British Orthodontic Society (BOS) Submission to the National Assembly for Wales Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales.

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Background

The British Orthodontic Society (BOS) 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.

The BOS 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 Orthodontic Specialists Group, Practitioner Group, Community Group, Consultant Orthodontist Group, University Teachers Group and the Training Grades Group.

Orthodontics is the dental specialty concerned with facial growth; the development of the dentition and occlusion; and the assessment, diagnosis and treatment of malocclusions and facial irregularities.

Orthodontic treatment provided by the National Health Service (NHS) is undertaken according to clinical need as determined by the Index of Orthodontic Treatment Need (IOTN).

Orthodontic treatment is recognised to have a range of health benefits including the reducing the risk of dental trauma from prominent teeth; reducing the risk of root resorption of adjacent teeth from impacted teeth; recreation of space for the replacement of missing teeth or eliminating the space completely to reduce the restorative burden in the future; improving the ability to clean the teeth and reducing the risk of dental caries; improving dental function; and correcting dento-facial deformity .

One must consider the definition of health in its entirety as promoted by the World Health Organisation: "Health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity."

With this in mind, in addition to the dental health benefits highlighted above, there is also an improvement in the appearance, self-esteem and psychological well being, which can be especially important during the formative years of adolescence.

Orthodontic provision in Wales is undertaken by a range of professionals: Orthodontic Therapists (under supervision), Dentists with Enhanced Skills (DES)/Dentists with Special Interest (DwSI) in Orthodontics; and Orthodontic Specialists; in a range of clinical environments: General Dental Practice; Specialist Orthodontic Practice; Community Dental

Clinics; District General Hospitals; and Cardiff University Dental Hospital. Who undertakes an individual's orthodontic treatment is determined by the complexity of the malocclusion and the treatment required; any additional dental, medical and social needs of the individual; and the availability of the required expertise within the geographical area.

To date there have been three major documents produced with regards to orthodontic provision by the National Assembly for Wales:

- National Assembly for Wales Health, Wellbeing and Local Government Committee – Orthodontic Services in Wales, February 2011
- National Assembly for Wales Health and Social Care Committee – Orthodontic Services in Wales, July 2014
- "Review of the Orthodontic Services in Wales 2008-09 to 2015-16." (Professor Richmond 14/12/16). This document supersedes the Professor Richmond's previous "Review of the Orthodontic Services in Wales 2013-14." (Professor Richmond 06/02/15)

With regards to the current Inquiry, the BOS have been asked to comment of the following areas:

1) Progress made to improve the efficiency of orthodontic services delivered in Wales, with reference to the recommendations of the previous reports.
2) Training, recruitment and retention of the orthodontic workforce
3) Waiting times for appointments and treatment.

1. Progress made to improve the efficiency of orthodontic services delivered in Wales, with reference to the recommendations of the previous reports.

The recommendations from the previous reports are detailed below with the subsequent action, as far as the Society is aware, that has been undertaken detailed in bold.

<u>National Assembly for Wales Health, Wellbeing and Local Government Committee Report on Orthodontic Services in Wales (February 2011) made the following recommendations:</u>

Recommendation 1. We recommend that the Welsh Government commissions further research to assess the orthodontic treatment need, ensuring that contracts for orthodontic treatment are adequate to meet demand.

Action: We are not aware of any Research in this area commissioned by Welsh Government. It is, however, established best practice, that before any procurement procedure, a Needs Assessment is undertaken within that area, with input from all professional stakeholders and representative bodies, to fully assess the local requirements.

Recommendation 2. We recommend that Local Health Boards improve the efficiency and effectiveness of orthodontic services delivery through effective procurement processes. This should include ensuring that contracts contain details about the number of treatment starts and treatment completes per year in each contract.

Action: Key Performance Indicators (KPI) form part of the Contracts issued to Orthodontic Providers. The exact nature and wording of the KPIs will be determined by the LHBs, who will take into consideration the steer of Welsh Government via the following document:

"Updated guidance: Delivery of orthodontics in primary care – November 2015".

