1. **PURPOSE**

1.1 **Introduction**

This specification represents the requirements for the provision of a Community Dental Service (CDS) in all London Boroughs. The commissioning of these services is a statutory requirement for NHS England (London region), and is also central to the NHS England (London region) commissioning objectives in providing care for hard to reach groups.

Service activity data will be collected and analysed during the first year(s) of the service. In light of this data slight adjustments may be made to ensure the service remains focused on patient needs.

1.2 **Aims of the Service**

- Providing quality dental care to special care and paediatric groups and selected other hard to reach groups, in both clinic and community settings.
- Providing a range of public health functions for special care and paediatric groups.
- Delivering the national dental public health epidemiology programme and any local surveys agreed with NHS England (London region) or the local authority (LA).
- Improving access for special care groups, paediatrics and selected hard to reach groups as defined in this specification.
- Providing support for outreach teaching as agreed.
- Providing post-graduate training as agreed with Health Education England (HEE) and NHS England (London region).
- Collaborating in relevant oral health research programmes.

1.3 **Policy context**

A number of policy documents have informed the development of this service specification:


- ‘Commissioning Guide’s’ have been developed by NHS England (London region)’s Dental Commissioning Working Groups and, although in draft form, are being used as the main driver for the commissioning and subsequent delivery of ‘Special Care Dentistry’ and ‘Paediatric Dentistry’

- ‘Commissioning Tool for Special Care and Dentistry’ - British Society for Disability in Oral Health (BSDH, 2007). This document describes activities necessary for effective commissioning of special care dentistry and the expected standards and best practice in the UK Salaried Primary Dental Care Services: Toolkit for Commissioners’ was published by NHS Primary Care Commissioning in January 2010. It advises commissioners in 4 key areas with respect to commissioning Salaried Primary Dental Care Services: assessing local needs, mapping existing services, measuring and monitoring and, shaping the market.
1.4 Borough/LOT Information

Borough based public health data for is attached as Appendices 1 -10. These are detailed in the table below and are grouped by the designated commissioning LOTs.

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<tr>
<th>Area</th>
<th>LOT Description</th>
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<td>Outer NE London</td>
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<tr>
<td>Homeless –Additional</td>
<td>4 sites (See Specification)</td>
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<tr>
<td>Bariatric - Additional</td>
<td>4 sites (See Specification)</td>
<td>Appendix 15</td>
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2. DEFINITION AND SCOPE

2.1 Service Description

The Speciality of Paediatric Dentistry is concerned with the care and oral health improvement of children in society, from birth through to adolescents, that may demonstrate a physical, sensory, intellectual, mental, medical, emotional, psychological or social impairment or disability or, more often, a combination of these factors. In some cases, there can be difficulty in accessing care in GDPs due to different factors or in the case of young children may be pre co-operative and require specialist level care. This speciality was recognised by the GDC in 2000 ([http://www.gdc-uk.org/Dentalprofessionals/Specialistlist/Documents/PaediatricDentistry.pdf see 1.1](http://www.gdc-uk.org/Dentalprofessionals/Specialistlist/Documents/PaediatricDentistry.pdf)).

Special care and paediatric dentistry is provided by General Dental Practitioners (GDPs), by CDS and by Hospital Dental Services (HDS), including Dental Hospitals. The Special Care Specialty focuses on the dental care and oral health of adolescents and adults only and includes the important period of transition as the adolescent moves into adulthood. The speciality was formally recognised by the

The CDS will adhere to all local care pathways for dentistry and will participate in the development of these through local clinical networks and other clinician lead commissioning bodies.

*Figure 1 below shows the an summarised illustrative patient journey*

[Diagram showing patient journey]

*Figure 2 describes how the special care pathway criteria (descriptors) transfers into the case mix complexities.*

<table>
<thead>
<tr>
<th>Level 1 – Special care needs that requires a skill set and competence as covered by dental undergraduate training and dental foundation training or its equivalent</th>
<th>Level 2 – Special care needs, case and/or procedural complexity, that require management by a dentist with additional competencies as outlined by NHS England (London region) but below the level of a professional recognised as a specialist at the GDC defined criteria</th>
<th>Level 3a - Special care needs that require management by a dentist recognised as a specialist in special care dentistry at the GDC defined criteria.</th>
<th>Level 3b - Special care needs to be managed by a dentist recognised as a specialist in special care dentistry at the GDC defined criteria and holding consultant status.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild/No complexity</td>
<td>Moderate complexity</td>
<td>Severe/extreme complexity</td>
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</table>

To limit the number of general anaesthetics carried out on children, the CDS will act as the gatekeeper for children and adults referred for treatment under general anaesthesia and sedation. Working in collaboration with Health Education England (HEE), NHSE, PHE, acute trusts and general dental practitioners will support this transition.

For referrals not deemed to require general anaesthesia the service will provide care if necessary using inhalation sedation or other behavioural management techniques. Where appropriate, patients should be referred back to a GDP for continuing care.
The CDS will be expected to provide a service for looked after children (LAC). This includes a dental check-up as part of the initial LAC health assessment, care plans for a follow-up pathway/managing their treatment needs in consultation with NHS England (London region) and individual local authorities.

Special care and paediatric groups experience varying levels of disability and ill health and there is a spectrum of need and complex additional care needs across the population. Importantly, disability does not imply need and for many people dental treatment can be provided within the general dental practice setting, whilst those at the more severe end of the spectrum may require more specialised special care and paediatric dental services.

People with disabilities, special care and paediatric needs, or people who suffer from extreme social exclusion experience poorer oral health and more barriers to achieving oral health and accessing appropriate services than other parts of the community. The service is required to target these groups, and ensure they have the competency, expertise and skill mix to manage appropriately the associated needs.

People with special needs may receive most of their care from a GDP for most of the time. Occasionally they may have an exacerbation of their condition, or require treatment that requires more specialised management, and so may require a referral. This shared care may be for a short period of time or for a specific episode of care. Once the episode of care or period of time has ended, they may safely be discharged back to a GDP for routine care and monitoring.

However, there are those patients whose condition is such that they will always require either specialised or specialist care. In these circumstances it will not be possible for their routine care to be provided by a general dental practitioner and they will be cared for by a more specialised service.

For some patients, it may be appropriate for shared care arrangements to exist, where a specialist or consultant supports a GDP with treatment planning or patient management advice.

The CDS will provide a comprehensive range of special care and paediatric dentistry to patients with moderate to severe special care and paediatric complexity in clinics within the stated boroughs, as well as via outreach services for defined hard to reach groups who cannot access services elsewhere (including assessment, treatment and preventative services such as fluoride application within special care schools), oral health promotion, and the collection of epidemiological information on dental needs and patterns of disease within the local population as required.

Within this remit CDS will support the development of effective local clinical networks by referring patients appropriately to General Dental Service (GDS) when their needs fall below the level of ‘moderate’ special care (BDA Weighted Case Mix Tool) (see page 9) and by ensuring that GDPs know how to refer appropriately into the service.

It is expected that CDS will provide advice and guidance on the service through available events and networks such as the local dental committee meetings, local clinical network meetings and existing oral health promotion sessions. Input will include providing training in CDS referral protocols as required.
Principles
It is expected that the following principles should guide the delivery of CDS work:

- To endeavour to improve oral health for both child and adult special care and paediatric patients through the provision of effective, evidence based preventative, routine and specialist dentistry in primary care.

- To reduce inequalities of access for their target groups through the provision of effective services that take into consideration the specific needs of individual special care and paediatric groups.

- Where no other option will work, to reduce inequalities in access for target groups through outreach.

- To minimise number of onward referrals of special care and paediatric patients to secondary care services.

- To ensure discharge to GDS of any patient whose special care and paediatric need falls below ‘moderate’ on the BDA Weighted Case Mix Tool (page 9).

- To operate clear care pathways, develop close, collaborative working relationships with local providers, social services and become an active part of local health and social care networks.

- To obtain high levels of positive feedback from service users, gathered through appropriate channels to ensure coverage of all patient groups.

- To minimise the number of formal complaints.

- To complete quality national dental public health epidemiology programmes subject to specific requirements.

- To provide training posts and a continuing role in dental undergraduate and postgraduate teaching, as agreed jointly with Health Education England and NHS England (London region).

- To collaborate on research programmes relevant to the specialty, as requested and agreed annually.

- To achieve demonstrable value for money for all elements of the service through an on-going commitment to increased efficiency.

- To engage with and actively participate in the Managed Clinical Network (MCN) relevant to the area where services are provided

Whole System relationships
The CDS will work with the following partners, as part of the wider local dental care pathways, to address the needs of priority groups, ensure all patients are treated in the setting appropriate to their need, and achieve optimum outcomes and efficient pathways to care for all patient groups.

- Schools, including special schools and Pupil Referral Units (PRU)
- Social care
• General dental practitioners and their teams
• General medical practitioners (GPs) and clinical commissioning groups (CCGs)
• Community health services
• Secondary care providers
• Mental health services
• Psychological services
• Transport services
• Public Health England
• Health Education England
• Local authorities – public health teams, local authority commissioners of services to target groups
• Academic institutions

The service is part of a local dental clinical network which also includes:

• General dental practitioners who provide general dental care services to the local population;
• Specialist primary care providers who provide specialist dentistry to the local population on referral only;
• Hospital Dental Services, which provide complex clinical care, and also routine care to patients with complex needs;
• Dental schools in London;
• Urgent care dental services – both in-hours and out-of-hours.

The service will:

• Receive referrals from health and social care services.

• Send referrals to secondary care when they need either general anaesthetic or a type of complex treatment beyond the skills of service staff

• Redirect or discharge patients to GDS who do not meet the requisite level of special care and paediatric need.

• Actively encourage patients through their service back into general dentistry.

• Actively participate in Managed Clinical Networks.

The service will receive referrals from other primary care services, as well as having some well-developed collaborative relationships with individual services, to facilitate uptake of dental care by special needs groups where required. This includes joint working with child development teams, with special care schools, mental health teams, with residential homes, day care centres and hospices, with homeless centres, drugs and alcohol centres and other local health and social care providers.

Interdependencies

The CDS will work together with general dental practitioners, general medical practitioners, hospital dental services, and primary care specialist dental services to ensure seamless provision of care.

It will also build strong links with;

• Public Health England and their Dental Public Health teams
• NHS England (London region) and Dental Commissioning Teams
• Community Health Services
• Local authorities (LAs)
• Secondary care establishments
• Clinical Commissioning Groups
• Health Education England
• Health and Wellbeing Boards
• Patient transport providers and interface between these and salaried services
• Advocacy and interpreting service providers

Patients/client groups included
The British Dental Association’s Weighted Case Mix Tool (WCMT) was developed to describe the complexity of an individual patient during specific Courses of Treatment. It is based on six criteria that could potentially provide barriers or difficulties in providing oral care. Leading to five possible complexity outcomes – none, mild, moderate, severe and extreme

Case mix model

The BDA WCMT will be applied to every non urgent assessment. Special care and paediatric patients will only be seen where they are assessed as meeting moderate, severe or extreme levels of complexity.

