



Commissioning Standard for Dental Specialties – Paediatric Dentistry

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1 Foreword

The [NHS Five Year Forward View](#) sets out a shared view of the challenges ahead and the choices about health and care services in the future. It applies to all services including dentistry and seeks to bring a greater preventative focus into the way we plan and deliver health services. This is particularly appropriate for children.

It is a future that will dissolve the artificial divide between primary dental care and hospital specialists; one that will free specialist expertise from outdated service delivery and training models so all providers can work together to focus on patients and their needs.

The need for change and the shared ambition for the future is the context in which this commissioning standard has been produced. Clinicians, commissioners and patients have contributed to this work to describe how dental care pathways should develop to deliver consistency and excellence in commissioning NHS dental services across the spectrum of providers to benefit patients.

In order to deliver this ambition and implement the pathways NHS England, Health Education England (HEE) and Public Health England (PHE), specialist societies and others who have contributed to their development will need to respond in the implementation phase by unlocking structural and cultural barriers to support transformational change in dental service delivery.

This standard sets out a framework for local work and should be read in conjunction with the [Introductory Guide for Commissioning Dental Specialties](#). The implementation and the pace of change will vary across England and will be dependent on local progress to date. A collaborative approach with a willingness to rapidly share good practice, innovations and learning is required to accelerate the speed and impact of change to improve patient care.

I would like to thank all those who contributed to the development of this document and in particular to Stephen Fayle, Consultant in Paediatric Dentistry, Leeds Dental Institute and chair of the paediatric guide working group.

In addition, my thanks go to those public and patient representatives who attended the various engagement events that were held to seek their views with regard to future commissioning and provision of NHS dental services.



Sara Hurley
Chief Dental Officer for NHS England

2 Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

3 Executive Summary

The majority of children access care and treatment from general dental practitioners (GDPs) but those with severe disease and/or complicating health or social factors need dentists with specialist skills and/or specialist facilities. This commissioning standard explains what specialist paediatric care is, when it is needed, how it can be accessed and how it should be delivered to ensure consistent quality and outcome. It dovetails with the commissioning of programmes at a population or community level to monitor and improve the oral health of children.

In the implementation of these standards, commissioners must have access to an effective Managed Clinical Network (MCN) that covers paediatric dentistry in their area. An up to date need assessment for paediatric dentistry should be available which commissioners and the MCN can consider, together with a stocktake of current service provision and patient pathways. This document contains information on paediatric treatment complexity levels and the corresponding competence of the dental professional required to deliver care at each level of complexity. Commissioners and the MCN should assess current pathways against these complexity levels; this will demonstrate where service transformation is required, so that children receive the care they need, provided by an appropriately qualified and trained member of the dental team. This care should be delivered as local to the child as is possible. Where specialist care is needed, commissioners and the MCN will need to use their knowledge of the current workforce to plan the changes required. The MCN will have a critical role in devising innovative solutions such as hub and spoke services and local pathways that enable support and development of the workforce. Commissioner support to enable these transformations will be necessary.

The aim of this publication is to support commissioners to deliver the transformation necessary by working in conjunction with local clinicians through an effective and supported MCN. Children should then be able to access the appropriate level of care to meet their needs.

4 Introduction

This document defines the NHS England paediatric dental care pathway and sets out the minimum standards that when implemented commissioners must expect all providers of paediatric dental services to adhere to.

4.1 Requirements to conform

The standards and process laid out in this document are to be applied to all new applications to tender and subsequent awards of contract for NHS England commissions of paediatric dental services. Commissioners are to work with existing providers and agree a timetable for adoption of these standards. Commissioners are to aim for a compliance date as soon as possible. All providers must meet those standards set by professional bodies and be compliant with those standards set out in this document as agreed with their commissioners.

5 What is Paediatric Dentistry?

5.1 Description and scope of the specialty

The specialty of paediatric dentistry provides specialist oral healthcare for children from birth to adolescence whose needs cannot be managed by their GDP.

This includes children and young people (CYP):

- with extensive oral disease,
- whose oral health care is complicated by intellectual, medical, physical, social, psychological and/or emotional factors/disability.
- with developmental disorders of the teeth and mouth.
- who are either too anxious or too young to accept routine dental treatment.

The age range covered by the specialty is normally regarded as 0-16 years; however children will start the transition process to adult oral health services some time before their 16th year.

- Paediatric dentists may also play a role in care for 'looked after children', and those for whom the local authority and their partner commissioning bodies must make arrangements for their healthcare. This may include vulnerable children with special educational needs or a disability.

5.2 Relationship to other specialties

Management of children with complex dental problems requires paediatric dentists to work in multidisciplinary teams (MDTs) with other appropriate dental specialties, including orthodontics, restorative dentistry, maxillofacial and oral surgery and oral medicine. Specific multidisciplinary clinics need to be established to enable this.

For those requiring on going specialist care into adulthood, transition to other adult specialties such as special care dentistry or restorative dentistry, may occur during adolescence. Transition must be carefully planned, co-ordinated, systematic, and prepared well in advance of the actual transition phase.

Close links with key medical paediatric specialties is essential, especially in the hospital setting for children where dental disease either presents a special or increased risk to a child's health and wellbeing or where the management of dental disease might involve specialist paediatric support. Consultant-led paediatric dentistry services should be available in all children's hospitals.

5.3 Description of the national picture

The most common disease affecting children in England is dental decay which is largely preventable. Poor oral health has a significant impact on the quality of life causing pain and embarrassment, limitation of function and is costly to treat. Children's pain and sleep disturbance also affects parents and carers, often disturbing home and work routines.

The latest [Child Dental Health Survey for England](#) showed 31% of 5 year olds and 45% of 8 year olds has experience of dental decay. Over half of 12 year olds and nearly two-thirds of 15 year olds in the UK have 'clinical' decay. In addition it reported children coming from lower income families are:

- almost twice as likely to have decay,
- more likely to experience toothache,
- likely to have difficulty in finding an NHS dentist and
- likely to report problems in their daily life caused by their oral health.

In 2015-16 tooth decay was the most common reason for hospital admission for children aged 5 to 9 years-old and the sixth most common procedure in hospital for children aged 4 years and under. In 2015-16 tooth extractions in children aged 0-19 years cost approximately £50 million. [Data from Public Health England](#) show the majority of these extractions were for tooth decay.

6 Understanding current provision

The majority of dentistry delivered to children is provided in primary care by dentists, therapists, hygienists and dental nurses as part of general dental service arrangements (GDS). According to [NHS Dental Statistics for 2016/17](#), the number of children seen by an NHS Dentist in the 12 months up to the 30th June 2017 was 6.8 million. This equates to 58.2 per cent of the child population. Fluoride varnish treatment was provided to children 4.7 million times during the same period. This represents a 13.9 per cent increase from 2015-16.

GDS children's dentistry is normally delivered under the current national contract using weighted courses of treatment (units of dental activity) as an activity measure. It has been suggested that the contract does not overtly incentivise prevention and that is the perception of many GDSs. Some progress has been made, particularly around fluoride varnish application, following the publication of national prevention guidelines, [Delivering Better Oral Health \(DBOH\)](#). Given that all children over the age of 3 should be receiving fluoride varnish application at least annually more needs to be done to promote an active approach to preventive care and treatment in primary dental care delivery in England to reduce this inequality. Additionally in some areas of the country NHS England's "Starting Well" programme which aims to increase access to early evidence based prevention and support families and practices in caring for young children is being promoted" (Appendix 1)

Commissioners should consider whether any of the options in the Starting Well programme are appropriate within their locality, based on local needs assessment. To support this initiative, NHS England has issued an [avoidance of doubt notification](#) to provide clarity for dentists about examining and treating very young children.

Although the majority of care for children is routine and preventive and carried out in the GDS, there are sub groups of the child population who will require professionals with additional competencies or skills because of their additional needs, both in terms of technical difficulty and patient modifying factors (such as impairment, disability, anxiety, medical co-morbidities).

Traditionally, those with additional competencies or skills are specialists or consultants in paediatric dentistry and are mainly based in community dental services (CDS), or in dental hospitals. A small number of specialists are based in other hospitals (such as teaching hospitals without dental schools or district general hospitals) or in primary care specialist practices. In addition a number of generalists with an interest in paediatric dentistry provide some care in specialist practices, CDS and hospitals. It is important to recognise at this point that specialist paediatric dentistry is not synonymous with the CDS. It is a specialty related wholly to children, whereas many CDSs will also provide other services such as special care dentistry (adult service) in addition. Children with special needs fall under the remit of paediatric dentistry rather than special care dentistry but their transition to special care dentistry is jointly the responsibility of both specialties.

Some children also need access to specialist facilities as well as professionals with additional competencies, such as those requiring a general anaesthetic or sedation. Although many CDS and all dental hospitals provide such services, treatment under general anaesthetic is often carried out in district general hospitals by maxillo-facial and oral surgery teams without paediatric dentistry specialist input. This approach is not aligned with current specialist paediatric anaesthetic guidelines, [Guidelines For The Management Of Children Referred For Dental Extractions Under General Anaesthesia](#). As such, commissioners must agree a timetable with the provider for meeting the professional guidelines.

In addition to the provision of dentistry for children with additional needs, there is specialist paediatric dentistry input into various multidisciplinary teams including cleft lip and palate networks, some medical teams (often via paediatric dentistry).

Many providers of specialist paediatric dentistry within community dental services (CDS) still have contracts inappropriately based on units of dental activity (UDAs). There is a recognised need for consistency in the commissioning and provision of specialist paediatric dentistry. Commissioners should review contracts for specialist paediatric dentistry and ensure they are based on appropriate metrics and KPIs.

7 Commissioning steps for delivering paediatric dental services

7.1 Establishing a Paediatric MCN

Commissioners should familiarise themselves with the National NHS England current core MCN terms of reference (Appendix 2) and MCN job description (Appendix 3) and liaise with the local dental network (LDN) to establish one.

The British Society for Paediatric Dentistry can help to locate local specialists or consultants. They can be contacted by emailing administrator@bspd.co.uk

In addition to commissioning paediatric dental services commissioners are to seek opportunities for collaboration with other healthcare teams such as allied health professionals in common factors causing caries, childhood obesity, diabetes and fatty liver disease.

7.2 Assessing the need for Paediatric Dentistry

7.2.1 Assessing the need and current service scoping

The commissioning of any dental service should be based on a future proofed needs assessment. Commissioners and MCNs are expected to be engaging with local consultants in dental public health to assess whether any existing oral health needs assessment can be identified and remains relevant or whether a new paediatric oral health needs assessment is required for their child population.

Commissioning of appropriate services requires a need led approach. Commissioners will need to assess the amount of care that will need to be secured at the different levels of care. There is no one single source of data which identifies children who may require specialist dental care. A child may require specialist care for some or all of their dental care. This may vary with age, time and changing nature of their dental or medical conditions.

The groups of children for whom specialist paediatric dental services should be commissioned will include those with:

- Medical conditions classified [ASA2](#).
- Moderate / severe and profound and multiple learning disabilities.
- Moderate / severe physical and/or communication impairment.
- Moderate / severe chronic mental health problems.
- Moderate / severe behavioural problems.
- Cardiac, cleft lip and / or palate in conjunction with specialised commissioning.
- Children 'in need' from a safeguarding perspective and those 'looked after' with additional or complex needs.
- Severe dental anxiety.
- High levels of dental disease.
- In-residential settings.
- Additional needs.

Appendix 4 provides a tool to aid the estimation of volumes of children requiring different levels of care.

Commissioners can also use the following to assist with their needs assessments:-

- [Introductory Guide to Dental Specialties](#); section 6.
- [NICE guidance Oral Health](#); local authorities and partners.

The findings of this needs assessment will need to be compared with current service provision and local evidence of need for care (for example, referral volumes).

A separate scoping of current services needs to be carried out with reference to the needs assessment, regarding their adequacy, effectiveness and appropriateness. This will determine the level to which services will need to be redesigned and developed. To help identify any gaps in current provision the review of services should encompass the entire clinical pathway and not focus on individual services in isolation.

The result of the needs assessment and an understanding of current services should be considered in collaboration with the MCN to determine the volume(s) and level of services which need to be commissioned in the future.

Around 20% of children are not taken for regular dental care, so development of innovative and imaginative ways to identify these children and facilitate and monitor their attendance is needed. ([Child Dental Health Survey 2013, England, Wales and Northern Ireland](#))

8 Treatment complexity levels

The Department of Health (DH) Advanced Care Pathway Working Group previously defined procedures and modifying patient factors that describe the complexity of a child's dental care.

These have been refined to provide a more comprehensive framework to guide the commissioning process:

Level 1

Conditions to be performed or managed by a dentist commensurate with level of competence as defined by the Curriculum for Dental Foundation Training or its equivalent.

- Oral health assessment of need and circumstances, oral health review, risk screening and treatment planning including appropriate referral where necessary for all children
- Evidence-based preventive care, advice and interventions
- Restorations of primary and permanent teeth with the use of local anaesthesia where appropriate, including pulp therapies of primary molars and pre-formed metal crowns where appropriate
- Uncomplicated endodontic treatment of permanent teeth
- Simple partial dentures and removable space maintainers
- Routine extraction of primary and permanent teeth under local anaesthesia
- Emergency and / or urgent treatment and management of pain, infection and dento-alveolar trauma including avulsed teeth
- Timely identification and referral of significant developmental defects of the dental tissues and disturbances of the developing dentition
- Management of dento-alveolar traumatic injuries to the primary and permanent dentition (for example subluxation and mild luxation injuries of primary and permanent teeth; uncomplicated crown fracture of primary or permanent incisors)
- Appropriate referral of children requiring more complex treatment that is Level 2, 3a or 3b

Level 2

Care is defined as procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register. This care may require additional equipment or environment standards but can usually be provided in primary care.

- Management of dento-alveolar trauma of increased complexity including
- Management of complicated crown fracture of permanent teeth
- Management of injuries to primary teeth not manageable by restoration or extraction
- Root and crown-root fractures of permanent teeth without complicating factors.
- Post-emergency follow-up of multi-tooth injuries in the permanent dentition
- Post emergency follow-up of permanent tooth avulsion and significant luxation injuries, especially where complications are more likely to develop.
- Emergency management of injuries to primary and permanent teeth where the complexity of emergency management lies beyond Level 1

- Management of hard-tissue dental defects and disturbances of the developing dentition not requiring specialist or multi-disciplinary management for example early permanent tooth surface loss, developmental defects of primary or permanent teeth amenable to and stabilised by simple restoration.
- Management of more complex problems affecting the developing dentition or dental hard tissues under the direction of a specialist or consultant in Paediatric Dentistry.
- Extraction of teeth under general anaesthesia.
- Management of children with routine oral health surveillance or treatment needs but where behavioural/psychological development or significant anxiety increases the complexity of delivery of care such as those requiring sedation.
- Management of children with routine oral health surveillance or treatment needs but where medical comorbidity or disability increases the complexity of delivery of care.
- Inhalation sedation where appropriate for all ages of children and IV sedation for children of 12 years of age and above.
- Management of children with extensive caries or early childhood caries amenable to care under local analgesia or with sedation as described above as an adjunct.
- Assessment and management (or referral to a higher level as appropriate) of children subject to a child protection plan or looked after by the local authority (usually in foster or residential care) who either have no current arrangement for on-going oral health review with the GDS or who are identified to have unmet dental needs.

Level 3a

Care & procedures/ conditions to be Performed or managed by a dentist recognised as a specialist in paediatric dentistry by the GDC.