Recommendation 3. We recommend that the Welsh Government produces guidance for Local Health Boards on the effective and efficient procurement of orthodontic services. This should include guidance on developing agreements based on the number of treatments provided per year, quality of services, orthodontic treatment outcomes and value for money.

Action: Welsh Government issued the following documents:

"Guidance on Management of NHS Orthodontic Contracts in Primary Dental Care – July 2013"

"Updated guidance: Delivery of orthodontics in primary care – November 2015"

Recommendation 4. We recommend that the Welsh Government discusses with the Welsh Consultant Orthodontic Group how to introduce standardised UOA rate to address the disparity in UOA value and volume of treatment provided.

Action: Not undertaken.

Recommendation 5. We recommend that Local Health Boards review contracts identified as delivering orthodontic assessments only or mainly assessments and very few treatments.

Action: We believe that the LHBs have identified and eliminated Providers who were delivering assessment only contracts.

Recommendation 6. We recommend that Local Health Boards introduce specific contractual changes to take account of treatment provided rather than just delivery of UOAs. This should include consideration of whether practitioners should be allowed to claim for a repeat assessment within a short period of time unless it is clinically justified.

Action: We believe that the LHBs have introduced variations to the KPIs which have stipulated the recommended ratios between different types of claim in accordance with the Guidance documents issued by Welsh Government. Any variations from the average

by individual providers is automatically highlighted to the LHBs and these will be discussed as the routine contract review or at an earlier meeting if necessary.

Recommendation 7. We recommend that the Welsh Government facilitates the development of an electronic referral system in line with Recommendation 6 of the Government's national review, which will allow records to be monitored centrally.

Action: The Electronic Referral Management System (eRMS) for all Dental Referrals has been commissioned following an open tendering process by Welsh Government. The eRMS is currently under construction with expected phased roll out to the LHBs toward the end of 2018 and into 2019.

Recommendation 8. We recommend that Local Health Boards support the establishment of local Managed Clinical Networks (MCNs) in orthodontics with the view of improving patient care. MCNs should take lead responsibility for reducing early, multiple and inappropriate referrals in line with Recommendation 12 of the Government's national review.

Action: Orthodontic MCNs have been established in North Wales & Powys, South East Wales and South West Wales. The MCNs input into their local Oral Health Strategy Groups as well as having representation on the Welsh Government's Strategic Advisory Forum in Orthodontics. All MCNs have established local referral proformas and criteria to improve the quality of referrals as well as leading the way with regards to quality and safety within their regions.

For MCNs to operate efficiently, it is essential that they have full engagement from all the relevant stakeholders within the Profession and the HB. This is never more important when considering policy introduction that will have a profound effect on local service provision such as appeals processes and retendering of services.

The three Welsh MCNs have also liaised to produce a National Orthodontic Referral Form which has formed the basis for the orthodontic section of the forthcoming All Wales Electronic Referral Management System and a number of orthodontic electronic referral systems in England.

Recommendation 9. We recommend that the Welsh Government funds a one off waiting list initiative to clear the backlog of patients waiting for orthodontic treatment.

Action: Not undertaken.

Recommendation 10. We recommend that the Welsh Government discusses with the General Dental Council how to ensure that the issue of inappropriate referrals is addressed and whether IOTN training should be mandatory for all GDPs.

Action: No information available as to whether this has been undertaken.

Recommendation 11. We recommend that the Welsh Government amends Regulations to include a contract penalty for practitioners who persistently refer patients early or making a high volume of inappropriate referrals in order to encourage them to change practice.

Action: Not undertaken

Recommendation 12. We recommend that Local Health Boards set out clear contractual arrangements with DwSIs including close monitoring of treatment outcomes, with a view to the development of specific orthodontic Personal Dental Services agreements.

