National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from North Wales Orthodontic Managed Clinical Network – OS 15

Welsh Assembly For Wales' Health And Social Care Committee Inquiry Into Orthodontic Services in Wales

Response From The North Wales Orthodontic Managed Clinical Network

Author – Benjamin Lewis, Consultant Orthodontist, Chair of the North Wales Orthodontic Managed Clinical Network

1. Background

1.1 Since the last Welsh Government review into Orthodontic services in Wales, the following developments have been made within Besti Cadwaladr University Health Board:

A. Establishment of an Orthodontic Managed Clinical Network (OMCN) which provides an advisory role to the North Wales Oral Health Strategy Group and acts as an interface between all relevant stakeholders.

B. Development of the Local Orthodontic Committee (LOC) to encompass all orthodontic providers (Dentists with Enhanced Skills, Orthodontic therapists, and Specialists in Primary & Secondary care as well as the Community Dental Services).

C. A retendering exercise for Primary Care Orthodontic Services in Specialist Practice. The level of service need across North Wales was established by a needs assessment undertaken by the Dental Public Health Team. This information was then utilised to determine the number of Units of Orthodontic Activity (UOA's) commissioned and the preferred localities of the Specialist Practices. The overall value of recurrent Orthodontic Spend within North Wales has remained the same, but cost savings made within the retendering process have been reinvested within the service (by increasing the total number of UOA's available) along with a redistribution of UOA's to address the recognised need and its geographic variation as well to reduce the current excessive waiting times for assessment and treatment.

D. Establishment of a Quality and Safety Protocols document, which was utilised in the recent retendering exercise for Primary Care Orthodontic Services in Specialist Practice.

E. Establishment of an Accreditation Process for Dentists with Enhanced Skills. It was recognised during the Orthodontic Needs Assessment undertaken by the Dental Public Health Team that the Specialist Practice Services would inevitably be established in areas of high population density and this would potentially leave a population group with access difficulties to orthodontic provision due to the geographical constraints of North Wales. There is already a network of Dentist with Enhanced Skills within North Wales that was established before the introduction of Specialist Practices to the area. This network provides an invaluable service to their local community with Consultant Orthodontic input during the initial diagnosis and treatment planning stage along with monitoring reviews as appropriate, meaning a substantial reduction in the travelling and time away from education/work for these children and their carers. It is recognised that this service within the General Dental Service (GDS) and Community Dental Service (CDS) needs to be supported locally with educational and clinical attachments. All non-specialist dentists providing orthodontic treatment on the NHS will be required to be accredited via this process.

F. Health Board Wide Referral System. Currently all the individual service providers (Personal Dental Service [PDS], CDS and Hospital Dental Service [HDS]) have their own historic referral proformas. Working is currently been undertaken to establish a Local Health Board (LHB) wide standardised proforma for all service providers to use. This work has only been able to be undertaken since the completion of the recent retendering process, so that all appropriate stakeholders can be engaged.

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1.2 This report is on behalf of the North Wales Orthodontic Managed Clinical Network whose membership include:

- Clinical Director for Oral Health from the Surgical & Dental Clinical Programme Group, BCUHB
- Director of Dental Public Health (DPH), BCUHB
- Chairman of the Local Dental Committee (LDC), representing the General Dental Service within BCUHB
- Chairman of the Local Orthodontic Committee, representing all the NHS orthodontic providers within BCUHB
- Assistant Director, Primary Care Support, representing BCUHB
- Two Consultants in Secondary Care Orthodontics
- Specialist Orthodontist from Primary Care
- Community Dental Service (CDS) Representative
- Clinical Dental Director from Powys LHB
- Primary Care Dental Practice Advisor

With regards to the specific terms of reference indicated by the Committee:

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 There are Consultant led services in the three District General Hospitals (DGH's) serving North Wales. The Hospital Consultant Orthodontist Service Guide describes the role of the Consultant Orthodontist and is available via:
http://www.bos.org.uk/Resources/BOS/COG%20assets%20and%20download%20documents/Hospital%20consultant%20guide.pdf
Routine orthodontic care in Wales, as in the rest of the UK, wherever possible undertaken outside the Hospital Sector by specialist providers in Primary Care and the Community Dental Service. North Wales historically only had a limited Specialist Practice service located in the West of North Wales and with the remainder of the primary care orthodontics being delivered through a network of experienced General Dental Practitioners (GDPs) with Consultant support and supervision or being referred to Specialist Practices in England. Between 2006 and 2010, new specialist Practices were established to attempt to address this historic lack of appropriate local specialist capacity. In 2013 an Orthodontic Needs Assessment was undertaken by the Dental Public Health Team in preparation for a retendering of the Primary Care Specialist Orthodontic Service. This information was then utilised to determine the number of UOA's commissioned and the preferred localities of the Specialist Practices. Following the completion of the retendering process, the overall value of recurrent Orthodontic Spend within North Wales has remained the same, but cost savings made within the retendering process have been reinvested within the service (by increasing the total number of UOA's available) along with a redistribution of UOA's to address the recognised need and its geographic variation as well to reduce the current excessive waiting times for assessment and treatment. Although it is expected to take some time for the additional resources to have the desired effects.