- Severe early childhood caries or unstable/extensive caries (especially where treatment under general anaesthesia may be necessary).
- Moderate to severe tooth surface loss in the permanent dentition.
- Abnormalities of dental development not amenable to simple preventive or restorative management or where specialist management is needed e.g. moderate/severe molar incisor hypomineralisation (MIH), amelogenesis imperfecta, dentinogenesis imperfecta, mild to moderate hypodontia.
- Supernumerary teeth and/or delayed eruption of permanent teeth not requiring complex surgical or multidisciplinary management.
- Restorative and exodontia treatments for children being managed under the direction of a regional MDT with cleft lip and/or palate.
- Dento-alveolar trauma requiring more specialised management including:
 - Avulsion injuries and post-avulsion management, especially where complications have developed.
 - Management of injuries to immature permanent incisors where endodontic management is required.
 - Moderate to severe luxation injuries, especially where complications have developed.
 - Injuries involving significant damage to multiple teeth.
 - Aggressive periodontitis or other less common periodontal/gingival conditions.
 - Uncomplicated dento-alveolar surgical interventions.
- Dental care of children with significant anxiety and/or behavioural disturbance.

- Treatment planning, support and follow up for children requiring extractions under general anaesthesia.
- Treatment planning and delivery of comprehensive dental care under general anaesthesia.
- Oral health surveillance and or treatment needs where significant medical comorbidity or disability increase the complexity and risks of delivery of care. Such care may be shared with a consultant and many such children will be under the on-going care of a Paediatrician. For example:
 - Significant cardiovascular disease.
 - Significant abnormalities of haemostasis.
 - Children undergoing treatment for haematological or organ malignancies.
 - Children with significant disability or learning difficulties.
- Children with significant behavioural problems or communication disorders (autism).

Level 3b

Care should be delivered by a dentist recognised as consultant in Paediatric Dentistry.

- Assessment and management of complex dental or cranio-facial conditions which require a multi-disciplinary team input to treatment planning and care or where management of a disturbance in dental development is complicated by features requiring input/active treatment from other dental specialties. Examples include:
 - Moderate to severe hypodontia, and significant dental hard-tissue developmental defects, especially during transition into orthodontic and definitive adult restorative management and treatment.
 - Traumatic dento-alveolar injuries where significant complications have arisen, especially where multidisciplinary planning and care is required.
 - Premolar transplantation.
- Patients requiring obturators or other more advanced intermediate restorative management.
- Patients with complex presentations of tooth morphology (macrodonia, double teeth, dens-in-dente, talon teeth).
- Assessment and management of oral pathology or oral medical conditions.
- Assessment, surveillance and treatment of children with significant co-morbidity being managed by other paediatric specialities (for example oncology, cardiology, haematology, hepatology, nephrology, endocrinology). This may include providing urgent dental treatment prior to open heart surgery, organ transplant or prior to commencing chemotherapy, for example.
- Assessment and management of children with a significant disability, co-morbidity, significant behavioural disturbance (e.g. children with severe autism) or severe anxiety who require hospital based and/or multidisciplinary work-up and support prior to and/or as an adjunct to delivery of dental treatment.
- Treatment planning and comprehensive care under general anaesthetic, involving more difficult surgical or restorative procedures, or where the child is undergoing joint procedures with another surgical specialty.
- Acute dental emergencies.

Modifying Factors:

The level of procedural complexity may however change depending on severity of disease and/or one or more of the following factors:

- Medical History.
- Social factors.
- Anxiety.
- Social and cognitive maturity.

Children referred with a suspected oral malignancy should be seen in line with the locally agreed cancer referral pathways and protocols.

9 Components of clinical care pathways specific to specialist paediatric dental care

Commissioning of specialist paediatric dentistry services should encompass the entire clinical pathway and not just focus on individual services. But certain service components specific to paediatric dentistry require a detailed understanding to ensure they are appropriately commissioned and integrated within holistic care pathways.

9.1 Dental care under general anaesthesia

Dental treatment under general anaesthetic (DGA) is an essential adjunct to providing care where the surgical intervention is complex or to those children who are cognitively immature, highly anxious or who have a medical condition where general anaesthesia is the most appropriate or only way to deliver dental treatment.

The assessment and planning prior to DGA should be led by a specialist or consultant in paediatric dentistry (with the possible exception of some acute admissions being managed by maxillofacial and oral surgery teams). Dental procedures should only be performed under general anaesthesia when it is judged to be clinically necessary. Other options should be considered and be available to the specialist team carrying out the assessment, including local anaesthesia and conscious sedation.

Children undergoing DGA should receive the same standard of assessment and preparation as children admitted for any other procedure under general anaesthesia as set out in the [Standards for Children's Surgery' RCOA 2011](#). Comprehensive dental care, such as cases where restorative care is being provided, should be provided by specialists and/or consultants. This has been shown to improve patient experience, perioperative morbidity and reduce the need for repeat general anaesthesia, which in turn reduces risk and cost.

Appendix 9 provides an example of specialist pathway guidance.

9.1 Description of current workforce and training

In the main dental care for children is provided in primary care. The primary care teams are expected to provide comprehensive dental care for children where delivery is not complicated by significant modifying factors which may cause difficulty in a child being able to co-operate

or be at risk of receiving dental care, due to anxiety, medical comorbidity, disability or age and severity of disease.

Specialists in paediatric dentistry on the General Dental Council (GDC) Specialist List have completed 3 years postgraduate training to obtain a certificate of completion of specialist training (CCST). Registered specialists can provide a full range of care and treatment within the competencies defined by the Curriculum of Specialist Training. Some provide this treatment themselves but some also provide the treatment as part of a team utilising dentists with enhanced skills and competence and/or dental therapists.

Consultants have undertaken a further 2 years training to achieve additional competencies in specific areas such as complex multidisciplinary care, including delivery of integrated care with other paediatric and dental specialties.

9.2 Anxiety Management and Care with/without sedation

Anxiety Management and care under sedation can allow comprehensive care to be provided for children who suffer disproportionate anxiety or need potentially distressing dental procedures such as minor oral surgery. Availability of dental treatment under sedation (especially inhalation sedation with nitrous oxide and oxygen) is an essential component of clinical care pathways and in common with general anaesthesia services, commissioners and MCNs need to ensure adequate provision to meet population needs.

Commissioners need to consider contemporary standards when drawing up specifications for new sedation services and should refer to the [Dental Commissioning Guide – Service Standards for Conscious Sedation in Primary Care](#).

Dental assessment and treatment planning should only be carried out by an appropriately trained and experienced dentist.

9.3 Safeguarding

It is a statutory requirement for all healthcare professionals to contribute to safeguarding children by working with social care and other agencies as set out in [Working Together to Safeguard Children](#).

Clinical input to safeguarding children by dentists falls into three domains:

- Making child protection referrals to children's social care where a child is thought to be experiencing or at risk of significant harm because of maltreatment. Wider measures contributing to safeguarding children's health and wellbeing, such as the identification and referral of children who may benefit from social care assessment and early help.
- Communication with other professionals (including writing reports) regarding children already identified as at risk or maltreated (identifying persistent failure to bring children for dental care should be considered a safeguarding issue)
- Communication with other professionals (including writing reports) regarding children already identified as at risk or maltreated:

- (a) Children who are undergoing medical examination for suspected neglect.
- (b) Children subject to a child protection plan.
- (c) Some looked after children (annual dental visits for looked after children are a requirement and are already subject to monitoring).

Achievement of this should be considered by commissioners and MCNs in transforming services together with identifying safeguarding leadership for dentistry.

9.4 Referral management system

Referral management systems (RMS) which employ appropriate and consistent referral acceptance criteria should be established to improve services for patients and allow us to get the best use of limited resources. To achieve this, the following will need to be considered:

- Referral proformas and guidelines. Appendix 6 and Appendix 7 contain more detail.
- Referral handling processes and mechanisms.
- Acceptance/Triage criteria.
- RMS Data capture and monitoring parameters.

10 Transforming services and future commissioning

Commissioners should work with partner organisations such as the local authorities and PHE to ensure that public health functions such as dental epidemiology are completed and health improvement programmes are in place. The Health and Social Care Act (2012) conferred the responsibility for health improvement, including oral health improvement, to local authorities. [Improving oral health: an evidence-informed toolkit for local authorities](#) to support these responsibilities was issued in June 2014. Whilst not the direct remit of NHS England, it is helpful that commissioners and clinicians involved in the commissioning or delivery of care are aware of these commissioning responsibilities and help to co-ordinate approaches locally.

Commissioners and clinicians are expected to work with key partners including local authorities to ensure that their responsibilities are fulfilled. NHS England encourages commissioners and clinicians to work with their local authorities to ensure the development and delivery of services to improve the oral health of children.

10.1 Ten priorities

To give the commissioning process focus, a summary of the key priorities are below:

- Ensuring all children have the best chance of maintaining good oral health by keeping preventable dental disease to a minimum should be a key aim at all levels of care. Better integration between dental services and other key child health services is essential for the most effective prevention of dental disease.
- All children should have their first oral health assessment (dental check including all DBOH evidence-informed advice) by one year of age. This should be encouraged and monitored by other healthcare professionals in contact with families of young children.
- Children experiencing a sleepless night because of severe dental pain or infection should be able to access appropriate urgent and/or emergency care within 24hrs.
- All children should be able to access regular dental care. If they require specialist paediatric dental care, services should be accessible within a reasonable travelling distance and have short waiting times - especially for children with a history of pain and/or infection.
- There should be parity of timely access to, and outcome of, primary and specialist paediatric dental care regardless of geography. This may be achieved by consultants working in a network, providing services in outreach clinics (outside of hospitals and within community settings) and supporting local dentists with advice and training.
- Specialist dental care for children should follow an agreed and communicated plan and should be overseen by a named clinician.
- Ideally all children who need dental treatment under an elective general anaesthetic should have that care treatment planned by a specialist paediatric dentist. When adopting these standards, dentists providing this, who are not specialists, must be aligned to a specialist led Paediatric Dental MCN and follow its protocols, and undertake training and audit under the direction of the MCN. Paediatric MCNs may need to cover a broad geographic footprint to ensure that specialist leadership is available.

- There should be adequate numbers of paediatric dental consultants, specialists and dental care professionals working within specialist led teams to meet identified need and take a proactive role in MCNs.
- Information about a child's paediatric dental management should be fully integrated into NHS information registers, and those involved in delivering dental care for children should have access to the appropriate information systems. This will also facilitate reporting of relevant dental care with other health and social care providers.
- There should be adequate and consistent data capture and reporting of need and the outcome of paediatric dental care to support informed commissioning and QA of paediatric dental services.

10.2 Support to primary care

Commissioners need to support GDPs providing services in areas of high deprivation or where health inequalities exist by exploring flexibility in current contracting arrangements to enable practices to provide care for vulnerable children and their families. This may require outreach into community settings, links with health visitors and use of dental care professionals.

10.3 Delivery of paediatric dentistry in the community dental service

Many clinicians currently working in CDS provide paediatric dentistry and special care dentistry, but the commissioning of each specialist service needs to be addressed separately and [Guides for commissioning dental specialties – Special Care Dentistry \(SCD\)](#) have been produced. Although there should be separate specifications, both services can be commissioned from one provider, this aids transition between child and adult services.

10.4 Trauma and out of hours care

Commissioners are to ensure sufficient 24/7 provision and clear signposting to trauma care and out of hours dental care services for the timely and effective management of dental trauma in children. Commissioning should be based on a needs assessment, appreciate and be sensitive to seasonal change and local geo-demographic factors.

10.5 Care for medically and dentally complex children

There are variations in the current coding systems which make it difficult to collect accurate data about medically complex patients accessing consultant-led paediatric dentistry services. Consideration should be given to the establishment of specialty specific tariffs and use of the specialty code to identify specialist provision and complexity of procedure and patient care for dentally complex children.

Secondary care paediatric dentistry services are often stretched by the numbers of CYP requiring exodontia under GA. This has made it increasingly challenging to provide adequate and appropriate high quality restorative care for patients with high dental needs such as children with dental anomalies, hypodontia and those who require fixed and removable prosthodontics following trauma.

10.6 Opening Hours

Parents face continual problems with removing children from school to attend dental appointments. Across the spectrum of dental care for children, service providers are to be responsive and offer a range of appointments outside school hours wherever possible. Commissioners should utilise flexibility in current primary care contracts to ensure that those practices and services operating in deprived/high needs areas are supported to offer proactive evidence informed prevention and effective restorative care.

10.7 Transition to adult services

Commissioners are to actively work with, support and facilitate MCNs to develop appropriate pathways for transition.

Where children are likely to require on-going specialist oral and dental care through adolescence and into adulthood (usually beyond their 16th birthday) it is important to plan appropriate transition on to relevant adult oral health care services.

Transition should be a managed process, facilitated by an introduction to adult services at a suitable stage prior to full discharge from paediatric dentistry services. Each paediatric dentistry MCN should work in conjunction with the relevant MCN(s) responsible for appropriate adult specialist services (for example special care dentistry, restorative dentistry) to agree and define the local principles and pathways for transition from paediatric dental care into adult oral health care services.

10.8 What can be done now?

The MCN should advise on which current pathways need to be evaluated and redesigned to accommodate the new recommendations. Appendix 8 sets out an illustrative patient pathway. Relationships with other paediatric medical and surgical specialties, and other dental specialties, should be considered. The following specific issues need to be considered:

- Levels of complexity and which patients are likely to be successfully managed at which level.
- Models for commissioning/delivery of different levels.
- Movement of patients between levels/providers.
- Special considerations/components within the integrated pathway:
 - Out-of-hours emergency care.
 - Paediatric Dentistry contribution to cleft lip and palate services.
 - Sedation.
 - General anaesthesia.
 - Dento-alveolar trauma.
 - Care required within a children's hospital setting or district general hospital
 - Patients for teaching/training.
 - Transition from paediatric dentistry to adult dentistry services.

Any service provision for DGA should include specification of the workforce to include appropriate specialist input as above. Where this is not available providers should have

additional skills, competence and experience and a formal link to a MCN for paediatric dentistry to ensure case planning is specialist led.

Commissioners, the LDN and MCN will need to review general anaesthetic services for children and young people as part of service transformation. They need to understand need, criteria for acceptance and likely volumes. The requirement to have a paediatric anaesthetist and recovery nurse may mean that theatre time for GA sessions have to be aggregated to single sites. Commissioners will need to work with the hospital providers to ensure that appropriate levels of dedicated theatre time are available to meet the identified need.

Current [NICE guidance](#) recognises that professionals should “consider neglect if parents or carers have access to but persistently fail to obtain NHS treatment for their child's dental caries (tooth decay)”. Hence, failure to bring children for appointments on multiple occasions (WNB – ‘was not brought’) needs appropriate follow up and action. Whilst it may currently be difficult to ensure that the NHS number is available and used throughout dentistry access until dentistry has access to the NHS spine to considerably facilitate these activities, commissioners and their providers need to ensure that appropriate mechanisms are in place.

To assist with safeguarding issues, commissioners should ensure that local safeguarding boards have a formal link to a specialist in paediatric dentistry that can offer professional advice and attend as necessary.

11 Procuring services

The introductory guide, Commissioning Specialist Dentistry Services, sets out the commissioning intentions and approaches to procurement and should be read in conjunction with this standard.

11.1 Minimum service specification

Commissioners must consider elements such as location of services and hours of operation. The illustrative patient journey at Appendix 8 also contains details of standards which should form part of any specification.