Action: DwSIs should be monitored to the same level with the same expectations of the outcome as orthodontic specialists (although the range and complexity of cases they have undertaken will be inevitably reduced). It would be anticipated that DwSi, who are only treating patients from their own Practice, should be using a higher proportion of their allocated UOAs, if not all their allocated UOAs for treatment, as any reviews before treatment is commenced would be undertaken with their General Dental Practitioner "hat" on.

Recommendation 13. We recommend that Local Health Boards work with local MCNs to introduce a local accreditation scheme and continuing professional development for DwSIs.

Action: Accreditation schemes have been undertaken by all three MCNs, each with variations to accommodate local circumstances, but underpinned by a tripartite agreement that all orthodontic treatment plans should be undertaken by an orthodontic specialist.

Recommendation 14. We recommend that the Welsh Government facilitates the development of the skills base of the orthodontic workforce.

Action: No information available as to whether this has been undertaken.

Recommendation 15. We recommend that the Welsh Government strengthens the current General Dental Council guidance to ensure orthodontic therapists must be supervised by an orthodontist on the specialist register as opposed to a general practitioner at all times.

Action: No information available as to whether this has been undertaken at a Welsh Government level, however modifications to the required level of supervision of orthodontic therapists have been included in Contracts issued in North Wales following the PDS Specialist Orthodontic Contract re-tendering process. In addition, it has been agreed by the Strategic Advisory Forum in Orthodontics that the BOS Guidelines on supervision of Qualified Orthodontic Therapists 2017 should act as the <u>minimum</u> standard as this document also uses the term "dentist" as many areas of the UK do not have Accreditation Schemes for DESs/DwSIs.

Recommendation 16. We recommend that the Welsh Government amends Regulations to include a contract penalty for poor quality treatment (based on PAR and excluding those cases where the patient was not compliant with the treatment).

Action: No information available as to whether this has been undertaken.

Recommendation 17. We recommend that the Welsh Government develops an implementation process to facilitate close monitoring of treatment outcomes through PAR and establish a system where PAR score reductions are monitored independently on annual basis for all providers.

Action: No information available as to whether this has been undertaken at a Welsh Government level, however within each MCN area, Peer Assessment Rating (PAR) score monitoring is undertaken instigated by either the Local Orthodontic Committee (LOC), MCN or HB.

National Assembly for Wales Health and Social Care Committee Report on Orthodontic Services in Wales (July 2014) made the following recommendations:

Recommendation 1. The Committee recommends that the Minister for Health and Social Services works with local health boards and managed clinical networks to develop robust monitoring arrangements to ensure consistent compliance with treatment outcome requirements.

Action: PAR score audits are undertaken within all MCN areas. These are conducted by either the LOC, MCN or HB. It is essential that all practitioners with responsibility for the treatment outcome are included and judged to the same standards, accepting that PAR is not designed to assess the outcome of certain malocclusion types.

Recommendation 2. The Committee recommends that the Minister for Health and Social Services confirms when the electronic referral system will be introduced, and sets out the actions local health boards and managed clinical networks can take to identify patterns of inappropriate referrals, and plan and deliver suitable targeted interventions.

Action: The Electronic Referral Management System for all Dental Referrals is currently under construction and is due to be rolled out 2018/2019.

Recommendation 3. The Committee recommends that the Minister for Health and Social Services sets out the actions local health boards and managed clinical networks can take, with associated timescales, to improve waiting times in each local health board area, and identifies the monitoring arrangements he will put in place.

Action: No information available as to whether this has been undertaken.

Recommendation 4. The Committee recommends that, to ensure that the service received by patients is of a sufficient standard, the guidance issued to local health boards by the Chief Dental Officer in relation to commissioning orthodontic services includes best practice for the establishment and monitoring of such services.

Action: This is included within the Welsh Government's document: "Updated guidance: Delivery of orthodontics in primary care – November 2015"

Recommendation 5. The Committee recommends that the Minister for Health and Social Services takes steps to reform payment arrangements for orthodontic services to address the concerns raised by the Committee.

