NHS England

ICB toolkit: CYP SEND oral healthcare service specification

Oral healthcare service specification for children and young people with special educational needs and disabilities (SEND) in special educational settings

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Contents

Introduction and background

1. The NHS Long Term Plan (2019) set out a commitment to provide oral health checks for autistic children and young people and/or those with learning disabilities in residential special educational settings (SES).

   A programme of work was undertaken to develop a clinical and commissioning model for delivery of this commitment, and a clinical standard and commissioning toolkit has been published outlining the national model.

2. This service specification outlines the non-clinical requirements to meet the Clinical standard for oral healthcare for autistic children and young people and/or those with learning disabilities in SES. Subject to local commissioning issues, this can be adapted by commissioners of dental services to suit those local requirements.

3. While the NHS Long Term Plan commitment related specifically to children and young people in residential SES, much of the clinical model would also apply to autistic children and young people and/or those with learning disabilities in non-residential SES; and, to some degree, to those in mainstream schools.

   Subject to local priorities, dental commissioners may therefore also wish to adapt this service specification to commission services for children and young people in these other settings.

4. This service specification template should be read alongside:

   - the clinical standard for oral healthcare for autistic children and young people and/or those with learning disabilities in SES (NHS England website)
   - the paediatric dentistry commissioning standard (NHS England website)
   - the special care dentistry commissioning standard (NHS England website)
   - other guidance and requirements relevant to dental commissioning more generally (NHS England website)

5. While this template service specification is likely to be of most use to dental commissioning teams, local dental networks and their associated paediatric dentistry and special care managed clinical networks, it may also be of interest to providers of general dental services and SES.

6. In addition to the national service specification, guidance on completion of a population needs assessment is included in this document at appendix 1.

7. For ease of reading for the remainder of the document, the ‘clinical standard for oral healthcare for autistic children and young people and/or those with learning disabilities in special educational settings’ will be referred to as the SES clinical standard.

Service specification

8. The provider will agree with commissioners a defined list of special schools for which they will provide clinical care and treatment to meet the need of patients, in line with guidelines set out in in the SES clinical standard, with school sites to be clearly set out in appendix 2.

   The provider must agree with the commissioner prior to any changes being made to the list of specials schools allocated.

9. The provider will be expected to work closely with commissioners, the local dental network, and any supporting managed clinical network.

10. The provider will identify a named individual or role in the practice/organisation as a point of contact for the special schools identified in appendix 2.

11. The provider will also work collaboratively with other general, special care and paediatric dental service providers identified by the commissioners, to support the care and or treatment of children identified in appendix 2.

12. The provider will use the resources identified in the SES clinical standard – ‘Resources for delivery of oral healthcare in SES’ – to support delivery of clinical care and treatment to patients.

13. The provider will undertake any training required prior to commencement of delivery of the service as detailed in the SES clinical standard, unless otherwise agreed with the commissioner.

14. The provider and commissioners will work together and agree a priority set of no more than 5 quality improvement indicators from the list of options detailed in appendix 3, with a focus on quality improvements in clinical care and treatment to patients. The provider must agree any changes to the indictors with the commissioner.

15. An FP17 for all face-to-face courses of treatment provided, dental checks and treatment, will be required to be submitted to the NHS Business Services Authority (NHS BSA) within the 2-month rule.

16. The provider will complete any locally agreed data collection tool for quality improvement indicators agreed with the commissioner.

17. Activity data will be made available to the provider via NHS BSA Dental Services.

Oral health check

18. The provider will follow the clinical care model detailed in the SES clinical standard.

19. The care model includes an oral health check-in to determine oral health risk status, agreement of mouth care plans, and face-to-face oral health assessments.

20. Individual oral health assessments will be carried out for all children and young people in the SES at defined intervals that are tailored to individual needs, depending on child/young person's level of risk, and in line with National Institute Clinical Excellence (NICE) recall guidance.

21. When undertaking the oral health check-in with the children and young people in the schools identified in appendix 2, the provider will undertake the steps detailed in the SES clinical standard 'Check list for oral health team'.

22. Commissioners will support the provider to plan with the school to undertake face-to-face oral health assessments for children and young people, or prevention activities to support improvements in oral health, on the school premises. Key considerations and resources are set out in appendices 1 and 2 of the SES clinical standard.

23. Where specialist care is required, the dental teams should manage referrals in line with local pathways overseen by chairs of the regional managed clinical network. Where applicable, and only with consent of the child/young person and carer, a referral should be copied to the child/young person's own dentist.

24. The provider will establish and maintain excellent relationships with the providers who may be in receipt of onward referrals, ensuring that all relevant information required by the referral provider is included with the referral.