Level 1 care is provided by primary care dental workforce and services are included within GDS and PDS contracts. Commissioners need to ensure that the expected care is being appropriately provided under those contracts. Anxiety Management and behavioural support may enable comprehensive care to be provided for many children for whom routine dental care is initially distressing. Commissioners should consider the variety of GDP (Level 1 care) contractual options that can support and remunerate GDPs for the requisite additional time involved in anxiety management and the subsequent provision of routine dental care for children.

A minimum service specification for the Level 2 and Level 3 services commissioners need to commission should be drawn up using the guidance included within this guide. The MCN should be involved in this process once an initial draft has been formulated.

An example Core service specification is included at Appendix 5 and a minimum specification included below

This is not a comprehensive service specification: these elements need to be included in addition to other requirements which might be defined and determined locally.

Level 2 Care

Facilities

In addition to the requirements at Level 1, identified in the introductory guide, providers accepting Level 2 complexity referrals should ensure that they are able to provide (not every surgery but across the service):

- Child friendly and child safe environment (child health to be included in review of this)
- Where manual transfer, hoisting or lifting of patients into the dental chair is not appropriate, equipment should be available to safely recline wheelchair patients in order to carry out dental treatment
- A variety of communication aids should be available and staff trained to use them
- Equipment to support the delivery of conscious sedation to the contemporaneous national standard
- Access to intra-oral and OPG radiography equipment
- Appropriate equipment to perform any Level 2 complexity treatment that may be required by the patient, for example microscopes to support endodontic delivery.
- Paediatric Resuscitation equipment and appropriate training
- Access to a multi-disciplinary team for any complex care.
- Access to facilities for providing treatment under general anaesthesia for children should be available in the MCN geographical area
- Orthodontic equipment to support treatment of trauma

Training

- Continuing professional development of relevance to Paediatric Dentistry including evidence informed preventive interventions and treatment
- Adherence with the current national guidelines on sedation.
- Working knowledge of Mental Capacity Act including consent issues in children
- Conscious sedation techniques
- Ability to undertake treatment under GA
- Safe use of specialised equipment, for example hoists and use of positioning aids
- Range of behavioural management skills and techniques
- Non-verbal communication methods
- Skills in examining the mouth in children with limited ability to cooperate
- Clinical holding skills
- Paediatric Immediate Life Support including Immediate Life Support
- Dental nurses appropriately trained e.g. Certificate in Special Care/Paediatric Dental Nursing Certificate in Dental Sedation

Access

- Providers should offer timely assessment (no longer than 48 hours) for patients who have an urgent clinical need
- Patients requiring non-urgent care (including treatment under sedation) should be able to commence treatment within 18 weeks of referral to the service

Clinical Governance

As Level 1 and in addition:

- Providers will have appropriate risk management policies and processes and be able to demonstrate how risks are monitored, reviewed and managed.
- Providers will review clinical and other standard operating procedures on a regular basis and be able to demonstrate that this is undertaken and staff appropriately informed.
- Access to support of a specialist in paediatric dentistry. This may be from involvement in specialist led MCN.
- Two qualified clinicians will be available to participate in best interests decisions when necessary.

Information Governance

As at Level 1

Level 3 Care

Facilities

In addition to the requirements at Level 1 and Level 2, providers accepting referral for Level 3 complexity are expected to have premises that include:

- Child friendly and child safe environment (Ref national service framework for children, families and maternity services).
- Access to multi-disciplinary team and facilities for cases where shared care approach is required.
- Arrangements for transport of patients requiring more than one handler should be available (for example two-man ambulances).
- Facilities for the safe treatment of bariatric patients should be available.
- Access to cone beam tomography facilities.

Training

Training for the dental team at Level 3 should include all of Level 2 requirements and:

- Medical risk assessment.

- Conscious sedation techniques as applied to medically compromised patients and patients with behavioural problems (ASA II, III).
- Assessment and treatment planning skills for treatment under general anaesthetic.
- Leadership skills so service is able to provide clinical leadership across the paediatric pathway for example by chairing MCN.
- Skills to support collaborative working with medical specialities in secondary care including haematology, cardiology, oncology and mental health.
- Specialist and consultant included on specialist list in paediatric dentistry.
- Appropriate training to support the delivery of education and training for example training the trainers, equality and diversity, bullying and harassment.

Access

- Providers should be able to offer an assessment within 48 hours for patients who have an urgent clinical need.
- Dedicated theatre sessions are to be available each week for patients who require GA (with appropriate dental nurse support who has experience in paediatric dentistry).
- Patients should be able to access treatment under GA within 4 weeks if there is an urgent clinical need (for example pain/ infection) or 18 weeks for routine treatment for example extraction of supernumerary teeth.

Clinical Governance

In addition to the requirements at level 1 and Level 2:

- Clinical leadership from a consultant in paediatric dentistry.

Information Governance

As at Level 1 and 2.

12 Quality and outcome measures

There are currently no specific outcome measures in widespread use throughout the specialty, and so this is seen as a key area for future development.

Ideally, the following five key areas should be encompassed:

- Access.
- Communication.
- Value for money.
- Clinical care (including safeguarding).
- Patient experience.

At this stage, only a limited number of specific measures are proposed, with the intention to trial these across the specialty. It is proposed that a broader range of measures, including some Patient Related Experience Measures (PREMs) of dental anxiety and communication be developed in the future.

12.1 Patient reported outcome measures and patient reported experience measures

Patient reported outcomes (PROMS)

These should be able to measure any difference in oral health after specialist treatment, irrespective of the presenting condition or treatment. The following self-completed global questions could be utilised as a measure of children's perceived oral health and oral health-related quality of life at baseline and following any intervention:

Global rating of oral health (Gilchrist 2015)			
How much of a problem are your teeth for you?	A lot.	A bit.	Not at all.
Global change in oral health condition (following treatment) (Gilchrist 2015) Please circle one answer			
Since your treatment, do you think your teeth are:	Better?	The Same?	Worse?

Parent/carer reported outcome measures

These should complement those being used by children, so two global questions could be applied to record parents'/proxy assessment of the child's oral health as well as treatment-related change:

Global question about impact of oral health on life overall rating (proxy) (Jokovic 2003)					
How much is your child's overall well-being affected by the condition of his/her teeth, lips, jaws and mouth?	Very much.	A lot.	Some.	Very little.	Not at all.
Global treatment-related change (D'Souza et al, 2016)					
Since the treatment of your child's teeth, has your child's overall quality of life been:	Much improved?	A little improved?	The same?	A little worse?	Much worse?

Patient Reported Experience Measure

This should reflect the development and understanding of the child through a child friendly delivery mechanism for example pictorial or computer-aided.

Example: Did the dentist deliver understandable advice?

13 Contracting

13.1 Consultation and patient involvement

The development of this standard and the main guide has been influenced by several patient engagement events where the views of children and young people and their parents and carers have been heard.

Whilst patient involvement has been central to the development of all the standards and guides, this does not mean that commissioners can omit this vital work as part of service transformation or the re-commissioning of services. Commissioners will need to consider, on a case by case basis, whether consultation and patient engagement activities may be necessary and whether their duty to undertake such a process is triggered by any service transformation or commissioning/procurement activity. Commissioners need to be aware that a service change which may not result in the tendering for a new contract may also require patient involvement and consultation.

NHS England has a legal duty under section 13Q of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) to properly involve patients and the public in commissioning processes and decisions.

The ways in which NHS England is to do this are set out in the [Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning](#).

13.2 Contracting forms

[NHS Personal Dental Services \(PDS\) Agreement 2013](#)

[NHS General Dental Services Contract 2013](#)

[NHS Standard Contract](#)

NHS PDS Agreements and GDS Contracts enable contracting for advanced mandatory primary care services that could include paediatric dentistry. PDS contracts can specify the length of contract and can be used where the full range of mandatory services are not being provided. The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.

13.2.1 Factors for consideration

- Patient charge revenue (PCR): PDS and GDS contracts permit collection of PCR; NHS standard contract does not.

- Differing activity measures and currencies: PDS and GDS (Units of Dental Activity, UDA); National contract (activity based upon outpatients, in patients and day case volumes – national tariff).
- Performers List: GDS and PDS contracts require performers delivering services to be on the national performers list; no such requirement exists for clinicians based in secondary care settings.
- Performance metrics: in order to seek to establish a level playing field for services on referral (regardless of provider) there should be consistent expectations with respect to quality and outcomes.
- Remuneration for service providers: This should be consistent, and should reflect consistency in the competencies of clinicians delivering the services and consistent standards with respect to the service facilities/environment.
- Currently there is significant variation across secondary care provision, and almost no way of benchmarking between primary and secondary care provision, even where this is comparable.
- Coding: Use of consistent coding is necessary so that commissioners have access to comparable information and can comprehensively understand the services being delivered to the local population.
- Tariff considerations: particularly in light of 'local tariffs' and variable overhead costs.
- Local variation: Models of service delivery may need to vary to reflect different geography and local skill mix. Commissioners may wish to consider a contract to deliver services at multiple sites.
- Training requirements: It may be appropriate to incorporate training requirements within some contracts to enable:
 - o Maintenance of performer competency levels.
 - o Training/support for referring clinicians who need to improve core skills.
 - o More formal undergraduate and postgraduate student training placement requirements.

13.3 Information Governance

During the commissioning process it is important to have in mind whether or not the service being commissioned is a continuation of existing services with slight variations to contracted services, or whether the service being commissioned makes significant changes to the patient pathway. If significant or wholesale changes are envisioned in the planning stages, it will be beneficial to carry out a Privacy Impact Assessment (PIA, found in the 'New Processes Procedure') in conjunction with your local Information Governance representative. This process will help highlight any Information Governance risks associated with the service being commissioned and these risks can be addressed appropriately at an early stage. You can find the [PIA procedure and documents on this link](#).

The NHS Standard Contract states that all organisations must meet the required Information Governance Standard of Compliance to be able to tender for any service being commissioned. This statement of compliance falls out of a service provider's completion of the IG Toolkit. It is worth checking the [Information Governance Toolkit Version 12 and 13 Requirements Specification](#) via the NHS Digital website.

There must be a legal basis for NHS England and commissioning organisations to receive any flows of data directly or indirectly from service providers that contain identifiable personal,

and / or sensitive information. Although data sets within Dentistry received by commissioners are usually anonymised, if a new programme or situation arises where there is any need for identifiable data please refer to the ICO's [Data Sharing Code of Practice](#), and [Anonymisation Code of Practice](#) for further advice on Anonymisation.

Accurate and comprehensive record keeping is essential in order to deliver the best patient care possible. Dental records should be managed and retained in accordance with the [NHS Records Management Code of Practice](#).

In terms of records retention, this best practice guidance notes that:

- Dental records for children must be kept until their 25th birthday (or if the patient was 17 at the conclusion of the treatment, until their 26th birthday).
- Dental records for adults must be kept for 10 years after the patient has de-registered or 10 years after the last treatment date.

When a dental office closes the records of the patient go to the new provider of their dental service. Failure to protect patient records may result in a breach of the Data Protection Act 1998 and could potentially lead to a fine from the information Commissioner's Office.

Appendix 1 Starting Well summary

Starting Well is a commissioning approach designed to improve access for children aged 0-5 years, followed by the provision of cost effective evidence-based prevention activities; such as fluoride varnish and dietary advice. The improved offer of earlier access to preventive care for pre-school aged children is a key element in reducing the number of young children requiring a general anaesthetic for the removal of decayed teeth.

The initiative aims to reduce health inequalities and improve oral health for children aged 0-5 years.

The objectives of the initiative include:

- Increasing dental access and attendance for children aged 0-5 years.
- Delivery of practice-based preventive care, including interventions such as oral health and dietary advice, support for oral health behaviour change, and fluoride interventions.
- Engagement with local early years providers in the areas with the highest levels of tooth decay in young children
- Delivery of a public and professional awareness programme to promote the timely attendance of children aged 0-5 years; and
- Providing NHS England dental commissioners with a method of commissioning the offer through the existing dental contract.

Appendix 2 MCN Terms of Reference

Name: District, Area or Region? Managed Clinical Network Terms of Reference

Introduction

NHS England supports a clinically-led commissioning approach.

NHS England has established Local Dental Networks (LDN) which are an integral part of NHS England and lead NHS England's strategic commissioning approach to dentistry and oral health.

In making the strategic intent operational, NHS England will formalise or establish Managed Clinical Networks (MCN) which will be accountable to the LDN, via the LDN Chair, and NHS England and who will, using their specialty expertise, develop and transform services in line with the local strategic intention.

The Managed Clinical Network is a group governed by NHS England that provides a link to all specialists and clinicians with a contract to provide a *"insert the specialty's name here"* service on referral in the locality the network covers.

The MCN will be inclusive and may, therefore, include dental care professionals (DCPs), general dental practitioners (GDPs), other primary care providers and lay or public representation, all of whom will be co-options that are determined to be relevant by the Core Group. Further details of relevant members of the MCN are contained in Appendix 1.

The MCN may establish a Core Group to steer the network using the guidance contained within this document, depending on the size of the MCN.

The Chair (or nominated Deputy) of the LDN will be ex officio members.

Purpose and Aims of an MCN

The purpose of the MCN is to facilitate patient-centered care. It will provide assurance to the LDN through advising on transformational change, improving clinical effectiveness, cost-effectiveness, equity of access, efficiency and offer parity of outcome in service delivery.

The aim of the MCN is to offer a way of working where clinicians from all settings across the clinical care pathway can focus on patient services.

Function of Managed Clinical Network

The MCN links all clinicians from primary, salaried, secondary and tertiary care to work in a coordinated manner, unconstrained by existing professional and organisational boundaries to ensure equitable provision of high quality, clinically effective services.

The MCN is an NHS England managed clinically-led and managed advisory and assurance group, which will:

- Work with the LDN to contribute to local planning and prioritisation.
- Agree a work plan and objectives with NHS England LDN linked to these priorities and regularly report back on delivery.
- Receive and consider information on clinical needs, assessments, service delivery, quality, treatment outcomes, cost-effectiveness and equity of access data, in order to advise NHS England, Health Education England (HEE), Public Health England (PHE) and Local Dental Network (LDN) leads.
- Interface with the LDN to understand wider local priorities and action plans.
- Contribute to the development and subsequent implementation of strategies that will improve service care provision to include the development of referral management systems.
- Support the implementation of evidence-based patient pathways across all providers.
- Work with other MCNs in the same specialty nationally to learn and adopt best practice, avoid duplication of effort and share the workload.
- Work with MCNs in other specialties locally to develop integrated pathways across specialties.
- Work with the LDN to ensure there is a mechanism for patients' views on their local clinical services to be expressed and heard.
- Ensure providers are participating in an appropriate appraisal and personal development plan setting process.
- Advise the LDN on areas where further education or training would develop service capacity or capability.

Objectives

The MCN will communicate clear statements regarding specific clinical and service improvements that patients and referrers can expect, such as:

- Increased flexibility and more efficient use of the skills within clinical teams and of the available resources.
- Improved communication between service providers and between providers and referrers to benefit patients.
- Develop and implement needs-led and evidence-informed care pathways across primary and secondary care to improve equity of access and ensure parity of outcome.
- Improve quality and value regardless of setting.
- Contribute to and support implementation of audit/outcome assessment programmes to benchmark provider performance in order to identify and support commissioners address sub-standard performance as well as recognise excellence.