Action: This has not been undertaken. Retendering of Specialist Primary Care Contracts within Wales is currently ongoing. However, different approaches have been taken by the different Health Boards. It was highlighted in this report how important it was that

Practices have the "confidence to invest" with longer term contracts. However, it is also essential that any new contractual arrangements are viable, as there is concern that new UOA rates that do not take into account local circumstances and National requirements will pose a risk to the long term sustainability of Specialist Practice and the associated service provision.

Recommendation 6. The Committee recommends that the Minister for Health and Social Services reviews the guidance available to support local health boards in entering into contracts for the provision of orthodontic services which take local needs into account. Such guidance should cover, as a minimum, determination of contract length, robust performance and quality monitoring arrangements, protections against the selling on of contracts, and contract exit arrangements.

Action: See concerns raised above.

Review of the Orthodontic Services in Wales 2008-09 to 2015-16. (Professor Richmond 14/12/16)

Recommendations:

Welsh Government

• The Welsh Government in association with the various dental authorities and the Orthodontic Strategic Advisory Forum should lay out a clear strategy for orthodontics in Wales for the next 5 years. This should incorporate:

i. The personnel (skill mix) who should deliver care (GDP, Practitioners with a special interest in orthodontics, Specialist practitioners, Specialist/Orthodontic therapists
ii. The setting of the delivery (PDS, Hospital, Community, Private) and treatment thresholds with defined numbers requiring multiple dental/medical specialty treatments.
iii. Pragmatic patient access and coverage of orthodontic provision across Wales
iv. The type and quantity of orthodontic cases treated in the various settings.
v. Encourage contracts that are purely treatment driven to ensure equity and fairness for all Performers across Wales.

Action: It is believed that this work is ongoing, but yet at a relatively early stage in the process.

• Promote improved communication in Health Board decisions and local implementations of any local orthodontic decision/strategy.

Action: This can be achieved by a fully functioning MCN, however, as has previously been mentioned, for an MCN to operate efficiently it requires full engagement of all the

relevant stakeholders from within the Profession and the HB working together in an environment of mutual respect and cooperation.

• Facilitate improvement of data sharing and ensure robust systems for data recording/reporting with regard to all aspects of orthodontic provision in all provider settings.

Action: We are unaware as to how much progress has been made within this area.

Health Boards

• Orthodontic contracts should be based on "Assess and accept" only.

Action: Orthodontic provision includes both advice and treatment. To alter the renumeration system to cover only treatment would be unfair to the practitioners and a retrograde step.

• The practice of "Assess and review" should cease unless there is a clear indication.

Action: There are clinical circumstances where a further review, prior to commencing treatment, following an initial assessment, is entirely appropriate. To prevent inappropriate levels of "Assess and Review" the HB Contracting Teams have put into place expected ratios, outside which further investigations will be triggered.

• Ensure that there are contracts that reflect population provision in each Unitary authority and cross border flows are fully accounted for with robust pre-determined contracts.

Action: This should be established by a local "Needs Assessment". However, there is concern that the calculations of need based on a third of 12 year olds within an area can underestimate the actual local demand in practice. It is also essential that cross border activity, both between HBs and between Wales and England are full appreciated by those undertaking any "Needs Assessment" and are taken into account fully when considering any changes in policy.

• The Health Boards should monitor the performers according to key performance indicators, specifically the number of patient receiving active orthodontic treatment and whether these patients fulfil the orthodontic entry requirements as well as assess the outcome of treatments assessed by the PAR Index.

Action: We believe that these processes are in place within each HB. However, there are anecdotal reports that the level of monitoring by the HB can vary between different Providers within a HB.

• The number of Performers in each Health Board should match the likely need of the local population (as close as possible to expected numbers) and/or needs of the population in nearby Unitary authorities in other Health Boards.