Groups seen will include the following:

Those that cannot be treated in GDS:
• Adults and children with learning disabilities;
• Adults and children who are housebound (domiciliary and residential and nursing homes);
• Adults and children with physical, including sensory, disabilities;
• Adults and children who are medically compromised;
• Adults and children with mental health problems (including dementia);
• Adults and children with behaviour problems e.g. Attention Deficit Hyperactivity Disorder (ADHD);
• Adults and children with dental phobias (health/social care professional referral only);
• Adults and children with drug or alcohol addiction problems;
• Adults and children as part of the anxiety management pathway i.e. Inhalational Sedation, IV sedation;
• Children, without access to a dentist, under the care of social services or with complex social problems;
• Adults and children who are homeless or temporarily housed;
• Housebound adults who are frail and elderly;
• Children that require an assessment prior to general anaesthetic.

3. SERVICE DELIVERY
Service Model

Special care and paediatric dentistry (Mandatory and Advanced Services)

The CDS will provide a comprehensive and proactive oral health care service for people of all ages resident in London, who have special needs which are defined as moderate, severe or extreme in accordance with the agreed service referral protocol. All patients will be triaged to assess their case complexity and suitability for treatment by the CDS prior to commencement of treatment, and assessments will be recorded and monitored by the Provider and Commissioner in line with the requirements of the Key Performance Indicators (KPIs) for this service. People not meeting the referral criteria will be signposted to general dental practices or secondary care providers as appropriate. No special care and paediatric patient will be seen within the service without having been triaged and deemed to meet the set criteria first except those special care patients requiring urgent dental care.

3.1. Mandatory Services

3.1.1. Referral management for children and adults requiring general anaesthesia and sedation.

3.1.2. Dental care and treatment:
- The care which a dental practitioner usually undertakes for a patient, and which the patient is willing to undergo;
- Treatment, including urgent treatment;

The dental care and treatment referred to above includes the following treatments:

- Examination
- Diagnosis
- Oral health advice and planning of treatment
- Preventative care and oral health promotion advice (in line with Delivering Better Oral Health (PHE, 2014))
- Periodontal treatment
- Conservative treatment, including endodontics
- Surgical treatment
- Supply and repair of dental appliances
- The taking of radiographs
- The supply of listed drugs and listed appliances
- The issue of prescriptions
- Smoking cessation and alcohol reduction advice

3.1.3. Treatment for anxiety management

The CDS will provide a full range of appropriate anxiety management techniques including treatment under conscious sedation i.e. inhalation sedation, IV sedation, for children and adults who have disabilities or where sedation is necessary to enable the patient to access primary care dental treatment, providing they can fulfil the criteria set out in A Conscious Decision.

3.1.4. Domiciliary dental services

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1 Delivering better oral health: an evidence-based toolkit for prevention - Publications - GOV.UK
2 Standards for Conscious Sedation in the Provision of Dental Care (2015) — The Royal College of Surgeons of England
Whilst it is anticipated that the majority of patients will access services in a fixed site/clinic, domiciliary dental care will be available to those patients who are genuinely unable to leave their home to access fixed clinics/GDP practices.

The CDS will engage with the Local Authority, PHE and NHSE (London region) to ensure that services provided are locally appropriate and access to the domiciliary service is by locally defined protocols.

3.1.5. Unscheduled and Out of Hours dental care

The CDS is expected to see regular patients of the service who contact or present for urgent dental care during normal working hours, on the same day. The unscheduled appointment need not necessarily be offered at the clinic of the patient’s usual attendance.

Daily ‘access slots’ will be held for appropriate patients requiring urgent dental care.

In addition, urgent dental care will be available for unscheduled housebound patients.

Arrangements will be in place for the service to accept next day referrals from the Out of Hours Dental Nurse Telephone Triage Service where a patient with special needs has an urgent dental care problem.

3.1.6. Dental Public Health Functions

Oral Health Promotion

This section will be amended to reflect the requirements for each lot, depending on the arrangements for oral health promotion in each borough. Where OHP funding has not yet been withdrawn from CDS contracts and transferred to Local Authorities, Directors of Public Health will need to confirm whether they want to move this funding to the local authority, or if they want it to remain within the CDS core contract and monitored by NHS England (London region). This section will be updated when confirmation has been received from the relevant Directors of Public Health and will be reflected in the final version of the service specifications.

Oral health promotion and preventative advice will be provided to patients as part of their regular dental care. An annual programme for oral health promotion will be jointly agreed annually between NHS England (London region) and the local authority with the support of advice from Public Health England (London) Dental Public Health team.

The responsibility for commissioning dental public health and oral health promotion services lies with the local authority; however we recognise a lot of these teams are embedded within the CDS. Where the local authority agrees that these arrangements will continue the local authority will work with NHS England (London region), as an associate to the contract, to agree an annual work plan and performance management arrangements. Where the local authority decides to commission dental public health and oral health promotion directly, they will be responsible to determine the service delivery elements.
Epidemiology & screening programmes

- Deliver fieldwork for national dental public health epidemiology programmes and any local survey as agreed with NHS England (London region) or the local authority.

- Screening of children in special support schools within the local authority and provision of an annual report to NHS England (London region) and Public Health England (London) Dental Public Health team.

- Screening of residential and care homes, as agreed with commissioners.

Epidemiology

Every London borough is required to engage in the activities required by the national dental public health epidemiology programme. This programme supports the collection, analysis and sharing of reliable and robust information on the oral health needs of local populations thus enabling local authorities and NHSE (London region) to meet their responsibilities with regard to improving oral health.

The CDS will undertake the necessary surveys required by Statutory Instrument No 3094. This will ensure compliance with the Health and Social Care Act 2013, Delivering Better Oral Health 2014, Public Health Outcomes Framework (PHOF, 2013-2016).

The CDS will engage with the Local Authority, PHE and NHSE (London region) to ensure the delivery a minimum and enhanced sample to provide smaller area data in the form of ward or cluster level samples dependant on local interventions, need and deprivation.

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

Suitable clinical examiner(s) will be identified from among the workforce, along with sufficient support staff for administration, recording and data entry, and relieved of clinical duties to allow for all activities to be undertaken within the prescribed timescale. Relevant members of the fieldwork team will be supported to attend all necessary training and calibration events provided at regional level. The CDS will only use a clinical examiner who has been successfully calibrated at the relevant calibration session, using guidance provided by the PHE Knowledge and Intelligence Teams.

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

The CDS will ensure that the raw data are made available in a suitable format as defined by PHE. Once verified and published, Public Health England will ensure data and reports will be made available to NHS England (London region).
3.1.7 Teaching & Research

The CDS will provide outreach teaching sessions for dental students and dental therapy students where appropriate and as agreed with NHS England (London region), dental school and Health Education England. Outreach teaching sessions will contribute to the service output of the service.

The CDS will work with Health Education England to continue to provide postgraduate training via DF1, DCT1, DCT2 posts and Specialty Registrar posts, as agreed with NHS E.

The CDS will collaborate with the Consultant in Dental Public Health to carry out research projects that are pertinent to the service as agreed with NHS England (London region). In addition, NHS England (London region) and the Service will agree on the time to be spent on, the expectations and outcomes from any research that is to be undertaken.
4. REFERRAL, ACCESS & ACCEPTANCE CRITERIA

Geographic coverage/boundaries

The service described in this agreement is expected to cover all London Boroughs, therefore London residents can choose to be seen by services outside their borough of residence.

Referral criteria & sources

The service will operate an access policy where patients can be referred in by professionals (health and education), social care, a family member/carer etc. This is to ensure that excluded groups have minimum barriers to first point of contact. However, strict triage processes will then be applied, to ensure that only patients whose special care and paediatric needs are at levels of complexity which are moderate or above, are accepted into the service. The referral form to be used when referring a patient is detailed as Appendix 12 & 13. The full triage process is set out in the associated commissioning guide:


Locations & opening times

The provider must have an appropriate premises solution with

- Sufficient services to meet the needs of the population.
- At least one multi-surgery site per borough that would enable equitable access.
- Appropriate opening times (9am-5pm; 5 days opening per week with at least one clinic open from 9-1 Saturdays/late opening).
- Appropriate accessibility and accommodation, with details of transportation links within each borough covered

Any changes to opening times and clinic locations will be agreed with the commissioner prior to changes taking place.

Domiciliary Dental Services

Domiciliary visits will be at a variety of settings including patients own home, nursing and residential care homes. The use of existing mobile units for onsite special care and paediatrics shall not be classed as domiciliary care, and will be used in preference to domiciliary care where possible due to the wider range of services available through a mobile unit.

No routine access for non-special care and paediatric patients from current mobile dental units shall be provided within this service from the date of this contract, unless agreed in writing with the commissioner.

Access to Services

Access to appointments will be required through:

- A telephone and/or an SMS appointment booking system after triage
- Patients will be recalled according to their appropriate level of need (NICE Clinical Guideline 19).
- Under this contract and, on the basis of the standard definitions, maximum waiting time for appointments should be:
  - Patients requiring Urgent Dental Care- within 24 hours
  - Routine first assessments will be available within 4 weeks of referral acceptance
- Treatment shall commence within 14 weeks from date of assessment
- Date of referral to start of treatment shall never exceed 18 weeks as above
- Non-attenders will be re-routed back to their GP or social services

**Exclusion Criteria**

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

- Persistent non-attendance (DNAs). The service will develop and share a policy to reconnect patients to GPs or social care.
- Persistent non-payment of dental charges by fee-paying adults;
- Threatening behaviour/violence;
- Patients who do not meet the BDA Weighted Case Mix Tool criteria (page 9).

**5. DISCHARGE CRITERIA & PLANNING**

The following discharge processes will apply:

- Patients with a special care and paediatric needs which meet the criteria for moderate complexity or above will remain in the service and are recalled according to NICE guidelines.

- Patients without a special care and paediatric need are discharged after one course of treatment. This applies only when explicit licence has been given by the commissioner to see non-special care and paediatric patients.

- Patients currently seen in the service who do not meet the criteria for moderate complexity above, or who through their time with the service pass to a state where they no longer meet the moderate complexity or above, shall be discharged, and then signposted and supported back into general practice.

**6. SELF CARE & SERVICE USER/CARER INFORMATION**

All patients to the service will receive evidence-based oral hygiene and disease prevention advice and instruction, as set out in the Department of Health's toolkit 'Delivering Better Oral health' (PHE, 2014). An assessment of oral health risk must be made at the beginning of every course of treatment and preventive interventions given that address risks.

Patient Information Leaflets will be provided at all sites and disseminated widely by the Service.