- Receive and advise on formal quality assurance data to support commissioners in their contract monitoring.
- Provide specialist advice to LDNs and commissioners to support the commissioning function and influence service specifications to seek high value and quality service.
- Offer clinicians the opportunities to be innovative in order to achieve improved outcomes and efficiencies, stimulate new ways of working and be an integral and valued component of the commissioning process.
- Be aware of the current workforce, the opportunities to enhance skill mix, advise on continuing professional development (CPD), education and training requirements and suggest how educational programmes can be adapted to meet future needs.
- MCNs will not be involved in individual performance management of clinicians. Instead, its role will be to encourage and improve the performance of the clinicians as a network, whilst individual clinical or contractual performance issues will be covered by the respective Medical Directors of either a NHS Trust employer or by an NHS England Commissioner.

MCNs will use the evidence base, and will receive service performance data, Patient Reported Outcome Measure (PROMs) and Patient Reported Experience Measure (PREMs) data and be committed to the expansion of the evidence base through appropriate research and development.

There must be clarity about the role of each health professional in the MCN, particularly where new or extended roles are being developed as part of the Network.

The MCN will work with the LDN to develop a policy on the dissemination of information to patients, and the nature of that information.

An integral part of the MCN must be a quality assurance programme acceptable to the commissioning body, NHS England.

The educational and training potential of the MCN should be recognised. The MCN should work in partnership with HEE and other training or education stakeholders as appropriate.

The MCN will work with the LDN to develop leadership and management skills to enhance its core functions.

Membership of the Core Group

As stated above, the MCN will be an inclusive group. If the MCN is large then this may require establishment of a Core Group, to be agreed between the MCN Chair and the LDN.

Members of the Core Group will be recruited from within the MCN's representative area and they will spend the majority of their time working within that NHS region.

The Chair will be appointed through an interview process overseen by the LDN and relevant commissioners. The position of Chair will be held for three years.

The establishment and exact number of members of the Core Group of the MCN will be agreed with the LDN through the LDN Chair.

If a member of the Core Group is unable to attend they must make reasonable efforts to nominate a deputy.

The Core Group should mirror the composition of the MCN and ensure an appropriate balance of members with the relevant skills and experience.

The Core Group Members will be recruited from the MCN and will be appointed for three years.

It is expected that the Core Group will meet more frequently than the MCN, dependent upon local arrangements.

Co-options

Additional Core Group members will be co-opted as necessary. Further attendees will be invited as and when required with the majority agreement of the Core Group's membership or at the wish of the Chair if necessary.

Short-Life Working Groups (SLWGs)

SLWGs of the MCN Core Group may be established to take forward particular pieces of work.

The MCN Chair

The Chair will normally either be a consultant or a specialist who will be recruited from the eligible pool in the MCN representative area. It should be noted that if the Chair is a non-consultant specialist then the MCN should be "consultant-supported" through a formal connection to a consultant from the appropriate specialty, who will have both the expertise and access to facilities that will provide support in respect of professional and clinical governance issues. This support would need to be agreed by the consultant and their employing trust.

The Chair's role will be:

- To lead the MCN
- To develop a work plan with the MCN and LDN
- To facilitate MCN meetings, set meeting agendas and maintain MCN representation
- Nominate a deputy chair
- Ensure contemporaneous notes of the meetings are compiled and disseminated in a timely and accurate manner
- Represent the views of MCN in the wider health economy
- Represent the MCN and report to the LDN

Meeting arrangements

Frequency of meetings

Meetings of the MCN and the Core Group will be held at a frequency to be determined by the membership. The Chair will be able to call additional meetings as and when required.

Declarations of Interest

Any agenda items that are highlighted by a member as a potential conflict of interest should be declared at the start of a meeting and recorded as such within the minutes. The other members will then decide whether that member can participate in that particular discussion.

A Declaration of Interest (DoI) should be signed by each member before joining.

The LDN will maintain the DoI register.

Attendance at meetings

The members of the Core Group should normally attend all of their relevant meetings, whenever possible. If a Core Group member fails to attend a meeting of the Core Group MCN on two consecutive occasions, the Chair may seek alternative appropriate representation, unless he/she is satisfied that the absence was due to a reasonable cause.

Quoracy

The meeting of a Core Group will be quorate when a minimum of 75% of members are in attendance, in addition to the Chair or Deputy Chair.

Accountability

To ensure transparency and encourage good relations between members of the group and to develop the network, there should be:

- Contemporaneous minutes taken at each meeting.
- Publication of agendas and minutes
- A written annual report to the LDN

Review of Arrangements

The arrangement set out in these Terms of Reference will be reviewed annually, or as and when requested by a majority vote of the steering group members.

Any changes or amendments to the Terms of Reference will be agreed and signed off by the LDN.

Confidentiality

All members will respect the confidentiality of all patient relevant data abiding by:

- Current General Dental Council guidelines
- The Data Protection Act
- Caldicott principles
- Common Law Duty of Confidence

Resources

The commissioning process will include recognition of the time commitment of the Chair, Core Group members and the MCN.

The MCN Chair will be supported by administrative personnel agreed with the LDN Chair.

Appendix

The following sets out the constitution of the full MCN.

All clinicians in the locality who have a contract to provide treatment on referral at Level 2 or Level 3 will be members of the MCN and be contractually obliged to participate in audit and in open, anonymised review of results.

This may involve providers, performers, dental care professionals, general dental practitioners and other primary care providers.

The MCN should be representative of all NHS clinicians providing NHS treatment. It should interface directly with the local NHS England team, LDN, HEE and PHE.

The members of the MCN whenever possible should attend a meeting of the full MCN. If a member fails to attend a meeting of the MCN on two consecutive occasions, the Chair may seek to remove the member from the MCN, unless he/she is satisfied that the absence was due to a reasonable cause.

Appendix 3 MCN job description



JOB DESCRIPTION

JOB TITLE :	Chair of Managed Clinical Network
ACCOUNTABLE TO:	Chair of Local Dental Network
REPORT TO:	Chair of Local Dental Network
PROFESSIONAL LINE TO:	Medical Director, NHS England in the appropriate locality
TIME COMMITMENT:	Up to a maximum of 2 Programmed Activities (Pas) per week (additional PAs may be required in the early stages to establish the MCN)
CONTRACT PERIOD:	3 years fixed term
NOTICE PERIOD:	3 months

1. Job Purpose

NHS England has published Commissioning Guides for some of the specialties in dentistry. The intention of the Guides is to encourage improved patient experience in receiving dental care across all aspects of dentistry in primary, salaried, secondary and tertiary care. The comprehensive integration of these services will require NHS England to establish Managed Clinical Networks (MCN) for each of the specialties that will link clinicians across all settings to provide patient-centred care throughout the clinical pathway including improving clinical effectiveness, equity of access, efficiency and parity of outcome. It will be the responsibility of the Chair of each Managed Clinical Network to oversee the functioning of such in line with the Terms of Reference published by NHS England. This will require close communication with identified clinicians from all aspects of dentistry who have successfully applied and been appointed to the Network. Ultimately, the role of the MCNs, through the leadership of the Chairs, will be to ensure high quality patient care in an equitable manner across the country. It should be appreciated that time commitments are likely to be greater in the early months during establishment of each MCN. This would need to be negotiated as required by local circumstances. Time commitments are to be reviewed and renewed on a regular basis.

It will be the responsibility of the Chair to be both aware and maintain stability of existing teaching and training taking place in secondary care environments at undergraduate, Dental Core Training (DCT) and Specialty Registrar levels.

2. Key Responsibilities

2.1 Clinical Leadership & Collaborative Working

- Establish and maintain an effective MCN involving all appropriate stakeholders
- Create and foster a culture of clinical engagement across the MCN
- Demonstrate clinical leadership that is central to the delivery of all commissioning activities
- Maintain the engagement of all members of the MCN in developing and implementing evidence-based pathways
- Establish effective collaborative working to ensure the Network meets local and national priorities and action plans
- Maintain effective communication with the Local Dental Network (LDN)
- Report regularly to the Local Dental Network on progress in respect of agreed workplans
- Share information, such as the establishment of improved care and pathways, with other MCNs both locally and nationally
- Ensure that each MCN member engages with a robust appraisal system specifically designed for members of the MCN that is in place through collaboration with Health Education England
- Ensure that good managerial practice is maintained in the running of the MCN, such as the organization of regular meetings, setting of agendas and release of minutes of meetings
- To adhere to the relevant professional codes of conduct
- Provide direction and support to the MCN through effective management and leadership
- Appropriate support will be provided dependent upon the development needs of the individual chair.
- The Chair working with the LDN and commissioners will undertake work, as necessary, to understand the specialist services that are currently being provided, by whom and where, along with the quality and quantity of those services.

2.2 Improving Quality and Outcomes

- Enable the Network to synthesise and use the information received on clinical needs assessments, service delivery, quality, treatment outcomes, cost-effectiveness and equity of access data, in order to advise the LDN and, through the LDN, NHS England, Health Education England (HEE) and Public Health England (PHE).
- Develop and improve referral management systems through effective leadership
- Assure an appropriate and effective quality assurance programme is in place at all times

- Communicate with the LDN and, through the LDN, HEE where a need for further education has been identified
- Encourage the MCN to develop more flexible and efficient use of the clinical skills available within the specialty through identifying potential improvements and recommending change to the LDN and commissioners where it is considered beneficial
- Enable and assure that the MCN implements systems to benchmark provider performance using audit and outcome measures
- Encourage and lead on the use of innovation in all aspects of work
- Mediate where necessary, in such matters as conflicts of view or interest between members of the MCN or commissioners, to enable and encourage reconciliation

2.3 Enabling Patient and Public Involvement

- Promote an open and transparent policy of public engagement within the MCN
- Ensure effective and regular interaction with patient and public groups in respect of feedback and consultation on proposed workplans
- To act as a champion for patients and their interests in respect of the strategy development and decision-making of the MCN

2.4 Promoting Equality

- Ensure robust communication between all members of the MCN at all times
- Ensure that the MCN consider improvement of care and systems regardless of setting
- Ensure all members of the MCN complete Conflicts of Interest declarations on an annual basis
- Encourage the development of a wide range of skillmix within the MCN and across all clinical settings
- Uphold organizational policies and principles on the promotion of equality

JOB DESCRIPTION AGREEMENT	
Job Holder's Signature:	Date:
Medical Director Signature:	Date:
LDN Chair's Signature	Date:

Person Specification

Education/Qualifications	Essential	Desirable
Inclusion in the GDC register with either an appropriate post graduate qualification to practice within the specialty, as named by the title of the MCN, or to be included on one of the GDC's relevant Specialist Lists, instead	√	
Experience		
Working at Consultant/Specialist level	√	
Managing, training & mentoring staff	√	
Practical experience in facilitating change	√	
Scientific publications, presentation of papers at conferences & seminars		√
Experience of active involvement in local, regional or national strategy groups	√	
Personal qualities		
Able to prioritise work	√	
Able to work well against a background of change and uncertainty	√	
Adaptable to situations, can work productively with people of all capabilities and attitudes	√	
Commitment to team-working and respect and consideration for the skills of others	√	
Self-motivated, pro-active and innovative	√	
Cope with uncertainty and lead others through such		
High standards of professional probity	√	
Proven and recognised interest in clinical service development		√
Skills		
Strategic thinker with proven leadership skills	√	
Excellent oral and written communication skills with the ability to develop strong working relationships with clinicians and managers at all levels	√	
Effective interpersonal, motivational and influencing skills	√	
Ability to respond appropriately in unplanned and unforeseen circumstances	√	
Good presentational skills (oral and written)		√
Pragmatic negotiator with sensible expectation of what can be achieved	√	
Computer literate (evidence of knowledge and use of a variety of software packages <i>e.g. MS Office</i>)		√
Ability to design, develop, interpret and implement policies	√	
Able to operate effectively across organisational boundaries To cope with uncertainty and lead others through such	√	√
Knowledge		
Understanding of the broader framework of the NHS alongside current policies in relation to health and social care	√	
Understanding of social and political environment		√
Other		
Ability to travel throughout the MCN area as required and to travel to meetings nationally		√

Appendix 4 Needs assessment tool

Summary of estimated proportion of children requiring level 1, 2 and 3 paediatric dental care

	Level of service complexity	Measures used to estimate numbers	Estimate of % of local child population requiring this level of service
Specialist led network to link all levels	Level 1 Primary care, no additional complexity or setting requirements.	Children who can manage well in mainstream primary care for routine care and most other procedures.	To be completed locally.
	Level 2 Primary care additional complexity: Clinician with additional knowledge and skill. Extended appointment times accommodated. Flexibility with appointments possible. Inhalation sedation facilities.	Mild and moderate LD. Mildly medically compromised. Physical disability. Moderate behavioural problems – ADHD. Looked after children. Cleft lip and palate. Children with extensive disease.	To be completed locally.
	Level 3 Primary care with specialised team, including specialist in Paediatric Dentistry. Inhalation sedation facilities. Extended appointment times accommodated. Flexibility with appointments possible. Additional admin time to link with partner professionals. Children who require general anaesthesia for routine or occasional treatment.	Severe LD. Profound and multiple LD. Severely medically compromised. Severe behavioural problems - Children at severe end of ASD spectrum. Severe dental anxiety.	To be completed locally.

Appendix 5 Example Core Specifications

Core Service Specification for Level 2 complexity Paediatric Dentistry Service

Description of service

1. Description and scope of the specialty

The specialty of Paediatric Dentistry provides specialist oral healthcare for children from birth to adolescence whose needs cannot be managed by their General Dental Practitioner, including children and young people:

- with extensive oral disease.
- whose oral health care is complicated by intellectual, medical, physical, social, psychological and/or emotional factors/disability.
- with developmental disorders of the teeth and mouth.
- who are either too anxious or too young to accept routine dental treatment.

The age range covered by the specialty is normally regarded as 0 -16 years; however children will start the transition process to adult oral health services some time before their 16th year.

Paediatric dentists may also play a role in care for looked after children, and those for whom the local and their partner commissioning bodies must make arrangements ("joint commissioning arrangements") about the education, health and care; those who have :

- special educational needs.
- a disability.

2. Scope of this service

This specification is for provision of care and treatment of level 2 complexity for children. This service will be provided on a referral basis from general dental practitioners, community dentists or consultants or specialists.

Level 2 care is defined as procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register. This care may require additional equipment or environment standards but can usually be provided in a primary care setting.

2.1 The service will provide care and treatment as follows:

- Management of dento-alveolar trauma of increased complexity including:
 - management of complicated crown fracture of permanent teeth.
 - management of injuries to primary teeth not manageable by restoration or extraction.
 - root and crown-root fractures of permanent teeth without complicating factors.
 - post-emergency follow-up of multi-tooth injuries in the permanent dentition.
 - post emergency follow-up of permanent tooth avulsion and significant luxation injuries, especially where complications are more likely to develop.

- emergency management of injuries to primary and permanent teeth where the complexity of emergency management lies beyond Level 1.
- Management of hard-tissue dental defects and disturbances of the developing dentition not requiring specialist or multi-disciplinary management for example, early permanent tooth surface loss, developmental defects of primary or permanent teeth amenable to and stabilised by simple restoration.
- Management of more complex problems affecting the developing dentition or dental hard tissues under the direction of a specialist or consultant in Paediatric Dentistry.
- Extraction of teeth under general anaesthesia.
- Inhalation sedation where appropriate for all ages of children and IV sedation for children of 12 years of age and above.
- Management of children with extensive caries or early childhood caries amenable to care under local analgesia or with sedation as described above as an adjunct.
- Assessment and management (or referral to a higher level as appropriate) of children subject to a child protection plan or looked after by the local authority (usually in foster or residential care) who either have no current arrangement for on-going oral health review with the GDS or who are identified to have unmet dental needs.