Action: It must be recognised that it is the "whole time equivalent" number of performers that is most important to match rather than the actual number of performers. This will then be more able to reflect variations in working patterns and professional demographics. It is also essential that any cross border activity, and appropriate supervision of non-specialist orthodontic performers, is taken into account when calculating the "ideal" numbers.

• The data obtained relating to orthodontic treatment in the GDS/PDS is improving. More resources should be allocated to document orthodontic provision in other settings.

Action: We are not aware that this has occurred.

Orthodontic providers/performers

• Performers should routinely accept patients above the orthodontic treatment threshold and deliver average treatment outcomes consistent with 70% reduction in PAR scores

Action: All practitioners should only accept patients for treatment who qualify for NHS Orthodontic treatment according to the current threshold of IOTN. All completed treatment should be competed to a satisfactory standard as stipulated within the PAR guidance.

• Waiting list data (specifically date of birth, post code and date placed on waiting list) should be routinely collected and reported annually to the Health Boards.

Action: This should be available following the introduction of the Electronic Referral Management System.

• Re-treatments should be undertaken through the private sector.

Action: It is accepted that only one course of definitive treatment should be provided by the NHS to an individual patient, unless there were exceptional extenuating circumstances which the HB felt justified a second course of NHS funded treatment.

2. Training, recruitment and retention of the orthodontic workforce

The Orthodontic workforce undergo a variety of training pathways. These are summarised below:

Orthodontic Therapist – Dental Nurses who undertake a 12 month course cumulating in an exit examination by one of the Royal College of Surgeons.

Dentists with Extended Skills (DESs) / Dentists with Special Interest in Orthodontics (DwSI) – Dentally qualified practitioners who have experience in orthodontic management, often

having training in posts which are not monitored or approved by the Specialist Advisory Committee (SAC). In Wales, these individuals will then have been formally assessed by the DwSI Accreditation Process established by each MCN.

Orthodontic Specialist Practitioner – Dentally qualified practitioner who has undertaken a number of years training in related specialties such as Paediatric dentistry, oral and maxillofacial surgery, before embarking, via competitive entry, on a 3 year Orthodontic Specialty Training Pathway (StR 1-3) recognised by the SAC which also includes undertaking a taught postgraduate qualification such as a Masters or Doctorate. This cumulates in an exit examination by one of the Royal Colleges.

Consultant Orthodontist – Dentally qualified practitioner who has undertaken the Specialty training detailed above to become a Orthodontic Specialist Practitioner and then embarks, via competitive entry, on a SAC approved higher training pathway lasting from 2 to 2 ½ years (StR 4-5). This additional training focuses on the multi-disciplinary care that is the mainstay of secondary care orthodontic provision, but also provides training in the wider remit of an orthodontic consultant. This cumulates in an exit intercollegiate examination by the Royal Colleges.

It is recognised that throughout the UK, the more rural the environment, the harder it is to recruit suitably trained professionals. This is due to a number of factors, with two of the most important being where an individual's family/social connections are based, and secondly, that professionals tend to "settle down" near to where they trained due to the personal and professional links they established during their training period. The Welsh Orthodontic Training Programme is provided by Cardiff University which introduces logistical challenges to undertaken orthodontic training posts within North Wales. The Welsh Deanery have been very supportive of orthodontic training in North Wales, recognising its importance in recruitment and retention locally. A pragmatic solution has been agreed between the Welsh Deanery and Liverpool Orthodontic Training Programme to allow orthodontic trainees in North Wales to obtain their education element as well as some clinical training within Liverpool University Dental Hospital and Alder Hey Children's Hospital.

