National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from the British Orthodontic Society – OS 07

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Health and Social Care Committee Inquiry

Orthodontic Services in Wales

Response on behalf of the British Orthodontic Society

1.1) The British Orthodontic Society is a charity that aims to promote the study and practice of orthodontics, maintain and improve professional standards in orthodontics, and encourage research and education in orthodontics.
It is also a representative body of all branches of general dentists and specialist orthodontists in the UK who provide orthodontic care. The Groups within the Society are the Specialist Practitioner Group and General Practitioner Group working in Primary Care and the Consultant Orthodontist Group working within the Secondary Care Hospital services, together with the University Teachers Group.

1.2) The BOS seeks to improve the quality of medical care for the benefit of patients. The immediate benefits of correcting a malocclusion include reducing the risk of trauma to teeth that protrude; treatment of impacted teeth that may become cystic or resorb (dissolve) the roots of adjacent teeth, creating space for replacement of teeth that are congenitally absent, improving the ability to clean areas where food packing increases risk of caries and improved long-term dental health with improvement in oral hygiene following orthodontic intervention.
In addition, the benefits of orthodontic treatment also include an improvement in appearance, self-esteem and psychological well being, especially important during the school years of the younger patients, with a reduction in bullying and teasing found following correction of malocclusion.

A reduced body image arising from the dissatisfaction with dental appearance persists into adulthood. There remains the possibility that career opportunities may be limited compared with individuals with a more aesthetically pleasing smile and dentofacial appearance in general, who are known to possess a better body image and greater self-confidence.

Orthodontic treatment as an intervention at an appropriate age decreases the burden of dental treatment for those patients who would otherwise have a great commitment to care throughout life. Much of this care would be the responsibility of the NHS and an orthodontic treatment intervention at an appropriate age therefore provides good value for money. A course of orthodontic treatment takes on average 2 years to complete with appointment intervals of 6 – 8 weeks during that time.

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BOS members have responded to the requests of the enquiry and the BOS response is as follows:

Response to inquiry into the provision of appropriate orthodontic care in Wales:

2) *Access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales.*

2.1) Access to orthodontic services:
Access will depend upon the availability of services locally and also the waiting times for treatment.

2.1.1) Primary Care Services
Members of BOS report long waiting times in primary care and up to 2.5 years in some areas. Patients whose orthodontic treatment is appropriate in primary care will start their treatment immediately after assessment. However these long waiting times will delay the transfer of patients with more severe and complex problems to secondary care and may compromise their treatment.
In rural areas there are fewer patients requiring orthodontic treatment and most areas would not support a specialist practice. Salaried specialists working in the Community Dental Service could provide local access to care.

2.1.2) Secondary Care Services
Treatment within the secondary care service is usually restricted to the very complex and multidisciplinary cases and services are located within areas of greatest population.
The waiting times to see new patients in secondary care are within the Referral to Treatment Times of within 36 weeks. However the time to start the treatment after assessment is not within RTT and a recent survey of waiting times reported an average of 24 to 40 months in the majority of Hospitals.

2.2) It is the view of BOS that a commitment to proper funding and recruitment within Orthodontics is essential. Recommendation 9 from the Report on Orthodontic services in Wales February 2011 from the Health, Wellbeing and Local Government Committee was: “We recommend that the Welsh Government funds a one-off waiting list initiative to clear the backlog of patients waiting for orthodontic treatment.”
The implementation of this Recommendation would reduce the treatment waiting times and improve the accessibility of orthodontic treatment for the population of children in Wales that need orthodontic treatment.

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3) *The effectiveness of working relationships between orthodontic practices and Local Health Boards in the management of local orthodontic provision, and the role of Managed Clinical Networks in helping to deliver more effective orthodontic services in Wales (e.g. effective planning and management, improvement in the appropriateness of referrals and performance management, workforce arrangements).*

3.1) A recent survey of the BOS membership relating engagement with local networks has shown that Managed Clinical Networks have been established in North Wales, South West Wales and South East Wales. There are also professional advisory bodies (LOCs) in South West and South East Wales as a forum for all providers to advise on standards of care, policies and protocols. The MCNs contribute to the Oral Health Advisory Group/Dental Services Planning Group in their area.
New referral protocols have been developed to allow GDPs to consider the appropriateness of the referral and to help them refer to the most appropriate provider in either primary or secondary care. Most referrals, particularly in primary care, are from GDPs which gives the best opportunity for the patients to be referred at the most appropriate time and with the appropriate level of dental health. These new referral forms and protocols seem to be working well and the number of inappropriate referrals is thought to be reducing and with more efficient referral of the patients to the most appropriate provider.

4) *Whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money.*

4.1) Provision of orthodontic treatment in Wales is determined by use of the Index of Treatment Need and not on demand, but in some areas the need still exceeds the present capacity, despite greater efficiency within the referral management process.

4.2) The provision of orthodontic care should be through a number of pathways: Hospital Consultants, primary care Orthodontists on the GDC Specialist List, salaried Community Dental Services, Dentists with enhanced skills in Orthodontics and Orthodontic Therapists. Those who are not registered Orthodontic Specialists must receive training and ongoing supervision by specialists to ensure they are working within their competence.

