brookes, Mr P Grove, Prof J W Raine, Mrs M A Rayner, Mr C Rogers, Mr A Stafford and Mr C B Taylor
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Agenda

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Date of Issue: Tuesday, 10 September 2019

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NHS England (West Midlands): Review of the Community Dental Service. Findings and Recommendations

EXECUTIVE SUMMARY

A review of Community Dental Services in the West Midlands has now been concluded. NHS England would like to thank all those organisations that participated in the various engagement events or supplied information to support the review.

This document sets out in detail the methodology used for the review, the evidence considered and the views of participants as expressed through a market engagement, a patient and public engagement exercise and two dedicated stakeholder sessions. It also includes a summary of the key issues that need to be addressed so as to bring services into line with the expectations set out in the two national Dental Commissioning Guides for Paediatric and Special Care.

As a result of the review we have generated a set of recommendations that set out the key steps needed locally which will facilitate the move towards a new model and ensure a more consistent approach to service delivery for the future.

Commissioners have reviewed the current position and the different ways forward and have sought and received permission to undertake a re-design of services with existing providers as an alternative to the immediate re-procurement of these services. This paper sets out the process we intend to follow to facilitate a re-design in line with our recommendations. It is NHS England's intention to liaise with Sustainability and Transformation Partnerships to facilitate the collaboration that will be needed to ensure services meet local population needs.

The situation will be kept under review and if we are unable to achieve the necessary realignment with the updated guidance then it may be that a procurement exercise will need to be undertaken in the future.

Contents

1. Background and initial findings (from fact-finding stage)

1.1 The Dental Team within NHS England (West Midlands[1]) has undertaken a Review of the Community Dental Service (CDS). The purpose of this document is to present the findings and recommendations of the Review for the future commissioning of these services within the West Midlands. The intended audience for this document is those services and other stakeholders who contributed to the Review and have shaped the recommendations.

1.2 Most Community Dental Services provide an element of paediatric dentistry[2] and special care dentistry[3] and may include care at Level 1, 2 and 3[4]. The workforce providing these services across the West Midlands includes a wide range of dentists and dental care professionals with general, additional and/or enhanced skills, specialists and consultants.

1.3 Community Dental Services are delivered from a variety of premises including hospital settings, clinics and others. These vary in the facilities available (for example for sedation), versatility and accessibility. Each service covers a specific geographic area and has its own eligibility criteria.

1.4 Within the West Midlands there are ten local authority areas. Each of them has a Community Dental Service. The providers of these services are as follows:

Local Authority Area	**Provider of Community Dental Service**
Birmingham	Birmingham Community Healthcare NHS Trust
Dudley	
Sandwell	
Walsall	
Coventry	Coventry and Warwickshire Partnership NHS Trust
Herefordshire	Wye Valley NHS Trust

[1] From 1 April 2019 changes in the geographic configuration of NHS England meant that Local Offices will no longer exist. The geographic area forming the current West Midlands Local Office will form part of the new Midlands region.

[2] The NHS England Commissioning Standard for Paediatric Dentistry states that the specialty 'provides specialist oral healthcare for children from birth to adolescence whose needs cannot be managed by their GDP'.

[3] The NHS England Commissioning Guide for Special Care Dentistry states that the speciality 'is concerned with the improvement of the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors. The specialty focuses on adolescents and adults only….'

[4] Levels 1, 2 and 3 refer to the levels of care described in the relevant NHS England Guides for Commissioning Dental Specialties: Special Care Dentistry and the NHS England Commissioning Standard for Dental Specialties: Paediatric Dentistry. These can be found at https://www.england.nhs.uk/commissioning/primary-care/dental/dental-specialities/ The Levels of Care are described at pages 14 onwards of each document.

Solihull	University Hospitals Birmingham NHS Foundation Trust
Warwickshire	George Eliot Hospital NHS Trust
Wolverhampton	Royal Wolverhampton NHS Trust
Worcestershire	Worcestershire Health and Care Trust

1.5 In 2018/19 the financial value of the contracts for Community Dental Services within the West Midlands totalled approximately £21.7 million. It is difficult to measure accurately the number of unique patients served by the Community Dental Services due to the different ways in which services are configured, contracted for and counted. However, we estimate that approximately 50,000 patients are treated each year by the Community Dental Services within the West Midlands.

1.6 These services were originally commissioned by the relevant Primary Care Trust and have subsequently developed over a number of years to meet the needs of their local populations and, in some cases, to address gaps elsewhere in the local dental health economy.

1.7 As a consequence it was apparent prior to the Review that there may be a degree of variation in current provision in terms of the nature and scale of the services provided and therefore access for patients. In addition, it was already apparent that the manner in which these services were contracted and paid for varied between areas. Some were known to be paid for on a fixed sum basis (block contract) whilst others were paid (in whole or in part) on the basis of activity undertaken and (in some cases) partly on the basis of achievement of Key Performance Indicators.

1.8 NHS England was concerned that there may be inequity of both provision and access to the CDS for the public across the West Midlands and this was the catalyst for the Review. The key aims of the Review were therefore to:

– Fully understand the nature of each service in light of the relevant NHS England Guides for commissioning dental specialties;

– Assess the need for change and to identify and consult upon options in order to improve equity of access to CDS services across the West Midlands.

1.9 The scope of the Review included the services provided by the CDS across the West Midlands (including paediatric and special care dentistry, sedations and General Anaesthetic).

1.10 A number of elements were considered to be outside of the scope of this Review.

These included:

- Services being examined through other reviews being undertaken by the West Midlands dental team such as

    - Out of hours services;
    - Access services;
    - Minor Oral Surgery.

- Services commissioned originally to address gaps in provision elsewhere in primary or secondary care[5];

- Services commissioned by local authorities[6] (but commonly delivered through the CDS) such as

    - Epidemiology;
    - Oral Health Promotion.

1.11 The methodology of the Review comprised a number of elements including

- Completion of a questionnaire by each current provider of CDS services giving detailed information regarding current service provision (such as the nature, scale and location(s) of the services provided;

- Completion of a Finance template by each current provider of CDS services detailing the costs of the current service;

- Completion of a Market engagement questionnaire to understand respondents views regarding various financial and contractual issues in connection with the CDS;

- Stakeholder Engagement events in Birmingham and Worcester to discuss the findings of the above three elements;

- A Patient and Public Engagement study involving more than 200 one-to-one interviews;

- Further stakeholder engagement events to inform the development of the options for the future commissioning of the CDS in the West Midlands set out in this document.

1.12 The initial (fact-finding) phase of the Review found evidence of significant variance between local authority areas in:

[5] An example is that one Community Dental Service currently provides an orthodontics service to address a gap in provision within their local authority area identified when the service was first commissioned;
[6] Whilst these are outside of the scope of the Review (as they are commissioned separately), the relevant activity does typically appear within the NHS England contracts and so we have commented on these arrangements within this document where necessary.

- The size and demographic composition of the population and of the vulnerable groups within it;

- The volume of activity per capita delivered by the Community Dental Service;

- Expenditure and numbers of patients served per '000 population on the Community Dental Service;

- The nature of the contracts in force (Personal Dental Services (PDS) or PDS Plus) and the basis on which the contracts are paid (block, activity-based, performance etc.);

- The units of activity on which the contract is based (contacts, Units of Dental Activity, cost per case etc.);

- The nature and scope of the services provided by the Community Dental Service (including mobile, general anaesthetic, sedation, domiciliary services and Dental Access Centres);

- Arrangements in place to measure quality and safety of services – for example there are no Key Performance Indicators in respect of seven of the ten Community Dental Services within the West Midlands;

- The referral and acceptance criteria in operation at each service;

- The nature and scale of Oral Health Promotion services (which are commissioned by local authorities but, generally, included within the NHS England contract for the Community Dental Service);

- Expenditure allocated to Epidemiology surveys and the associated sample sizes. Again these are commissioned by local authorities but, generally, included within the NHS England contract for the Community Dental Service.

1.13 Following on from these findings the key principles of the Review were:

- To improve equity of provision and access to these services
- To encourage the development of sustainable services
- To enable greater equity in the distribution of the associated funding and resources;

It should be clarified that reduction of expenditure is not a driver for the Review. However, it is likely that expenditure in some areas will change in order to ensure that there is a proportionate allocation of resource based on need to ensure consistent delivery of the agreed core elements of the service.

2. Future scope of Community Dental Services

2.1 The nature of the services provided by the current Community Dental Services across the West Midlands varies significantly. While all of the services incorporate elements of paediatric and special care dentistry there were significant differences in the acceptance criteria between the services.

2.2 In addition, some services incorporated bolt-on components (for example to address gaps in primary or secondary care provision) which were either unique to them or offered by few other services. For example one service offers an Orthodontic service which is open to all patients and is in place due to the limited provision in secondary care within that local authority area.

2.3 A further example is provided by the availability of mobile services within the CDS across the West Midlands. Currently there are mobile services in 7 of our 10 local authority areas. They are used for a variety of purposes, for example focusing on Oral Health promotion in some areas while visiting special schools to offer examination and/or treatment services in others.

2.4 We consider that in deciding how future services should be commissioned and delivered it is first important to decide which elements should be considered core components of the Community Dental Service and therefore offered throughout the West Midlands based on the same (or essentially similar) acceptance criteria. By agreeing a 'core offer' for the CDS, we believe that there will be greater equity of access to the CDS for patients across the West Midlands. Failing to do so would mean that the current inequitable provision would continue.

2.5 We undertook a Patient and Public Engagement study. Among the key findings

- Some patients used Community Dental Services because they couldn't get regular appointments with a High Street dentist;
- The majority of users of Community Dental Services said that they would not attend a high street dentist if asked to transfer;
- However, many respondents from vulnerable groups said that they regularly visited their high street dentist and were content with the service provided.

2.6 At the Stakeholder Engagement events participants were asked to consider whether specific named components should be delivered by the CDS across the West Midlands and so form part of the 'core offer'.

2.7 The wording in respect of the named components were derived mainly from the NHS England Commissioning Guides for Paediatric and Special Care Dentistry with the addition of services and/or patient groups relating to the current provision of the

CDS within the West Midlands which are not specifically identified within these Commissioning Guides.

2.8 Annexe A contains a table which sets out the advantages and disadvantages of each element identified by participants and/or Commissioners as being appropriate to form part of the core offer. In addition the Annexe contains a list of elements identified by participants and/or Commissioners that should not form part of the core offer.

2.9 At the event we emphasised to participants that if they identified a service (or patient group) as sitting outside the core offer that they were expressing the view that it is not necessary for the CDS to deliver that element – **not that it should not be delivered at all**. In some cases it may be appropriate for these services to be commissioned separately and existing CDS providers would be able to compete to deliver these services alongside other providers. In other instances we would envisage that these patient groups would routinely access services through a General Dental Practice (GDP).

2.10 We recognise that there may occasionally be specific circumstances where individual patients are unable to access these services through a GDP (or it is not appropriate for them to do so) and in these instances we envisage that the CDS would provide a failsafe. Particular consideration needs to be given where a specific patient group may benefit from an outreach approach. This will need to be considered collaboratively with the relevant local authority and additional services may be specifically commissioned locally where there is a particular need.

2.11 We therefore consider that the core offer of the Community Dental Service within the West Midlands should comprise of the following elements:

<u>For adults</u>

- Level 2 Special Care Dentistry (including Cognitive Behavioural Therapy and psychological therapies for Anxious Adults);
- Level 3 Special Care Dentistry;
- Unscheduled care (in hours treatment and out of hours assessment) and domiciliary services specifically for patients with Level 2 or 3 complexities as defined in the NHS England Commissioning Guide to Special Care Dentistry.