The main Orthodontic Training Programme in Wales is run via Cardiff University. All trainees undergo competitive entry via National Recruitment. The potential trainee ranks each available post and they are matched depending on their performance during the National Recruitment Process. Unfortunately, this system has resulted in some unintended consequences as it has been reported that trainees, who have a local connection to Wales and a desire to remain in the region in the long term, have not secured training places in these areas. This has lead to increased challenges in recruitment of specialists in Wales following completion of their training. Discussions have been held about the regional benefits of undertaking a recruitment process outside National Recruitment. In an attempt to improved Consultant recruitment, run through training has been established where a

trainee undertakes both the Specialist Orthodontic Practitioner and Consultant Orthodontist training in succession within the same Region over a 5 year period. There are currently 4 "run through" trainees in post and it is hoped that they will continue through to the completion of the Consultant training. Unfortunately, in other regions with "run through" training pathway, some trainees have stopped their training after the end of the Specialist Orthodontic Practitioner training period rather than completing their Consultant training, so it will need to be seen if the new policy increases the prospects of successful Consultant Orthodontic recruitment in due course.

For 2018 intake there have been two Orthodontic Specialist Trainees recruited (StR 1-3), one in South Wales and one in North Wales. Only one higher trainee (StR 4-5) was appointed out of 3 posts which were advertised. There is currently no Orthodontic Therapist Course being run in South Wales.

Another issue which has been raised as a potential barrier for trainees to accept orthodontic training posts within Wales is the differential payscales between England and Wales and the varying costs of the University fees to undertake the Orthodontic academic postgraduate qualification as Cardiff University reportedly has one of the highest course fees. This can lead to an income differential of £23,000 per annum between a trainee in England and Wales.

The issues with training along with the topography and rural nature of Wales has resulting in significant problems in recruitment and retention of certain sections of the orthodontic workforce. Within Primary Care Specialist Orthodontic Practice, some issues with regards the recruitment of Specialist orthodontists has been reported. There is a tendency for this to more common with Corporate Bodies as they can have a higher turnover of staff as well as the orthodontic performers not having a financial investment within the Practice. Within secondary care, the problem is more acute. This is due to numerous factors including issues of supply and demand, with at least 48 unfilled consultant posts within the UK, the tendency of newly appointed consultants to work part time, decreased uptake of Consultant training positions, and the inability of some posts to offer the prospect of a fully integrated Multi-Disciplinary Team and teaching opportunities, due to vacancies in other areas.

Table 1 Current Vacancies by Health Board

Health Board	Vacant Post(s)
ABMU (including Hywel Dda)	1wte Consultant 2 x post CCST (x3 attempts to recruit)
BCUHB	0.5 wte Consultant (YGC) 0.6 wte SAS (YMW & YG)
Cardiff and Vale	1.4 wte Consultant

Table 2 Further additional Vacancies from retirements in the next 5 years by Health Board

Health Board	Vacant Post(s)
ABMU (including Hywel Dda)	1 wte Consultant
Aneurin Bevan	None envisaged
BCUHB	1.2 wte Consultant (YG)
Cwm Taf	1.1 wte Consultant 1 wte CDS Post
Cardiff and Vale	None Envisaged

3. Waiting times for appointments and treatment

Waiting times within an area will be determined by a number of factors including the following:

I. Treatment Need
II. Treatment Demand
III. Commissioned Activity
IV. Availability of suitably trained professionals
V. Geographical influences
VI. Overall dental health
VII. Levels of deprivation

I. Treatment Need

An estimate of the treatment need can be calculated using a recognised traditional formula of a third of 12 year olds. However, as has been eluded to above, there is some evidence that this frequently used ratio can underestimate the actual treatment need in practice. The 2003 Child Dental Health Survey revealed that 8% of 12 year old and 14% of 15 years were undergoing orthodontic treatment and that a **further** 35% of 12 year olds and 21% of 15 year olds were assessed as having a treatment need. This equated to a recognised treatment need in 43% of 12 year olds and 35% of 15 years old. In addition, even this data is likely to underestimate the true treatment need as the "need" in the Survey was qualified as IOTN Dental Health Component of Grades 4 and 5 or an Aesthetic Component of 8-10, which is higher that the threshold currently in use for the allocation of NHS resources.