**7. QUALITY & PERFORMANCE**

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

**General Quality Standards**

The CDS will provide a safe environment for staff and clients. In particular, the CDS will abide by the standards below:

- CDS Directions 2006;
- All Health and Safety legislation;
- Infection Control Policy (British Dental Association A12 and HTM0105)
- Ionising Radiation Regulations 1999 and Ionising Radiation (Medical Exposure) Regulations 2000;
Clinical Governance
The CDS will fully comply with the following:

- Co-operate with such clinical governance arrangements as the NHS England (London region) determines
- Comply with the Standards applied under the aegis of the Care Quality Commission and produce evidence to demonstrate compliance with the Care quality Commission as well as producing an annual clinical governance action plan;
- Maintain strong internal governance systems;
- Ensure that all staff undertake regular continuing professional development relevant to their function to meet GDC registration requirements.

The CDS will nominate a lead person who will have responsibility for ensuring co-operation with clinical governance arrangements and provision of reports to the NHS England (London region).

The service shall at all times be registered with the CQC under the appropriate categories, and have systems and processes in place to offer assurance of continuing compliance and registration.

Safeguarding
The service must ensure that policies and procedures relating to safeguarding are adhered to, that staff have undertaken training appropriate for their professional role and should be represented on local children and adults safeguarding boards. All staff working with children and young people & vulnerable adults will have undertaken a Disclosure and Barring Service (DBS) check (for dentists this will be in accordance with the NHS Performers List Regulations). Reference should be made to the safeguarding clauses within the National Community Contracts.
Workforce

- All CDS Dentists and Dental Care Professionals must be registered with the General Dental Council.
- All CDS Dentists must be on a performers’ list, in accordance with the NHS (Performers’ List) Amendment Regulations 2005.
- The staff of the CDS will fully adhere to the General Dental Council’s (GDC) guidance ‘Standards for Dental Professionals’.
- All staff must attend appropriate education and training programmes to maintain their level of competency and comply with their professional body’s requirements.
- Clinical staff must have a special interest in the procedures covered by their contracts, and the opportunity to treat a sufficient number of patients to maintain their skills.
- A staff training, CPD and investment plan will be developed and updated annually with processes in place to monitor completion and effectiveness of training.
- A 3-year workforce plan will be developed and reviewed annually, this will include plans to develop other dental care professionals such as dental therapists to deliver services.
- A performance management policy must be in place together with performance appraisals that support the provider’s proposed workforce strategy and complies with all applicable legislative and prescribed requirements. Conduct and performance issues of all Staff must be effectively managed and all staff must have regular supervision and performance appraisals. Appropriate procedures must be followed for the appointment of locums and fixed term staff and adequate supervision given to trainees.
- While working in the employment of an NHS body all CDS practitioners are covered for insurance purposes under standard (NHSLA) arrangements arranged by the employing organisation. While not mandatory it is recommended that they also have personal professional indemnity insurance in place, through an appropriate professional defence organisation.
- Recruitment and selection processes must be compliant with NHS Employment Check Standards. The Provider must also ensure that any recruitment agencies that they propose to use comply with the NHS Employment Check Standards. These provisions also apply to temporary and locum staff and any staff employed by a sub-contractor.
- Robust recruitment and selection processes must be in place to effectively assess individuals’ experience, competence, training, qualifications, and, when appropriate, English language communication skills.
- All staff must undergo a comprehensive and robust induction process.
- The Equality Act 2010 and Public Sector Equality Duty must be complied with.

The service is required to have appropriate structures for clinical leadership, including but not restricted to, a suitably qualified Clinical Director. The service can be specialist led with consultant input (either employed or outreach). It is also essential that the service workforce contains systems for clinical governance to ensure compliance with the quality requirements of this specification. The workforce for provision of this service must be provided within the stated budget, and no additional funding will be provided for the purpose of additional workforce deployment during the life of the contract.
Evidence Based Dentistry Programmes

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

- Public Health England (PHE)
- Department of Health;
- Royal College of Surgeons (RCS);
- Faculty of General Dental Practice UK (FGDP(UK));
- Faculty of Dental Surgery (FDS);
- British Society for Disability and Oral Health (BSDOH);
- British Dental Association (BDA);
- British Society of Paediatric Dentistry (BSPD)
- National Institute for Health and Care Excellence (NICE)
- Cochrane Collaboration.

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

The NICE guidelines on dental recall intervals will be fully adhered to. Patient records should show that appropriate recall intervals have been identified by the CDS, based on the assessment of risk in discussion with the patient.

Professional Leadership

The CDS will be led by a suitably qualified dentist who will ensure and develop clinical effectiveness in professional practice. In particular this will be delivered through:

- Clinical Leadership (particularly in Special care and paediatric dentistry);
- Clinical Governance/Quality Leadership;
- Mentoring clinical staff;
- Advisory role;
- Outreach to GDPs and GPs;
- Influencing Commissioning;
- Appraisal, performance and development review (PDR) and continuing professional development (CPD);
- Involvement in managed clinical networks.

Service Information

The CDS will provide a suitable patient information leaflet and key messages, clearly outlining services offered and the criteria required to be seen within the service. The service will also provide materials for signposting of patients back into general practice.

The Service website will be kept up to date with key information and links to key websites such as NHS choices.

As required under the terms of, and as detailed within the PDS Contract the service will be expected to produce a leaflet, to include the NHS services offered by the service, the opening hours, the names and specialist areas of the key practitioners, emergency and out of hours arrangements. The Service must also add to the
information leaflet/website, a brief indication of those services available on the NHS. More detailed advice should be separately available.

**Complaints Procedure**

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

If the patient feels unable to resolve the matter in a manner satisfactory to them, they will be able to invoke the NHS England (London region)’s standard complaints procedure.

All complaints processes will comply with the NHS complaints guidelines.

**8. INFORMATION TECHNOLOGY**

Transmission of FP17s to the Business Services Authority (BSA) should be via an electronic data link, and where applicable the service will install a system that can communicate data for achievement against national KPIs directly to the BSA. The service will employ an integrated clinical and reporting IT system.

In addition the following IT functionality is required:

- Use of electronic patient records including electronic recording of complexity scores.
- Ability to generate monthly reports e.g. DNAs, complexity scores, audit, use of DBOH
- Ability to make and receive electronic referrals directly via a secure referral system.
- Electronic communication with commissioners including the use of nhs.net
- Ability to use social media and other technology to contact patients i.e. text, twitter
- Ability for patient satisfaction questionnaires to be completed using social media or on-line
- Ability for staff to access the internet for professional use.
- Up to date service website

**9. ACTIVITY**

Given the specialist nature of many of the services, the following qualitative and quantitative data will be recorded by the service and reported as agreed with commissioners. These data requirements (Table 1 & 2) will be subject to review by NHS England (London region).


**Table 1: CDS data form 1 - Activity by Age Group**

<table>
<thead>
<tr>
<th>Ages</th>
<th>0-5</th>
<th>6-17</th>
<th>18-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of unique patients seen by BDA WCMT band</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CoT by BDA WCMT band</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes (number of UDAs by band)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of new referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of rejected referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of domiciliary visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of onward referrals to secondary care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 2: CDS data form 2 – Number and CoT by Care Group**

<table>
<thead>
<tr>
<th>Care Group</th>
<th>Number of child patients</th>
<th>Number of adult patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physically disabled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically compromised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housebound frail elderly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phobic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug &amp; alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looked After Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requiring Inhalational sedation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric pre- general anaesthesia assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Courses of Treatment and Patient Charge Income

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

The NHS England (London region) will monitor patient charge collection as required. The service will be paid net of collected patient charges, as calculated through the BSA system based on FP17 submission.

10. PERIOD OF SERVICE
The contract shall run for an initial period of 5 years from 1st April 2017 – 31st March 2022 with the provision to extend for an additional 5 years.

Notice of whether the commissioner intends to take up the extension offer will be given no later than 6 months prior to the end of the initial period of the contract.

11. TYPE OF CONTRACT
Services described within this specification will be provided via a PDS Agreement between the NHS England (London region) and the Provider.

12. CONTRACT VALUE AND PAYMENT UNDER THE CONTRACT
The contract for this service will be based on the above service line costs.

Payment will be based on activity delivery only in the first instance, and the Total Contract Value will be paid in 12 equal monthly instalments of the total value, net of Patient Charge Revenue.

13. PERFORMANCE MONITORING
The specific monthly, quarterly, biannual and annual reports required will be defined in schedule 6 of the contract, ‘Key Performance Indicators (KPIs) and Data Requirements’.

The service KPIs are detailed in Appendix 11

In general NHS England (London region) will place a strong emphasis on quality of service, for both clinical and non-clinical activities. The areas for assessment will include:

- Performance against KPIs;
- Patient and public views;
- Clinical governance to ensure the quality of services provided;
- Standards compliance, environment, health and safety and infection control compliance;
- Access to and availability of dental services;
- Information governance & data reporting.

Reporting of all data required to monitor performance against KPIs will include:

- Patient numbers
- Courses of treatment
- Compliance with NICE Guidelines on dental recall intervals
- New patients seen
- Treatment bands
- Audit of delivering ‘delivering better oral health advice’
- Ethnicity data
- BDA Weighted case Mix Tool data
- Onward referrals
- Waiting times
- Patient feedback

These will be based where possible on BSA data (via forms FP17). The provider will be required to implement a system that guarantees regular submission of FP17s to the BSA in order that data is recorded in a timely manner.

In addition the provider will be expected to work collaboratively with the NHS England (London region) to supply information on a quarterly, biannually and annual basis for purposes of evaluating performance against the service model and specifically against KPIs. This will also be required to enable both parties to manage activity within the service to ensure appropriate use of resources where demand alters, and to wherever possible avoid claw backs at year end.

The provider will also be expected to take part in the review process as outlined in the PDS agreement. The Provider will be required to meet with the NHS England (London region) to review progress on a quarterly basis or as required.

The provider will supply any further information reasonably required by the NHS England (London region) for the purposes of monitoring the contract.

14. CONTINGENCY PLANNING
The provider will be wholly responsible for the performance of the contract for its duration and will not assign any part of the delivery to a third party. A third party does not include the performers within the service.
The provider is required to demonstrate that contingency plans are in place to address failure or breakdown in service provision and that these state how business continuity will be sustained in cases of loss of staffing, major incidents, communications failure, loss of IT systems, equipment or premises.

15. INDEMNITY
The provider will be expected to carry the appropriate level of professional indemnity.
Hillingdon

Hillingdon borough has a population of 269,500\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 317,600 by 2020\(^2\). The most important factor accounting for health inequalities between Hillingdon and elsewhere is socioeconomic deprivation.