2.2 It was recognised during the Orthodontic Needs Assessment undertaken by the Dental Public Health Team, that the Specialist Practice Services would inevitably be establish in areas of high population density (along the A55 Corridor) and this would potentially leave a population group with access difficulties to orthodontic provision due to the geographical constraints of North Wales. There is already a network of Dentist with Enhanced Skills within North Wales that was established before the introduction of Specialist Practices to the area.

This network provides an invaluable service to their local community with Consultant Orthodontic input during the initial diagnosis and treatment planning stage along with monitoring reviews as appropriate, meaning a substantial reduction in the travelling and time away from education/work for these children and their carers. It is recognised that this service within the GDS and CDS needs to be supported locally with regards to Continued Professional Development (education and clinical attachments).

2.3 Over the last 8 years there has been a constant under capacity within the Hospital Service, due to ill health, retirements, unfilled posts and removal of financial support. This has lead to an exacerbation of waiting times for both new patient assessments and active treatment. There has been recent agreement with the LHB to proceed with additional Consultant sessions to help address this chronic deficit. This will be important, not only to stabilise the service & provide the appropriate timely care for the complex multidisciplinary cases which are managed by the Hospital Orthodontic Service, but also the support of the Dentist with Enhanced Skills who's role in delivering local orthodontic care to the geographically challenging areas of North Wales which is essential.

2.4 The current waiting times across North Wales are:

- Specialist Practice – 12 to 24 months from referral to initial assessment with subsequent treatment commencing within 2 months.
- Hospital Based Service – 7 to 11 months from referral to initial assessment with a subsequent wait to commence treatment of between 8 to 24 months

2.5 This waiting time disparity between Primary Specialist Practice and the Hospital Based service is because if the differences in the service model. In the Hospital Sector ideally new patients are seen within a short time frame, due to the advisory role of the Consultant Service, and if appropriate, added to a treatment waiting list. Whereas in Specialist Practice, the patient is usually seen for their initial assessment when a treatment slot becomes available and so the treatment, if appropriate, usually starts within 8 weeks as this is the usual interval between appointments and allows for any requested dental extractions to be undertaken.

2.6 The current referral system works well as referrals are usually via a patient's GDP. This provides the best opportunity for patients to be referred at the most appropriate time and when they have achieved a suitable level of dental health and the patients general dental health is likely to be supported during any future orthodontic treatment. The potential problem with long waiting times for assessment/treatment is that it encourages early referral and also the patients' level of motivation and dental health status can alter dramatically in that time.

2.7 The establishment of a Health Board wide universal referral proforma will enhance the current system and allow better prioritisation of patients into the most appropriate sector and also better identification of any patient requiring an urgent assessment.

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 The relationships between the LHBs and the orthodontic practitioners has improved with the establishment of the OMCN and the requirement of local practitioners (as part of the commissioning process) to be actively involved with their Local Orthodontic Committee. Local orthodontic provision will be influenced by the North Wales Oral Health Strategy Group, with

guidance from the MCN, which itself has input from all the appropriate stakeholders including representation from the LHB, LOC, LDC, CDS, HDS and DPH. It will also be influenced by national guidance from WAG with input from the Strategic Advisory Forum in Orthodontic (SAFO). The composition of the North Wales OMCN is far more collective than demonstrated many parts of the UK which ensures many differing views are taken into consideration during discussions and subsequent recommendations. All the Orthodontic MCNs in Wales report to the SAFO whose chair subsequently reports to David Thomas, the Chief Dental Officer.

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 There are substantial waiting times for orthodontic treatment throughout Wales, both in Primary & Secondary Care. These patients all have a recognised treatment need (as defined by the Index of Orthodontic Treatment Need [IOTN]). To reduce the current level of funding would only compound this issue. The level of the IOTN above which treatment on the NHS is available is currently 4 & 5 or 3 with an aesthetic component of 6 (the aesthetic component is scored from 1-10, with 10 being the most severe). This threshold could be raised to only include categories 4 & 5 (great treatment need). This would eliminate the aesthetic component, which can be subjective and therefore potentially open to more bias, and purely limit the assessment to objective criteria. It would also target the limit orthodontic resources at those patient would benefit the most from orthodontic intervention.

4.2 The elimination of the aesthetic component and the reliance on purely objective criteria would highlight the dental health need component of orthodontic treatment rather than the aesthetic to both the public and political classes. Although it must be noted the comment of one of the members of the WAG committee in the discussions with David Thomas:
*"[101] **Kirsty Williams:** As someone who never had orthodontic work, I am aware of the impact that that has on you and the self-esteem issues that arise if you do not have good teeth or teeth that look good. I just think that we should urge caution, because it will be the poorest in society who will end up not having the service and middle-class parents who will pay for it."*
This is a good example of the widely recognised psychological benefits of orthodontic treatment, and as such, it must be ensured that systems are in place for the application of individual funding requests when there is evidence of psychological distress.