II. Treatment Demand

The perception of body and dental image has radically changed over the last 20 years and along with it the acceptance of undergoing orthodontic treatment. This has led to a substantial increase in the demand for orthodontic treatment. Fortunately, the strict adherence to only providing NHS orthodontic treatment to those to qualify according to the IOTN criteria, means that precious NHS resources are only used on those individuals with the greatest clinical need.

III. Commissioned Activity

The majority of current orthodontic activity is based on the historical distribution that was in place when the "New Contract" was introduced in 2006. The level of activity was determined by the orthodontic activity that had been carried out previously rather than what was required by the needs of the local populous. A number of HBs have commissioned "Needs Assessments" along with additional activity to address any discrepancies identified, however, the accumulated "back log" of individuals waiting for an orthodontic assessment and possible treatment has never been addressed.

IV. Availability of suitably trained professionals

It is recognised that throughout the UK, the more rural the environment, the harder it is to recruit suitably trained professionals. This is due to a number of factors, with two of the most important being where an individual's family/social connections are based, and secondly, that professionals tend to "settle down" near to where they trained due to the personal and professional links they established during their training period (See section 3). Wales has additional challenges due to its topography and ignorance and misperception surrounding potential linguistic challenges.

V. Geographical influences

The topography of Wales with the associate transport infrastructure have a substantial influence on accessing Specialist care for those individuals who reside in the most rural areas. As most Specialist provision is based in areas of high population density, the provision of Orthodontic Treatment by outreach programmes such as the Community Dental Service or within the General Dental Service by DwSI/DESs is an important component of overall service provision in remote areas.

VI. Overall dental health

Orthodontic treatment can only be undertaken on individuals who have a stable dental health. In fact, the desire to undertaken orthodontic treatment can often be a very compelling motivator for individuals to change their behaviour to establish a good level of dental health. As this change is often permanent, it reduces general dental treatment needs for those individuals in the future resulting in a cost saving for the NHS over the long term. As the general dental health of the population improves following improved dental education and excellent interventions, such as "Design to Smile", then the proportion of children with a recognised need for orthodontic intervention, as identified by IOTN, who now demonstrate a level of dental health sufficient to support a course of orthodontic treatment increases. This subsequently increase demand.

VII. Levels of deprivation

Deprivation levels will have a bearing on accessing orthodontic provision in a number of ways including suitability, due to poor levels of dental health, and transport limitations. As general dental interventions targeted at this demographic have a positive effect then access to treatment is improved.

Within Wales there are substantial waiting times for orthodontic assessments and treatment. Not every individual who has an orthodontic assessment will go on to have NHS orthodontic treatment. This can be for a number of reasons including general dental health, patient motivation/compliance to undertaking a prescribed treatment, personal circumstances, and not reaching the qualifying criteria according to IOTN.

The processes of managing referrals varies between providers. In general, in primary care, when a patient is referred, they are placed on a “waiting list” for assessment and possible treatment and are then taken off this list when a “treatment slot” becomes available. This results in a long referral to assessment time, but a short assessment to treatment time.

In secondary care settings, the patients are usually seen within 26 weeks from initial referral for a New Patient Assessment, as the Referral To Treatment (RTT) is only applicable for that initial assessment and then the patients are either discharged with advice, referred to another discipline/primary care specialist as appropriate, added to a treatment waiting list or reviewed depending on the clinical circumstances. This results in a relatively short referral to assessment time, but a much longer assessment to treatment time.

There is a concern about the identification of individuals who would benefit from “priority” orthodontic assessment and intervention, such as impacted teeth causing damage to adjacent teeth. This will be improved by the introduction of the eRMS as this will help identify these individuals, although it is recognised that any identification process is only as good as the referral information provided. Consideration has been given to altering the referral management process in Primary care to the secondary care model with patients experiencing a shorter Referral to Assessment time and if appropriate then being added to a longer assessment to treatment time, however, due to the current back log of patients waiting for the initial assessment, this would have implications on orthodontic treatment activity.