Around 7.1% of Hillingdon residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Hillingdon are high. 736 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 13,261 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Hillingdon over the 18 to have a learning disability is 5,393 adults with 1,157 adults having a moderate or severe learning disability, and are projected to increase by 6.6% and 6.5% respectively by 2020.

Oral health in Hillingdon is reflected in the below key statistics:

- 25.3% of 3 year olds have experienced tooth decay\(^6\)
- 38.2% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 57.6% and adult 40.3%\(^8\)
Hounslow

Hounslow borough has a population of 249,200¹ and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 292,100 by 2020². The most important factor accounting for health inequalities between Hounslow and elsewhere is socioeconomic deprivation.

Around 8.3% of Hounslow residents live in the 20% most deprived areas in England³. The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Hounslow are high. 705 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 12,764 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.⁴

The projected population in 2015 of adult residents in Hounslow over the 18 to have a learning disability is 5,040 adults with 1,094 adults having a moderate or severe learning disability, and are projected to increase by 6.8% and 6.7% respectively by 2020.⁵

Oral health in Hounslow is reflected in the below key statistics:

17% of 3 year olds have experienced tooth decay⁶
36.4% of 5 year olds in the PCT have experienced tooth decay⁷
Access figures – child 71.7% and adult 52.9%⁸
Ealing

Ealing borough has a population of 334,100\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 369,000 by 2020\(^2\). The most important factor accounting for health inequalities between Ealing and elsewhere is socioeconomic deprivation.

Around 20.9% of Ealing residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Ealing are high. 910 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 16,452 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Ealing over the 18 to have a learning disability is 6,477 adults with 1,402 adults having a moderate or severe learning disability, and are projected to increase by 4.8% and 4.6% respectively by 2020.\(^5\)

Oral health in Ealing is reflected in the below key statistics:

- 16.8% of 3 year olds have experienced tooth decay\(^6\)
- 42.1% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 72.4% and adult 53.7%\(^8\)
Barnet

Barnet borough has a population of 351,400\textsuperscript{1} and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 411,400 by 2020\textsuperscript{2}. The most important factor accounting for health inequalities between Barnet and elsewhere is socioeconomic deprivation.

Around 5.7\% of Barnet residents live in the 20\% most deprived areas in England\textsuperscript{3}. The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Barnet are high. 946 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 16,975 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\textsuperscript{4}

The projected population in 2015 of adult residents in Barnet over the 18 to have a learning disability is 6,938 adults with 1,481 adults having a moderate or severe learning disability, and are projected to increase by 7.5\% and 7.2\% respectively by 2020.\textsuperscript{5}

Oral health in Barnet is reflected in the below key statistics:

- 16.2\% of 3 year olds have experienced tooth decay\textsuperscript{6}
- 25\% of 5 year olds in the PCT have experienced tooth decay\textsuperscript{7}
- Access figures – child 56.7\% and adult 36.2\%\textsuperscript{8}
**Brent**

Brent borough has a population of 304,800 \(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 336,300 by 2020 \(^2\). The most important factor accounting for health inequalities between Brent and elsewhere is socioeconomic deprivation.

Around 27.9% of Brent residents live in the 20% most deprived areas in England \(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Brent are high. 843 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 15,250 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc \(^4\).

The projected population in 2015 of adult residents in Brent over the 18 to have a learning disability is 5,969 adults with 1,291 adults having a moderate or severe learning disability, and are projected to increase by 4% and 3.7% respectively by 2020. \(^5\)

Oral health in Brent is reflected in the below key statistics:

- 20.3% of 3 year olds have experienced tooth decay \(^6\)
- 45.9% of 5 year olds in the PCT have experienced tooth decay \(^7\)
- Access figures – child 62.2% and adult 49.5% \(^8\)
**Harrow**

Harrow borough has a population of 237,500 and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 265,500 by 2020. The most important factor accounting for health inequalities between Harrow and elsewhere is socioeconomic deprivation.

Around 2.1% of Harrow residents live in the 20% most deprived areas in England. The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Harrow are high. 621 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 11,168 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.

The projected population in 2015 of adult residents in Harrow over the 18 to have a learning disability is 4,583 adults with 973 adults having a moderate or severe learning disability, and are projected to increase by 5.2% and 4.8% respectively by 2020.

Oral health in Harrow is reflected in the below key statistics:

- 18.3% of 3 year olds have experienced tooth decay
- 35.1% of 5 year olds in the PCT have experienced tooth decay
- Access figures – child 60% and adult 42.3%
Hammersmith and Fulham

Hammersmith and Fulham borough has a population of 180,800\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 183,000 by 2020\(^2\). The most important factor accounting for health inequalities between Hammersmith and Fulham and elsewhere is socioeconomic deprivation.

Around 26.3% of Hammersmith and Fulham residents live in the 20% most deprived areas in England\(^3\). High levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Hammersmith and Fulham are high. 516 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 9,265 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Hammersmith and Fulham over the 18 to have a learning disability is 3,526 adults with 769 adults having a moderate or severe learning disability, and are projected to increase by 1.4% and 1.2% respectively by 2020.\(^5\)

Oral health in Hammersmith and Fulham is reflected in the below key statistics:

- 7.6% of 3 year olds have experienced tooth decay\(^6\)
- 28.4% of 5 year olds in the PCT have experienced tooth decay\(^7\)
  Access figures – child 65.4% and adult 52.3%\(^8\)
Kensington and Chelsea

Kensington and Chelsea borough has a population of 160,500\(^1\) and is characterised by cultural and ethnic diversity and transience. The population is expected to decrease to 157,000 by 2020\(^2\). The most important factor accounting for health inequalities between Kensington and Chelsea and elsewhere is socioeconomic deprivation.

Around 23.5\% of Kensington and Chelsea residents live in the 20\% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Kensington and Chelsea are high. 427 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 7,659 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc\(^4\).

The projected population in 2015 of adult residents in Kensington and Chelsea over the 18 to have a learning disability is 3,041 adults with 652 adults having a moderate or severe learning disability, and are projected to increase by 0.7\% and -0.3\% respectively by 2020.\(^5\)

Oral health in Kensington and Chelsea is reflected in the below key statistics:

- 15.2\% of 3 year olds have experienced tooth decay\(^6\)
- 29.8\% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 46.4\% and adult 37.8\%\(^8\)
Westminster

Westminster borough has a population of 217,200 and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 245,500 by 2020. The most important factor accounting for health inequalities between Westminster and elsewhere is socioeconomic deprivation.

Around 23.5% of Westminster residents live in the 20% most deprived areas in England. The high levels of deprivation and significant health need which disproportionally affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Westminster are high. 651 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 11,786 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.

The projected population in 2015 of adult residents in Westminster over the 18 to have a learning disability is 4,631 adults with 928 adults having a moderate or severe learning disability, and are projected to increase by 5.1% and 4.5% respectively by 2020.

Oral health in Westminster is reflected in the below key statistics:

- 16% of 3 year olds have experienced tooth decay
- 39.6% of 5 year olds in the PCT have experienced tooth decay
- Access figures – child 58.6% and adult 50%
Waltham Forest

Waltham Forest borough has a population of 254,000\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 288,700 by 2020\(^2\). The most important factor accounting for health inequalities between Waltham Forest and elsewhere is socioeconomic deprivation.

Around 53.6% of Waltham Forest residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Waltham Forest are high. 706 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 12,751 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc\(^4\).

The projected population in 2015 of adult residents in Waltham Forest over the 18 to have a learning disability is 4,966 adults with 1,082 adults having a moderate or severe learning disability, and are projected to increase by 5.9% and 5.9% respectively by 2020\(^5\).

Oral health in Waltham Forest is reflected in the below key statistics. Please note there is no data available for the percentage of 3 year olds that have experienced tooth decay\(^6\)

26.5% of 5 year olds in the PCT have experienced tooth decay\(^7\)

Access figures – child 55.1% and adult 42.2\(^%\)\(^8\)
**Redbridge**

Redbridge borough has a population of 275,100\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 327,300 by 2020\(^2\). The most important factor accounting for health inequalities between Redbridge and elsewhere is socioeconomic deprivation.

Around 7.2% of Redbridge residents live in the 20% most deprived areas in England.\(^3\) The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Redbridge are high. 742 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 13,319 having two or more psychiatric disorders including the former, antisocial/ borderline personality disorders, etc\(^4\).

The projected population in 2015 of adult residents in Redbridge over the 18 to have a learning disability is 5,354 adults with 1,153 adults having a moderate or severe learning disability, and are projected to increase by 8.2% and 8.3% respectively by 2020.\(^5\)

Oral health in Redbridge is reflected in the below key statistics:

- 9.3% of 3 year olds have experienced tooth decay\(^6\)
- 27% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 72.7% and adult 53.3%\(^8\)
**Barking and Dagenham**

Barking and Dagenham borough has a population of 182,800\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 221,900 by 2020\(^2\). The most important factor accounting for health inequalities between Barking and Dagenham and elsewhere is socioeconomic deprivation.

Around 52.1% of Barking and Dagenham residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Barking and Dagenham are high. 485 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 8,679 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Barking and Dagenham over the 18 to have a learning disability is 3,419 adults with 745 adults having a moderate or severe learning disability, and are projected to increase by 8.9% and 9.3% respectively by 2020\(^5\).

Oral health in Barking and Dagenham is reflected in the below key statistics:

- 18% of 3 year olds have experienced tooth decay\(^6\)
- 35% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 58% and adult 55.5%\(^8\)
Havering

Havering borough has a population of 236,200 and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 261,200 by 2020. The most important factor accounting for health inequities between Havering and elsewhere is socioeconomic deprivation.

Around 7.7% of Havering residents live in the 20% most deprived areas in England. The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Havering are high. 588 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 10,530 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.

The projected population in 2015 of adult residents in Havering over the 18 to have a learning disability is 4,539 adults with 944 adults having a moderate or severe learning disability, and are projected to increase by 4.6% and 4.1% respectively by 2020.

Oral health in Havering is reflected in the below key statistics:

- 12.5% of 3 year olds have experienced tooth decay
- 19.8% of 5 year olds in the PCT have experienced tooth decay
- Access figures – child 66.1% and adult 49.7%
APPENDIX 5 - LOT 5; Inner NE London; City & Hackney, Tower Hamlets and Newham

Hackney

Hackney borough has a population of 241,700\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 280,100 by 2020\(^2\). The most important factor accounting for health inequalities between Hackney and elsewhere is socioeconomic deprivation.

Around 79.9% of Hackney residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Hackney are high. 729 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 13,101 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Hackney over the 18 to have a learning disability is 4,937 adults with 1,089 adults having a moderate or severe learning disability, and are projected to increase by 6.4% and 6.7% respectively by 2020.5

Oral health in Hackney is reflected in the below key statistics:

- 12.9% of 3 year olds have experienced tooth decay\(^6\)
- 31.4% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 43.3% and adult 39.1%\(^8\)
**Tower Hamlets**

Tower Hamlets borough has a population of 248,500\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 311,500 by 2020\(^2\). The most important factor accounting for health inequalities between Tower Hamlets and elsewhere is socioeconomic deprivation.

