National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from South Ease Wales Local Orthodontic Committee and Managed Clinical Network – OS 14

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Response: South East Wales Local Orthodontic Committee and Managed Clinical Network.
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1. 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.

1.1 The level of orthodontic service provision in SE Wales has been reported in various national and regional reports, and is considered to be better when compared to many other areas in Wales. This is partly due to good hospital provision in the region but mainly because there was a good level of provision of specialist orthodontic services in Primary Care prior to 2006, which continued when the current orthodontic contract was introduced. This accessibility is, however, largely limited to the M4 corridor

1.2 The majority of orthodontic treatments are provided by specialist orthodontists contracted to deliver the service through Personal Dental Service (PDS) arrangements. Patients access orthodontic treatment through referral. An Index of Orthodontic Treatment Need (IOTN) is used to identify children who qualify for NHS orthodontic treatment. It is an objective clinical index which is well understood and accepted by the profession.

1.3 A standardised proforma based referral system has been developed in SE Wales so that patients who qualify for NHS orthodontic treatments are referred to an appropriate setting for their treatment. Effectiveness of this system is yet to be fully evaluated but anecdotal evidence from orthodontic providers indicates that this system has improved the appropriateness and quality of referrals and has allowed practices to undertake some triage of referrals.

1.4 In terms of uptake of orthodontic treatment, less orthodontic treatment is taken up by children living in deprived areas. This is mainly due to patients not accessing dental services in general and to a high prevalence of dental decay in children living in these areas contra-indicating orthodontic treatment.

1.5 There is variation between Health Boards and between regions in terms of waiting time, use of various care settings (Community, Primary Care and Secondary Care) and how far patients have to travel to access orthodontic services. Patients requiring urgent specialist opinion or treatment should be prioritised to receive early care.

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1.6 Variation exists between Health Boards in terms of delivery of orthodontic services within secondary care. Consultants in orthodontics based in a hospital setting treat mainly complex malocclusions requiring multi-disciplinary dental care for e.g. cleft lip and palate patients, jaw surgery patients, patients who have multiple missing teeth etc.

1.7 There is a different approach to waiting lists between hospital and specialist providers.

1.7.1 Hospital Consultants have always aimed at short new patient waiting lists because of their advisory role and in recent years these have been subject to Government targets. This has led to short new patient waiting lists but long treatment waiting lists.

1.7.2 Specialists generally see patients when they have treatment allocation available and tend to have long new patient waiting lists but once seen can treat those patients straight away if appropriate. This can compound the problem for an inappropriately referred patient with a complex multidisciplinary problem who may wait for many months to see a Specialist only to be re-referred to the Hospital Consultant. In other cases the opportunity for interceptive measures is lost by this delay in obtaining a specialist appointment.

2. 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).

2.1 The Orthodontic MCN in SE Wales (MCN) has representation from the Health Boards, the Local Orthodontic Committee, Cardiff University, Dental Public Health and Local Dental Committees in SE Wales. It is linked to Oral Health Advisory Groups (OHAG) in each Health Board and the National Strategic Advisory Forum in Orthodontics (SAFO) set up by the Chief Dental Officer for Wales.

2.2 The MCN is not aware of any major issues in relationships between orthodontic practices and Local Health Boards in SE Wales. Health Boards have agreed to extend contracts and/or change in ownership of the contracts when requested by the orthodontic practices.

2.3 The MCN provides advice and support to Health Boards in the region. Health Boards are responsible for the management of orthodontic services in their area and the MCN only has an advisory role in contract management or performance management of orthodontic contracts. The MCN agreed that Health Boards should use the Welsh Government's Contract Management Guidance in monitoring and management of orthodontic contracts in the region.

2.4 Since its establishment, the MCN has provided advice and support to Health Boards on:

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- Establishment of a Referral Management System
- An accreditation process for Dentist with Enhanced Skills (DES)
- Development of an audit to monitor treatment outcomes
- Transfer of orthodontic care, orthodontic appeals etc
- Currently the MCN is actively participating in discussions on the development of a new orthodontic contract through the SAFO.

2.5 One of the issues identified by the Health, Wellbeing and Local Government Committee inquiry in 2010/11 was the size of Specialist Practice waiting lists, reported as 5498 patients in the South East Wales area, and what that might represent in terms of potential treatment need and resource when assessed. The LOC undertook an audit in early 2011 on the outcome of over 600 new patient assessments in the four regional hospital orthodontic departments and in Specialist Practices.

- The vast majority of referrals were made by GDPs but 22% of Hospital referrals were tertiary
- Hospital units only took on 22% of referrals for treatment using their strict treatment protocols
- 5% of patients referred to both services were deemed to be totally inappropriate
- 25% of referrals to hospital units should have been referred to specialist practice
- 12% of referrals to specialist practice should have been referred to hospital.
- 15% of hospital and 20% of specialist referrals had an IOTN <3.6

This would suggest that the current specialist practice waiting lists (currently 4829 in SE Wales) do truly represent those patients requiring a specialist opinion and that approximately 3863 will eventually require active treatment.

3 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.

3.1 The regional SE Wales orthodontic needs assessment concluded that there was adequate provision of orthodontic services in SE Wales provided the efficiency and effectiveness of orthodontic services is monitored and improved.