4.3) In September 2010, the Task and Finish Orthodontic Sub-group reported that 7.5% of funding should be reinvested to facilitate modernisation, detailed management and support. One of the Recommendations from the Report on Orthodontic services in Wales February 2011 was that the Welsh Government fund a waiting list initiative to reduce the number of patients waiting for orthodontic treatment.

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In order to ensure that those patients with the highest treatment needs are not disadvantaged, consideration could be given to changing the Index of Orthodontic Treatment need (IOTN) level at which treatment is available on the National Health Service.

The threshold for treatment could be increased from IOTN 3 to IOTN 4 and 5 only. This would thus direct funding to those with the greatest treatment need.

5) *Whether orthodontic services is given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector.*

5.1) Unlike preventable dental caries, the development of malocclusion is related to a genetic inheritance independent of the patient's life-style and choices. Orthodontic treatment is supported by evidence-based interventions that deliver a quantifiable health gain and should be maintained as a priority with the Welsh Government's oral health plan.

5.2) Appropriate contract monitoring is required for quality assurance and protection of the public. Orthodontics as a profession has robust measures already in place to monitor outcomes of care by using the Peer Assessment Rating Index.

5.3) The MCNs have a role in facilitating close monitoring of treatment outcomes through PAR and should be monitored for all providers on an annual basis for **all** providers.
In primary care, the practitioners use the PAR Index to score the outcomes for their patients both for the Business Service Authority (BSA) and for the Local Health Boards. The BSA also monitors standards of care in the GDS/PDS using a traffic light system on selected cases and aspects including record keeping and clinical outcomes are investigated and scored. These systems already in place are robust and accepted.
Secondary care providers are actively engaged in local and national outcome based audit and has increasingly become a contractual requirement within the Appraisal process for Hospital Consultants.
However, BOS is concerned that monitoring within the independent sector is inadequate. In this sector, Practitioners have no obligation to assess the quality of their care for patients as required by the BSA or Local Health Boards.

6) *The impact of the dental contract on the provision of orthodontic care.*

6.1) There is a minimum UOA (Unit of Orthodontic Activity) value below which appropriate, safe, quality care is not achievable. The UOA must take in to account the costs of maintaining the practice premises, all staff salaries,

consumables including appliances, laboratory costs, patient/practice records, environment and procedures compatible with HTM 01-05. This has not been determined in Wales.

6.2) The current contract system fixes the volume of activity for each practice without allowance for increased activity. With an increase in dental health awareness, there may be more of a demand from those with a need. Without an increase in the contracts, an inability to treat these patients will result. BOS members have reported that as Orthodontic contracts are fixed term, opportunities for financial investment and development are limited due to the uncertainty at the end of each contract period. Contracts renewals should be for a minimum of 5 years, or preferably rolling contracts for well-performing practices. BOS considers this to be essential for best patient care. Indeed it could be considered unethical to start treatment for patients when completion of that treatment cannot be guaranteed because of the contract time limit.

In addition there is considerable concern that the tendering process for contracts in primary care has on some occasions favoured corporate bodies with the award of multiple contracts in the same Health Board and/or neighbouring Health Boards to the same provider. This could lead to an unhealthy monopoly of orthodontic provision.

6.3) There are no contracts for orthodontic treatment for over 18 year olds in primary care in Wales and thus this will exclude some patients from receiving treatment when they may not have had the parental support to seek treatment earlier. Greater clarity is required for the management of those patients referred at the age of 18 or before as to whether the date of referral or the date of assessment determines eligibility for NHS treatment in primary care. The length of treatment waiting lists should not prevent this cohort of patients accessing appropriate care simply because of their age when seen to start such treatment.

7) Summary and Recommendations

- There are unacceptably long waiting lists for orthodontic treatment in both primary and secondary care in some areas of Wales.
    - Fund waiting list initiatives on a one time only basis to clear the numbers of patients waiting for orthodontic treatment.
    - Fund salaried specialists on a part-time basis in rural areas, where needed, to allow greater and easier access to treatment.
- MCNs have been established throughout Wales and there is efficient and effective communication between orthodontic providers in primary and secondary care with the LHBs.

  - MCNs and LOCs should to continue to advise on policies, protocols and standards of care.

- Orthodontic treatment has proven short and long-term dental health benefits and provides excellent value for money within the NHS financial framework both in primary and secondary care.

  - If funding is limited further, treatment is restricted to patients with IOTN 4 and 5, thereby concentrating funding on those with the highest need.

- Standard of care monitoring is quite robust within primary and secondary NHS services.

  - The monitoring of standards of care in the independent sector must be improved.

- Short term PDS contracts do not allow for any flexibility and limits potential investment by providers working within the primary care sector.

  - Consider contracts of a minimum of 5 years and rolling contracts in well-performing practices.

Stephen Rudge, Honorary Secretary, BOS, April 2014