Around 70.2% of Tower Hamlets residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Tower Hamlets are high. 790 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 14,358 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Tower Hamlets over the 18 to have a learning disability is 5,414 adults with 1,198 adults having a moderate or severe learning disability, and are projected to increase by 9.8% and 10.4% respectively by 2020\(^5\).

Oral health in Tower Hamlets is reflected in the below key statistics:

- 17.3% of 3 year olds have experienced tooth decay\(^6\)
- 45.9% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 50.4% and adult 38.8%\(^8\)
Newham

Newham borough has a population of 299,200\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 355,300 by 2020\(^2\). The most important factor accounting for health inequalities between Newham and elsewhere is socioeconomic deprivation.

Around 83.8% of Newham residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Newham are high. 872 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 15,925 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Newham over the 18 to have a learning disability is 6,055 adults with 1,336 adults having a moderate or severe learning disability, and are projected to increase by 7.6% and 7.6% respectively by 2020.\(^5\)

Oral health in Newham is reflected in the below key statistics:

- 23.1% of 3 year olds have experienced tooth decay\(^6\)
- 39% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 59.1% and adult 39.9%\(^8\)
Enfield

Enfield borough has a population of 307,600\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 355,200 by 2020\(^2\). The most important factor accounting for health inequalities between Enfield and elsewhere is socioeconomic deprivation.

Around 27.7% of Enfield residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Enfield are high. 817 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 14,600 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Enfield over the 18 to have a learning disability is 5,895 adults with 1,264 adults having a moderate or severe learning disability, and are projected to increase by 6.8% and 6.6% respectively by 2020.\(^5\)

Oral health in Enfield is reflected in the below key statistics:

- 18.4% of 3 year olds have experienced tooth decay\(^6\)
- 43.9% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 61.7% and adult 47.3%\(^8\)
**Haringey**

Haringey borough has a population of 252,700\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 286,600 by 2020\(^2\). The most important factor accounting for health inequalities between Haringey and elsewhere is socioeconomic deprivation.

Around 57.6% of Haringey residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Haringey are high. 731 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 13,198 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Haringey over the 18 to have a learning disability is 5,092 adults with 1,117 adults having a moderate or severe learning disability, and are projected to increase by 7.3% and 7.3% respectively by 2020.\(^5\)

Oral health in Haringey is reflected in the below key statistics:

- 10.6% of 3 year olds have experienced tooth decay\(^6\)
- 38 % of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 78.8% and adult 55.2%\(^8\)
Camden

Camden borough has a population of 214,700\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 248,700 by 2020\(^2\). The most important factor accounting for health inequalities between Camden and elsewhere is socioeconomic deprivation.

Around 24.9% of Camden residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Camden are high. 652 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 11,737 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Camden over the 18 to have a learning disability is 4,636 adults with 1,005 adults having a moderate or severe learning disability, and are projected to increase by 6.1% and 6% respectively by 2020.\(^5\)

Oral health in Camden is reflected in the below key statistics:

- 12.5% of 3 year olds have experienced tooth decay\(^6\)
- 36.3% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 68.9% and adult 52.4%\(^8\)
Islington

Islington borough has a population of 200,100\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 240,900 by 2020\(^2\). The most important factor accounting for health inequalities between Islington and elsewhere is socioeconomic deprivation.

Around 52.9\% of Islington residents live in the 20\% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Islington are high. 646 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 11,647 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Islington over the 18 to have a learning disability is 4,482 adults with 981 adults having a moderate or severe learning disability, and are projected to increase by 7.7\% and 8\% respectively by 2020.\(^5\)

Oral health in Islington is reflected in the below key statistics, please note there is no data available for the percentage of 3 year olds that have experienced tooth decay\(^6\)

- 30.4\% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 57.1\%and adult 45.1\%\(^8\)
Bexley

Bexley borough has a population of 230,700\textsuperscript{1} and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 252,700 by 2020\textsuperscript{2}. The most important factor accounting for health inequalities between Bexley and elsewhere is socioeconomic deprivation.

Around 9.2\% of Bexley residents live in the 20\% most deprived areas in England\textsuperscript{3}. The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Bexley are high. 578 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 10,325 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\textsuperscript{4}

The projected population in 2015 of adult residents in Bexley over the 18 to have a learning disability is 4,339 adults with 912 adults having a moderate or severe learning disability, and are projected to increase by 4.1\% and 3.7\% respectively by 2020.\textsuperscript{5}

In Bexley, oral health is reflected by 62\% of children and 41.2\% access dental treatment.\textsuperscript{8} There is no data available on the percentage of 3 and 5 year olds that have experienced tooth decay.\textsuperscript{6,7}
Bromley

Bromley borough has a population of 308,600\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 342,400 by 2020\(^2\). The most important factor accounting for health inequalities between Bromley and elsewhere is socioeconomic deprivation.

Around 7.9% of Bromley residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Bromley are high. 778 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 13,908 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Bromley over the 18 to have a learning disability is 5,908 adults with 1,241 adults having a moderate or severe learning disability, and are projected to increase by 5.2% and 4.8% respectively by 2020.\(^5\)

Oral health in Bromley is reflected in the below key statistics:

- 8% of 3 year olds have experienced tooth decay\(^6\)
- 21.5% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 70.2% and adult 37.4%\(^8\)
Greenwich

Greenwich borough has a population of 249,200\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 284,500 by 2020\(^2\). The most important factor accounting for health inequalities between Greenwich and elsewhere is socioeconomic deprivation.

Around 43.7\% of Greenwich residents live in the 20\% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Greenwich are high. 696 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 12,553 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Greenwich over the 18 to have a learning disability is 4,912 adults with 1,070 adults having a moderate or severe learning disability, and are projected to increase by 5.6\% and 5.5\% respectively by 2020.\(^5\)

In Greenwich, oral health is reflected by 73.3\% of children and 52.3\% access dental treatment.\(^6,7\) There is no data available on the percentage of 3 and 5 year olds that have experienced tooth decay.\(^6,7\)
Lambeth

Lambeth borough has a population of 297,700\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 338,500 by 2020\(^2\). The most important factor accounting for health inequalities between Lambeth and elsewhere is socioeconomic deprivation.

Around 36.6\% of Lambeth residents live in the 20\% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Lambeth are high. 924 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 16,668 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Lambeth over the 18 to have a learning disability is 6,281 adults with 1,380 adults having a moderate or severe learning disability, and are projected to increase by 5.4\% and 5.6\% respectively by 2020.\(^5\)

Oral health in Lambeth is reflected in the below key statistics:

- 10.2\% of 3 year olds have experienced tooth decay\(^6\)
- 23.8\% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 65.4\% and adult 54.7\%\(^8\)
Lewisham

Lewisham borough has a population of 272,500\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 314,500 by 2020\(^2\). The most important factor accounting for health inequalities between Lewisham and elsewhere is socioeconomic deprivation.

Around 36.6\% of Lewisham residents live in the 20\% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Lewisham are high. 787 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 14,120 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc\(^4\).

The projected population in 2015 of adult residents in Lewisham over the 18 to have a learning disability is 5,457 adults with 1,195 adults having a moderate or severe learning disability, and are projected to increase by 6.5\% and 6.7\% respectively by 2020\(^5\).

Oral health in Lewisham is reflected in the below key statistics:

- 9\% of 3 year olds have experienced tooth decay\(^6\)
- 21.9\% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 61.9\% and adult 53.3\%\(^8\)
Southwark

Southwark borough has a population of 283,800\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 326,500 by 2020\(^2\). The most important factor accounting for health inequalities between Southwark and elsewhere is socioeconomic deprivation.

Around 35.6% of Southwark residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Southwark are high. 871 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 15,674 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Southwark over the 18 to have a learning disability is 5,938 adults with 1,308 adults having a moderate or severe learning disability, and are projected to increase by 6.4% and 6.5% respectively by 2020.\(^5\)

Oral health in Southwark is reflected in the below key statistics:

- 10.7% of 3 year olds have experienced tooth decay\(^6\)
- 21.9% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 59.7% and adult 45.4%\(^8\)
Sutton
Sutton borough has a population of 189,300\textsuperscript{1} and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 215,600 by 2020\textsuperscript{2}. The most important factor accounting for health inequalities between Sutton and elsewhere is socioeconomic deprivation.

Around 4.8\% of Sutton residents live in the 20\% most deprived areas in England\textsuperscript{3}. The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Sutton are high. 495 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 8,878 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\textsuperscript{4}

The projected population in 2015 of adult residents in Sutton over the 18 to have a learning disability is 3,662 adults with 780 adults having a moderate or severe learning disability, and are projected to increase by 6.2\% and 5.8\% respectively by 2020\textsuperscript{5}.

Oral health in Sutton is reflected in the below key statistics:

- 5.8\% of 3 year olds have experienced tooth decay\textsuperscript{6}
- 27.9\% of 5 year olds in the PCT have experienced tooth decay\textsuperscript{7}
- Access figures – child 67.7\% and adult 44\%\textsuperscript{8}
Merton

Merton borough has a population of 199,100\textsuperscript{1} and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 223,900 by 2020\textsuperscript{2}. The most important factor accounting for health inequalities between Merton and elsewhere is socioeconomic deprivation.

Around 1.5\% of Merton residents live in the 20\% most deprived areas\textsuperscript{3}. The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Merton are high. 548 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 9,853 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\textsuperscript{4}

The projected population in 2015 of adult residents in Merton over the 18 to have a learning disability is 3,900 adults with 843 adults having a moderate or severe learning disability, and are projected to increase by 5.8\% and 5.8\% respectively by 2020\textsuperscript{5}

Oral health in Merton is reflected in the below key statistics:

- 13.7\% of 3 year olds have experienced tooth decay\textsuperscript{6}
- 29.2\% of 5 year olds in the PCT have experienced tooth decay\textsuperscript{7}
- Access figures – child 52.2\% and adult 45.2\%\textsuperscript{8}
Croydon

Croydon borough has a population of 358,000 and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 402,400 by 2020. The most important factor accounting for health inequalities between Croydon and elsewhere is socioeconomic deprivation.

Around 17.3% of Croydon residents live in the 20% most deprived areas in England. The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Croydon are high. 952 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 17,033 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.

The projected population in 2015 of adult residents in Croydon over the 18 to have a learning disability is 6,838 adults with 1,467 adults having a moderate or severe learning disability, and are projected to increase by 5% and 4.6% respectively by 2020.