<u>For children</u>

- Medically compromised children (Level 3) with specific conditions, significant disability or learning disability;

- Level 2 Paediatric Dentistry for children where there is increased complexity of delivery of service due to behavioural/psychological issues or significant anxiety – particularly where these children require inhalation or intravenous sedation and/or General Anaesthetic;

- Mobile service for special schools (Level 2).

2.12 There are some further elements of Level 2 Paediatric Dentistry – for example hard tissue dental defects and disturbances of the developing dentition, more complex problems affecting developing dentition or dental hard tissues, dento-alveolar trauma, increased complexity of delivering care due to medical comorbidity or disability children requiring acclimatisation to help overcome anxiety – which may initially form part of the core offer until the wider workforce in General Dental Practices is sufficiently developed to provide this care. While it is not envisaged that these services would remain part of the core offer of the CDS in perpetuity, it is likely that there will need to be a limited failsafe element for patients[7].

2.13 We have developed a number of patient pathways Following on from our proposals regarding the core offer for the Community Dental Service we have developed illustrative Patient Journeys for:

- Children with high needs and Adult Special Care patients;
- Special Schools
- Urgent Level 3 Special Care Dentistry

These can be found in Annexe B

2.14 In addition, we have considered whether it was appropriate to develop a Looked After Children Patient Journey within this document. However, the feedback we have received from local authorities and other stakeholders is that there should be no presumption that Looked After Children should be routinely examined and treated by Community Dental Services. Instead every effort should be made for these children to be examined and treated within a General Dental Practice. However, where additional needs are identified which cannot be met within the competence level of the GDP a referral to Community Dental Services should be made[8]. The local Paediatric MCN has reviewed this issue and prepared guidance about management of these children.

2.15 A number of Commissioning Guides have been published by NHS England; the relevant ones for this Review are the NHS England Commissioning Guide for Special Care Dentistry and the Standard for Dental Specialties: Paediatric Dentistry. There is a consensus amongst professionals that greater consistency with the commissioning

[7] This is likely to apply only to a small group of patients and will be related to individual patient circumstances rather than to their condition or to the general availability of dental services in the locality. For example, for particular groups who are not settled enough to be able to access routine services.
[8] This would be an example of failsafe provision as mentioned previously.

guides can be assured by more clearly defining the core services which are to be provided by the CDS. This will mean that services will be delivered by the CDS where there is a genuine need to do so. Equally services should routinely be provided by high street dental services where it is appropriate for them to do so. This will ensure patients are treated in the most appropriate setting to their needs and maximise the resources available for the vulnerable population served by the CDS.

Recommendation 1

We recommend that the services and/or patient groups listed in paragraph 2.11 will comprise the core offer of Community Dental Services within the West Midlands in future.

Under section 13Q of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), NHS England has a duty to 'make arrangements' to involve the public in commissioning services for NHS patients. These arrangements must be **fair** and **proportionate** [9] whereby the extent of the change and the number of people affected by the change is used to determine whether it is enough to just engage with the public or whether a formal consultation is required.

In general, we do not propose to consult on this aspect of the re-design, as we will be implementing provisions of the Commissioning Guides and there has already been extensive patient public involvement nationally as these were developed. However, we recognise in some localities individual changes linked to implementation of the proposed new model may be significant for particular groups of patients and in those cases we do intend to consult.

As a general principle throughout this document we will be indicating in each section whether or not we anticipate there being a need for Consultation for that specific aspect.

3. Geography.

3.1 A key element of the Review was to consider whether Community Dental Services should most appropriately be provided separately for each of the ten local authority areas[10] within the West Midlands or whether an alternative configuration would be better.

3.2 It is important to note that any change to the geography over which services are commissioned is not expected to affect the locations at which services are provided. Any review of service provision from a particular site would be subject to the normal consultation prior to any changes being made in the future. Any change to the

[9] Page 16 of the NHS England Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning Guide gives further explanation of what is considered Fair and Proportionate.
[10] Currently one NHS Trust provides Community Dental Services in four local authority areas – Birmingham, Sandwell, Walsall and Dudley.

location of service provision is out of scope of the current review except with respect to the provision of services under General Anaesthetic – please see Section 4

3.3 In considering this issue a number of key factors were examined by the Commissioners, respondents to the Market Engagement questionnaire and participants in the Stakeholder engagement events. These factors included:

- Travel times for patients and staff;
- Disruption to existing services;
- Fit with the current direction of travel in respect of configuration of health services (for example (Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICS);
- Scope for achieving economies of scale;
- Recruitment and retention of staff (often with scarce skills and experience);
- Likely effectiveness of models of leadership and service management.

3.4 At the Stakeholder Engagement Events in May 2018 we invited participants to consider the advantages and disadvantages of the following four possible configurations:

- Commissioning ten separate services – one for each local authority area

- Commissioning services from a reduced number of providers who would provide services in more than one local authority area

- Commissioning services from a single provider for the entire area.

- Commissioning services based on the configuration of the four local Sustainability and Transformation Partnerships– (that is Birmingham & Solihull, the Black Country, Coventry & Warwickshire and Herefordshire & Worcestershire).

3.5 Participants at the Stakeholder Engagement Events were invited to outline any other configurations that should be considered but none were identified.

3.6 The table in Annexe C sets out details of the advantages and disadvantages identified by the participants at the events and by the Commissioners.

3.7 In deciding which configuration should be adopted, it is clearly crucial that the model selected enables significant improvements to be made regarding access to the provision of dental care delivered under General Anaesthetic – see section 4

3.8 Clearly there are advantages and disadvantages to all the configurations. Taking into account the relative strength of these advantages and disadvantages in each

instance, our assessment is that Commissioning services based on the four Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) areas is the strongest (and preferred) option as per Model C in the table in Annexe C. This also aligns with the relevant sections of the NHS Long Term Plan[11] and fits with the direction of travel nationally for the NHS. The new regional NHS England geographies are too broad to use as the unit of geography upon which future services can be configured, and the focus now is on a population-based approach to health within each STP/ICS area.

Recommendation 2

We recommend that in future Community Dental Services within the West Midlands should be delivered by services aligned with the four local Sustainability and Transformation Partnership Areas[12] and that providers work collaboratively within these geographies to deliver a service for their relevant population.

As the organisation and management of services will not in itself affect the configuration or detail of services provided we do not propose to consult on this aspect.

4. Provision of services under General Anaesthesia

4.1 Services that involve dental care delivered under General Anaesthetic (GA) must be delivered in a hospital setting with access to critical care facilities. The provision of these services currently relies in many areas on a partnership between CDS and Acute or Private Hospitals. Typically the Hospital provides the theatre facilities, nurses and the anaesthetic team whilst the CDS provides the dental staffing. There are a number of problems with this arrangement – both in terms of the clinical governance and in terms of the way in which the services are funded. It can also be difficult for the CDS to secure the necessary number of theatre sessions to ensure sufficient capacity to prevent long waits for patients as there is no requirement on the hospital to provide the sessions which are typically delivered and paid for under a commercial arrangement between hospital and service. Because of this arrangement there is currently a lack of capacity and in many cases theatre sessions can be cancelled at short notice particularly during winter pressures.

4.2 There are however a couple of areas within the West Midlands where the service is commissioned directly under an NHS Standard Contract from an Acute Hospital provider with payment made through Payment by Results (PbR) tariffs. In these

[11] The NHS Long Term Plan sets out the future plans for the NHS with 7 Chapters of key aims, including Chapter 2: More NHS action on prevention and health inequalities and Chapter 3: Further progress on care quality and outcomes; both of which are relevant to the re-design of CDS.

[12] These are Herefordshire & Worcestershire, Coventry & Warwickshire, Birmingham & Solihull and the Black Country.

cases there is generally a sub-contract from the secondary care provider to the community care provider for the dental staffing. This arrangement facilitates a more robust approach to the governance surrounding these services which better clarifies the corporate and clinical responsibilities for patient care.

4.3 It should be noted that the use of GA is part of a holistic pathway that considers first other options such as local anaesthesia (LA) or sedation. We intend to strengthen the focus on prevention (through the Starting Well initiative) and to increase the provision of sedation services. Whilst GA is a specialist service that can only be provided in a hospital setting, we believe that it is important for sedation services to be available locally to prevent patients having to travel unnecessary distances. This should lead to a reduction in the number of patients where treatment needs to be undertaken under GA.

4.4 In many cases the need for GA (particularly for children) is due to longstanding issues that have not previously been identified or dealt with. There is a clear link to deprivation. Whilst it is important that such specialist services are provided at centres with the appropriate facilities and expertise, there is also a need to ensure that vulnerable patients are able to travel to attend for treatment. This is particularly the case for some special care patients who may be unable to tolerate long journeys. Whilst many special care patients qualify for patient transport due to associated conditions, the majority of children will not qualify. There are particular safeguarding issues to be considered especially where patients are not brought for treatment and a need to ensure appropriate follow up in these cases.

4.5 In order to balance accessibility with the need to ensure robust and sustainable provision we propose that GA services are consolidated to a set of agreed specialist centres across the West Midlands. The aim of the reconfiguration would be to ensure services within each STP have sufficient activity to ensure staff retain competency and experience and that support services are in place that deliver the necessary degree of specialist experience (such as anaesthetists who are skilled in dealing with the relevant patient groups).

4.6 As mentioned in paragraph 4.1, there are problems currently in securing sufficient theatre slots to meet the need and prevent long waiting times for patients. Birmingham Dental Hospital (who currently provide paediatric GA services for Birmingham and Solihull areas) rely on temporary modular theatres which are in urgent need of replacement. Plans are in place to build permanent theatre accommodation and this provides an opportunity to increase the capacity across the West Midlands.

4.7 The retention of GA services within STP areas is dependent on local hospitals making available sufficient dedicated theatre slots for these patients to be treated. Clearly there are competing priorities that need to be considered. The consolidation of some (rather than all) GA services at a regional centre would strengthen the case to

build additional dedicated theatres which would address the current lack of capacity across the West Midlands and help to reduce waiting times for patients. New theatres would allow additional capacity with dedicated facilities for those patients needing comprehensive care who are able to travel. This issue will need to be considered as part of a formal consultation.

4.8 A review of GA service pathways (both Paediatric and Special Care) has been undertaken in conjunction with the local Managed Clinical Networks (MCN) for Paediatric Dentistry, Special Care Dentistry, Oral Surgery and Urgent Care Dentistry. This identified a need to provide more sedation services for extractions, as an alternative to General Anaesthetic, to avoid unnecessary GA for those patients for whom comprehensive care is not a requirement.

Recommendation 3

We recommend that General Anaesthetic services for both Paediatric and Special Care patients are consolidated and provided in future from a reduced number of specialist centres across the West Midlands.

Recommendation 4

We recommend that more sedation services should be made available across the West Midlands as a local alternative to General Anaesthetic where clinically appropriate.

Recommendation 5

We recommend that commissioning arrangements for General Anaesthetic services are strengthened locally to ensure the appropriate level of governance. Future services should be commissioned as a shared care model hosted by the relevant Acute Service with dental staffing provided by the relevant Community Dental Service teams.

It is our judgement that these changes to arrangements for GA would be a significant change and we will consult on these proposals. We will engage with Health and Scrutiny Oversight Committees, the public and patients and other stakeholders (including current providers) within the four STP boards within the West Midlands – Birmingham and Solihull, Coventry and Warwickshire, Herefordshire and Worcestershire and The Black Country to further explain and consult on our proposals.