Following the item or course of treatment, the child will be discharged to their referring dentist. If referral has come from a community dentist, consultant or specialist, the child will be discharged to their general dental practitioner.

2.2 The service will provide on-going care for children as follows:

- Management of children with routine oral health surveillance or treatment needs but where behavioural/psychological development or significant anxiety increases the complexity of delivery of care such as those requiring sedation.
- Management of children with routine oral health surveillance or treatment needs but where medical comorbidity or disability increases the complexity of delivery of care.

3. Location

The service should be provided at a location or locations to minimise travel times for children, parents and carers. MCN should advise on appropriate travel time for the locality.

4. Facilities

Practices or clinics should have a child friendly and child safe environment.

Providers should ensure that they are able to provide (not necessarily in every location if multiple locations are available):

- Where manual transfer, hoisting or lifting of patients into the dental chair is not appropriate, equipment should be available to safely recline wheelchair patients in order to carry out dental treatment.
- A variety of communication aids should be available and staff trained to use them
- Equipment to support the delivery of conscious sedation to the contemporaneous national standard.
- Access to intra-oral and OPG radiography equipment.
- Appropriate equipment to perform any Level 2 complexity treatment that may be required by the patient, for example microscopes to support endodontic delivery.

- Paediatric Resuscitation equipment.
- Orthodontic equipment to support treatment of trauma.

The service should also demonstrate:

- Access to a multi-disciplinary team for any complex care.
- Access to facilities for providing treatment under general anaesthesia for children where GA is part of the specification.

5. Opening Hours

The service should demonstrate child friendly opening hours so that school age children can be offered appointments outside school hours and during school holidays.

6. Workforce

Dentists should have fulfilled the criteria to be accredited as a performer of care of level 2 complexity. When national criteria are available these should be used. Until that time the paediatric MCN should advise on suitable criteria and be involved in the assurance process.

Providers should demonstrate appropriate skill mix for these cases and patients. This is likely to include suitably trained and qualified dental therapists, hygienists and dental nurses.

The workforce should demonstrate:

- Continuing professional development of relevance to Paediatric Dentistry including evidence informed preventive interventions and treatment.
- Adherence with the current national guidelines on sedation.
- Working knowledge of Mental Capacity Act including consent issues in children.
- Ability to undertake treatment under GA.
- Safe use of specialised equipment, for example hoists and use of positioning aids.
- Range of behavioural management skills and techniques.
- Non-verbal communication methods.
- Skills in examining the mouth in children with limited ability to cooperate.
- Clinical holding skills.
- Paediatric Immediate Life Support.

Dental nurses should be appropriately trained for example Certificate in Special Care/Paediatric Dental Nursing Certificate in Dental Sedation.

The MCN should advise on appropriate training required for the local service.

7. Quality Standards

7.1 Access

Providers should offer timely assessment (no longer than 48 hours) for patients who have an urgent clinical need.

Patients requiring non-urgent care (including treatment under sedation) should be able to commence treatment within 18 weeks of referral to the service. MCN might advise shorter timescale.

7.2 Patient reported outcomes (PROMs)

The service should routinely collect PROMs involving patients (where possible) and parents/carers.

These should be collected in a child friendly format where possible.

7.3 Clinical Audit

The service must participate in nationally agreed audits.

Local audits that should be undertaken are:

- Antimicrobial resistance (AMR) audit.
- Fluoride varnish application audit.

MCN can advise on further audits and methodology.

7.4 MCN participation

All performers of care of level 2 complexity must be members of the associated paediatric MCN and must demonstrate attendance at meetings and participation in audits, peer review and other quality assurance as agreed by the MCN.

8. Data reporting

A minimum dataset must be reported on a frequency as defined below:

Data item	Frequency
Waiting times for assessment (weeks).	Monthly.
Waiting times for treatment (weeks).	Monthly.
Number waiting for assessment.	Monthly.
Number waiting for treatment.	Monthly.
Length of time of longest wait (weeks).	Monthly.
Number seen for assessment.	Monthly.
Number seen for treatment.	Monthly.
New to follow up ratio by performer.	Monthly.
Number assessed and discharged.	Monthly.
Number assessed and referred for L3 care.	Monthly.
Number discharged complete.	Monthly.
Number on review.	Monthly.
DNA/WNB rate (%).	Monthly.
Cancel by provider rate (%).	Monthly.
Cancel by patient rate (%).	Monthly.
PREMs.	Quarterly.

Core Service Specification for Level 3a complexity Paediatric Dentistry Service

Description of service

9. Description and scope of the specialty

The specialty of Paediatric Dentistry provides specialist oral healthcare for children from birth to adolescence whose needs cannot be managed by their General Dental Practitioner, including children and young people:

- with extensive oral disease
- whose oral health care is complicated by intellectual, medical, physical, social, psychological and/or emotional factors/disability.
- with developmental disorders of the teeth and mouth.
- who are either too anxious or too young to accept routine dental treatment.

The age range covered by the specialty is normally regarded as 0 -16 years; however children will start the transition process to adult oral health services some time before their 16th year.

Paediatric dentists may also play a role in care for looked after children, and those for whom the local and their partner commissioning bodies must make arrangements ("joint commissioning arrangements") about the education, *health* and care; those who have:

- special educational needs.
- a disability.

10. Scope of this service

This specification is for provision of care and treatment of level 3a complexity for children. This service will be provided on a referral basis from GDP, community dentists or consultants or specialists.

Level 3a care is defined as:

Care and procedures or conditions that can be performed or managed by a dentist recognised as a specialist in Paediatric Dentistry by the GDC.

The service will provide care and treatment as follows:

- severe early childhood caries or unstable/extensive caries (especially where treatment under general anaesthesia may be necessary).
- moderate to severe tooth surface loss in the permanent dentition.
- abnormalities of dental development not amenable to simple preventive or restorative management or where specialist management is needed.
- moderate/severe molar incisor hypomineralisation (MIH).
- amelogenesis imperfecta.
- dentinogenesis imperfecta.
- mild to moderate hypodontia.
- supernumerary teeth and/or delayed eruption of permanent teeth not requiring complex surgical or multidisciplinary management.
- restorative and exodontia treatments for children being managed under the direction of a regional multi-disciplinary team with cleft lip and/or palate.
- dento-alveolar trauma requiring more specialised management including:
 - avulsion injuries and post-avulsion management, especially where complications have developed.

- management of injuries to immature permanent incisors where endodontic management is required.
- moderate to severe luxation injuries, especially where injuries involving significant damage to multiple teeth.
- Aggressive periodontitis or other less common periodontal/gingival conditions.
- Uncomplicated dento-alveolar surgical interventions.
- Treatment planning, support and follow up for children requiring extractions under general anaesthesia.
- Treatment planning and delivery of comprehensive dental care under general anaesthesia.
- Dental care of children with significant anxiety and/or behavioural disturbance.
- Oral health surveillance and or treatment needs where significant medical comorbidity or disability increase the complexity and risks of delivery of care. Such care may be shared with a consultant and many such children will be under the on-going care of a paediatrician. For example:
 - significant cardiovascular disease.
 - significant abnormalities of haemostasis.
 - children undergoing treatment for haematological or organ malignancies.
 - children with significant disability or learning difficulties.
 - children with significant behavioural problems or communication disorders.
- A clear pathway for acceptance and management of dental emergencies requiring specialist level care. This will include more complex dento-alveolar traumatic injuries and acute dental infection in children with significant disability or co-morbidity.

10.1 Transition

Where children are likely to require on-going specialist oral and dental care through adolescence and into adulthood (usually beyond their 16th birthday) it is important to plan appropriate transition onto relevant adult oral health care services.

Transition should be a managed process, facilitated by introduction to adult services at a suitable stage prior to full discharge from paediatric dentistry services.

11. Location

The service should be provided at a location or locations to minimise travel times for children, parents and carers. MCN should advise on appropriate travel time for the locality.

12. Facilities

Practices or clinics should have a child friendly and child safe environment.

Providers should ensure that they are able to provide (not necessarily in every location if multiple locations are available):

- Where manual transfer, hoisting or lifting of patients into the dental chair is not appropriate, equipment should be available to safely recline wheelchair patients in order to carry out dental treatment.
- A variety of communication aids should be available and staff trained to use them.
- Equipment to support the delivery of conscious sedation to the contemporaneous national standard.

- Access to intra-oral and panoramic dental radiography equipment.
- Appropriate equipment to perform any Level 2/3a complexity treatment that may be required by the patient, for example microscopes to support endodontic delivery.
- Paediatric Resuscitation equipment.
- Orthodontic equipment to support treatment of trauma.
- Access to appropriate dental laboratory to support advanced restorative treatment and construct appliances.
- Arrangements for transport of patients requiring more than one handler should be available (for example two-man ambulances).
- Facilities for the safe treatment of bariatric patients should be available.
- Access to cone beam tomography facilities.

The service should also demonstrate:

- Access to a multi-disciplinary team for any complex care.
- Access to facilities to enable provision of treatment under general anaesthesia for children.

13. Opening Hours

The service should demonstrate child friendly opening hours so that school age children can be offered appointments outside school hours and during school holidays. Out of hours and when clinics are otherwise closed, appropriate arrangements and pathways should be in place to manage children requiring specialist level emergency dental care.

14. Workforce

Providers should demonstrate appropriate skill mix for these cases and patients. Level 3a teams will be paediatric dentistry specialist-led but will include dentists at other grades and are also likely to include suitably trained and qualified dental therapists, hygienists and dental nurses.

The workforce should demonstrate:

- Continuing professional development of relevance to Paediatric Dentistry including evidence informed preventive interventions and treatment.
- Adherence with the current national guidelines on sedation.
- Working knowledge of Mental Capacity Act including consent issues in children.
- Ability to undertake treatment under GA.
- Safe use of specialised equipment, for example, hoists and use of positioning aids.
- Range of behavioural management skills and techniques.
- Non-verbal communication methods.
- Skills in examining the mouth in children with limited ability to cooperate.
- Clinical holding skills.
- Paediatric Immediate Life Support.
- Medical risk assessment.
- Conscious sedation techniques as applied to medically compromised patients and patients with behavioural problems ([ASA II, III](#)).
- Appropriate specialist level Paediatric Dentistry training in the assessment and dental treatment of children under general anaesthesia.

- Specialist Paediatric Dentistry clinical leadership. This will include being able to provide clinical leadership across the paediatric pathway, for example, by chairing MCN.
- Skills to support collaborative working with medical specialities in secondary care including haematology, cardiology, oncology and mental health.
- Appropriate training to support the delivery of education and training for example training the trainers, equality and diversity, bullying and harassment.

Dental nurses should be appropriately trained for example, Certificate in Special Care/Paediatric Dental Nursing Certificate in Dental Sedation.

The MCN should advise on appropriate training required for the local service.

15. Quality Standards

15.1 Access

Providers should offer timely assessment (no longer than 48 hours) for patients who have an urgent clinical need.

Patients requiring non-urgent care (including treatment under sedation) should be able to commence treatment within 18 weeks of referral to the service. The MCN may advise shorter timescales for certain patient-groups or for patients with certain conditions.

15.2 Patient reported outcomes (PROMs)

The service should routinely collect PROMs involving patients (where possible) and parents/carers.

These should be collected in a child friendly format where possible.

15.3 Clinical Audit

The service must participate in nationally agreed audits.

Local audits that should be undertaken are:

- Antimicrobial resistance (AMR) audit.
- Fluoride varnish application audit.

MCN can advise on further audits and methodology.

15.4 MCN participation

All performers of care of level 3 complexity must be members of the associated paediatric MCN and must demonstrate attendance at meetings and participation in audits, peer review and other quality assurance as agreed by the MCN.

16. Data reporting

A minimum dataset must be reported on a frequency as defined below:

Data item	Frequency
Waiting times for assessment (weeks).	Monthly.
Waiting times for treatment (weeks).	Monthly.
Number waiting for assessment.	Monthly.
Number waiting for treatment.	Monthly.
Length of time of longest wait (weeks).	Monthly.
Number seen for assessment.	Monthly.
Number seen for treatment.	Monthly.
New to follow up ratio by performer.	Monthly.
Number assessed and discharged.	Monthly.
Number assessed and referred for L3 care.	Monthly.
Number discharged complete.	Monthly.
Number on review.	Monthly.
DNA/WNB rate (%).	Monthly.
Cancel by provider rate (%).	Monthly.
Cancel by patient rate (%).	Monthly.
PREMs.	Quarterly.

Core Service Specification for Level 3b complexity Paediatric Dentistry Service

Description of service

17 Description and scope of the specialty

The specialty of Paediatric Dentistry provides specialist oral healthcare for children from birth to adolescence whose needs cannot be managed by their General Dental Practitioner, including children and young people:

- with extensive oral disease.
- whose oral health care is complicated by intellectual, medical, physical, social, psychological and/or emotional factors/disability.
- with developmental disorders of the teeth and mouth.
- who are either too anxious or too young to accept routine dental treatment.

The age range covered by the specialty is normally regarded as 0 -16 years; however children will start the transition process to adult oral health services some time before their 16th year.

Paediatric dentists may also play a role in care for looked after children, and those for whom the local and their partner commissioning bodies must make arrangements ("joint commissioning arrangements") about the education, *health* and care; those who have:

- special educational needs.
- a disability.

18 Scope of this service

This specification is for provision of care and treatment of level 3a complexity for children. This service will be provided on a referral basis from general dental practitioners, community dentists or consultants or specialists.

Level 3b care is defined as:

Care should be delivered by a dentist recognised as consultant in Paediatric Dentistry.

The service will provide care and treatment as follows:

- Assessment and management of complex dental or cranio-facial conditions which require a multi-disciplinary team input to treatment planning and care or where management of a disturbance in dental development is complicated by features requiring input/active treatment from other dental specialties. Examples include:
 - moderate to severe hypodontia, and significant dental hard-tissue developmental defects, especially during transition into orthodontic and definitive adult restorative management and treatment.
 - Traumatic dento-alveolar injuries where significant complications have arisen, especially where multidisciplinary planning and care is required.
 - premolar transplantation.
 - patients requiring obturators or other more advanced intermediate restorative management.
 - Patients with complex presentations of tooth morphology (macrodonia, double teeth, dens-in-dente, talon teeth).
 - Assessment and facilitating management of oral pathology or oral medical conditions in children.
 - Assessment, surveillance and treatment of children with significant co-morbidity being managed by other paediatric specialities (for example oncology, cardiology, haematology, hepatology, nephrology, endocrinology. This may include providing urgent dental treatment prior to open heart surgery, organ transplant or prior to commencing chemotherapy, for example.
 - Assessment and management of children with a significant disability, co-morbidity, significant behavioural disturbance (e.g. children with severe autism) or severe anxiety who require hospital based and/or multidisciplinary work-up and support prior to and/or as an adjunct to delivery of dental treatment.
 - Treatment planning and comprehensive care under general anaesthetic, involving more difficult surgical or restorative procedures, or where the child is undergoing joint procedures with another surgical specialty.
 - Acute dental emergencies, especially complex dentoalveolar trauma and acute treatment for children with significant disability and/or significant co-morbidity.

18.1 Transition

Where children are likely to require on-going specialist oral and dental care through adolescence and into adulthood that is (beyond their 16th birthday) it is important to plan appropriate transition on to relevant adult oral health care services.

