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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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.