The current waiting times within both Primary and secondary care sectors is a result of historic and current discrepancy between referrals/need for treatment and actual treatment capacity.

The current orthodontic waiting times within Wales are reported as follows:

Table 3 Waiting times in primary care by Health Board

Local Health Board	New Patient Waiting Times (RTT)	Treatment Waiting Times after NP Assessment
ABMU (including Hywel Dda)	3-48 months	2 months
Aneurin Bevan	3-30 months	2-24months
BCUHB	8-10 weeks 16-24 months	18 months 2 months
Cardiff and Vale	6-30 months	2-6 months
Cwm Taf	17 weeks 6-22 months	6-15 months 2 months
Powys	4-12 weeks	2 months

Table 4 Waiting times in secondary care by Health Board

Local Health Board	New Patient Waiting Times (RTT)	Treatment Waiting Times after NP Assessment
ABMU (including Hywel Dda)	4-13 weeks according to urgency	In excess of 48 months
Aneurin Bevan	Up to 26 weeks (2 units)	54 months
BCUHB	20-26 weeks (3 units)	18-37 months
Cardiff and Vale	26 weeks	Longest wait 43 months
Cwm Taf	19-26 weeks	9-36 months
Powys	Up to 20 weeks	30 months

The current waiting times are a result of a discrepancy between need/demand for orthodontic treatment and commissioned orthodontic activity as well as issues with the recruitment and retention of appropriately trained clinicians. Previous Reports have recommended a one off initiative to clear the treatment backlog, however, this would need

to be carefully thought through with regards the overall service provision and there may be greater merits in distributing any additional initiative funding over a longer period to allow a sustainable approach to be adopted, as this would allow for a managed recruitment process to be undertaken with diversification of the workforce as appropriate.

4. Summary & Recommendations

a. There is a wide variation in the waiting times within individual Health Boards and Wales as a whole. This is evident in both primary and secondary care settings. It is suspected that this is primarily due to an intrinsic discrepancy between the treatment need and the commissioned activity, however, the reasons for this need to be fully established and options investigated to address these discrepancies in sustainable way which allows services to adapt.
b. The introduction the Orthodontic MCNs has been greatly beneficial. It is essential that all stakeholders remain fully committed and engaged and that the recommendations of the MCNs are incorporated into HB policy via their Oral Health Strategy Groups and their Oral Health Plans.
c. Continue the collective work of the Strategic Advisory Forum in Orthodontics to obtain a All Wales approach within Orthodontic Provision.
d. Continue with the introduction of the eRMS to produce a universal referral pathway and help identify individuals who require priority assessment and intervention as well as allowing more robust data collection. Although the introduction of the eRMS will streamline the referral process and it is anticipated that there will be an initial reduction in referrals while the referral base adapts to the new system, it is unlikely to have a significant downward effect on treatment need in the long term.
e. The awarding of short term contracts results in a limitation in the flexibility of the Practices to invest and modify their current practices. It is prudent to commission longer term contracts with appropriate quality safeguards incorporated within the KPIs to ensure qualify and productivity. It is essential that any reduction in UOA value is sustainable and that any cost savings achieved due to a reduction in UOA value are reinvested within the orthodontic provision to help address discrepancies between need and capacity.
f. Orthodontics is the most monitored speciality within dentistry. We would advise the continue monitoring of treatment outcomes to ensure quality and value for money is achieved within the framework of Prudent Health Care. The exact monitoring mechanisms will be determined at a HB level under advice from MCN and SAFO.
g. Training, recruitment and retention of the orthodontic workforce within Wales is problematic. This area needs to be investigated and options devised to address it. This needs to be done expediently as upcoming retirements are going to compound the problem leading to further disruptions to service delivery, and an exacerbation of the excessive waiting times currently experiences within all sectors.