5. Workforce

5.1 At the Stakeholder Engagement events we sought participants views on three issues, as follows:

- How should the skills and experience of the various members of the CDS teams be best used to deliver the core services identified by them in an earlier workshop at the event;

- What are the advantages and disadvantages of the various clinical leadership and service management models that have been adopted across the West Midlands? Which, if any, should be the preferred model going forward?

- What are the other key issues regarding workforce development (such as skill mix, succession planning etc.) that need to be addressed?

5.2 From the financial templates completed by each of the current CDS providers it was clear that there were significant differences in the composition of the dental teams delivering the CDS across the West Midlands. This raised the question of whether the nature of the roles of the members of the dental team differed between services. For example, were specific tasks or procedures undertaken by different members of the team in the various CDS teams across the West Midlands?

5.3 As a result we asked participants at the Stakeholder Engagement Events to consider each of the services that they had identified as being core components of the CDS in the earlier workshop (as mentioned at paragraph 4.10 above) and to confirm which member(s) of the team should play a part in delivering them. In doing this we wanted participants to consider how these services could be delivered most safely, efficiently and effectively.

5.4 In many cases there was not consensus between the participants' responses. In some instances this was due to differences in the way in which participants had termed either the core service or the team member (and the necessary skills). In others there were differences of opinion regarding who should most appropriately undertake a particular task or procedure.

5.5 The minimum skill level required of dentists within the Community Dental Services is Level 2, so the dentists must demonstrate competence to treat patients whose needs are of level 2 complexity. A national accreditation scheme for providers and performers of care of level 2 complexity in paediatric and special care dentistry will be introduced in the near future although this is likely to be linked to the procurement of new services rather than for implementation with existing providers.

5.6 We considered that it is not appropriate for us to stipulate (for example) how a particular procedure should be staffed or the optimal constitution of the dental team within the CDS. These, instead, are matters for the provider of the service. However, in the process of developing a service specification we will consider whether it is appropriate to revisit this issue informed by suitable input from the relevant Managed Clinical Networks.

5.7 Prior to the Review, the Commissioners were aware that there were a number of different models of clinical leadership and/or service management in place within the CDS across the West Midlands. At the Stakeholder Engagement Events we asked

participants to consider the advantages and disadvantages of four models of clinical leadership/service management – consultant led, specialist led, non-dentist led and clinical director led. A summary of the participants' views can be found in the table at Annexe D.

5.8 Participants were also invited to identify any further models which may be preferable. The following models were identified

- A triumvirate structure (for example comprising a non-clinical service manager, the clinical director and the principal dental nurse);

- A clinically-led, managerially supported model.

5.9 There was little consensus regarding which should be the preferred model. One participant commented that the preferred model would depend on the number of services ultimately comprising the CDS within the West Midlands. Another commented that what was needed was 'what works'. This implies that people with the mix of necessary skills is (understandably) relatively scarce within the West Midlands and points to a more pragmatic solution.

5.10 At present Consultant staffing and Specialist staffing is concentrated at a relatively small number of centres. This can be problematic when implementing recommendations for the way pathways are delivered particularly where there is a requirement for Consultant or Specialist input. This is a particular issue in terms of Clinical Leadership. Proposals to align services locally to STP/ICS areas gives an opportunity to revisit this issue and consider whether or not shared appointments can be used to make arrangements more robust.

5.11 We also offered participants the opportunity to identify any further workforce-related issues that they wished to be taken into account within this Review. The principal issue identified was the availability of suitable patients to service the training needs of the CDS following any reconfiguration.

5.12 Providers will need to demonstrate how they intend to succession plan and to build in sustainability and continuity of skillsets and competencies (for example by introducing a Workforce Development plan).

Recommendation 6

We recommend that there should be a requirement for each service to be able to offer access to Consultant and/or Specialist provision in both Special Care and Paediatric Dentistry locally.

As the clinical leadership or service management model will not in itself affect the configuration or detail of services provided we do not propose to consult on this aspect. Given the lack of consensus we do not feel that it is appropriate to make a

recommendation at this stage regarding the type of clinical leadership or service management model that should be adopted. Our view is that it is crucial that a robust Job Description and personal specification is developed in respect of the role. Clinical leadership skills are a scarce commodity. With this in mind moving to an STP based model offers the opportunity for leaders to operate over a wider geography and strengthen leadership in areas where these skills are not currently available.

6. **Contracting** (type, units of measurement, reporting, basis of payment).

6.1 The fact-finding stage of the Review found that there were significant differences in the way the CDS were contracted and paid for across the West Midlands, in particular in respect of the following four aspects:

- There are two types of contracts let to CDS providers within the West Midlands (Personal Dental Service (PDS) contracts and PDS Plus contracts[13]);

- Some services are principally paid based on the number of patients they examine and/or treat (an 'activity-based' contract) while others are paid a fixed sum with no account taken of the activity undertaken (a 'block contract'). In some instances services receive payments based on both of these methods;

- Even where services are paid on the basis of activity, there is variance between the units of measurement used to calculate the payments made[14];

- There are significant differences in the way in which providers measure and report on their performance (for example in respect of activity, quality measures, complaints, workforce issues and safety). In many cases these arise from a provider's historic custom and practice rather than a contractual requirement.

6.2 There are a number of consequences (actual and potential) to this variance in contracting and payment mechanisms as follows:

[13] The principal difference between these types of contracts is that PDS Plus contracts contain a number of targets with associated financial payments (If achieved) while PDS contracts do not. A further type of contract – an NHS Standard Contract – is used in respect of Secondary Care Dentistry. However, it is our understanding that regulatory constraints (such as an inability to collect patient charges) preclude them from being used for Community Dental Services.

[14] The units include Units of Dental Activity (UDAs), courses of treatment, numbers of contacts and numbers of patients.

- There is inconsistent measurement of quality, workforce and safety (among other issues) across the services. There is a consequent risk of inconsistent standards of patient care and waiting times;

- Some services have access to more resources (for example financial, staffing etc.) than others[15], potentially leading to inequity of access for patients and inequity of quality of the services delivered;

- NHS England does not currently receive consistent data on which to base sound future commissioning decisions to ensure a more equitable service across its geographic area.

6.3 We issued a Market Assessment Questionnaire which was completed by all current providers of Community Dental Services within the West Midlands. Among the key findings of this survey were

- The majority of the responses received indicated that paediatric dentistry and special care dentistry should continue to form part of a single contract;

- The majority of the responses received indicated they would prefer a contract length of between three to five years;

- Of the responses received there was no clear preference for the funding mechanism of the contract.

6.4 At the Stakeholder Engagement Events participants were invited to

- Identify the advantages and disadvantages of using PDS and PDS Plus contracts respectively in respect of Community Dental Services;

- Identify the appropriate unit of payment (block, activity, per capita[16] etc.) for each of the core services they had identified earlier in the event (see paragraph 2.10 above);

- Identify what they consider to be the most appropriate Key Performance Indicators (KPIs) for each of these core services.

6.5 Annexes E1 to E3 detail the advantages and disadvantages identified by participants at the Stakeholder Engagement Events in respect of:

[15] This can be for a number of reasons including the historic allocations made by Primary Care Trusts (as the original Commissioners of the services) but also the internal allocation of resources within Trusts.
[16] At present there are no contracts for Community Dental Services within the West Midlands that are paid on a per capita basis. Capitation is a payment arrangement for health care providers (such as Community Dental Services) whereby they receive a set amount for a defined patient population for a defined period of time, whether or not that person seeks care.

- E1: Types of contracts;

- E2: Basis of payment;

- E3: Units of measurement on which payment is calculated.

6.6 In particular, we recommend that Community Dental Services should be paid based on a mixed model (for example combining elements of activity-based, capitation-based and/or block payment). We believe that this model enables the greatest flexibility for both Commissioners and Providers and helps ensure that the appropriate payment mechanism is used for each element of the Community Dental Service. We therefore intend to implement this model in re-designing Community Dental Services in the West Midlands.

6.7 Participants at the Stakeholder Engagement events were invited to identify the most appropriate measures of performance (such as key performance indicators) for Community Dental Services in future. **Annexe E4** gives a list of participants responses grouped by the four Dental Assurance Framework domains.

6.8 Historically contracts have been issued for a one year period and reviewed annually. We have considered whether contracts should in future cover a longer period in order to provide greater stability to contracted providers and to encourage investment and development of services while balancing the needs of Commissioners to minimise risk and ensure meaningful competition. As this is a Specialist type service, we believe that in the longer term a contract period of 5 years best balances these needs appropriately.

6.9 For the present, whilst the re-design is ongoing, it is proposed that contracts of two years be issued for 2019/20 and 2020/21 with the option to extend for a further year subject to satisfactory progress in moving to the new model of care.

6.10 NHS England is currently trialling a number of prototype contracts which blend elements of contracting by capitation and by activity. There are Community Dental Service Providers included within this programme elsewhere in the country, but not locally.

Recommendation 7

We recommend that a Personal Dental Service (PDS) contract model incorporating Key Performance Indicators should be used in future for Community Dental Services in the West Midlands.

Recommendation 8

We recommend the adoption of a mixed model for payments in respect of contracts for Community Dental Services.

We do not plan to consult on these recommendations as we believe that decisions regarding contractual arrangements should be made by the Commissioners.

7. Options and Transition

7.1 Following careful examination of the responses in this Review NHS England has considered what changes are appropriate in respect of the future commissioning of Community Dental Services in the West Midlands and the steps required to implement them.

7.2 NHS England has a clear preference to explore any options to achieve any such change by encouraging the evolution of services (for example by re-design in partnership with current provider(s)) – but if this is not achievable some degree of procurement may be required. This re-design would be progressed under the oversight of emerging Integrated Care Systems locally and recognises the complexity of both patients and pathways and links to other part of the healthcare system.

7.3 In implementing the re-design of Community Dental Services in the West Midlands a dedicated Project Manager will be appointed to oversee the monitoring of progress in delivering the necessary changes to move to the new model.

7.4 We intend to add Paediatric Dentistry and Special Care Dentistry to the local Dental Electronic Referral Management System (also known as REGO). The ability of Community Dental Service providers to receive referrals through this system will provide a further mechanism to ensure the necessary changes are implemented and help to clarify new arrangements and ways of working. The Managed Clinical Networks will have a key role in agreeing the necessary pathways and acceptance criteria that will be used in each area.

7.5 As some skills are in short supply across the West Midlands it will be necessary for providers to work together closely to best utilise the available resources across the geography through the use of mechanisms such as joint/shared posts.

7.6 Service Development Improvement Plans will be agreed between Commissioners and Providers to implement the proposed changes within the services. Progress in implementing the new model will be monitored during the re-design to ensure that the necessary changes are made in line with the action plan.

7.7 The implementation of the planned re-design will involve close negotiation between the commissioners, finance managers and providers in each STP area, overseen by the project manager. The SDIP will set out how the various organisations will work

together going forwards and the expected timescales to progress the re-design. The requirements contained within this plan will include the following elements:

- A requirement to work collaboratively with other providers within the STP area;
- A requirement for providers will undertake a gap analysis. This is a comparison of current, actual service delivery with the required service delivery set out in the relevant Service Specification;
- A requirement for providers to develop a plan to set out how they intend to implement the necessary changes locally to bring their services into line with the new model;
- A requirement for a joint review of funding to ensure services have the appropriate level of resources to be able to undertake the services going forwards.