25. There should be regular communication between all stakeholders, including:

- local dental networks
- integrated care system (ICS) commissioning teams
- consultants in dental public health
- local authority representatives
- children's universal services
- oral health promotion teams
- special residential schools and colleges

26. The provider will be familiar with the SES clinical standards for the special schools detailed in appendix 2.

Workforce considerations

27. Everyone involved in providing oral healthcare to children and young people must be appropriately trained and experienced. Training for clinicians is set out in the SES clinical standard.

28. The provider will adopt a whole team approach for delivering the service, using the skills of the wider dental workforce dental care professionals (DCPs), within their scope of practice. Review long guidance on this via the NHS England website.

29. All dentists and DCPs will have completed (as a minimum) the following training:

    - The Oliver McGowan Mandatory Training in learning disability and autism as it is now mandatory for all CQC registered services.
    - Training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. The provider is responsible for ensuring all staff receive this training.
    - Staff must also receive appropriate supervision in their role to ensure they demonstrate and maintain competence in understanding the needs of people with a learning disability and autistic people, including knowing how to support them in the best way.

30. The provider will share details of the services workforce, including discipline of staff and whole-time equivalents (WTEs), at regular intervals to be agreed between the provider and commissioner.

Safeguarding

31. The provider will have a named safeguarding lead, who will work with the local commissioners and professional networks, to undertake training. The safeguarding lead will have in-depth knowledge of mental capacity and consent legislation and guidance, and will act as an advisor for the provider.

32. The provider will ensure valid consent is gained in line with the SES clinical standard, from all patients and/or carers prior to initiating assessment and/or treatment. Effective and robust arrangements must be in place to promote and safeguard the health and wellbeing of children/young people and vulnerable adults.

33. All staff must receive annual safeguarding training to the appropriate level. Most dental professionals, including dental nurses, will require Level 2 (4 hours) safeguarding training. Level 3 (8 hours) certification should be carried out by those providing paediatric or special care dentistry; this will be determined locally depending on need and risk.

34. The provider must have a safeguarding policy that meets the commissioners' and regulators Care Quality Commission requirements for safeguarding children and young people is in place.

Contract type and length

35. The contract is offered under the terms of the NHS personal dental services (PDS) agreement regulations 2005, effective from 1 April 2006 and any subsequent regulatory revisions.

36. PDS regulations identify mandatory, additional services and further services. The clinical services are to provide all necessary care and treatment to maintain good oral health, in line with the care pathway set out in the clinical standard, to SEND children and young people and children in a SES.

37. The contract will run for a term to be agreed between the commissioner and contractor.

Eligibility to provide services

38. The provider must be willing and eligible to enter a time limited bespoke PDS agreement with the integrated care board, and to provide primary care dental services, specifically to see and treat young people and children in an SES.

    The Policy book for primary dental services, published on the NHS England website, gives details of who can enter a PDS agreement.

39. The provider must have the ability to meet all terms and conditions set out in the published PDS agreement Model contracts and contract variations: dental services; and if not already in place, establish an nhs.net email account.

    Details of how to set up an account can be found on the NHS England website.

Accessibility and service hours

40. The service will be flexible and responsive to individual patient need in accordance with the Equality Act 2010 and the NHS and Social Care Act 2008. Wheelchair access is particularly important.

41. Service hours should allow for access outside of school/college hours and should be set to maximise attendance from children from all socioeconomic backgrounds; for example, consideration should be given to a range of daytime, evening and weekend appointments.

42. The provider will monitor patient satisfaction to include accessibility and implement change where reasonable and appropriate following discussion and agreement with the commissioner.

Provider premises and equipment

43. The provider will ensure that they have the relevant practice infrastructure and access to undertake face-to-face care for patients in clinical premises.

44. The provider will ensure they have the relevant practice software or access to the online NHS BSA portal to submit electronic FP17 forms to Dental Services, NHS Business Services Authority.

45. The provider will ensure that they have the relevant digital technology to support video conferencing for remote contact with patients and/or school settings where this is required.

Remuneration

46. The provider will be remunerated £650 per session to provide all necessary care and treatment to maintain good oral health, in line with the care pathway set out in the SES clinical standard.

47. The appropriate units of dental activity (UDA) for face-to-face checks and courses of treatment undertaken will be recorded in line with the PDS regulations, for data collection purposes only.

Performance and activity reporting

48. The contractor should adhere to the contract monitoring and quality improvement indicators as set out in appendix 3.

49. Providers will be expected to engage on the provision of evidence data which support the quality improvement indicators.

50. Where face-to-face check-ups and treatments are undertaken, FP17s will need to be submitted against the contract number issued, which will be provided by the primary care commissioning team on award of contract.