Oral health in Croydon is reflected in the below key statistics:

- 12.8% of 3 year olds have experienced tooth decay
- X% of 5 year olds in the PCT have experienced tooth decay
- Access figures – child 62% and adult 48.4%
Richmond upon Thames

Richmond upon Thames borough has a population of 186,300\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 208,900 by 2020\(^2\). The most important factor accounting for health inequalities between Richmond upon Thames and elsewhere is socioeconomic deprivation.

Residents in the Richmond upon Thames borough are relatively affluent compared to the 20% most deprived areas in England and 26% of London residents\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Richmond upon Thames are high. 492 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 8,807 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc\(^4\).

The projected population in 2015 of adult residents in Richmond upon Thames over the 18 to have a learning disability is 3,588 adults with 769 adults having a moderate or severe learning disability, and are projected to increase by 5.6% and 5.1% respectively by 2020\(^5\).

Oral health in Richmond upon Thames is reflected in the below key statistics:

- 9.8% of 3 year olds have experienced tooth decay\(^6\)
- 17.4% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 57.7% and adult 31.9%\(^8\)
Kingston upon Thames

Kingston upon Thames borough has a population of 158,600\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 185,700 by 2020\(^2\). The most important factor accounting for health inequalities between Kingston upon Thames and elsewhere is socioeconomic deprivation.

Around 1.1\% of Kingston upon Thames residents live in the 20\% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Kingston upon Thames are high. 657 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 11,877 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc.\(^4\)

The projected population in 2015 of adult residents in Kingston upon Thames over the 18 to have a learning disability is 3,233 adults with 696 adults having a moderate or severe learning disability, and are projected to increase by 6.6\% and 6.3\% respectively by 2020\(^5\).

Oral health in Kingston upon Thames is reflected in the below key statistics:

- 6.2\% of 3 year olds have experienced tooth decay\(^6\)
- 19.3\% of 5 year olds in the PCT have experienced tooth decay\(^7\)
- Access figures – child 74.5\% and adult 47.4\%\(^8\)
Wandsworth

Wandsworth borough has a population of 302,600\(^1\) and is characterised by cultural and ethnic diversity, transience and high growth. The population is expected to rise to 332,100 by 2020\(^2\). The most important factor accounting for health inequalities between Wandsworth and elsewhere is socioeconomic deprivation.

Around 11.7% of Wandsworth residents live in the 20% most deprived areas in England\(^3\). The high levels of deprivation and significant health need which disproportionately affect the more disadvantaged groups and, significantly, vary across and within the borough. NHS England places the highest priority on tackling inequalities.

Numbers of people with special care and paediatric needs in Wandsworth are high. 915 adults aged 18-64 have psychotic disorders, including schizophrenia and bipolar disorders with 16,310 having two or more psychiatric disorders including the former, antisocial/borderline personality disorders, etc\(^4\).

The projected population in 2015 of adult residents in Wandsworth over the 18 to have a learning disability is 6,207 adults with 1,356 adults having a moderate or severe learning disability, and are projected to increase by 3.8% and 3.8% respectively by 2020\(^5\).

Oral health in Wandsworth is reflected in the below key statistics:

8.3% of 3 year olds have experienced tooth decay\(^6\)
29.1% of 5 year olds in the PCT have experienced tooth decay\(^7\)
Access figures – child 65.9% and adult 42.8%\(^8\)
References


5. Learning Disability, Projecting Adult Needs and Service Information System, PANSI, LD BASELINE ESTIMATES/MOD-SEV, 2014 data taken, aged 18+

6. 3 year old data: [http://www.nwph.net/dentalhealth/survey-results%203(12_13).aspx](http://www.nwph.net/dentalhealth/survey-results%203(12_13).aspx)

7. 5 year old data: [http://www.nwph.net/dentalhealth/survey-results5.aspx?id=1](http://www.nwph.net/dentalhealth/survey-results5.aspx?id=1)

## APPENDIX 11 – KPIs

<table>
<thead>
<tr>
<th>Area</th>
<th>No.</th>
<th>Requirement</th>
<th>Frequency</th>
<th>Achievement</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data</td>
<td>1</td>
<td>% special care patients who have had a Case Complexity Assessment</td>
<td>Quarterly</td>
<td>100%</td>
<td>Service</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Submission of full data requirements to NHSE within 15 days of quarterly end</td>
<td>Quarterly</td>
<td>98%</td>
<td>Service</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>% patients for whom ethnicity data is recorded</td>
<td>Quarterly</td>
<td>&gt;80%</td>
<td>BSA Data</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>% of FP17s for completed courses of treatment that were received at NHS DS within 2 months of the date of completion of the course of treatment</td>
<td>Quarterly</td>
<td>100%</td>
<td>BSA Data</td>
</tr>
<tr>
<td>Service</td>
<td>5</td>
<td>% of patients who receive and begin treatment within 18 weeks of referral</td>
<td>Quarterly</td>
<td>&gt;95%</td>
<td>Service</td>
</tr>
<tr>
<td>Management</td>
<td>6</td>
<td>% Complaints resolved within 25 working days</td>
<td>Monthly</td>
<td>&gt;95%</td>
<td>Service</td>
</tr>
<tr>
<td>Treatment</td>
<td>7</td>
<td>% Patients seen for treatment who are given an oral health assessment and written treatment plan provided</td>
<td>Quarterly</td>
<td>&gt;95%</td>
<td>BSA Data</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>% of courses of treatment for new patients accepting a oral health assessment where a record of tooth decay status has been made</td>
<td>Quarterly</td>
<td>&gt;95%</td>
<td>BSA Data</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>% of courses of treatment for new patients accepting a oral health assessment where a record of BPE Score or a visible plaque assessment has been made</td>
<td>Quarterly</td>
<td>&gt;95%</td>
<td>BSA Data</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Frequency</td>
<td>Target</td>
<td>Data Source</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------</td>
<td>--------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>% of courses of treatment for new patients, aged 13 or above, accepting an oral health assessment where a record of smoking status has been made</td>
<td>Quarterly</td>
<td>&gt;95%</td>
<td>BSA Data</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>% of new courses of treatment where a record of delivering Delivering Better Oral Health advice has been made</td>
<td>Quarterly</td>
<td>&gt;95%</td>
<td>BSA data</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>% of courses of treatment for child patients, aged 3 or above, where fluoride varnish was provided</td>
<td>Quarterly</td>
<td>100%</td>
<td>BSA Data</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>% of Patients who completed an NHS DS survey who said they were either fairly or very satisfied with the NHS Dentistry that they had received</td>
<td>Quarterly</td>
<td>&gt;80%</td>
<td>BSA Data</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>% of Patients who completed an NHS DS survey who said they were satisfied with the time taken to get an appointment</td>
<td>Quarterly</td>
<td>&gt;80%</td>
<td>BSA Data</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>% patients who report during the monthly telephone survey that they would recommend the service to another person.</td>
<td>Quarterly</td>
<td>&gt;95%</td>
<td>Service</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Participation in and compliance with the national dental public health epidemiology programme</td>
<td>Yearly</td>
<td>100%</td>
<td>Service</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>All data files and appendices to the protocol are completed and returned within the timeframes set out in the protocol</td>
<td>Yearly</td>
<td>100%</td>
<td>Service</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>All special support schools should be offered comprehensive care and annual screening. Reports to be submitted annually.</td>
<td>Yearly</td>
<td>100%</td>
<td>Service</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 12 – PAN LONDON PEDIATRIC REFERRAL FORM

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>GMP practice name:</th>
<th>GDP practice name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.O.B.:</td>
<td>GMPs name:</td>
<td>GDPs name:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Preferred Tel no:</td>
<td>Tel no:</td>
<td>Tel no:</td>
</tr>
<tr>
<td>Mobile:</td>
<td>NHS Number:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Gender:
- [ ] Male
- [ ] Female
- [ ] Prefer not to say

#### Reason for referral
- [ ] Dental Caries – Pre co-operative (under 6)
- [ ] Dental caries – Over 6 years (expand under history why referral should be accepted)
- [ ] Primary and permanent tooth trauma
- [ ] Opinion about poor quality first permanent molars. No RCT.
- [ ] Tooth surface loss - erosion
- [ ] Dental Anomalies – altered tooth structure, number, shape, size, form
- [ ] Periodontal (gum) problems
- [ ] Soft Tissue Conditions – mucoceles, frenums,
- [ ] Disorders of tooth eruption and loss
- [ ] Surgical management e.g. unerupted teeth/ broken down teeth
- [ ] Complex medical problems – expand below
- [ ] Complex behavioural problems who can't be seen in General Practice
- [ ] Children in the care of social services i.e. Looked after children
<table>
<thead>
<tr>
<th><strong>DENTAL HISTORY</strong> Including treatment attempted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TREATMENT MODALITY REQUIRED</strong></td>
<td>Please tick those that apply:</td>
</tr>
<tr>
<td></td>
<td>□ Local anaesthesia</td>
</tr>
<tr>
<td></td>
<td>□ Inhalational sedation</td>
</tr>
<tr>
<td></td>
<td>□ Intravenous sedation</td>
</tr>
<tr>
<td></td>
<td>□ General anaesthesia</td>
</tr>
<tr>
<td><strong>PAST MEDICAL HISTORY:</strong></td>
<td>1.</td>
</tr>
<tr>
<td></td>
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<tr>
<td><strong>CURRENT MEDICATION:</strong></td>
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<td>6.</td>
</tr>
<tr>
<td><strong>SOCIAL HISTORY:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>RADIOGRAPHS:</strong></td>
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</tr>
<tr>
<td></td>
<td>□ Sent digitally</td>
</tr>
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<td>□ Yes (please state Language) ____________________________</td>
</tr>
<tr>
<td></td>
<td>□ No</td>
</tr>
</tbody>
</table>
APPENDIX 13 – PAN LONDON SPECIAL CARE DENTISTRY REFERRAL FORM

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>GMP practice name:</th>
<th>Dental practice name:</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>D.O.B.:</th>
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<th>Dentists name:</th>
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<table>
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<th>Tel no:</th>
<th>Tel no:</th>
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<td>Mobile:</td>
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<table>
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<table>
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<tr>
<td>☐ Male</td>
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<tr>
<td>☐ Female</td>
<td></td>
</tr>
<tr>
<td>☐ Prefer not to say</td>
<td></td>
</tr>
</tbody>
</table>

**Reason for referral**

- [ ] Physically complex disabilities
- [ ] Medical complex conditions
- [ ] Frail elderly
- [ ] Learning disability
- [ ] Autism/ ADHD
- [ ] Homeless/ temporary accommodation
- [ ] Complex Mental Health
- [ ] Bariatric (Please state patients weight______________)
- [ ] Other (please state)

<table>
<thead>
<tr>
<th>DENTAL HISTORY Including treatment attempted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>
| PAST MEDICAL HISTORY: | 1.  
|                      | 2.  
|                      | 3.  
|                      | 4.  
|                      | 5.  
|                      | 6.  |
| CURRENT MEDICATION: | 1.  
|                     | 2.  
|                     | 3.  
|                     | 4.  
|                     | 5.  
|                     | 6.  |
| SOCIAL HISTORY:     |                                |
| RADIOGRAPHS:        | □ Enclosed  
|                     | □ Sent digitally |
| Interpreter required: | □ Yes (please state Language) ____________________  
|                     | □ No  |
APPENDIX 14

ADDITIONAL SERVICES – DENTAL SERVICES FOR THE HOMELESS
SPECIFICATION FOR THE PROVISION OF DENTAL SERVICES FOR THE HOMLESS

1. Introduction

This specification represents the requirements for the provision of dental services for people whose unpredictable living circumstances prevent them from accessing general dental practice. These services are being procured as additional services linked to the core community dental service procurement.