4.3 The difference between demand and need should also be clarified. There has always been unmet need within the population, this has been due to a variety of reasons including poor general dental health, non-diagnosis, lack of referral to the appropriate specialist, lack of patient/parent motivation, geographical constraints, historic limitations of orthodontic/restorative/surgical treatment techniques etc. Demand for treatment has increased, some of which will be due to changes in the aesthetic perception of the general population, but will also include the majority due to improved knowledge of the public and general dental practitioners, availability of appropriate services and improvement in operative techniques. So to suggest that this increase in demand for orthodontic treatment is treating a population without a recognised need would clearly be incorrect as all orthodontic treatment provided on the NHS is done so according the IOTN rating which defined treatment need.

4.4 The introduction of the New Orthodontic Contract in 2006, essentially capped the orthodontic spend and the number of patient who could be seen on an annual basis. Although there have been some inflation related increase in the orthodontic funding on established contracts, this tends to be below both the national rate of inflation and also level of inflation in healthcare which tends to be far greater. So in real terms the orthodontic spend in many areas has decreased.

4.5 Please see comments above with regards to the Value for Money and cost savings which were realised in the recent retendering process. The LHB had the foresight to maintain the current funding level and reinvest this cost saving back into orthodontics with a subsequent increase in the total number of UOAs. Whether the current level of funding on orthodontics nationwide is sustainable can only be determined by the WAG Finance Department, but any reduction to the current orthodontic spend will only exacerbate current waiting times and delays that patients experience to obtain treatment.

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 Dental malocclusion has a significant genetic component, whereas dental caries is a preventable. One could argue why should individuals, who would benefit from orthodontic treatment, be denied this treatment, due to a reallocation of resources because of the inability to eliminate dental caries, which is inherently down to patient choice of whether or not to avoid a cariogenic diet. However, eliminating dental caries, especially in children, whose diet and social circumstances are often beyond their control, is an important aspiration and can not be underestimated. With this regard, Orthodontic treatment often promotes life long dental health awareness among patients, as well of often eliminating teeth of poor long term prognosis to leave the patients with an optimal dentition after their two year course of orthodontic treatment.

5.2 The Orthodontic Specialty is already one of the most monitored areas of dentistry and the outcome of orthodontic treatment is already assessed via Peer Assessment Rating (PAR) scoring and Key Performance Indicators (KPIs). Quality and monitoring is likely to be further improved by the OMCN's introduction of PAR scoring assessment for all NHS Orthodontic providers of consecutive cases to reduce bias & introduce an educational element.

5.3 The independent sector should be held to the same level of quality as the NHS, however, one must recognised that a high proportion of the private treatment undertaken will be on adults with potentially limited treatment aims and objectives.

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

6.1 The 2006 Contact introduced acceptance criteria as determined by IOTN which was a great step forwards as it allocated the limited financial resourced to those identified with the greatest treatment need.

6.2 The introduction of the 2006 Dental Contract established a limit of the number of orthodontic cases undertaken. This has placed a definite cap on the orthodontic spend in England & Wales, see comments above.

6.3 It also introduced an inequity within the profession as the system is now biased towards established practitioners, as new qualified specialist find it very difficult to obtain a new NHS contract. This has potentially reduced patient and referrer choice. The Personal Dental Service (PDS) contracts awarded for orthodontic service provision are time limited, often at 3 years. This introduces a fundamental difficultly to a Practice business model when Practices are trying to secure finance and this is never more so than during the retendering process as it will potentially bias the financial viability assessment undertaken as part of the retendering process to large practice groups or Corporate bodies which can potentially distort

local service provision. The potential disadvantages of short term PDS contracting in orthodontics has been addressing in North Wales in the recent retendering process with the provision of longer contracts with an extension built in, subject to satisfactory outcomes as judged by KPIs and PAR scores.

7. Summary & Recommendations:

7.1 Orthodontic treatment offers a cost effective service with provision in the most appropriate clinical setting by the most appropriate clinician according to the patient's needs taking to account the geographical challenges of North Wales.

7.2 Orthodontic Treatment provided on the NHS is based on dental need (according the UK wide accepted criteria of the IOTN). Consideration could be given to raising the threshold to access treatment to only include categories 4 & 5, to eliminate the subjective aesthetic component, and target the limited resources at those with the greatest dental health need. However, systems should be in place for individuals who would benefit significantly from a psychological perspective, but do not meet the raised treatment threshold, to apply for individual patient funding in exceptional circumstances.

7.3 MCN's, LOC's and the LHB are working effectively together to ensure the maximum efficiency & value for money is obtained, whilst also taking into consideration the geographical challenges of the rural; communities in North Wales.

7.4 The potential disadvantages of short term PDS contracting in orthodontics has been addressing in North Wales with the recent retendering process and the provision of longer contracts with an extension built in subject to satisfactory outcomes as judged by KPIs and PAR scores.