Transition should be a managed process, facilitated by introduction to adult services at a suitable stage prior to full discharge from paediatric dentistry services.

19 Location

The service should be provided at a location or locations to minimise travel times for children, parents and carers. MCN should advise on appropriate maximum travel time for the locality.

20 Facilities

Clinics should have a child friendly and child safe environment.

Providers should ensure that they are able to provide (not necessarily in every location if multiple locations are available):

- Where manual transfer, hoisting or lifting of patients into the dental chair is not appropriate, equipment should be available to safely recline wheelchair patients in order to carry out dental treatment.
- A variety of communication aids should be available and staff trained to use them.
- Equipment to support the delivery of conscious sedation to the contemporaneous national standard.
- Access to a comprehensive range of dental radiography and imaging. This should include dental intra-oral and panoramic radiography on site, and access (not necessarily on site) to more specialised imaging such as cone-beam CT and ultrasound.
- Appropriate equipment to perform any Level 2/3 complexity treatment that may be required by the patient, for example microscopes to support endodontic delivery.
- Paediatric Resuscitation equipment.
- Orthodontic equipment to support treatment of trauma.
- Access to appropriate dental laboratory to support advanced restorative treatment and construct appliances.
- Arrangements for transport of patients requiring more than one handler should be available (for example two-man ambulances).
- Facilities for the safe treatment of bariatric patients should be available.

The service should also demonstrate:

- Access to a multi-disciplinary team for any complex care.
- Access to facilities to enable provision of treatment under general anaesthesia for children, including facilities to support dental care under general anaesthesia for children with multiple complex co-morbidities. (In practical terms this will require access to operating, admission and GA facilities in a Children's Hospital environment or in a General Hospital with appropriate Paediatric Support.

21 Opening Hours

Appropriate to supporting other hospital based and specialist Paediatric Services.

A consultation service should be available on all normal working days and during normal working hours.

Appropriate provision of out of hours acute services. This is often provided as part of out-of-hours cover provided by local Maxillo-Facial and Oral Surgery teams.

22 Workforce

Providers should demonstrate appropriate skill mix for these cases and patients. 3b teams will be consultant-led but will include dentists at other grades and are also likely to include suitably trained and qualified dental therapists, hygienists and dental nurses.

The workforce should demonstrate:

- Continuing professional development of relevance to Paediatric Dentistry including evidence informed preventive interventions and treatment.
- Adherence with the current national guidelines on sedation.
- Working knowledge of Mental Capacity Act including consent issues in children.
- Ability to undertake treatment under GA.
- Safe use of specialised equipment, for example, hoists and use of positioning aids.
- Range of behavioural management skills and techniques.
- Non-verbal communication methods.
- Skills in examining the mouth in children with limited ability to cooperate.
- Clinical holding skills.
- Paediatric Immediate Life Support.
- Medical risk assessment.
- Conscious sedation techniques as applied to medically compromised patients and patients with behavioural problems ([ASA II, III](#)).
- Assessment and treatment planning skills for treatment under general anaesthetic.
- Consultant Paediatric Dentistry Leadership. This will include being able to provide clinical leadership across the paediatric pathway, for example, by chairing MCN.
- Skills to support collaborative working with medical specialities in secondary care including haematology, cardiology, oncology and mental health.
- Appropriate training to support the delivery of education and training, for example, training the trainers, equality and diversity, bullying and harassment.

Dental nurses should be appropriately trained for example Certificate in Special Care/Paediatric Dental Nursing Certificate in Dental Sedation.

The MCN should advise on appropriate training required for the local service.

23 Quality Standards

23.1 Access

Providers should offer timely assessment (no longer than 48 hours) for patients who have an urgent clinical need.

Patients requiring non-urgent care (including treatment under sedation) should be able to commence treatment within 18 weeks of referral to the service. The MCN may advise shorter timescales for certain patient-groups or for patients with certain conditions.

23.2 Patient reported outcomes (PROMs)

The service should routinely collect PROMs involving patients (where possible) and parents/carers.

These should be collected in a child friendly format where possible.

23.3 Clinical Audit

The service must participate in nationally agreed audits.

Local audits that should be undertaken are:

- Antimicrobial resistance (AMR) audit.
- Fluoride varnish application audit.

MCN can advise on further audits and methodology.

20.4 MCN participation

All performers of care of level 3 complexity must be members of the associated paediatric MCN and must demonstrate attendance at meetings and participation in audits, peer review and other quality assurance as agreed by the MCN.

24 Data reporting

A minimum dataset must be reported on a frequency as defined below:

Data item	Frequency
Waiting times for assessment (weeks).	Monthly.
Waiting times for treatment (weeks).	Monthly.
Number waiting for assessment.	Monthly.
Number waiting for treatment.	Monthly.
Length of time of longest wait (weeks).	Monthly.
Number seen for assessment.	Monthly.
Number seen for treatment.	Monthly.
New to follow up ratio by performer.	Monthly.
Number assessed and discharged.	Monthly.
Number assessed and referred for L3 care.	Monthly.
Number discharged complete.	Monthly.
Number on review.	Monthly.
DNA/WNB rate (%).	Monthly.
Cancel by provider rate (%).	Monthly.
Cancel by patient rate (%).	Monthly.
PREMs.	Quarterly.

Appendix 6 Referral Proforma: Minimum Data Set

Example Mandatory Elements for core data set (minimum data set)

Please note the format is simply in order to list the elements. This could be modified as required.

Date of referral:		<i>DD/MM/YYYY</i>	
Patient details		Referrer Details	
First name:		Name:	
Surname:		Address:	
Date of birth:	<i>DD/MM/YYYY</i>	Postcode:	
Sex:	Male: <input type="checkbox"/> Female: <input type="checkbox"/>	Practice code:	
Address:		Tel:	
Postcode:			
Home Tel:		GP details	
Work Tel:		Name:	
Mobile:		Address:	
		Postcode:	
Patient No		Tel:	
The patient/carer requires an interpreter: <input type="checkbox"/>		Language:	
Referral details			
History/Clinical details:			
Radiographs taken:			
Urgent:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>		
Treatment/opinion required:			
Medical History			
Details:			
Medications:			
Allergies:			

Optional elements (with explanations of why these might be considered for inclusion in a referral form – shown in light grey boxes in italics).

Referral to:			
<i>Could be a tick box for service type (CDS/Acute) or by actual service name.</i>			
Patient details		Referrer Details	
Age:		Practice code:	
<i>Not necessary as have date of birth but often saves validators/graders some time.</i>		<i>Given likely commissioning intentions, probably will be mandatory to include soon.</i>	
School/nursery:		Fax:	
<i>May be useful for safeguarding.</i>		Email:	
Ethnicity:		GDC Number:	
Smoker:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>This may discourage non-dental referrers but included in a number of existing forms.</i>	
<i>Could move to medical section.</i>		Usual dentist (if different):	
Are you aware of any child protection plans or Social workers involved with the family?	Yes <input type="checkbox"/> No <input type="checkbox"/> Details:		
Parent/Guardian details		Person 1	Person 2
First name:			
Surname:			
Preferred telephone number (tick)			
<i>The telephone numbers are mandatory but tick boxes could be added to indicate preferred one.</i>			
Email:			
Referral details			
Main Reason: <input type="checkbox"/> Swelling/Infection <input type="checkbox"/> TMJ Issues <input type="checkbox"/> Complex extractions (surgical/failed) <input type="checkbox"/> Multiple extractions <input type="checkbox"/> Complex endo (open apex, re-treatments) <input type="checkbox"/> Trauma	<input type="checkbox"/> Cooperation issues <input type="checkbox"/> Dental anxiety <input type="checkbox"/> Sedation required <input type="checkbox"/> General anaesthetic required <input type="checkbox"/> Learning disabilities <input type="checkbox"/> Gag reflex	<input type="checkbox"/> Supernumeraries <input type="checkbox"/> Impacted teeth <input type="checkbox"/> Disorders of eruption <input type="checkbox"/> Enamel/Dentine defects <input type="checkbox"/> Other Dental anomalies <input type="checkbox"/> Hypodontia	<input type="checkbox"/> Periodontal problems <input type="checkbox"/> Soft tissue pathology <input type="checkbox"/> Bone pathology <input type="checkbox"/> Tooth surface loss
Patient complaint:			
History:			
Clinical findings:			
Treatment carried out to date:			
Cooperation for dental treatment:			
<i>Referral details are part of the mandatory data set. However, including a tick list may help encourage appropriate referral. The list could be adapted to local needs/referral guidance. The extra breakdown of complaint/history/clinical findings/treatment to date may increase quality of referral.</i>			
I confirm that prevention has been carried out in line with DBOH:		Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>A number of existing forms include this.</i>			
Radiographs taken:	BWs <input type="checkbox"/>	DPT <input type="checkbox"/>	Periapicals <input type="checkbox"/> Other (_____)

OFFICIAL

Referral to:				
	Date DD/MM/YY Enclosed <input type="checkbox"/>	Date DD/MM/YY Enclosed <input type="checkbox"/>	Date DD/MM/YY Enclosed <input type="checkbox"/>	Date DD/MM/YYYY Enclosed <input type="checkbox"/>
<i>Radiographs taken are part of the mandatory data set. However, including a tick list may increase quality of referral.</i>				
Urgent:	Reason:			
<i>Whether referral is urgent (yes/no tick box) is part of the mandatory data set. However, including a reason may increase quality of referral.</i>				
Help requested:	Opinion <input type="checkbox"/> Opinion and treatment <input type="checkbox"/> 2 nd opinion <input type="checkbox"/>			
<i>Of limited value but potentially helpful in reminding referrers they can request an opinion only. Then again may be better for referred to service to decide on this once assessed and tellreferrer to do if Level 1.</i>				
Treatment/opinion required:	Extractions (X) , restorations (R) and endodontics (E) should be indicated below: PERMANENT DENTITION 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 PRIMARY DENTITION E D C B A A B C D E E D C B A A B C D E			
Do you feel pharmacological management will be required?	No <input type="checkbox"/> Inhalation sedation <input type="checkbox"/> IV sedation <input type="checkbox"/> GA <input type="checkbox"/>			
<i>Treatment required is part of the mandatory data set. However, also having a grid/tick boxes may ease the difficulty of a long form for referrers.</i>				
Medical History				
Does the patient have/experience any of the following?	<input type="checkbox"/> NONE OF THE BELOW <input type="checkbox"/> BLOOD OR BLEEDING DISORDER <input type="checkbox"/> ANAEMIA <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> PACE MAKER <input type="checkbox"/> CONGENITAL HEART DEFECT <input type="checkbox"/> HEART MURMUR NOT DIAGNOSED AS INNOCENT <input type="checkbox"/> BRONCHITIS, ASTHMA OR OTHER CHEST COMPLAINT <input type="checkbox"/> EPILEPSY <input type="checkbox"/> INFECTIOUS DISEASES <input type="checkbox"/> PREGNANT OR POSSIBLY PREGNANT <input type="checkbox"/> LIVER DISEASE <input type="checkbox"/> KIDNEY PROBLEM <input type="checkbox"/> SKIN PROBLEMS		<input type="checkbox"/> VISUAL/HEARING IMPAIRMENT <input type="checkbox"/> COMMUNICATION PROBLEM <input type="checkbox"/> LEARNING DISABILITY <input type="checkbox"/> AUTISM <input type="checkbox"/> ADHD – BEHAVIOURAL DISORDER <input type="checkbox"/> EATING DISORDER <input type="checkbox"/> OBESITY <input type="checkbox"/> ENDOCRINE DISORDER <input type="checkbox"/> DIABETES <input type="checkbox"/> GASTROINTESTINAL DISORDER <input type="checkbox"/> NEUROMUSCULAR DISORDER <input type="checkbox"/> SYNDROME – PLEASE SPECIFY BELOW <input type="checkbox"/> ONCOLOGY / CANCER – DESCRIBE <input type="checkbox"/> TX OTHER – PLEASE DESCRIBE BELOW	
Please elaborate on above (for example impact of condition, treatment received, relevant dates):				
Medications:				
Allergies:				
The patient is under the care of a	Name of consultant/hospital:	Specialty/What for:		

OFFICIAL

Referral to:		
hospital consultant <input type="checkbox"/>		
<i>Medical history is part of the mandatory data set. However, also having a tick boxes and further questions may ease the difficulty of a long form for referrers/increase quality of referral.</i>		
Why does this patient require specialist care?		
<i>This is included in one current form. This might be useful at first but then standard forms of words may be developed by referrers which will become meaningless.</i>		
Has the patient consented to this referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has referral been copied to GP (and specialist if necessary)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>A number of existing forms include these.</i>		

Appendix 7 Example Criteria for Referral

Example criteria for referral to Specialist Paediatric Dental Service (Such as Regional or Consultant led Paediatric Dental Services R/CPDS).

The R/CPDS accepts referrals for children under the age of 16 years. Where young people are approaching their 16th birthday, it may be prudent to consider referral to the most appropriate adult speciality.

We accept referrals for:

- Children with complex medical problems that place them at risk from dental disease and/or its treatment.
- Children with developmental problems, learning difficulties and behavioural problems, that makes dental care more difficult to provide.
- Children who have sustained complex dental trauma (for example pulp involvement in immature teeth). Please note, wherever possible patients who have suffered dento-alveolar trauma are expected to have received emergency treatment within 24 hours of the trauma. Referral to the R/CPDS for specialised trauma management should be following this once the patient is stabilised.
- Children with congenital or acquired dental anomalies who may require complex restorative or orthodontic treatment (for example Hypodontia, Aneodontia, Imperfecta, Dentinogenesis Imperfecta, Molar Incisor Hypominerisation, Micro /macro-dontia and delayed eruption).
- Children with soft or hard tissue pathology such as ulceration, swellings, and cysts.
- Children with non-contact tooth surface loss, requiring specialist intervention.
- Children with periodontal problems.
- Children with cleft lip and palate and other cranio-facial anomalies.
- Supernumeraries, odontomes, impacted teeth, submerging teeth, abnormal frenal attachments, and tongue-ties which may require surgical management.
- Pre-cooperative children who require extractions.
- Children with extreme dental anxiety who have proven unable to co-operate with routine dental treatment.

We regret that we are unable to accept referrals for:

- Routine or emergency dental care for healthy, co-operative children (for example caries in cooperative children, endodontic treatment in permanent teeth with closed apex).
- Root canal treatment in permanent molars unless there is good clinical indication for retention of the compromised tooth that is severe hypodontia.
- Orthodontic extractions under general anaesthesia.
- Any patient aged 16 years or older.
- Orthodontic assessment or treatment.

Access to the Paediatric Dentistry GA or sedation services.

Referrals for extractions under general anaesthesia or sedation, should follow the guidelines published by the GDC in [Maintaining Standards: Guidance to Dentists on Professional and Personal Conduct](#).

"Clear justification for the use of General Anaesthesia, together with details of the relevant medical and dental histories, must be contained in the referral letter".

Further Information may be found on the [General Dental Council web site](#).

It would be helpful for referrers to discuss the available treatment options however it is not necessary for the final decision to be made at the time of referral. It is expected that referrers would set out the clinical, medical and anxiety needs (MDAS) of the patient (IOSN is a helpful and validated tool to capture this) and attach appropriate diagnostic quality radiographs. Having a general anaesthetic **should not** be confirmed with the patient/parent/carer at the time of referral as that decision on options will be made at the assessment appointment following a discussion with the patient/carer and a review of the presenting needs.