Defining homelessness is complex. The most commonly used definition is of those ‘rough sleeping’ on the street. Nevertheless, it is now widely accepted that homelessness includes a much broader range of circumstances than just that of literally lacking a roof over one's head. There are also homeless families who are housed in temporary accommodation by local authorities. And there are those single homeless people who are not sleeping rough, but living with friends or family, or in temporary accommodation.

The commissioning of this service in London is central to NHS England (London region’s) commissioning objectives in providing care for vulnerable groups.

The issues that need to be addressed in providing oral care for this group of people are:

- Oral health in this population is very poor, with high clinical treatment needs but low perceived need by the patient.
- Poor oral health in this group is related to poor physical and mental health, alcohol and drug misuse, tobacco use, trauma and stress.
- Chaotic lifestyles of the homeless means attending dental services are not perceived to be a priority.

2. Background

Oral health and general health are intrinsically linked. It is well evidenced that people who are homeless have poorer general and oral health. This is attributed to a number of reasons:

- Poor diet and nutrition (resulting from: low disposable income; self neglect - because of mental health problems, substance misuse and / or more pressing needs)
- Prolonged exposure to the elements (damp, cold, heat, sun);
- Lack of adequate hygiene (due to: lack of access to hygiene facilities and self neglect)
- Increased contact with communicable diseases, due to conditions in hostels and shelters)
- Stress and fatigue

Physical ill health is compounded by the prevalence among homeless people of chronic mental health problems and chronic substance misuse. Studies show that,
on the whole, homeless people are significantly more likely to exhibit symptoms of mental distress than the adequately housed population, and are at much greater risk of death due to suicide than people who are adequately housed.

Research has shown that the single most common health problem amongst homeless people is actually substance misuse - encompassing: alcohol abuse; tobacco use (smoking and chewing); use of illegal drugs; abuse of prescription medications; and volatile substance abuse. Alcohol abuse is particularly widespread among homeless people, as is drug use. Young single homeless people are more likely to be intravenous drug-users and to have unprotected sex, putting them at risk of viral hepatitis and HIV-AIDS. Prevalence of blood-borne viruses (BBVs) among these homeless people, of course, raises infection control issues for those seeking to deliver healthcare to them.

Oral and dental disease
Homeless people are at higher risk of oral and dental diseases. This is due to:

- Chaotic lifestyle with no established routines of eating and personal (including oral) hygiene & limited access to hygiene facilities (including washing facilities)
- Low priority given to healthy eating and oral hygiene, due to having more pressing survival needs
- Acceptance among homeless people that poor dental health and poor dental appearance as the norm within their peer group
- Low disposable income, contributing both to poor diet and to inadequate hygiene
- Lack of awareness of diet and oral hygiene issues
- Prevalence of mental-health problems and prevalence of substance misuse
- Higher rates of smoking and tobacco use

Access to dental services
In addition to increased risk and prevalence of dental diseases, homeless people access dental services less frequently. Access to urgent care dental services when a problem arises is more common. In addition, fewer completed full courses of dental treatment, with high levels of failed appointments, characterize access for homeless people.

A combination of patient led and dentist led factors inhibits access to dental services for the homeless.

- Patient Led: Chaotic lifestyles, poor perception of need, anxiety, embarrassment, mental health issues and financial considerations all inhibit access to dental services. These factors result in low levels of access to routine dental services.

- Dental service led: availability and spread of the dental service, organisational issues (such as opening times and appointment availability), inflexibility of the service, lack of staff confidence and competence in treating the homeless and stigmatization all contribute to the attendance pattern of the homeless.
Some homeless people, often with support from outreach link workers or peer support schemes can access mainstream General Dental Services (GDS). However, for some homeless people, GDS is not the most appropriate service to meet their needs. For these individuals a dedicated dental service that meets the unique challenges for this group is required to ensure fair and equitable dental care which is a real necessity for this group to avoid pain and discomfort.

3. Aims of the service

- To provide access to quality dental care for the homeless, whose circumstances prevent them from accessing general dental practice
- To improve their oral health and reduce inequalities in oral health
- To improve their dental patient experience
- To foster innovation and continuous improvement in the delivery of dental services for this group of patients

4. Policy context

See CDS core service specification.

5. Current service provision

A review of dental services for homeless people showed that community dental services were the main provider of services mainly via outreach clinical sessions and the dental mobile clinic. Current services are inequitable across London, with few formal agreements around service delivery. Few activity data are available on homeless services provision for London.

6. Definition and scope

The service being contracted is for the provision of dental care to meet the needs of people whose homelessness prevents them from accessing general dental practice in London. The services being procured are primarily mandatory (including urgent) primary dental care services.

It is the aim of NHS England (London Region) through this procurement, to improve oral health and access to dental services for homeless people. The proposal is to develop a service which is accessible to London residents and which promotes dental and oral health as integral to health and well-being. The Provider(s) will be required to reach out to local communities, develop links with voluntary organisations and charities to create awareness of, encourage and support take-up of these dental services to establish a dental service of which London residents will be justifiably proud.
The Provider(s) will be expected to operate from modern well equipped premises, accessible to the local community. Bidders will be expected to identify their proposed premises solutions and demonstrate that they have the necessary equipment and suitably trained staff to provide dental care for the homeless population.

The service will cater for both planned and urgent care and serve both fee paying and fee-exempt NHS patients. However, it is expected that a significant proportion of care carried out will be urgent care.

The proposed service design reflects legislation which has freed previous restrictions to innovations in dental team working. The Provider(s) will be expected to adopt this model of working and to pioneer innovations in dental team working, developing skill mix, focusing on preventive activity and delivering new models of care which recognise oral health as integral to general health and well-being and the dental team as healthcare professionals. Hence NHSE (London Region) will be seeking a Provider(s) willing to innovate and to work in partnership with them to develop a modern service which demonstrates that it truly meets the needs of this group. The Provider(s) will need to have a clear communication strategy and must ensure that all sections of the community who require these services are informed about, and encouraged to use the service. This is an NHS dental service and necessary treatment to secure oral health must be offered under the NHS.

7. Acceptance criteria

- People who have no permanent place of residence such as rough sleepers.
- People residing in temporary shelters and hostel and night shelter dwellers.
- People classified as ‘statutory homeless’ and therefore are in temporary accommodation awaiting housing by their local authority.

8. Indicative volumes

The indicative volumes are predictions based on the current homelessness statistics available. It should be noted that the nature of the homeless population makes the data on numbers a prediction, as absolute numbers are not recordable. Based on the CHAIN (combined homelessness and information network) database, the total numbers of rough sleepers and of those how many are ‘new rough sleepers’ per London borough in 2014/15 are detailed below.

Rough sleepers are defined as those ‘Living on the streets (ie. have had a high number of contacts over 3 weeks or more which suggests they are living on the streets) and Intermittent rough sleepers (ie. people who were seen rough sleeping before the period began at some point, and contacted in the period - but not regularly enough to be ‘living on the streets’).

New Rough sleepers are defined as those who had not been contacted by outreach teams rough sleeping before the period

The highest ten boroughs are highlighted in the table and shown in the map.
### North West London

<table>
<thead>
<tr>
<th>London Borough</th>
<th>Number of rough sleepers 2014/15</th>
<th>Number of New rough sleepers 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillingdon</td>
<td>57</td>
<td>45</td>
</tr>
<tr>
<td>Heathrow*</td>
<td>266</td>
<td>201</td>
</tr>
<tr>
<td>Harrow</td>
<td>45</td>
<td>31</td>
</tr>
<tr>
<td>Hounslow</td>
<td>161</td>
<td>122</td>
</tr>
<tr>
<td>Ealing</td>
<td>219</td>
<td>136</td>
</tr>
<tr>
<td>Brent</td>
<td>359</td>
<td>300</td>
</tr>
<tr>
<td>Barnet</td>
<td>125</td>
<td>120</td>
</tr>
<tr>
<td>Hammersmith and Fulham</td>
<td>161</td>
<td>110</td>
</tr>
<tr>
<td>Kensington and Chelsea</td>
<td>225</td>
<td>124</td>
</tr>
<tr>
<td>Westminster</td>
<td>2570</td>
<td>1533</td>
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</table>

### North Central and North East London

<table>
<thead>
<tr>
<th>London Borough</th>
<th>Number of rough sleepers 2014/15</th>
<th>Number of New rough sleepers 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enfield</td>
<td>174</td>
<td>155</td>
</tr>
<tr>
<td>Haringay</td>
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<td>77</td>
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<tr>
<td>Camden</td>
<td>563</td>
<td>319</td>
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<tr>
<td>Islington</td>
<td>135</td>
<td>78</td>
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<tr>
<td>City</td>
<td>373</td>
<td>168</td>
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<tr>
<td>Tower Hamlets</td>
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<tr>
<td>Hackney</td>
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<td>Waltham Forest</td>
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<td>Redbridge</td>
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<tr>
<td>Havering</td>
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<td>23</td>
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<tr>
<td>Barking and Dagenham</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>London Borough</td>
<td>Number of rough sleepers 2014/15</td>
<td>Number of New rough sleepers 2014/15</td>
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<td>-------------------------------------</td>
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<tr>
<td>Kingston</td>
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<td>Merton</td>
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<td>Sutton</td>
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<td><strong>Lambeth</strong></td>
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<td><strong>Southwark</strong></td>
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<td>Lewisham</td>
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<td>Bromley</td>
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<tr>
<td>Greenwich</td>
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<tr>
<td>Bexley</td>
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<td>21</td>
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</tbody>
</table>

*Heathrow is not a London borough but due to numbers, has been separated out.*
This data has informed the indicative volumes of dental services required for this population. One session is defined as 3 hours. Each service (Lot) will be delivered via:

1. One session per week for engagement, staff signposting and training at hostels / outreach teams / key workers.
2. Three sessions per week will be offered for routine and urgent care. These will be fixed sessions on Monday, Wednesday and Friday mornings. Half an hour will be left in each session for urgent patients that may be booked or walk in.