3.2 Current waiting lists in SE Wales would suggest that this is not the case.

- 4829 patients on Specialist Practice new patient waiting lists.
  Waiting time 12-30 months
- 1053 assessed patients on hospital treatment waiting lists with a confirmed high treatment need and complexity. Waiting time 6-42 months
- 283 assessed patients on CDS waiting lists with a confirmed treatment need. Waiting time 18-24 months

- An unknown but large number of patients in all settings who have been assessed but are on review waiting for growth, dental development or surgical intervention before commencing active treatment

3.3 Considering the spending pressures facing the NHS, lack of growth in overall dental funding and priority given for dental access and development of other dental specialities in the National Oral Health Plan, it is highly unlikely that orthodontics will see any growth in the foreseeable future but this will a large pool of patients waiting almost indefinitely for treatment. There is a concern that if there is any disinvestment in the orthodontic service it will not remain adequate, effective or sustainable in the medium to long term.

3.4 Throughout Wales, the MCNs have been involved with Health Boards on the implementation of independent treatment outcome audits. Information on quality, outcome and output achieved for the money spent in orthodontics should help Health Boards and the Welsh Government to decide if orthodontic services provide value for money.

4 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.

4.1 The National Oral Health Plan prioritises urgent dental care, access to general dental services, the national oral health improvement programme (Designed to Smile) and development of other specialist dental services involved in complex multi-disciplinary care.

4.2 Orthodontics, like all specialities, needs to ensure that it is providing efficient, cost effective treatments to the patients that want and have a proven need for treatment. Orthodontics has a robust measure (Peer Assessment Rating (PAR)) to monitor outcomes and is supported by evidence based interventions that deliver a quantifiable health gain.

4.3 Health Boards and the Business Service Authority (BSA) are responsible for monitoring standards of delivery and outcomes within the NHS and Health Inspectorate Wales (HIW) is responsible for monitoring standards within the independent dental sector.

- HIW does not routinely monitor independent orthodontics and will only investigate quality in the situation of a complaint.
- There is a mechanism for PAR monitoring of outcome for those patients treated under the NHS in Specialist Practice. This amounts to a sampling of a percentage of completed cases. Systems are also in place at the BSA, that manages the system, to pick up "outliers" for further investigation.
- The salaried services, both Community and Hospital, have no formal monitoring mechanism although have an obligation to audit. Consultants are subject to annual appraisal.

4.4 The need for improved monitoring of treatment outcomes has been recognised and all MCN orthodontic providers across primary and secondary care have agreed to participate in annual audit that aims to provide assessment of treatment outcomes.

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

5.1 The current "Units of Orthodontic Activity" (UOA) based orthodontic contract was introduced in 2006. PDS orthodontic contracts were offered to all those dentists who were providing some form of orthodontics in the old cash unlimited system. Although this resulted in fixing of orthodontic funding it also effectively fixed historic inequalities in the distribution of orthodontic services.

5.2 Many small orthodontic elements were retained within the mandatory General Dental Services and some of these contracts were later found to be delivering assessments, but little or no treatment. These have now been largely eliminated by the Health Boards on advice from the MCN.

5.3 There was, and remains, variation in UOA rates between contracts within and between Health Boards. However, this variation in UOA rate is not dependent on the quality of the service, rurality or cost of service delivery.

5.4 Qualifying criteria for NHS orthodontics were introduced to ensure only those with a high objective treatment need based on IOTN are provided with NHS treatment.

5.5 The new contractual arrangements offered NHS orthodontic treatment in Primary Care to children (17 years and under) and at a slightly higher rate for adults. Most, if not all, Health Boards and Specialist Practices opted to contract only for children's contracts. This has led to a disenfranchised group of adults who, often through no fault of their own, are unable to access NHS orthodontic treatment.

5.6 Aspects such as ratios of assessments to treatment starts and completions are covered through Key Performance Indicators (KPIs) in line with the Welsh Government's Contract Management Guidance for monitoring and management of orthodontic contracts. Even so the contract and contract management tends to focus on the delivery of UOAs rather than delivery of quality treatments.

5.7 The current orthodontic contract is underpinned by the NHS Personal Dental Services Agreement (PDS) Regulation which allowed creation of time limited contracts. While some Health Boards have repeatedly extended these contracts, others have retendered these services. There is no uniformity of approach for contract continuation or re-commissioning of orthodontic services.

5.8 Specialist Orthodontic Practices are self financed by the clinicians. The time limited PDS contract compared to the rolling GDS contract puts orthodontic practices at a major disadvantage when attempting to raise funds in the financial market. Uncertainty prevails at the end of each contract period which stifles investment, planning and development of the practice. The longitudinal nature of orthodontic treatment, however, means that there must

be some certainty with regard to continuity of patient care. There must be consideration of a mechanism to allow rolling contracts for well performing practices.

5.9 The economics of running an orthodontic practice means that there is inevitably a tension between delivering an efficient cost effective service and accessibility.

5.10 The new contract effectively fixed delivery of care both in terms of volume and geography. There is very limited flexibility for expansion or contraction of activity or for new start-ups.

5.10 Overall, the current orthodontic contract is considered an improvement from the previous orthodontic contract under the old 'fee for item' system. However, there are areas that could be changed to improve efficiency and effectiveness. The new system needs to identify and reward high quality performing contracts and improve or stop poorly performing contracts. However, the creation of such a system will require changes in the underpinning Dental Regulation.

6 Summary and recommendations

6.1 Orthodontics offers a cost effective, value for money service with evidence based treatment and measurable outcomes.

6.2 Treatment is restricted to patients with proven treatment need using a robust index. Even so there are large waiting lists of patients in all sectors. Consideration may need to be given to raising the threshold for NHS orthodontic treatment to IOTN 4 & 5

6.3 LOCs and MCNs are working effectively with Health Boards to maximise the efficiency of the service and to monitor and maintain high treatment standards.

6.4 Short term PDS contracts are limiting investment and flexibility in primary care and consideration must be given to rolling contracts for well performing practices.