Arrangements for the patient's first appointment

Patients will receive an initial assessment appointment where the treatment plan will be discussed and the most appropriate form of behavioural management determined. This may involve sedation or general anaesthesia. Please advise the patient that active treatment may not begin on the first appointment (unless clinically urgent) and that if general anaesthesia or sedation is required, it will be carried out at a subsequent appointment in hospital.

Courses of Treatment and Continuing Care

Generally, a regional / complex paediatric dental service will see patients for part of a course of treatment (for example for extractions under general anaesthesia) or for a complete course of treatment (for example a course of restorative treatment and extractions under sedation) but we may ask you to work with us in providing shared care.

In all cases we ask that preventative advice and intervention are delivered in line with [Delivering Better Oral Health](#).

On completion of the episode of care, the patient will be referred back to the referring General Dental Practitioner to complete the course of treatment or to make arrangements for the patient's continuing care.

Continuing care for paediatric patients will only be provided under exceptional need and/or complexity circumstances and where possible this will be arranged closer to home within a primary care specialist led paediatric service where clinicians can offer additional experience and competence in paediatric dentistry.

Emergency / Acute Referrals

Children in the following categories requiring urgent attention must ideally be referred directly to [INSERT LOCAL DETAILS]:

- Children with acute facial swelling and/or systemic involvement.
- Children with oral pathology requiring urgent diagnosis and management, or those with lesions requiring biopsy.
- Children with uncontrolled bleeding.
- Children with severe acute dento-alveolar trauma.

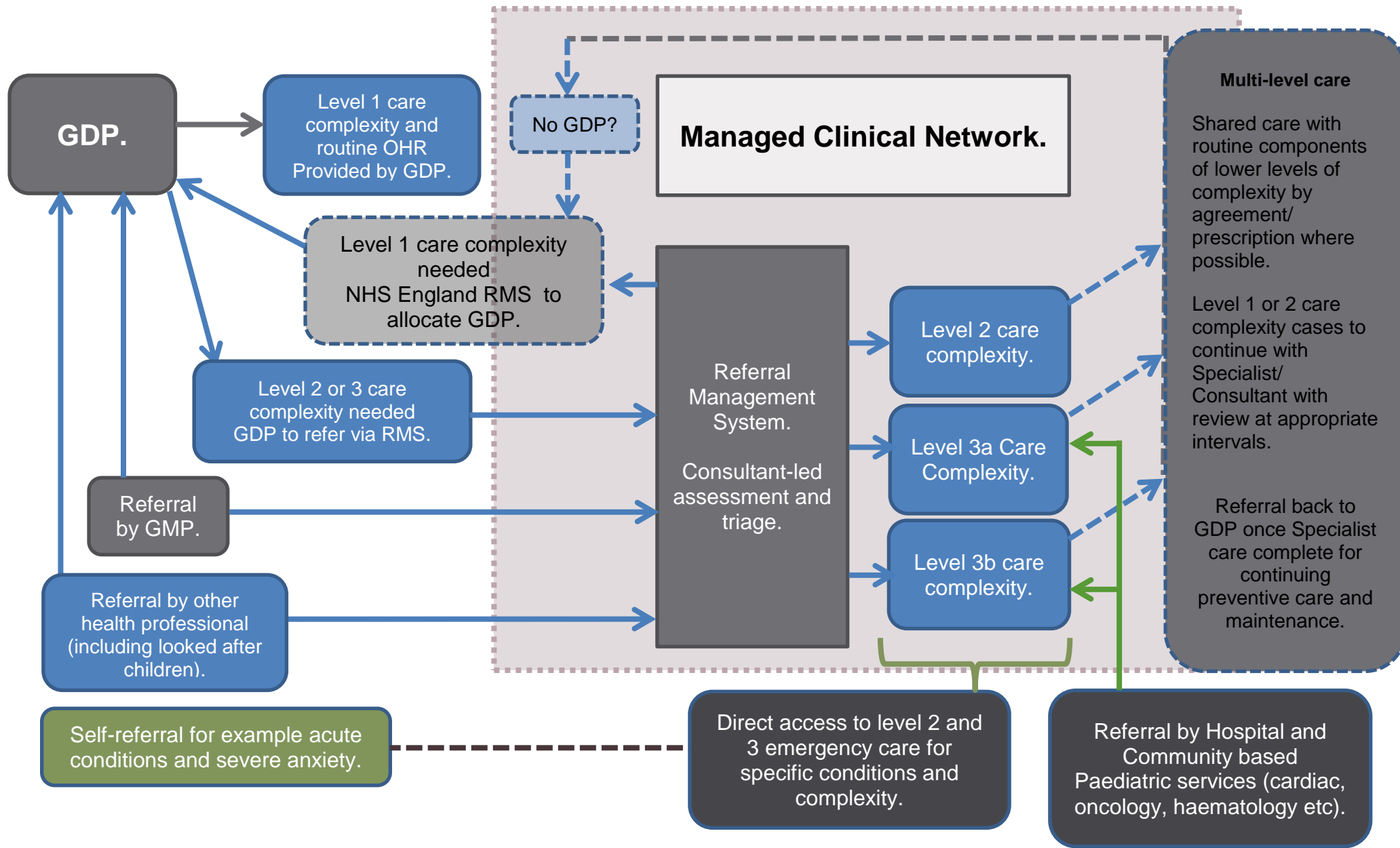
This service operates on [INSERT LOCAL ACCESS INFORMATION]. Each case is assessed for urgency and prioritised.

Inappropriate/ inadequate referrals will be monitored and the child or young person directed to appropriate care. Your compliance with the above guidelines will avoid unnecessary delays in patient care. Thank You.

Please use the locally agreed urgent referral management system in-hours and be aware of and observe the local out-of-hours arrangements.

The details of these systems will require local development and agreement to ensure that specialist led paediatric urgent/emergency dental care is accessible at a local level. This may involve capacity building and agreement with OMFS units whose junior staff are on call in the hospital settings.

Appendix 8 Illustrative patient journey



The standards, metrics and enablers are elements which can be used to assess performance of a provider and the enablers are factors which would support the transformation of care.

Primary Care Services

PRIMARY DENTAL CARE

Illustrative Patient Journey

Information on how and why children should and can access primary dental care locally is available wherever patients, parents and/or carers are likely to seek information.

All children will access primary dental care by the age of one.

Comprehensive assessment of behaviour/diet, clinical need and risk together with an assessment of co-operation/ maturity is carried out at every new and annual review.

Evidence informed and proactive advice, treatment and preventive intervention is delivered according to need and appropriate to level of co-operation/maturity to DBOH guidance.

Children continue to attend primary dental care at routine intervals following referral for specialist care.

Key Principles

Information about local primary dental care services is available and explains why and how children should be accessing primary dental regularly.

Access to GDS or (CDS if needed) is secured locally.

Timely access to primary care for urgent services or with trauma is offered.

DBOH recommendations for professional are followed and delivered.

Need and Risk assessment with Recall according to NICE guidelines.

Continued access with a GDP.

No pain left unaddressed.

No infection left unaddressed.

Radiographs to FGDP standards.

All Level 1 case and procedural complexity delivered in primary care.

No more than one sleepless night due to dental pain (within 24 hours) for any children.

Providers of acute care have access to or can provide necessary first line treatment of children including trauma.

Metrics

Evidence of information being available.

Proportion of under 1's and all children accessing a NHS primary dental care services.

Fluoride Varnish delivery.

Fissure sealant delivery.

Toothpaste prescription for high risk over 10s.

PREMs collected and reported on: Did the dentist deliver understandable advice.

Outliers for number repeat antibiotic prescriptions are identified and followed up (FP17 BSA data).

Children attending A and E with dental problems.

111 usage by parents of children.

Enablers

Up to date list of dental practices and services is available and accessible to all health, education, social care and voluntary agencies who are in contact with children and in addition it is readily available to the public.

Available and timely access to primary dental care for children, including those with additional needs in locality.

The child health record 'red book' contains a mandatory section on dentistry and other health and social care teams are required to complete and follow-up non-attendance.

Outreach and follow up of children within 'hard to reach' groups is agreed within local plans.

Joint electronic child health & social record.

Peer Review Audits of active treatment interventions are completed and shared via the MCN for Paediatric Dentistry.

Mandatory updates and CPD in Paediatric Dentistry and paediatric trauma for all primary dental care team.

Timely specialist paediatric advice is available to primary care teams in normal working hours.

PRIMARY CARE PROVISION

Illustrative Patient Journey

Children and YP with a mild to moderate physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors receive continuing primary dental care in General Dental Practice wherever possible.

Key Principles

Dental practices and CDS specialist providers ensure information about the services they provide is readily accessible in [web based and written forms](#).

Specialist paediatric CDS providers ensure:

- their service name is appropriate to role.
- key intermediaries have referral information including specialist nurses, medical specialists, local charities/patient groups, schools.

Providers of GDS/PDS primary care ensure provision of a level of care that patients in these groups can reasonably expect. In doing so they should:

- be aware of current guidelines relevant to Paediatric Dentistry.
- understand the importance of prevention for CYP and for those sub groups with additional needs for whom dental disease or the consequences of its management places them at additional risk.
- be familiar with specialist Special Care Dentistry services available locally in the preparing and planning for transition.

It is recognised that:

- there is a spectrum of need and complexity which means shared care with specialist services is appropriate in some cases.
- the threshold for referral varies between clinicians according to experience. They have a duty of care to be aware of the boundaries of their own competence as well as the need to avoid discrimination by referring CYP whose needs can reasonably be expected to be met in mainstream services.

Metrics

“Mystery shopper” Web search to locate information availability on:

- acceptance of new child patients for NHS care.
- accessible premises and child friendly facilities.
- specialist services including acceptance criteria and referral process.

Practice policies and procedures include reasonable adaptations to accommodate the additional needs of CYP and particularly for those CYP with additional needs.

Number of CYP and % of those patients on practice database with a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability.

% treatment plans which include diet / fluoride advice / FS, and oral hygiene support.

Complaints, comments about service access for patients with additional needs (role for disability / patient groups).

All other expected standards in the GDS contract/PDS agreement. Metrics are already covered in the existing Dental Assurance Framework.

Enablers

Practice IT systems collect and report this information.

GDPs and LDC engages with MCN to achieve representation of local paediatric dentists.

Practice systems to include the ability to record patients with a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability.

MCN in Paediatric Dentistry established:

- work with the LPN.
- normally led by consultant or if not available a specialist in paediatric Dentistry and included in their job plan.
- governed by commissioners.
- red book central to data collection and inter professional liaison.
- consultant in Dental Public health leads local population needs assessment.
- work closely with Consultant in Dental Public Health on transformation.
- communicates and receives information with and from GDS/PDS primary care contractors.
- leads local service communication strategy which involves public information providers to include service information on:
NHS choices website
NHS 111 operator information
LDC websites
NHS trust websites.
- interdependency of MCN with clinical networks including those children with additional needs and in transition to adult SCD services.

MCN engages with local deanery in making available:

- Paediatric Dental training.
- awareness training for GDPs on local Paediatric Dentistry referral guidelines.
- signposting to guidelines relevant to Special Care Dentistry.

Specialist providers engage and support GDPs in the continuing care of appropriate CYP with additional needs.

Referral to Specialised Service

Illustrative Patient Journey

Referrer completes the referral form ensuring required data set is complete, to include:

- medical history.
- social/mental health history.
- disability needs.
- IOPDN / Case mix tool as appropriate.
- Radiographs.
- MDAS/IOSN.

Information regarding referral process explained to patient and/or carer.

Responsibility for care of patient remains with referring dentist where referral is for a single episode of care and should provide continuing care until seen and accepted for care by specialist service and shared care arrangement may be agreed.

Key Principles

Decision to refer is appropriate e.g. meets referral criteria.

Referral made within one week, unless patient requires urgent treatment when referral to be made the same day.

CYP/Patient/carer information about specialist referral provided at the point of referral (NHS England approved).

Patient is given choice of specialist providers where options exist.

Specialist services to accommodate rapid response for those patients who require urgent assessment.

Metrics

% of referrals received that:

- have complete referrer details.
- have complete patient demographic and contact details.
- are appropriate to acceptance criteria.

% of patients/ carers:

- informed about specialist service referral.
- referred within 1 week of decision to refer.
- referred the same day if urgent.

Enablers

Referral acceptance criteria and adherence to NHS England Paediatric Dentistry referral guidance.

Referral guidance and the requirements of minimum and core data set communicated to referrers.

Electronic pro-forma and referral system.

Referral IT system able to produce reports on referral patterns by practice and practitioner.

Development of an Index of Paediatric Dental Need IOPDN.

Triage of Referrals

Illustrative Patient Journey

Specialist/consultant led team triages the referral to identify the complexity of the patient's needs using appropriate clinical risk assessment measures and complexity tools.

CYP/Patient/carer receives information on where and when assessment/consultation will take place.

CYP/Parent/carer has choice of appointment time and location.

Key Principles

Referrals to be triaged within 1 week or same day if urgent referral.

Triage outcome for non-urgent patients communicated within one-week to:

- Patient/carer.
- Referrer.

Metrics

% Referrals that are:

- triaged within 1 week.
- same day (urgent).
- requiring Level 3 care.
- requiring Level 2 care.
- requiring Level 1 care.
- requiring additional facilities.
- Rejected.

Enablers

Job plan of Paediatric Dentist: specialist/consultant includes leading team in triage and validation of referrals.

Triage team according to local arrangements.

Clinical Assessment for Specialised Care

Illustrative Patient Journey

Clinical assessment and treatment planning undertaken under the care of a specialist / consultant. Individualised risk assessments as necessary for example for patients with:

- ASA III / IV medical conditions.
- Challenging behaviour
- Significant dental disease burden.
- Relevant support to Level 2 / 3 care complexity patients who fail to attend appointments to ensure they receive help in accessing services.
- Information on those who have identified need and who do not attend or fail to attend planned treatment is shared routinely with other health/social care professionals such as safeguarding team.

Key Principles

Clinical notes document:

- outcome of risk assessments.
- agreed treatment plan and grade of staff providing the treatment.
- arrangement for continuing care needs.

All records completed using key diagnostic words and procedure codes agreed toolkit.

Metrics

% patients:

- treated by grade of staff.
- requiring specific procedures or facilities for example IHS/IV/GA, hoist wheelchair tipper, bariatric facilities.

Numbers of:

- cancellations by provider.
- failures to attend / late cancellations by patient followed up by provider and reported.

Appraisal and peer review in place and outcomes benchmarked and reported through MCN.

Enablers

Specialist providers review workforce plan, skill mix, facilities and estates planning and report via MCN.

Level 2 provider Service Level Agreement (SLA) in place including supervision by consultant / specialist as part of job plans.

Choice of provider and performance metrics published.

Consistent diagnostic, procedure and tariff toolkit available and used by all providers. Consultant/Specialist led.

HEE to ensure that appropriate training is available to ensure a work force capable of meeting Special Care Dentistry patients' needs.

Level 2 and 3 Specialised Care Provision

Illustrative Patient Journey

CYP including those with moderate to severe physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or complex dental disease/conditions or, more often, a combination of these factors can receive appropriate specialised care which is time limited or on-going according to their individual needs.

Communication with relevant health and social care professionals for example GPs and consultants re medical history.

Multidisciplinary assessment and care arranged as necessary.

Consultation with family members, advocates and carers re best interests in those lacking capacity to consent.

Special arrangements made for care in appropriate service setting.