7.8 NHS England will continue to engage with the relevant stakeholders, including providers, STP boards and the public as appropriate throughout the implementation.

We would welcome your comments on our recommendations for the re-design. You can comment by writing or e-mailing us by 31 August 2019 as follows:

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NHS England – West Midlands
Wildwood, Ground Floor West Wing, Wildwood Drive, Worcester, WR5 2LG

RECOMMENDATIONS

Recommendation 1
We recommend that the services and/or patient groups listed in paragraph 2.10 will comprise the core offer of Community Dental Services within the West Midlands in future.
Recommendation 2
We recommend that in future Community Dental Services within the West Midlands should be delivered by services aligned with the four local Sustainability and Transformation Partnership Areas and that providers work collaboratively within these geographies to deliver this service for their relevant population.
Recommendation 3
We recommend that General Anaesthetic services for both Paediatric and Special Care patients are consolidated and provided in future from a reduced number of specialist centres across the West Midlands.
Recommendation 4
We recommend that more sedation services should be made available across the West Midlands as a local alternative to General Anaesthetic where clinically appropriate.
Recommendation 5
We recommend that commissioning arrangements for General Anaesthetic services are strengthened locally to ensure the appropriate level of governance. Future services should be commissioned as a shared care model hosted by the relevant Acute Service with dental staffing provided by the relevant Community Dental Service teams.
Recommendation 6
We recommend that there should be a requirement for each service to be able to offer access to Consultant and/or Specialist provision in both Special Care and Paediatric Dentistry locally.
Recommendation 7
We recommend that a Personal Dental Service (PDS) contract model incorporating Key Performance Indicators should be used in future for Community Dental Services in the West Midlands.
Recommendation 8
We recommend the adoption of a mixed model for payments in respect of contracts for Community Dental Services.

If you wish to be kept informed or for us to involve you/your group or organisation please contact us by post or email at:

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8. List of Annexes

Annexe A - Table identifying advantages and disadvantages of the inclusion or non-inclusion of identified elements within the core offer of the Community Dental Service.
Annexe B – Patient Journeys
Annexe C - Table identifying advantages and disadvantages of possible commissioning geography configurations of the Community Dental Service within the West Midlands.
Annexe D- Table identifying advantages and disadvantages of clinical leadership and service management models.
Annexe E1 - Table identifying advantages and disadvantages of PDS and PDS Plus contracts respectively.
Annexe E2 - Table identifying advantages and disadvantages of various bases of payment.
Annexe E3 – Table identifying advantages and disadvantages of various units of measurement of activity.
Annexe E4 – Table of possible measures of performance.

Annexe A

Core offer	Advantages of the service being provided as part of the core CDS offer	Disadvantages of the service being provided as part of the core CDS offer
Adults		
Level 2 Special Care Dentistry (SCD) (including Cognitive Behavioural Therapy and psychological therapies for Anxious Adults).	• Access to specialist SCD support (if needed); • Access to appropriate facilities for treatment (e.g. hoists); • Explicit responsibility for co-ordination of the dental care pathway lies with the CDS; • Extra time and skills available in CDS.	• Reduced locations for services compared with General Dental Practices (GDPs); • Potential deskilling of GDPs; • Impedes normalisation of dental treatment.
Level 3 Special Care Dentistry.	• Access to specialists in SCD (if needed); • Access to appropriate facilities for treatment (e.g. hoists); • Explicit responsibility for co-ordination of the dental care pathway lies with the CDS.	
Urgent care[1] and domiciliary services for patients with Level 2 or 3 complexity as defined in the NHS England Commissioning Guide to Special Care Dentistry	• Provides continuity of care for patients; • Specialist skills needed to provide the appropriate level of care.	• Limited availability of provision in some locations.

[1] In hours urgent care for Special Care Patients (level 2 and 3) should be provided by the CDS. The arrangements for Out of hours urgent care is described by the diagram at para 5.8

Annexe A

Children		
Medically compromised children (Level 3[2]) with specific conditions, significant disability or learning disability.	• Access to specialist paediatric support and experienced staff; • Access to appropriate facilities for treatment; • Explicit responsibility for co-ordination of the dental care pathway lies with the CDS; • GA not available from GDPs; • Limited provision of inhalation sedation in GDPs across the West Midlands; • Inconsistent provision of IV sedation among GDPs across the West Midlands.	• Reduced locations for services compared with General Dental Practices (GDPs); • May lead to increased DNA rates (which may exacerbate any underlying safeguarding issues); • Potential deskilling of GDPs; • More than one dentist and location required for children requiring sedation;
Level 2 Paediatric Dentistry[3] for children where there is increased complexity of delivery of service due to behavioural/psychological issues or significant anxiety – particularly where these children require inhalation or intravenous sedation and/or General Anaesthetic.		
Mobile service for special schools (Level 2)	• Access to specialist paediatric support and experienced staff; • Access to facilities for treatment ; • Explicit responsibility for co-ordination of the dental care pathway lies with the CDS.	• Time consuming and resource intensive; • Lack of involvement of parents in treatment; • Transition when leave school into other services; • Frustration of normalisation of dental treatment.

[2] In the NHS England Commissioning Standard for Paediatric Dentistry.

[3] There are some further elements of Level 2 Paediatric Dentistry – for example hard tissue dental defects and disturbances of the developing dentition, more complex problems affecting developing dentition or dental hard tissues, dento-alveolar trauma, increased complexity of delivering care due to medical comorbidity or disability children requiring acclimatisation to help overcome anxiety – which may initially form part of the core offer until the workforce at High Street dentists is sufficiently developed to enable it to be taken out of scope. While it is not envisaged that these services would remain part of the core offer of the CDS in perpetuity, it is likely that there will need to be a limited failsafe element for patients unable to access High Street dental services (for example where there is no General Dental Practice available).

A number of elements were commonly considered by participants at the Stakeholder Engagement Event and/or the Commissioners to not appropriately form part of the core offer. These are as follows:

For Adults

- Anxious Adults (acclimatisation, Inhalation Sedation, Intravenous Sedation);
- Domiciliary services (other than for Level 2 and 3 Special Care Dentistry patients);
- Level 1 Special Care Dentistry;
- Level 2 Special Care Dentistry in respect of
    - Patients with a disability where only a limited examination is possible;
    - Oral hygiene requiring support of a third party;
- Mobile services for adults.

For Children

- Level 1 Paediatric Dentistry;
- Level 2 Paediatric Dentistry in respect of
    - Management of Dentoalveolar Trauma of increased complexity;
    - Management of dental defects and disturbances;
    - Extensive caries or early childhood caries amenable to care under local analgesia or with sedation;
    - Looked After Children who have no current arrangement for ongoing oral health review or have unmet dental needs;
- Mobile services for mainstream schools.

We would envisage that these patient groups would routinely access these services through their General Dental Practice. However we recognise that there may be specific circumstances where individual patients are unable to access these services through their GDP (or it is not appropriate for them to do so) and in these instances we envisage that the CDS would provide a failsafe.

The reasons given for these elements not forming part of the core offer were commonly:

- That it would be more cost effective for the service to be provided by General Dental Practices (GDPs);
- That provision by GDPs would offer greater access to patients (for example in terms of numbers of locations);

- That if the service was to be provided by the CDS, there is a risk of reducing the availability of the relevant skills among GDPs;
- Inappropriate use of specialist skills;
- That provision by GDPs helps avoid unnecessary fragmentation of care for patients;
- That provision by GDPs helps support the normalisation of dental treatment.

A number of specific reasons were given for the non-inclusion of the provision of mobile services within mainstream schools within the core offer as follows:

- Provision would be financially unaffordable for Commissioners;
- The lack of appropriate facilities for dentistry;
- Difficulties caused when parents are not present;
- The time consuming and resource intensive nature of the service for Providers;
- Ensuring that suitable arrangements are made for transition into other services after leaving school.

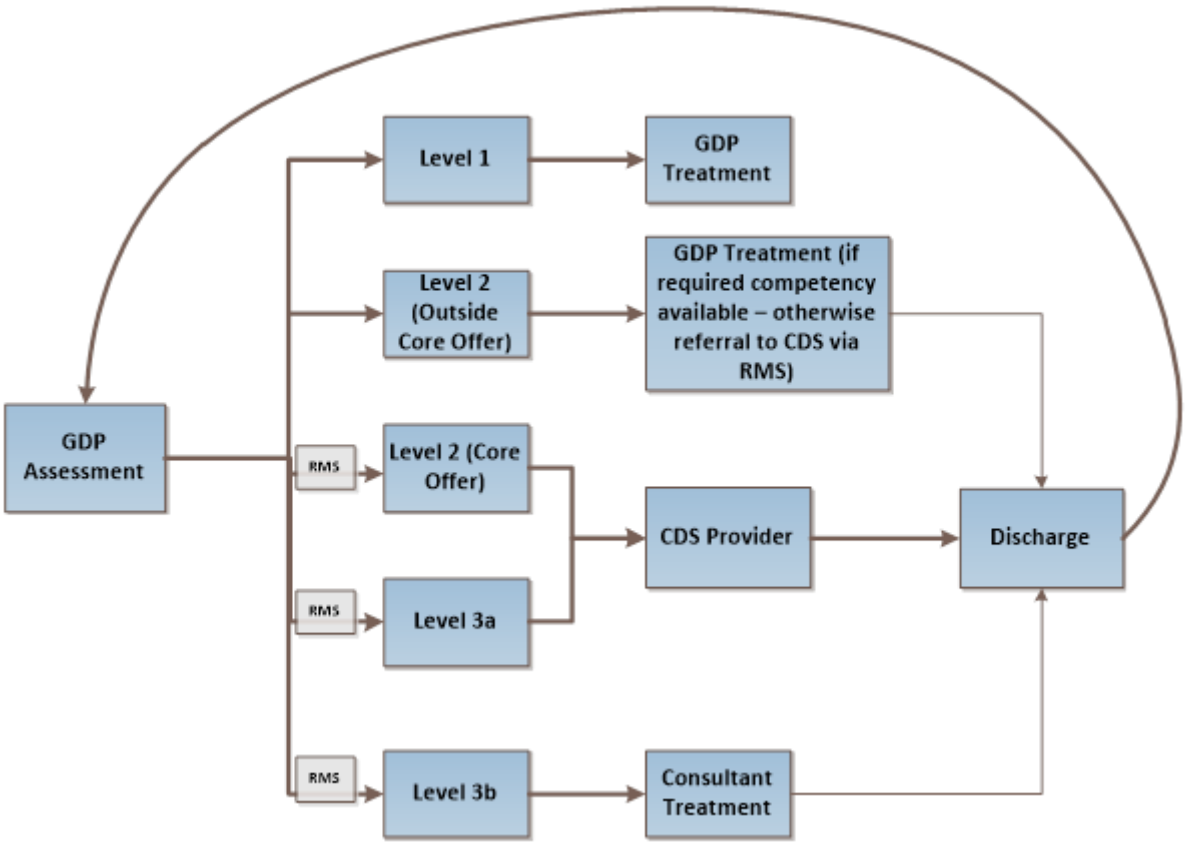
At the Stakeholder Engagement Events for completeness we invited participants to comment on the advantages and disadvantages of Oral Health Promotion, Epidemiology, out of hours, Minor Oral Surgery and Dental Access Centres being included within the core offer. These have not been included in the above table as they are outside of the scope of this Review (See para 1.10). In particular, Oral Health Promotion and Epidemiology services are typically provided by Community Dental Services at present, but the commissioning responsibility for these services lies with local authorities. For this reason, these services are not considered to be part of the core offer of the community dental services commissioned by NHS England.