<table>
<thead>
<tr>
<th>Lot</th>
<th>Number of engagement sessions per week</th>
<th>Number of clinical sessions per week</th>
<th>Total number of hours per session</th>
<th>Number of hours per week</th>
<th>Number of hours service accessible per year</th>
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<td>1</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>600</td>
</tr>
</tbody>
</table>

Homeless service provision will be reviewed over the first and second year of the contract and revised in the light of demand and the changing needs of the population.
8. Service locations

Based on the highest levels of homelessness in the above boroughs, the proposed service will be delivered from 4 sites located in the following London boroughs;


Lot 2 - **North West and North Central London**- Brent and Camden and Islington.

Lot 3 – **North East and North Central London** – City of London, Tower Hamlets and Newham.

Lot 4 – **South London** – Lambeth and Southwark.

As it is a London wide service, London residents will be able to access any of the services

9. Access to the service

Patients will access the service via two routes:

1. The provider service will engage with homeless shelters, hostels, local authority outreach teams and charities. The provider will signpost these services to the dental clinics offered, as well as provide training on key oral health messages. The patient / key worker can then book a routine / urgent appointment at the clinic.
2. Half an hour per session will be blocked for walk in urgent care patients, who may have been signposted to the service from the shelter / hostel or elsewhere.

10. Period of service

The contract shall run for an initial period of 5 years from 1st April 2017 to 31st March 2022. There will be an option to extend the contract for up to a total period of 5 years.

11. Type of contract

Services described within this specification will be provided via a PDS Agreement between NHS England (London Region) and the Provider.

12. Payment mechanism

Payment will be based on a sessional fee with an additional sum based on UDA delivery, which will be set at a level to reflect the complexity of this group of patients.

13. Clinical governance

See specification for core CDS service.

14. Dental service promotion

There is an expectation, that due to the hard to access nature of this group of patients, the service will work with key workers, local authorities and homeless charities to raise awareness of the dental service and provide training in oral health issues in this group. Promotion in this context would involve working with key workers and staff at shelters to raise awareness of the key dental issues, available dental service and referral processes.

15. Facilities and equipment

The dental services are expected to be provided from sites suitable for the care of homeless people. This will include fixed clinics at accessible sites in the proposed lots.

16. Information technology

The Provider will ensure that the practice is fully computerised with:

- electronic patient records
- a computerised appointment system
- ability to transmit data and information electronically to NHS England (London Region) and BSA
- connectivity to NHS net
- broadband access with full use of email and internet
- digital radiography
In supporting the provision of IM&T, Providers will be required to put appropriate information management and governance systems and processes in place to safeguard patient information. This will need to be supported by appropriate training of staff.

FP17 forms for completed courses of treatment should be submitted within 2 months of completion date.

17. Performance monitoring

The provider will supply routine monitoring information to NHS England (London Region), initially on quarterly basis.

The information reported will include:

Engagement Data:

- Number of contacts / sessions of engagement and training
- Number of key workers / staff trained on signposting and oral health
- Number of patients referred
- Source of referrals i.e. Which hostel / key worker site they were signposted from

Clinical services:

- Number accepted for treatment
- Number of failed appointments
- Treatment outcomes
- Patient experience via questionnaire to be developed with NHS England
- Complaints
- Serious incidents

18. Complaints procedure

See specification for core CDS service.

19. Contingency planning

See specification for core CDS service.

20. Indemnity

See specification for core CDS services.
1. Introduction

This specification represents the requirements for the provision of dental services for people whose obesity prevents them from accessing general dental practice. 'Bariatric dentistry' is used as an appropriate way of referring to dentistry for this group of patients. These services are being procured as additional services linked to the core community dental service procurement.

The commissioning of this service in London is central to NHS England’s commissioning objectives in providing care for vulnerable groups.

The issues that need to be addressed in providing oral care for this group of people are:

- The safe delivery of care for people weighing 23 stones (140kg) and above. The maximum lifting weight for the majority of modern dental chairs is 23 stones (140kg) which is considerably lower than the weight of obese individuals in the community
- The risk of co-morbidity in people who are overweight or obese and the effect on oral health

2. Aims of the service

- To provide equitable access across London to quality dental care for people whose obesity prevents them from accessing general dental practice
- To improve their oral health and reduce inequalities in oral health
- To improve their dental patient experience
- To foster innovation and continuous improvement in the delivery of Bariatric dentistry

3. Policy context

See CDS core service specification

4. Current service provision

A review of dental services for people whose obesity prevented them from accessing routine general dental services showed that community dental services were the main provider of services with a small number of hospital services providing care for this group. The CDS provided services at fixed sites as well as domiciliary care.
5. Definition and scope

The service being contracted is for the provision of dental care to meet the needs of London’s residents whose obesity prevents them from accessing general dental practice. The services being procured are primarily mandatory (including urgent) primary dental care services.

It is the aim of NHS England (London Region) through this procurement, to improve oral health and access to services for people whose obesity prevents them from accessing general dental practice. The proposal is to develop a service which is accessible to London residents and which promotes dental and oral health as integral to health and well-being. The Provider(s) will be required to work with the local communities to create awareness of, and encourage take-up of these dental services and to establish a dental service of which London residents will be justifiably proud.

The Provider(s) will be expected to operate from modern well equipped premises, accessible to the local community. Bidders will be expected to identify their proposed premises solutions and demonstrate that they have the necessary equipment suitable for the provision of dental care for people whose obesity prevents them from accessing general dental practice, as part of their bid.

The service will cater for both planned and urgent care and serve both fee paying and fee-exempt NHS patients.

The proposed service design reflects legislation which has freed previous restrictions to innovations in dental team working. The Provider(s) will be expected to adopt this model of working and to pioneer innovations in dental team working, developing skill mix, focusing on preventive activity in line with Delivering Better Oral Health – an evidence based toolkit for prevention and delivering new models of care which recognise oral health as integral to general health and well-being and the dental team as healthcare professionals. Hence NHS England (London Region) will be seeking a Provider(s) willing to innovate and to work in partnership with them to develop a modern service which demonstrates that it truly meets the needs of this group. The Provider(s) will need to have a clear communication strategy and must ensure that all sections of the community who require these services are informed about, and encouraged to use the service. This is an NHS dental service and necessary treatment to secure oral health must be offered under the NHS.

6. Acceptance criteria

Patients who are over the weight limit of 23 stones (140kg) and cannot receive dental treatment from a general dental service due to weight restrictions on dental equipment.

7. Service locations

The proposed service will be delivered from 4 sites covering the following London boroughs;
Lot 1 – **North East and North Central London** – City of London, Hackney, Tower Hamlets, Newham, Redbridge, Waltham Forest, Barking & Dagenham, Havering, Camden, Islington, Enfield, Haringey, Barnet

Lot 2 – **North West London** – Westminster, Kensington & Chelsea, Hammersmith & Fulham, Brent, Harrow, Hillingdon, Hounslow, Ealing

Lot 3 – **South East London** – Lambeth, Southwark, Lewisham, Bexley, Bromley, Greenwich

Lot 4 – **South West London** – Croydon, Merton, Sutton, Wandsworth, Kingston, Richmond

As it is a London wide service, patients will be able to access care in any lot area regardless of their borough of residence.

**8. Access to the service**

Patients will be able to access this service mainly through referrals from their doctor or dentist and social services. In addition self-referrals will be accepted. A referral form will need to be completed which must include the patient’s weight and the level of mobility.

**9. Indicative volumes**

Each service (Lot) will be delivered over 3 sessions a week. Each session will have 3 booked appointments and 1 appointment reserved for urgent dental care. Each Lot will therefore be expected to deliver 450 booked appointments and 150 urgent care appointments per annum. This is based on 50 weeks of the year.

Slots that are unused should be booked for regular services.

Bariatric services will be reviewed over the first and second year of the contract and revised in the light of demand and the changing needs of the population.

<table>
<thead>
<tr>
<th>Lot</th>
<th>Number of sessions per week</th>
<th>Number of booked appointments per week</th>
<th>Number of booked appointments per year</th>
<th>Number of urgent care appointments per week</th>
<th>Number of urgent care appointments per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lot 1</td>
<td>3</td>
<td>9</td>
<td>450</td>
<td>3</td>
<td>150</td>
</tr>
<tr>
<td>Lot 2</td>
<td>3</td>
<td>9</td>
<td>450</td>
<td>3</td>
<td>150</td>
</tr>
<tr>
<td>Lot 3</td>
<td>3</td>
<td>9</td>
<td>450</td>
<td>3</td>
<td>150</td>
</tr>
<tr>
<td>Lot 4</td>
<td>3</td>
<td>9</td>
<td>450</td>
<td>3</td>
<td>150</td>
</tr>
</tbody>
</table>

**10. Period of service**

The contract shall run for an initial period of 5 years from 1st April 2017 to 31st March 2022. There will be an option to extend the contract for up to a total period of 5 years.
11. Type of contract

Services described within this specification will be provided via a PDS Agreement between NHS England (London Region) and the Provider.

12. Payment mechanism

Payment will be based on UDA delivery which will be set at a level to reflect the complexity of this group of patients.

13. Clinical governance

See specification for core CDS service.

All staff delivering the service should have a manual handling policy and be trained on manual handling.

14. Facilities and equipment

The dental service are expected to be provided from sites suitable for the care of people whose obesity prevents them from accessing general dental practice. Ideally services should be provided on the ground floor with disability access for entry into the premises. Waiting room chairs, doors and toilets should be able to accommodate these patients.

Dental chairs should be capable of accommodating patients weighing 23 stone (140 kg) and above. This may include:

- Bariatric dental chair
- Wheelchair tilt with an insert turning it into a bariatric chair
- Heavy duty wheelchair
- Bariatric trolley

15. Information technology

The Provider will ensure that the practice is fully computerised with:

- electronic patient records
- a computerised appointment system
- ability to transmit data and information electronically to NHS England (London Region) and BSA
- connectivity to NHS net
- broadband access with full use of email and internet
- digital radiography

In supporting the provision of IM&T, Providers will be required to put appropriate information management and governance systems and processes in place to safeguard patient information. This will need to be supported by appropriate training of staff.

FP17 forms for completed courses of treatment should be submitted within 2 months of completion date.
16. Performance monitoring

The provider will supply routine monitoring information to NHS England (London Region) initially on a quarterly basis.

The information reported will include:

- Number of patients referred
- Source of referrals
- Number accepted for treatment
- Number of failed appointments
- Types of treatment and treatment outcomes
- Patient experience
- Complaints
- Serious incidents

17. Complaints procedure

See specification for core CDS service

18. Contingency planning

See specification for core CDS service

19. Indemnity

See specification for core CDS service
ANNEX B – Format for Submitting an Invitation to Tender Response
Potential Bidders wishing to participate in The Authority Procurement must submit an ITT as per instructions in paragraph Error! Reference source not found..