51. There is also a requirement that providers will contribute to the evaluation of the service to patients, by attending local or national evaluation meetings. Sufficient notice will be provided.

52. All data captured nationally and locally will support the evaluation of the service.

Appendix 1: Population health needs assessment

Planning oral healthcare services should be underpinned by an oral health needs assessment. In the context of this clinical standard, a population oral health needs assessment should be used to determine if current dental care service provision is meeting local oral health needs.

The local dental network (LDN) will have access to a locality oral health needs assessment, supported by local consultants in dental public health. However, where not explicitly described the following approach will support further understanding of what the needs for the area are. The method used for the need's assessment should answer the following:

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

10-step process for undertaking an oral health needs assessment (OHNA)

1. Establish (or reconvene) a working group

Ideally the group would be led by a consultant/specialist in dental public health. It should include relevant NHS England commissioners and commissioners from emerging ICSs, appropriate patient and public representatives, SES and dental service providers, and members of relevant managed clinical networks, for example paediatric/special care.

2. Agree aims, scope and timescales

The scope may be shaped by existing knowledge or by concerns requiring further investigation. Clarifying the goal of an OHNA will add focus to the task.

3. Collate existing OHNAs and other relevant information

The third step is partners pulling together any previous OHNAs, plus any additional information they already have or are aware of. If there is no previous OHNA work to draw upon (which is likely for SES), then the purpose of the initial OHNA can be to describe a comprehensive picture of what is known from readily available data.

Some data is available online from the oral health survey of children attending special support schools (at gov.uk).

4. Identify and close information gaps

- What do we know currently?
- What do we need to know and how can we secure that information?

Seek out the available local data. It is likely that some important data will not already be available and will need to be collected from the SES and dental care providers.

Consider work to engage the population/community of interest and other stakeholders, for example providers of dental care to SES.

5. Build a comprehensive picture of needs and resources

Analyse the information and data gathered and agree the problems or issues which are a local priority for potential action.

This step may result in a long list of priority problems which will be revised to a short list for action in step 6 (not all priorities will have actions). Prioritisation should be based upon issues requiring the greatest attention and where greatest impact can be made from available resources.

6. Interpretation of the information to identify unmet needs, and to agree priorities for potential action to meet these needs

Set out met and unmet need in relation to SESs and agree on actions to address any unmet need within local resource envelope.

Development of a prioritised list of actions which are recommended as locally appropriate completes this step. Any actions should be in line with the appropriate evidence base.

7. Identify how actions will be implemented

This step identifies how the local actions will be implemented. An action plan should be developed (a local implementation group may be convened to do this) which makes clear who is responsible and accountable for the delivery of the actions.

8. Final consultation phase

Consult with key stakeholders on the proposed actions/recommendations.

9. Implement action plan

Implementation of the action plan should be combined with data collection and monitoring. This information will be used to inform the review process in step 10.

10. Review implementation and impact of actions

Review/evaluate the actions and their impact at an agreed time point.

Appendix 2: List of special educational settings (SES)

A list of special educational settings can be found on the gov.uk site at this link.

Appendix 3: Quality Improvement Indicators

Quality indicators

Quality indicators will be collected on a retrospective annual basis at the start of each academic year and cover the previous academic year September to August or from the commencement of the contract.

Quality indicator	Objective	Data source
Number, expressed in a percentage, of the school pupil population that have received a remote oral health check up	To ensure that all pupils have received a remote oral health check up	Department of Education annual school population data Number of transmitted FP17 claim forms for unique patients
Number, expressed in a percentage, of the school pupil population that have received a dental check up	To ensure that all pupils have received a dental check up	Department of Education annual school population data Number of transmitted FP17 claim forms for unique patients
100% of all pupils tested to have a signed consent form	To ensure adherence to the legal requirements of consent as set out in the service specification	FP17 form
100% of all pupils checked to have a mouth care plan	To ensure outcome requirements are reported and disseminated to all relevant parties, enhancing	FP17 form

	the overall pupil outcome post dental check up	
Delivery of DBOH and effectiveness of toothbrushing interventions based on plaque scoring	Ensuring effectiveness of clinical quality (preventing, detecting, and managing disease)	FP17 form

Contract monitoring

Contract monitoring data will be collected on a quarterly basis from commencement of contract.

Contract monitoring indicator	Objective	Data source
Number of appointments cancelled; 1. Contractor cancelled; 2. School cancelled; and 3. Patient/guardian cancelled	Ensuring consistent service provision for pupils in schools	Declaration from the contract and school, cross referenced against school visitor reporting book
Proportion of pupils within each risk group, in line with the SES clinical standard	Ensuring efficient and equitable service delivery and measuring oral health improvements.	FP17 form

There is ongoing national work to determine the denominators within each data field and reporting mechanisms