1. Patient Journeys

1.1 Following on from our proposals regarding the core offer for the Community Dental Service we have developed illustrative Patient Journeys for

- Children with high needs and Adult Special Care patients;
- Special Schools
- Urgent Level 3 Special Care Dentistry

1.2 <u>Community Dental Service Patient Journey (Children with high needs and Adult Special Care patients)</u>

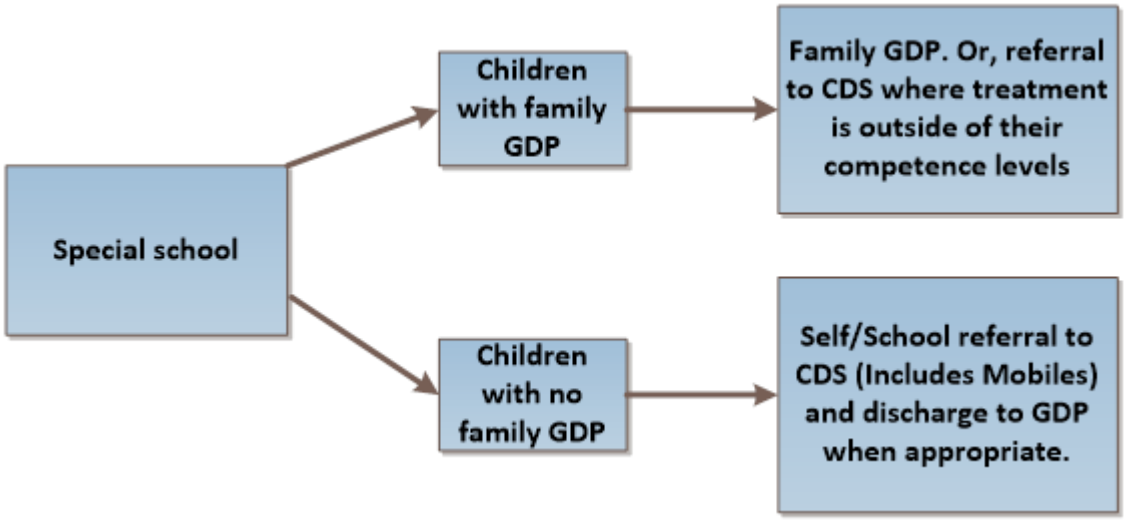


1.3 The above patient journey refers to the electronic Referral Management System ('RMS') which was introduced within the West Midlands from April 2018, initially in respect of referrals for Oral Surgery, Orthodontics and Oral Medicine. It is planned that the specialties covered by RMS will be expanded to include Paediatric Dentistry and Special Care Dentistry. (The above diagram assumes that this expansion has taken place).

1.4 The 'Levels' referred to in the diagram are the levels of care described in the relevant NHS England Guides for Commissioning Dental Specialties: Special Care Dentistry and the NHS England Commissioning Standard for Dental Specialties: Paediatric Dentistry[1].

1.5 Normally patients accessing the CDS will be treated and discharged back to their GDP once their needs have been met. In a small number of cases patients that have been treated by the Community Dental Service will not be discharged back to General Dental Practice at the end of their course of treatment because their additional needs are such that they could not be met by GDPs. Community Dental Services will review these patients to ensure that they only discharge these patients when it is appropriate for them to do so. Some patients will receive ongoing care due to their specific needs.

1.6 Special Schools Patient Journey

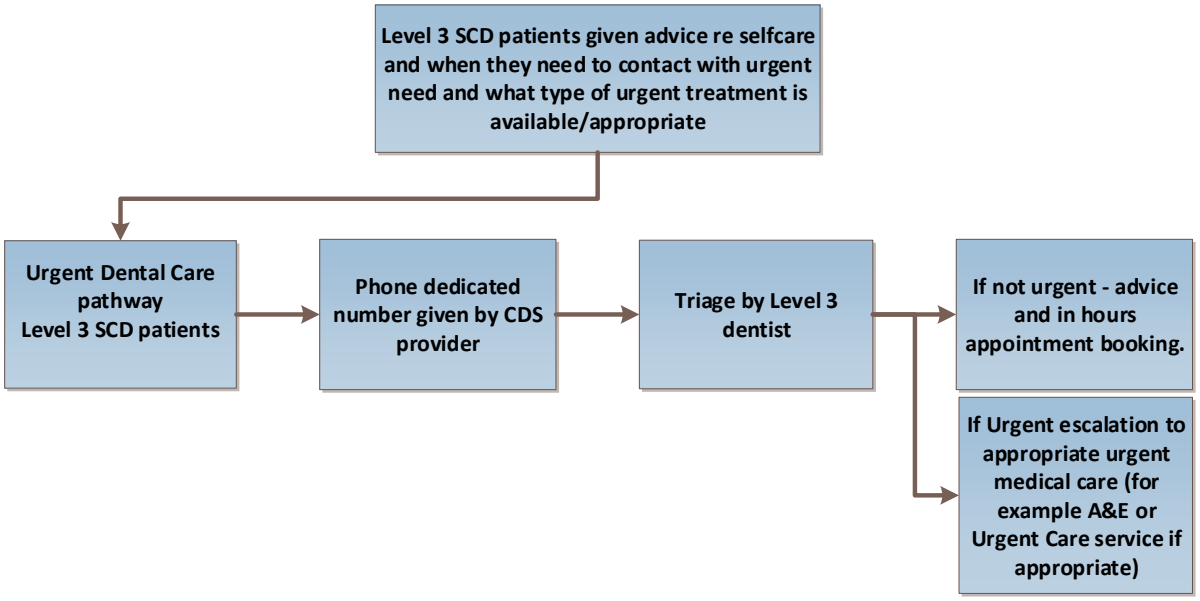


1.7 This Patient Journey is in respect of children attending a special school[2]. The Patient Journey envisages that in some cases these children would not regularly attend a family GDP. We believe that the CDS has a leading role to play in encouraging these families to attend a GDP in instances where their routine needs can be met by that service.

1.8 Urgent Level 3 Special Care Dentistry Patient Journey

[1] These can be found at https://www.england.nhs.uk/commissioning/primary-care/dental/dental-specialities/ The Levels of Care are described at pages 14 onwards of each document.

[2] Special schools are schools catering for students who have special educational needs due (for example) to severe learning difficulties, physical disabilities or behavioural problems.



1.9 The patients in this Journey for urgent care require Level 3 Special Care Dentistry and are therefore envisaged as already accessing the CDS 'system'.

1.10 For the Out of Hours period, the Urgent Dental Care pathway referred to in the diagram would be enacted via an on-call arrangement that would be set up and covered across the West Midlands on a rotational basis between providers.

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Annexe C

Model A – Commission services in ten local authority areas	
Advantages	**Disadvantages**
<u>Medium importance</u> Minimisation of disruption (for example in respect of IT, HR processes etc.) and stability of services; Current providers are familiar with local issues, needs and history and can tailor services appropriately to ensure access to patients; Retention of 'organisational memory' and existing relationships with local authorities, GPs etc. if current providers remain in place; Sensitivity to the needs of individual local authorities, for example to the requirements of multiple safeguarding boards. <u>Low importance</u> Continuity of care for patients and continuity for staff; Greater scope for Integration with current secondary care providers (particularly where the Trust provides both services); Workforce more likely to live locally. Reduced impact of travel time. More able to attend local meetings.	<u>High importance</u> Current premises are a mixture of historically decided premises. Some are understood to be not fit for purpose; If existing providers are retained it may be more difficult to re-design services (and so achieve a more standardised approach across the Local Office); More difficult to address existing inequity of resources and services provided; Perpetuates current boundary issues and inconsistencies (i.e. services not being provided to out of area patients); Misses the opportunity of economies of scale; Does not address issues regarding the commercial viability of the smaller services; Resilience of staffing (for example including recruitment issues and current skill/staff shortages) and impact on clinical leadership; Misses the opportunity to make better use of the skills mix available across a wider geography (and to secure greater access to specialist support); Lack of link to future configuration of Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) areas; Lack of consistency of the records maintained (for example to support safeguarding arrangements). <u>Medium importance</u> Inconsistent governance and approach to patients; May be difficult to address the current inconsistency of data collected and reported;

	Replication of posts between services. <u>Low importance</u> Does not address localised issues where there is a mismatch between existing CCG areas and coverage of current services; Does not address current use of Commissioners' resources to service seven separate contracting relationships; Less peer support and lack of flexibility regarding workforce/career.
Model B – Commission services from a single provider for the entire West Midlands area	
Advantages	**Disadvantages**
<u>High importance</u> Offers greater opportunity to exploit economies of scale and mitigates the potential issues regarding the viability of smaller services; Facilitates the development of common policies, approach and governance (for example safeguarding, training, investigation of Serious Incidents, discharge, pathways, acceptance criteria etc.); Facilitates re-design and likely to lead to greater equity of resources and services provided; Maintenance of common records (would lead to, for example, improved safeguarding arrangements); Likely to lead to better use of skills mix (and to greater access to specialists) <u>Medium importance</u> Greater consistency of data collected and reported;	<u>High importance</u> Scale of impact if the service fails (all the eggs in one basket); Whether there is a provider big enough to be able to deliver and manage the service effectively across a large and diverse geography; Leads to centralisation and a 'one size fits all' ethos; Increased travel time for staff (and possibly for patients) – may impact on recruitment; Practical considerations with change on that scale (for example dealing with legacy IT systems, estates, communications etc.); Danger of destabilising services, particularly during the transition period; Need for significant change – including cultural change - with the associated resource cost etc.); Lack of link to future configuration of STP and ICS areas;

More robust clinical leadership (for example by enabling better succession planning) and, potentially, resilience of staffing more generally; May offer the opportunity to review the facilities offered by current premises and lead to improved standards; Would remove current boundary issues (which instead may move to external boundaries). <u>Low importance</u> Reduced administrative burden on provider and commissioners (for example a single contracting relationship to service); May promote peer support and offer greater flexibility regarding workforce/career.	Whether the timing is appropriate for such a big change given the scale of change in the health sector and the wider environment; Significant loss of 'organisational memory '. <u>Medium importance</u> Resource needed to liaise with multiple local authority areas and their diverse needs; Ability to cope with disparate geographies; Lack of local knowledge, local ownership and/or sensitivity to local needs; Administrative resource needed to monitor any consequent sub-contract arrangements (if applicable); <u>Low importance</u> Need to secure buy-in from key stakeholders and partners; May lead to reduced scope for working with current secondary care providers (although this may be mitigated if sub-contract arrangements are in place); Workforce may need to travel greater distances which (for example) could impact on their ability to attend local meetings; Potential for some short-term disruption to patients (for example in respect of continuity of care).
Model C – Commission services based on the four Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) areas within the West Midlands area	
Advantages	**Disadvantages**
<u>High importance</u> Alignment with STP (and existing CCG) areas. Would assist with the integration with wider services (direction of travel).	<u>High importance</u> Practical considerations with change on that scale (for example dealing with legacy IT systems, estates, communications etc.);