CYP and their parents or carers provided with information regarding:

- after care following treatment.
- post-operative emergency contact details.

Key Principles

Waiting times to treatment start within 18 weeks or 1 days if urgent.

Inter-visit length that is the length between appointments should be appropriate to meet optimal clinical standards and sensitive to patients special needs.

Waiting times for GA do not exceed 18 weeks or 4 weeks if clinically urgent.

Specialised treatment undertaken to a high standard – outcome measures to be agreed with MCN.

All treatment plans include proactive prevention and restoration.

Timely management of problems arising during treatment.

Service complies with standards of environment accessibility and facilities / equipment required for Paediatric Dentistry delivery including sedation.

Clinical records comply with standards on record keeping including consent. Process. CYP/Patients/carers able to contact the service during surgery hours throughout the course of treatment.

Metrics

Number and % patients treatment started:

- Within 18 weeks of receipt of referral.
- Within 2 days if urgent.

Appraisal and peer review in place and outcomes benchmarked and reported through MCN.

% of patients

- Treated in shared care model.
- Who attend for a single course of treatment.
- In on-going care arrangements.

% treatment plans which include diet / fluoride advice/ FS, and oral hygiene support.

% clinical records which comply with standards.

Enablers

Activity reports matched against population needs assessment.

Local specialised services have sufficient specialised staffing and supporting skill mix.

Staff are given access to sufficient levels of specialised training and CPD in line with recommendations from specialist organisations and GDC.

Treatment outcome measures developed Gold standards published on equipment and environment reviewed as part of SLA.

Consistent diagnostic and procedure tool used by all Level 2 care providers.

Clear distinction between levels of care.

Discharge and Continuing Care

Illustrative Patient Journey

Arrangement appropriate to each individual made for discharge to GDP, recall or shared care.

Key Principles

CYP parent / care provider has all necessary information on:

- Who is providing continuing care.
- Self-care / assisted care to maintain oral health.

GDP informed of CYP's discharge within 1 month.

Metrics

PROMS collected and reported on routinely within one month of completion of care.

See quality and outcome measures.

Enablers

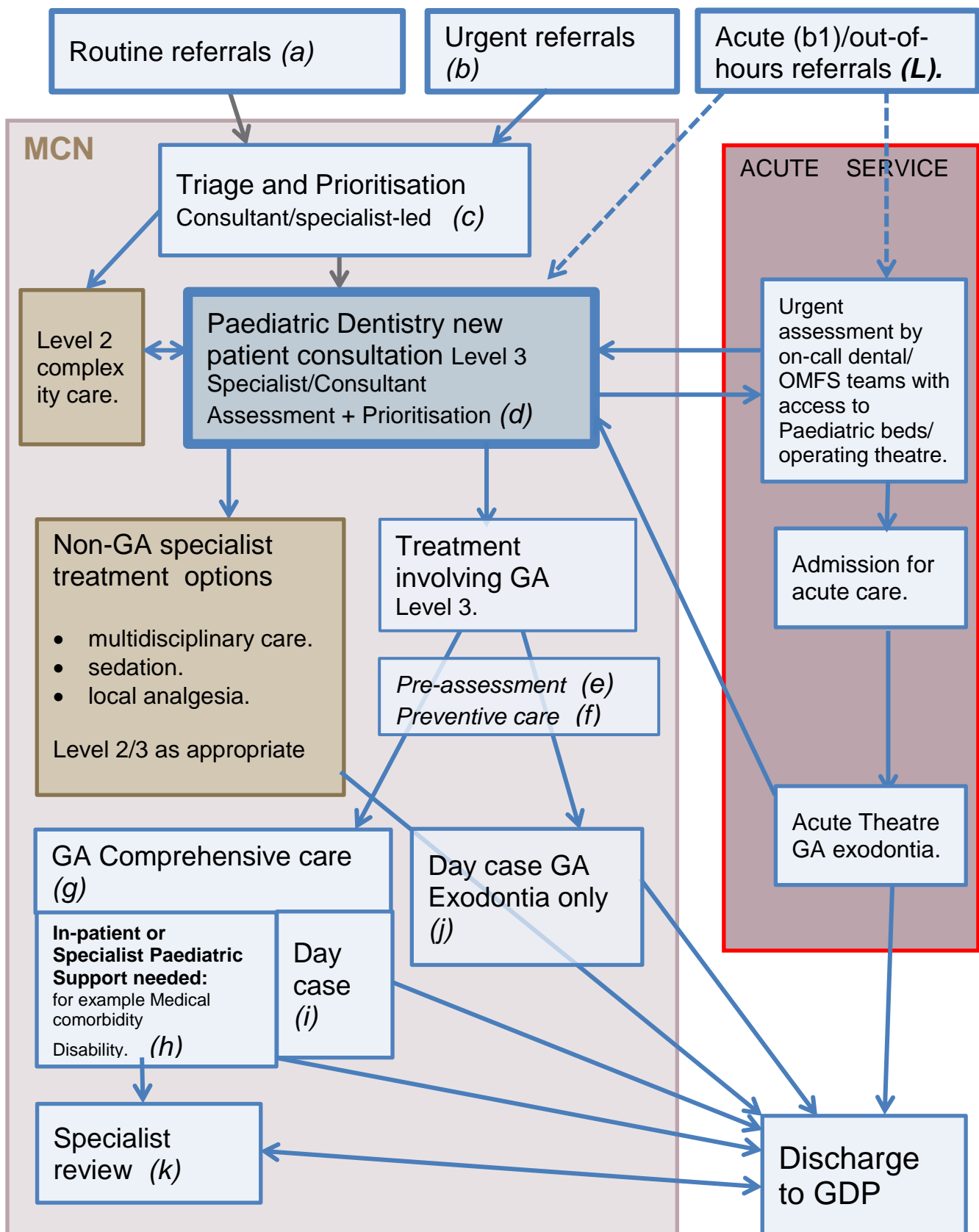
Adequate admin and IT support.

Appendix 9 Example of specialist paediatric dental care pathways with details of integration of dental care under general anaesthesia

The flowchart below explains the process that should be followed when a child is referred for dental care under general anaesthesia. The referral might be routine or the child might have pain (an urgent referral) and the referral might be in hours or out of hours if the child has pain.

The ideal route is that the referral is triaged by a specialist or consultant and then depending on the outcome, either sent on for a non GA treatment, for example sedation, or for treatment under GA where this is essential. The treatment might comprise exodontia (extraction of teeth) or in some cases the child might need more comprehensive care for example restorations. In all cases the child should be discharged after treatment to a GDP for routine care including prevention.

Where a child presents in pain, then it might not be possible for immediate paediatric consultant triage and the child may be assessed by the on call dental team in a hospital and treatment provided. Following treatment, the hospital dental team or the GDP should consider referral to the specialist paediatric team if the child has a history of acute dental episodes or has associated comorbidities.



Explanatory notes the specialist paediatric dental care pathway with details of integration of dental care under general anaesthesia:

A) Paediatric dentistry routine referrals

Whilst the majority will arise from GDPs, these may arise from other health professionals, including other paediatric specialities.

B) Urgent referrals

Children whose needs are not acute, but have a history of recurrent poorly managed pain or repeated dental infection require a priority route to ensure any child in pain can access timely assessment and care, and should still be managed through the RMS.

B1) Acute referrals

The criteria for acceptance should be locally defined but may include children with:

- Facial swelling secondary to dental infection.
- Significant systemic disturbance secondary to dental infection.
- Uncontrolled haemorrhage of oro-dental origin.
- Dento-alveolar trauma outside the scope of management within the GDS.

Direct/rapid access to hospital-based Paediatric Dentistry units and/or accident and emergency departments, and out of hours access should be agreed locally and should be managed by a locally agreed acute management pathway (see paragraph L).

C) Triage and Prioritisation

All routine referrals will be triaged and assessed by a consultant or specialist-led clinical team (referrals indicating possible requirement for GA will not be managed separately). Increased priority should be given to children where significant or persistent dentally-related morbidity is reported in the referral (for example where multiple courses of antibiotics over a short period have been necessary) or where their dental disease puts their general health at increased risk (for example children at increased risk of infective endocarditis).

D) Paediatric dentistry new patients

A specialist or consultant-led triage should be in place so that new referrals can be assessed and an initial consultation arranged if required. Following diagnosis, appropriate options for management will be discussed and agreed with the patients and those with parental rights. RMS, triage and assessment will act as a gateway to specialist paediatric dentistry services. In accordance with [GDC guidance](#), modalities of management other than general anaesthesia (for example sedation, local analgesia) will be considered and dental treatment under GA will only be prescribed where it is the most appropriate modality of management for the individual child. Written consent will be obtained for all treatment under GA. Non-GA treatment will be arranged as required according to need. Assessment clinics should be consultant or specialist-led and treatment plans for treatment under general anaesthesia must be agreed by a specialist or consultant in paediatric dentistry.

E) Pre-assessment

Except for urgent admissions, all children awaiting treatment under general anaesthesia should receive pre-assessment prior to attending for the anaesthetic

as is normal practice for most other children awaiting operations. How and when this is delivered will vary depending on local arrangement, but it may be carried out at the time of the consultation or later, either in person or by telephone. Pre-assessment is usually carried out by registered nursing staff.

F) Preventive care

All children requiring dental care under general anaesthesia for the management of dental caries or any other preventable oro-dental condition must receive appropriate preventive advice and support at the level for 'children giving cause for concern' in accordance with the guidance detailed in [Delivering Better Oral Health](#). This is generally the responsibility of the primary care dentist making referral but for children with no primary care provider it needs to be secured. Wherever possible prevention should be delivered whilst the child is awaiting treatment, and compliance with preventive advice assessed, as this may in turn help to inform the most appropriate treatment plan at the time of the dental treatment under GA.

G) GA comprehensive care

This is for children requiring dental treatments other than exodontia-only such as minor oral surgery and/or restorative care.

H) In-patient or specialist paediatric support needed

Some children will require specialist paediatric support or in-patient paediatric facilities to manage their dental care and GA safely and appropriately. This will include children with the following types of condition:

- cardiac disease.
- significant respiratory disease.
- Malignancies.
- bleeding disorders and other significant haematological problems.
- those being planned for or having received bone marrow and organ transplant.
- significant disability or impairment, including those with learning difficulties and communication disorders.
- hepatic and renal disease.
- immune deficiency.
- metabolic disorders.

Such children are likely to require consultant paediatric anaesthetic management, and also direct support from consultant-led general or specialised paediatric medicine services, and so will usually be located within children's hospitals. The arrangements for admission to paediatric beds within hospitals vary and should be locally agreed with the relevant paediatric specialities, commissioners and providers.

I) Day case comprehensive care

This is for children other than in the categories described in paragraph H above, requiring dental treatments other than exodontia-only and may include minor oral surgery and/or restorative care. These services will not normally require access to in-patient beds and whilst sometimes sharing the same facilities and theatre

lists as in-patient services, may take place in district general hospitals with appropriate paediatric anaesthetic support.

J) Day case exodontia only

For children where exodontia-only under GA has been determined to be the most suitable treatment. Children undergoing general anaesthesia for dental extractions should receive the same standard of care as children admitted for any other procedure under general anaesthesia.

K) Specialist review

Following dental treatment under general anaesthesia, most children will be discharged back to their GDP (e.g. Level 1 complexity). However a minority of children, especially those with complex medical comorbidity and/or significant disability, and those with complex dental conditions, may require on-going care or follow-up of level 2 or 3 complexity. In the majority of cases this will be on an agreed shared basis with the child's primary care practitioner within a CDS or general dental practice.

L) Acute/ out-of-hours referral pathway

The criteria for acceptance should be locally defined but may include children with:

- facial swelling secondary to dental infection.
- significant systemic disturbance secondary to dental infection.
- uncontrolled haemorrhage of oro-dental origin.
- dento-alveolar trauma outside the scope of management within the GDS.
- Direct/rapid access to hospital-based Paediatric Dentistry units and/or accident and emergency departments, and out of hours access should be agreed locally and should be managed by a locally agreed acute management pathway (see paragraph L below).

These services will often be provided by local Oral and Maxillo-Facial Surgery or Oral Surgery teams. It is recognised that these circumstances may not allow a full assessment of a child's overall dental needs and may by necessity focus on managing the urgently presenting oro-dental problem. Where a child is considered to potentially have other dental needs that may fall beyond the remit of the child's GDP (or where the child does not have a GDP), following acute management, onward referral for a formal Paediatric Dentistry opinion should be considered.

Appendix 10 Glossary

A&E	Accident & Emergency
ADHD	Attention deficit hyperactivity disorder
ARCP	Annual Review of Competence Progression
ASA	American Society for Anaesthesiologists
ASD	Autism Spectrum Disorders
BSA	NHS Business Services Authority
BSPD	British Society of Paediatric Dentistry
BDA	British Dental Association
CCST	Certificate of Completion of Specialist Training
CDGA	Comprehensive dental care under GA
CDS	Community Dental Services
CPQ	Child perceptions questionnaire
CPD	Continuing professional development
CYP	Children and young people
DBOH	Delivering better oral health
DGA	General anaesthesia for dental care.
DGI	Dentinogenesis imperfecta
DCP	Dental Care Professional
dt/DT	Decayed teeth
ECOHIS	Early Childhood Oral Health Impact Scale
EHCP	Education, health and care plan
FFT	Friends and Family Test
GA	General Anaesthetic – A medication used to cause a loss of consciousness so you're unaware of surgery
GDC	General Dental Council – Organisation that regulates dental professionals in the UK
GDP	General Dental Practitioner
GMP	General Medical Practitioner
GDS	General Dental Services
GMC	General Medical Council
GPs	General Practitioners
HEE	Health Education England
HES	Hospital episodes statistics
HSCIC	Health and Social Care Information Centre
IACSD	Intercollegiate Advisory Committee for Sedation in Dentistry
ICO	Information Commissioners Office
IOPDN	Index of Paediatric Dental Need
IOSN	Index of Sedation Need
ISFE	Intercollegiate Specialty Fellowship Examination
LA	Local anaesthesia
LD	Learning Difficulties
LDC	Local Dental Committee

LDN	Local Dental Network
LETB	Local Education and Training Boards
Level 1	Care/procedures/conditions to be performed or managed by a dentist commensurate with level of competence as defined by the Curriculum for Dental Foundation Training or its equivalent.
Level 2	Care is defined as procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register
Level 3a	Care and procedures/conditions to be performed or managed by a dentist recognised as a specialist in Paediatric Dentistry by the GDC
Level 3b	Complex level of care and should be delivered by a dentist recognised as consultant in Paediatric Dentistry
MCN	Managed Clinical Network
MDAS	Modified dental anxiety scale
MDT	Multi-disciplinary teams
NICE	National Institute of Health and Care Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
OHNA	Oral Health Needs Assessment
OPG	Orthopantomogram
P-CQP	Parental Caregivers Perception Questionnaire
PCR	Patient charge revenue
PDS	Personal Dental Services
PHE	Public Health England
PIA	Privacy Impact Assessment
PREM	Patient reported experience measure
PROM	Patient reported outcome measure
RCOA	Royal College of Anaesthetists
RCS	Royal College of Surgeons
RMS	Referral Management System
SCD	Special care dentistry
SDEB	Specialist Dental Education Board
SEN	Special educational need
SEND	Special educational needs and/or disability
SLA	Service Level Agreement
SOHO	Scale of Oral Health Outcomes
UDA	Units of dental activity
WNB	Was not brought
XGA	Exodontia with General Anaesthetic