Greater prospect of common policies, approach and governance – at least within an STP/ICS area; Facilitates re-design and likely to lead to greater equity of resources and services provided- at least within services within the same STP. Maintenance of common records (would lead to, for example, improved safeguarding arrangements). Likely to lead to better use of skills mix (and to greater access to specialists) <u>Medium importance</u> Offers some opportunity to exploit economies of scale and may help mitigate the potential issues regarding the viability of smaller services; More robust clinical leadership (succession planning) and, potentially, resilience of staffing more generally; Liaison is likely to be through the STP/ICS board which mitigates the resource required to liaise with multiple local authorities; Greater consistency of data collected and reported.- at least within STP areas; May offer the opportunity to review the facilities offered by current premises and lead to improved standards; Would reduce current boundary issues. <u>Low importance</u> May promote peer support and offer greater flexibility regarding workforce/career; Reduced administrative burden on provider and commissioners (for example a	<u>Medium importance</u> Ability to cope with disparate geographies (although less of a risk than in the case of a single provider solution); Scale of impact if one or more services fail; Administrative resource needed to monitor any consequent sub-contract arrangements (if applicable); Danger of destabilising services, particularly during the transition period; Need for significant change – including cultural change - with the associated resource cost etc.); Some loss of organisational memory; Possibility of no willing providers for one or more areas. <u>Low importance</u> Need to secure buy-in from key stakeholders and partners; Some reduction in local knowledge, local ownership and/or sensitivity to local needs; Workforce may need to travel greater distances which (for example) could impact on their ability to attend local meetings; Potential for some short-term disruption to patients (for example in respect of continuity of care).

reduced number of contracting relationships to service).	
Model D – Commission services from a number of providers[1] who would offer services across more than one local authority area	
Advantages	**Disadvantages**
<u>High importance</u> Greater prospect of common policies, approach and governance – at least within local authorities served by the same provider; Facilitates re-design to some degree and lead to greater equity of resources and services provided – at least within local authorities served by the same provider; Maintenance of common records (would lead to, for example, improved safeguarding arrangements). Likely to lead to better use of skills mix (and to greater access to specialists) <u>Medium importance</u> Offers some opportunity to exploit economies of scale and may help mitigate the potential issues regarding the viability of smaller services; More robust clinical leadership (succession planning) and, potentially, resilience of staffing more generally; Greater consistency of data collected and reported - at least within STP areas. Would reduce current boundary issues. May offer the opportunity to review the facilities offered by current premises and lead to improved standards; <u>Low importance</u>	<u>High importance</u> Non-alignment with STP (and existing CCG) areas. Might prevent integration with wider services (direction of travel). That said, there has been limited recognition of dental services within the development of STP/ICS strategies to date; Potential for non-alignment with local authority areas; Whether the timing is appropriate for such a big change – particularly as it runs counter to the direction of travel of change in the health sector and the wider environment; Practical considerations with change on that scale (for example dealing with legacy IT systems, estates, communications etc.); Difficulty in co-ordinating OHP and epidemiology across different local authority areas. More generally, resource needed to liaise with multiple local authorities. <u>Medium importance</u> Ability to cope with disparate geographies (although less of a risk than in the case of a single provider solution); Danger of destabilising services, particularly during the transition period; Scale of impact if one or more services fail; Some loss of organisational memory; Need for significant change – including cultural change - with the associated resource cost etc.);

1

May promote peer support and offer greater flexibility regarding workforce/career; Reduced administrative burden on provider and commissioners (for example a reduced number of contracting relationships to service).	Administrative resource needed to monitor any consequent sub-contract arrangements (if applicable); Possibility of no willing providers for one or more areas. <u>Low importance</u> Need to secure buy-in from key stakeholders and partners; Some reduction in local knowledge, local ownership and/or sensitivity to local needs; Workforce may need to travel greater distances which (for example) could impact on their ability to attend local meetings; Potential for some short-term disruption to patients (for example in respect of continuity of care).

Annexe D

Unit of measurement	Advantages	Disadvantages
Consultant led	• Has day-to-day contact with patients and so will have first-hand experience of patient issues; • High degree of specialist clinical knowledge and good knowledge of the locality and the service itself; • Trained in leadership; • Has responsibility for the service; • Facilitates robust Clinical Governance arrangements; • Facilitates collaboration with other consultants or agencies.	• Other staff may feel uncomfortable challenging a consultant; • Arguably a poor use of available time and money on non-clinical activity.
Specialist led	• Can challenge from a different perspective; • High degree of specialist clinical knowledge and good knowledge of the locality and the service itself; • Easier to collaborate with consultants; • Facilitates robust Clinical Governance arrangements; • Cheaper than a consultant-led model.	• May find it difficult to lead/manage consultants; • Arguably a poor use of available time and money on non-clinical activity; • Specialists tend to have purely clinically-focused training (i.e. not leadership) and would therefore need additional training and development.
Non-dentist led	• Time not taken from clinic; • Good knowledge of NHS procedures; • Time to dedicate; • Means increase in clinical time as clinicians have more capacity; • Cheaper; • Less risk of bias towards either specialty.	• May find it difficult to lead/manage consultants; • Lack of clinical knowledge and/or experience; • Lack of gravitas when dealing with clinicians or GDPs; • If there is a high turnover of non-clinical staff there may be increased disruption to the service); • Management but needs clinical leadership; • Lack of governance.
Clinical director led	• Management time is already built into job plan; • Less concentrated on specific clinical issues; • High degree of specialist clinical knowledge and good knowledge of the locality and the service itself.	• May be hindered by perception that he/she isn't a specialist or consultant; • Other staff may feel uncomfortable challenging a Clinical Director; • May find it difficult to lead/manage consultants; • Arguably a poor use of available time and money on non-clinical activity; • Financial cost (although it may be possible to share over more than one locality).

Annexe E1

Type of contract	Advantages	Disadvantages
PDS	• Access to automatic link to data from NHS Business Services Authority (BSA). • Compliant with relevant regulations for primary care services. • Consistency of approach with other primary care services. • Fully compliant with legislation re performers list, FP17 and patient charge obligations.	• Safeguarding reliant on the performer being covered by their GDC and other professional standards rather than contracting as there are no explicit requirements. • Neither PDS nor PDS Plus contracts have the same requirements with regard to incident reporting as the NHS Standard contract. • Existing contract is aimed at GDPs rather than Trusts and needs tailoring. • Need to have clinicians on performers list. • Need to complete exemption status forms (which can lead to vulnerable patients being fined). • Need to collect patient charges.
PDS Plus	• Able to include KPIs. • Data automatically provided by BSA. • It is possible to tailor wording of KPIs (or thresholds) – but would require local data collection. • Consistency of approach with other primary care services. • Fully compliant with legislation re performers list, FP17 and patient charge obligations.	• 23 schedules to populate – labour intensive for Commissioners and providers. • Safeguarding reliant on the performer being covered by their GDC and other professional standards rather than contracting as there are no explicit requirements. • Neither PDS nor PDS Plus contracts have the same requirements with regard to incident reporting as the NHS Standard contract. • Existing contract is aimed at GDPs rather than Trusts and needs tailoring. • Need to have clinicians on performers list.

		• Need to complete exemption status forms (which can lead to vulnerable patients being fined). • Need to collect patient charges.
NHS Standard Contract	• NHS Constitution is built in – removes boundary issues. • Safeguarding and incident reporting is built into NHS Standard Contract – (and is not present in PDS and PDS Plus contracts unless specifically added). • Ability to develop Local Quality and Reporting Requirements.	• Understood to contravene legal requirements – specifically requirements set out in dental regulations regarding collection of patient charges, completion of FP17s and the need for performers to be on a performers List (for which there is no equivalent requirement for staff working in secondary care dental services). • The contract template includes a great deal of content not relevant to dental and includes swathes of irrelevant material. • Patient Charge Revenue cannot be collected.

Annexe E2

Type of basis of payment	Advantages	Disadvantages
Block	• Gives providers the flexibility to spend the time necessary to meet each patient's individual needs. • Gives greater flexibility to Providers (for example in allocating resources between different parts of the service and covering overheads). • Offers certainty and stability to Providers to cover the costs of the service.	• Harder to measure the effective delivery of the service. • Difficulty for the Commissioners to recover payments in the event that the service fails to deliver appropriate numbers of treatments unless a collar is in place. • There is a perverse incentive for the Provider to stop offering treatment (or make patients wait) when demand exceeds available funds. • There is a perverse incentive for the Provider to restrict access to the service, in particular with regard to expensive elements. • Limited incentive for Providers to cover staff shortages and other factors affecting the delivery of the service.
Activity[1]	• The Provider is paid for the services that they deliver. • Strong incentive for the Provider to remedy any problems affecting service delivery so that they continue to receive payment. • Works particularly well with GA, sedation and domiciliary activity. • Incentive for the Provider to promote the service (and so increase demand).	• As tariffs are typically a flat rate, there is limited flexibility to adjust payment to match the time necessary to meet the individual patient needs without making the system unduly complex. • Can provide perverse incentives with regard to the treatments offered (for example 'cherry picking' less complex patients or unnecessary appointments in order to collect extra payment). • Trusts have varying levels of overheads which are not always accurately paid for through a tariff (flat rate) system. • Lack of incentive to undertake preventive activity. • Encourages unnecessary retention of patients within the service rather than discharge back to high street dentists.

[1] Activity can be measured by Units of Dental Activity, courses of treatment, contacts etc.

Capitation	• Gives providers the flexibility to spend the time necessary to meet each patient's individual needs. • Population-based activities (such as Epidemiology and Oral Health Promotion) benefit from a capitation approach to funding. • More closely reflects population needs.	• Difficult to accurately identify the numbers of patients requiring the CDS. • Finding appropriate outcome measures to ensure effective delivery of the service. • Difficulty for the Commissioners to recover payments in the event that the service fails to deliver appropriate numbers of treatments. • Lack of incentive for the Provider to promote the service (and so increase demand).
Mixed model **(includes elements of some or all of the above three types)**	• Flexibility to use the appropriate type of payment most suited to each element of the service. • In instances where the level of activity is variable or unknown (for example drop-in clinics for vulnerable people) a mixed model can provide better value for money by ensuring the provider can run a clinic regardless of numbers attending yet payments at least partially reflect the activity delivered . • More incentive to devise flexible approaches (such as a block element with minimum and maximum levels of activity) • Offers flexibility to provide appropriate payment for the most complex patients.	• Relatively more complex to administer and monitor than the other types.

Unit of measurement	Advantages	Disadvantages
Units of Dental Activity	- Consistency with other types of primary care dentistry and so a widely understood concept. - Ease of measurement of activity.	- Does not offer sufficient flexibility in view of the diverse range of needs of the patients. - UDAs were created for general dentistry with Bands created to match specific types of treatment in the general population – UDAs may not work well for the particular types of patients seen in CDS.
Contacts	- Provider receives payment for every appointment. - Ease of measurement of activity.	- Perverse incentive for Providers to arrange unnecessary appointments, particularly in respect of more straightforward patients.
Courses of treatment	- The payment linked to an entire episode of care. - Easier to measure numbers of sedation and domiciliary services (using FP17s).	- Does not offer sufficient flexibility in view of the diverse range of treatments provided. - Perverse incentive for Providers to end treatment early.
Numbers of patients (caseload)	- Provider receives payment for every patient under the care of the service. - Would work well with routine attendances by special care and paediatric patients.	- Perverse incentive for the service to retain patients unnecessarily within the service rather than to discharge them back to High Street dentists.

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Annexe E4 – Performance Measurement

Delivery Waiting times (including waiting times for paediatric general anaesthetics); Waiting times for New patient wait 6 weeks Time taken to triage, assessment and treat (genuinely) urgent cases; Antimicrobial Resistance (AMR) – completion of audit and completion of consequent actions; Percentage of patients for whom Casemix data is recorded; Did Not Attend (DNA) rate; Number of General Anaesthetics/sedations.	**Patient Safety** Number of repeat General Anaesthetics; Number of repeated courses of treatment; Outcome of Clinical audits; Number of completed audit cycles; Ratio of Intravenous Sedation (IV) to General Anaesthetic cases (Special Care); Ratio of Inhalation Sedation (IS) to General Anaesthetic cases (Paediatrics); General Anaesthetic - Morbidity/length of stay. Confirmation that the service meets basic criteria for sedation.
Patient experience Numbers of completed vs abandoned courses of treatment; Numbers of complaints and Patient Advice and Liaison Service (PALS) queries; Annual Patient Satisfaction Survey; Friends and Family Test; PROMs and PREMs.	**Quality/clinical effectiveness** Proportion of patients discharged to High Street dentists (for example because their anxiety had been reduced); Reduction in anxiety (particularly in relation to General Anaesthetic and Sedation cases); Proportion of patients to whom Fluoride varnish is applied; Percentage of new patients where a record of a soft tissue assessment has been made; Compliance with standards for domiciliary visits; Delivering Better Oral Health, application of fluoride Varnish, Oral Health advice, smoking cessation and lifestyle services; Percentage of patients given discharge plans.

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Re-design of the Community Dental Service: Briefing for HOSCs

NHS England and NHS Improvement

Background

A Review has been undertaken of the Community Dental Services (CDS) in the following Sustainability and Transformation Partnership (STP) areas:

- Birmingham and Solihull
- Coventry and Warwickshire
- Herefordshire and Worcestershire
- The Black Country

A review of current CDS service provision has been completed in order to:

- fully understand the nature of each service (in the context of the NHS England Guides for Dental Commissioning);
- identify, assess and engage regarding options for change to improve equity of access to CDS services across this geographic area.

The CDS provide care for those with special or additional needs who, because of these needs, cannot access appropriate care from a family or high street dentist. They all offer elements of Paediatric Dentistry and Special Care Dentistry. Across the area CDS currently provide a varied set of other services, sometimes for local historic reasons. These include domiciliary care, services for specific vulnerable groups and dental Public Health services for Local Authorities. CDS may in addition provide other services such as Orthodontics or Minor Oral Surgery but these are out of scope of this project.

The key principles underpinning the Review were:

- To improve equity of provision and access to these services;
- To implement the recommendations of the relevant national Dental Commissioning Guides;
- To encourage the development of sustainable services;
- To enable greater equity in the distribution of the associated funding and resources.

Methodology of the Review

The methodology of the Review comprised several elements including:

- A fact-finding stage where each current provider of CDS services provided detailed information regarding current service provision (such as the nature, scale, location(s) and costs of the services provided);

- Market, stakeholder and patient and public engagement activities and events to discuss and inform on the future of CDS services;

- Identifying options for change, presenting recommendations and engaging regarding the future of CDS (the current phase).

Findings and Recommendations

The Review found evidence of significant variance in the nature and scale of the services provided across the West Midlands, leading to inequitable access for patients.

We have produced an engagement document that is intended for current providers and other stakeholders setting out the findings and recommendations of the Review in more detail. It should be noted that while this document will be publicly available the intended audience is not patients or the public. The purpose of the document is to feed back to those who contributed to the review and so gives a detailed account of the complexities that they identified. It is this complexity which has informed the decision to pursue a re-design (rather than a re-procurement) in order to ensure that the necessary changes can be identified and enacted in a managed way. This will minimise disruption to the services delivered for patients during the transition to the new model.

A copy of this is attached for your information. An Easy Read version of this document is also available.

As detailed in this document, there has already been significant engagement both nationally and locally with respect to the development of the recommendations from the review. As the project moves to implementation through redesign, providers will continue to review the level of impact of any proposed change to services in each area and consult as appropriate when necessary.

The Review made eight recommendations as follows:

1: We recommend that the services will comprise a ‘core offer’ of the Community Dental Service within the West Midlands in future. (Note: further details of the composition of the core offer can be found in our engagement document).

2: We recommend that in future Community Dental Services within the West Midlands should be delivered by services aligned with the four local Sustainability and Transformation Partnership Areas and that providers work collaboratively within these geographies to deliver a service for their relevant population.

3: We recommend that General Anaesthetic services for both Paediatric and Special Care patients are consolidated and provided in future from a reduced number of specialist centres across the West Midlands.

4: We recommend that more sedation services should be made available across the West Midlands as a local alternative to General Anaesthetic where clinically appropriate.

5: We recommend that commissioning arrangements for General Anaesthetic services are strengthened locally to ensure the appropriate level of governance. Future services should be commissioned as a shared care model hosted by the relevant Acute Service with dental staffing provided by the relevant Community Dental Service teams.

6: We recommend that there should be a requirement for each service to be able to offer access to Consultant and/or Specialist provision in both Special Care and Paediatric Dentistry locally.

7: We recommend that a Personal Dental Service (PDS) contract model incorporating Key Performance Indicators should be used in future for Community Dental Services in the West Midlands.

8: We recommend the adoption of a mixed model for payments in respect of contracts for Community Dental Services.

Transition and Engagement Strategy

As previously stated we intend to work with existing providers to re-design Community Dental Services across the area in line with these recommendations. Providers will be encouraged to work collaboratively to reconfigure services in such a way as to meet the needs of their local STP population. If it is not possible to secure the required changes in line with the recommendations then it may be necessary, following the appropriate consultation, to conduct a procurement in respect of the relevant services. Contracts are being issued to existing providers for a period of two years from 1 April 2019 to allow time for this work to be undertaken.

A dedicated Project Manager will lead the re-design project and manage the service development improvement plans that will be used to support providers in its implementation.

NHS England will continue to engage with the relevant stakeholders, including providers, Sustainability and Transformation Partnership (STP) boards and the public throughout the implementation of the re-design. We will hold at least one launch event in each STP area.

We are happy to attend any Local Authority, Health Oversight Scrutiny Committee or other meetings to provide further details about the Review and our plans for the re-design.

We would welcome your comments on our recommendations for the re-design. You can comment (or obtain a copy of the engagement document setting out the recommendations and findings of the Review) by writing or e-mailing us by 31 August 2019 as follows:

Sharon Howard sharon.howard5@nhs.net
Contract Manager – Secondary Care Dental
NHS England – West Midlands
Wildwood, Ground Floor West Wing, Wildwood Drive, Worcester, WR5 2LG

NHS England and NHS Improvement (Midlands) out of hours dental services consultation document

Consultation on proposed changes to out of hours dental services in the West Midlands

Version number: 1

First published: 15th July 2019

Prepared by: Nuala Woodman, Deputy Head of Commissioning (Dental) and
Colum Durkan, Specialty Registrar in Dental Public Health

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

Please contact ENGLAND.dentalcontractswm@nhs.net

Contents

Introduction

Out of hours dental care is available for people who need urgent or emergency dental care from a dentist when their dental practice is closed. Urgent dental care covers dental problems that need emergency care (assessment within one hour) or urgent care (assessment within 24 hours) which is often followed by dental advice or treatment in hours. Further details and examples of emergency and urgent dental care are included in the needs assessment document. The number of people using these services each week is small, most dental problems can be dealt with by an urgent appointment with a dentist during normal opening hours.

NHS 111 can help patients with routine and urgent dental problems by providing self-care advice and signposting them to the appropriate service. A separate review of in hours dental services is currently being undertaken to ensure appointments are available for those who need to be seen in between routine check-ups.

This consultation is part of the work being undertaken by NHS England and NHS Improvement to look at out of hours dental services in the West Midlands.

The case for change

Contracts for the current out of hours dental services in the West Midlands expire in March 2020. These services were established when the population and its health needs were very different to what they are now. We are looking to make changes to these services so that services will more closely meet the current and future need of people living in the West Midlands.

We have engaged with service users, dentists and current providers to review existing services and used national guidance to create a proposed service that we feel will meet the needs. There is no intention to reduce the total spend on out of hours dental services in the West Midlands. Our consultation is limited to how and where services are delivered.

We propose the following:

- Fewer sites with longer opening hours offering a more equitable use of resources.
- The vast majority of patients, including those in rural areas, will have access to a service within 30 minutes by car and all patients will have access to a service within 60 minutes by car.

- All services will be situated close to public transport routes and their opening hours will align with public transport services.
- There will be no geographical restrictions, with patients free to choose which service they wish to attend.
- Ensuring easy access to safe and timely out of hours dental care, particularly for those most vulnerable, remains our foremost priority.

What you have already told us

To help inform these proposed changes we undertook an engagement exercise in 2018 to gather information from a range of people on out of hours dental care as we wanted to understand how out of hours dental care could be improved.

- We spoke to existing providers to gather a range of information about the current services and how these are provided.
- We consulted with our local Managed Clinical Dental Network for urgent dental care. This is a group of local dentists who meet regularly to discuss local services and how these can be improved.
- We undertook a market engagement exercise to talk to current and potential providers about their view of how services worked or could work more effectively.
- We contacted patients and the public by face-to-face interviews and a web-based survey. We received over 400 replies that helped us understand what people thought about existing services and which things were most important to them.
- We contacted all local Healthwatch groups in the West Midlands to find out about any local issues.

A report on each element of the engagement exercise is included in the needs assessment. The key findings were:

- Patients were unclear about how to access services in an emergency or that they could call NHS 111 for dental advice.
- Most people said that seeing a dentist within 24 hours was important when accessing urgent dental care.
- Most people thought that the opening hours of urgent dental services were important.
- The majority of people currently access services by car (either themselves or as a passenger). Parking was mentioned as being problematic by a number of patients.

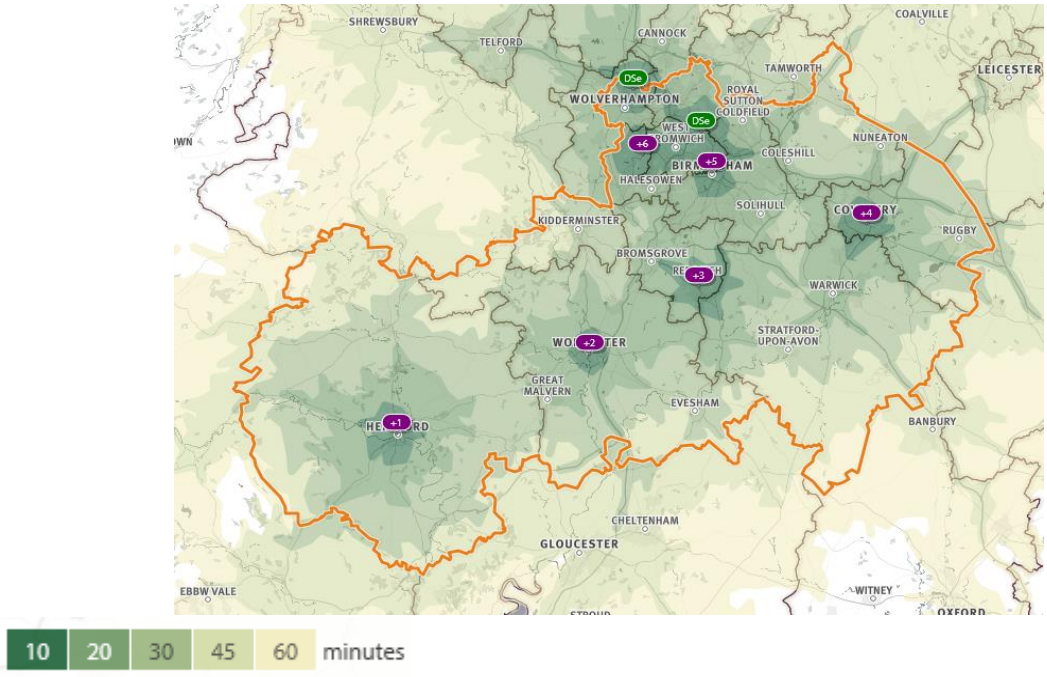
- Most people agreed that they received the level of service they expected, but some patients felt that they had ongoing issues that were not resolved on their first visit.
- A large number of patients received or expected to receive medication when accessing services.

What changes are we proposing?

Having considered the needs assessment, commissioning guidance and feedback from our engagement activities, we propose:

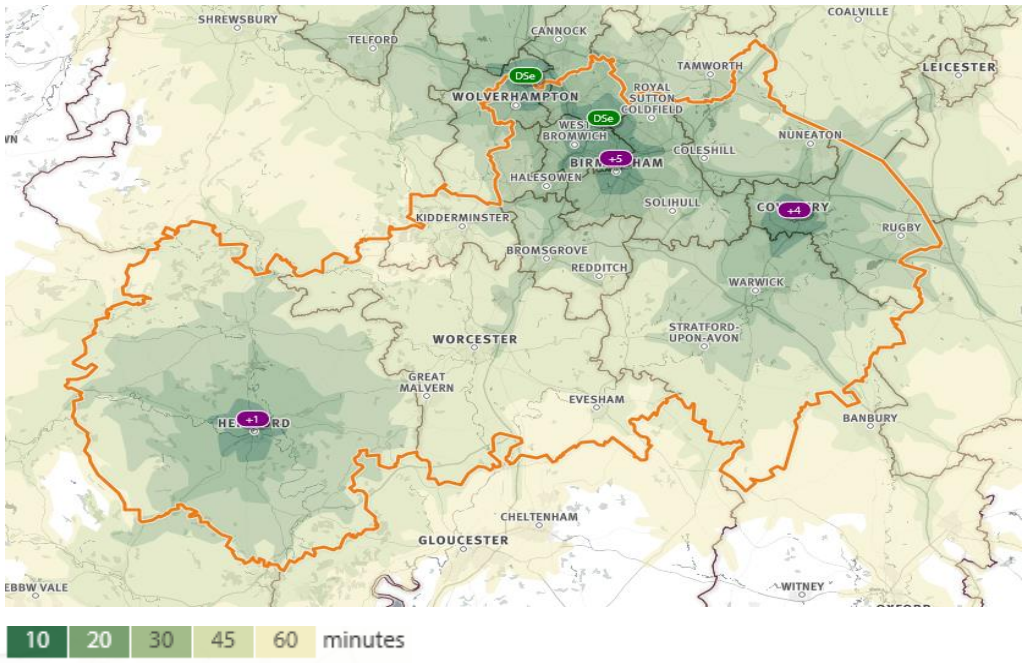
- To operate out of hours dental services at weekends and on bank holidays from eight sites; six new sites (marked purple on Map 1), in addition to two sites from which the existing services will continue on account of their contractual arrangements (marked green on Map 1). The sites marked in purple are indicative only and the actual locations selected will be informed by the outcome of this consultation and any feedback received.

Map 1. Proposed locations for weekend and bank holiday out of hours dental services. The green shading indicates the travel time by car outside of rush hour to each location.



- To operate out of hours dental services on weekday evenings from five sites; three new sites (marked purple on Map 2), in addition to two sites from which the existing services will continue on account of their contractual arrangements (marked green on Map 2). The sites marked in purple are indicative only and the actual locations selected will be informed by the outcome of the consultation and any feedback received.

  Map 2. Proposed locations for weekday evening out of hours dental services. The green shading indicates the travel time by car outside of rush hour to each location.



The consultation is proposing to retain weekday evening services to reflect the fact that further work is needed to improve access to in hours dental care. The reduced number of sites we are proposing during the week reflects the fact that this service will predominantly provide telephone assessment and advice and that fewer people than at a weekend will need to travel to receive treatment from one of the centres.

This service will be available to everyone across the West Midlands for the next two years and will be reviewed again once we have completed our review of in hours services.

Please note that apart from a few dental emergencies where people are seen in A&E, most people need to be seen for urgent dental care within 24 hours. Because of this some areas at present, including Worcestershire, Walsall and Solihull, currently have no weekday evening dental services. Where services are in place, most people receive advice from a dentist and attend a next day appointment. Very few people currently travel to a dentist for treatment in the evening.

Please note that special care dental patients will be telephone triaged by a specialist dentist who will determine the most suitable location should a person require out of hours dental care. For some people this may be A&E. Arrangements for these patients have been considered as part of a separate review of community dental services and are not part of the scope of this consultation.

What do we want to hear about?

We want to hear about your views on the proposed changes to the locations and opening times of out of hours dental services across the West Midlands. This consultation is only on **out of hours dental services** and not general dental services or any other dental services operating in hours.

Who do we want to hear from?

We welcome views from anyone who has opinions to offer on out of hours dental services.

In particular, we want to hear from:

- People who have used the services previously.
- Parents or carers of those who may have used these services.
- Members of the public who may need to use services in the future.
- Any organisations who work in dentistry or who represent groups of people who often access out of hours dental care.

Who is responsible for commissioning the services?

NHS England and NHS Improvement are responsible for commissioning all NHS dental services delivered in England. This consultation relates to services in the West Midlands which consists of the ten local authority areas of Birmingham, Coventry, Dudley, Herefordshire, Sandwell, Solihull, Walsall, Warwickshire, Worcestershire and Wolverhampton.

What do we want you to do?

We want you to share your views by completing the questionnaire. The consultation opens on Monday 15 July 2019 and will close at 23:59 on Friday 30 August 2019.

If you don't wish to complete the questionnaire, but would still like to give us your views please contact us:

By post: Dental Contracting Team, NHS England & NHS Improvement – Midlands, St. Chad's Court, 213 Hagley Road, Edgbaston, Birmingham, B16 9RG

By email: ENGLAND.dentalcontractswm@nhs.net

On the internet: https://www.engage.england.nhs.uk/survey/9ed984b7

By phone: 0113 825 1709

Confidentiality and next steps

All responses will be analysed by NHS England and NHS Improvement and will be handled in the strictest confidence.

- Responses from individuals will be made available to NHS England and NHS Improvement, but any identifiable data will be removed. No individual data will be shared or presented in any report. We may use quotations from responses in our final report about the consultation, but we will anonymise them.
- Responses made on behalf of an organisation may be made available to the public. Responses made on behalf of an organisation should not include any confidential or sensitive data.
- The responses provided will be used to create a consultation report which summarises people's views on the proposed changes to out of hours dental services.
- NHS England and NHS Improvement will provide feedback to patients, families, carers, clinicians, commissioners, other key stakeholders and the public regarding the results of this consultation activity. This feedback will reference clearly what may have changed as a result of the consultation and what the next steps are.
- Following careful examination of the responses to this consultation NHS England and NHS Improvement will consider any necessary amendments that need to be made in

respect of plans for out of hours dental care during week day evenings, weekends and bank holidays.

- It is our intention to run a procurement to identify new providers for services to start from Wednesday 1 April 2020. The findings of this consultation will be used to finalise the plans, service specification and criteria for the opening hours and locations of the new sites.

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Briefing Paper for HOSCs

Consultation on Dental Out of Hours services for the West Midlands (Birmingham, Solihull, the Black Country, Coventry, Warwickshire, Herefordshire and Worcestershire)

Contracts for Dental Out of Hours services in the West Midlands are due to expire on 31st March 2020. It is our intention to re-procure these services and this briefing paper is to inform HOSCs of the upcoming consultation on the options for service configuration. This will take place from 15th July 2019 to 30th August 2019 and will inform our procurement strategy.

NHS England and NHS Improvement – Midlands

What is out of hours dental care?

Out of hours dental care is available for people who need urgent or emergency dental care from a dentist when their dental practice is closed. Urgent dental care covers dental problems that need emergency care (assessment within one hour) or urgent care (assessment within 24 hours) which is often followed by dental advice or treatment in hours. The number of people using these services each week is very small; most dental problems can be dealt with by an urgent appointment with a dentist during normal opening hours.

Where are the existing out of hours dental services provided?

There are a total of 13 locations available for out of hours dental services on weekends and bank holidays across the West Midlands. On weekday evenings services are provided from eight locations across the West Midlands. It should be noted that some of the services are not routinely staffed and operate on a telephone triage model.

Where are the proposed new locations?

Please see the attached consultation document for details of proposals for locations for new services. This also contains a weblink to the consultation website where further information will be available including the full needs assessment which includes full details of current services.

Proposed locations have been chosen based on; the urgent care needs assessment, new commissioning guidance and previous patient engagement. These are indicative only at this stage and we intend to take account of the responses to the consultation when finalising plans before re-procuring the services.

Why is the change necessary?

Contracts for the current out of hours dental services in the West Midlands expire in March 2020. These services were established when the population and its health needs were very different to what they are now. We are looking to make changes to these services so that services will more closely meet the current and future need of people living in the West Midlands. An urgent dental care needs assessment has been undertaken to inform the changes and support addressing the lack of equity in the current service provision. It is envisaged that direct booking via NHS 111 will be introduced at a later date and the current model does not facilitate this.

There is robust evidence to support the proposed changes which can be accessed at:

https://www.england.nhs.uk/publication/commissioning-standard-for-urgent-dental-care/

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/790933/urgent_dental_care_evidence_review.pdf

How does this benefit patients?

Patients will have access to services which are more closely aligned to their needs as identified in the needs assessment and patient and public consultation exercise. The new services will have increased opening hours and the sites from which they operate will be staffed for the duration of their opening hours. This will improve both equity and accessibility.

Is this a cut in services?

No. If the proposal goes ahead the aim is to provide enhanced services within the existing budget.

Why are we suggesting changes to locations for services?

The needs assessment shows the locations and access arrangements of the current services are not equitable. The proposal represents improved equity and improved access for those most likely to use the services.

Will people need to travel further?

In some areas travel time may increase slightly, in other areas it is likely to be reduced. All patients would have access to a service within 60 minutes of their home by car in line with guidance. The vast majority of patients would have access to a service within 30 minutes by car. We intend to review the proposed locations following feedback received during the consultation.

Have patients and the public been engaged?

Yes. We have surveyed the views of people who have previously used the service, the wider public and groups specifically supporting vulnerable people. This formal consultation on the proposed changes will give us feedback on our proposals which will inform any changes necessary to ensure these services meet the needs of the local populations. We will respond to any concerns raised as we design the service for the future.

Why can we not clarify the exact location of the new centres?

It is important to consider feedback received during the consultation before we can determine the exact location of future services. Based on this the locations above are indicative only.

What are the next steps?

To proceed with a formal consultation exercise on how out of hours dental services are configured based on our proposed locations. We are asking the respondents to consider the location, opening times and transportation issues.

How do patients and the public feedback or find out more?

Comments or questions can be e-mailed to ENGLAND.dentalcontractswm@nhs.net or we can be contacted by telephone on 0113 825 4644 and we will arrange for a senior member of our team to return the call.

The deadline for providing feedback for consideration is 30th August 2019.