National Assembly for Wales
Health, Wellbeing and Local Government Committee

Orthodontic services in Wales

February 2011

The National Assembly for Wales is the democratically elected body that represents the interests of Wales and its people, makes laws for Wales and holds the Welsh Government to account.

An electronic copy of this report can be found on the National Assembly's website:
www.assemblywales.org

Copies of this report can also be obtained in accessible formats including Braille, large print, audio or hard copy from:

Health, Wellbeing and Local Government Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Tel: 029 2089 8617
Fax: 029 2089 8021
email: health.wellbeing.localgovt.comm@wales.gov.uk

© National Assembly for Wales Commission Copyright 2011
The text of this document may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not used in a misleading or derogatory context. The material must be acknowledged as copyright of the National Assembly for Wales Commission and the title of the document specified.

National Assembly for Wales
Health, Wellbeing and Local Government Committee

Orthodontic services in Wales

February 2011

Health, Wellbeing and Local Government Committee

The Health, Wellbeing and Local Government Committee is appointed by the National Assembly for Wales to consider and report on issues affecting health, local government and public service delivery in Wales. In particular, as set out in Standing Order 12, the Committee may examine the expenditure, administration and policy of the Welsh government and associated public bodies.

Powers

The Committee was established on 26 June 2007 as one of the Assembly's scrutiny committees. Its powers are set out in the National Assembly for Wales' Standing Orders, particularly SO 12. These are available at www.assemblywales.org

Committee Member	*Party*	*Constituency or Region*
Jonathan Morgan (Chair)	Welsh Conservative Party	Cardiff North
Lorraine Barrett	Labour	Cardiff South and Penarth
Veronica German	Welsh Liberal Democrats	South Wales East
Irene James	Labour	Islwyn
Ann Jones	Labour	Vale of Clwyd
Helen Mary Jones	Plaid Cymru	Llanelli
Dai Lloyd	Plaid Cymru	South Wales West
Val Lloyd	Labour	Swansea East
Nick Ramsay	Welsh Conservative Party	Monmouth

Contents

Chair's Foreword

Orthodontic treatment is a form of dental treatment for improving the appearance, position and function of crooked or abnormally arranged teeth, and it is very important that the service is delivered efficiently and effectively, especially for children.

Constituents have raised a number of issues with members of the Committee in relation to orthodontic services in Wales. These included possible shortages of NHS orthodontic practitioners in some areas and long waiting lists in some parts of the country. It was on this basis that the Committee agreed to undertake a short inquiry to look at the provision of appropriate orthodontic care.

In the course of our inquiry, we heard evidence that the number of patients that can be treated under the current contractual arrangements has remained fixed since 2006 while, at the same, demand has grown as the public become more aware of their dental health and the benefits that orthodontic treatment can have.

Witnesses suggested that there were a number of ways to improve the current system, including standardising payments made to practices for conducting orthodontic work and improving the effectiveness of the commissioning process. An area that caused us particular concern was the number of inappropriate referrals being made – we were told that if this was addressed, waiting times for new patient appointments would decrease and there would be sufficient capacity in Wales to meet the demand for orthodontic care. If accepted, we feel that the Committee's conclusions and recommendations will provide some solutions to these problems.

I thank my predecessor, Darren Millar AM, for all of his work on this inquiry and, on behalf of the Health, Wellbeing and Local Government Committee, I would like to express my gratitude to all those who have contributed to this inquiry. I would also like to thank the Members of the Committee for their work in producing this report, and I commend it to the Minister for Health and Social Services and to the National Assembly.

Chair, Health, Wellbeing and Local Government Committee
February 2011

The Committee's Recommendations

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. (Page 19)

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. (Page 20)

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. (Page 20)

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. (Page 20)

Recommendation 5. We recommend that Local Health Boards review contracts identified as delivering orthodontic assessments only or mainly assessments and very few treatments. (Page 20)

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. (Page 20)

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. (Page 20)

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. (Page 20)

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. (Page 21)

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. (Page 28)

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. (Page 28)

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. (Page 28)

Recommendation 13. We recommend that Local Health Boards work with local MCNs to introduce a local accreditation scheme and continuing professional development for DwSIs. (Page 28)

Recommendation 14. We recommend that the Welsh Government facilitates the development of the skills base of the orthodontic workforce. (Page 28)

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. (Page 28)

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). (Page 29)

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. (Page 30)

1. Introduction

1. The Committee agreed to conduct an inquiry into orthodontic services in Wales.

Terms of reference

2. The Committee agreed the terms of reference for the inquiry on 8 July 2010. They were:

To inquire into the provision of appropriate orthodontic care in Wales including:

- the impact of the new dental contract on the provision of orthodontic care, assuring sufficient geographical coverage and access for patients to the most appropriate care;
- consideration of how effective and robust the co-ordination of orthodontic treatment across the various orthodontic providers is in Wales; including, hospital orthodontic departments, specialist orthodontic practices, general dental practices and community dental clinics;
- the effectiveness of working relationships between orthodontic practices and Local Health Boards in the management of local orthodontic provision, especially in the context of NHS restructuring;
- consideration of the role of local University teaching departments in ensuring the highest standard of orthodontic care is provided by the local orthodontic workforce;
- the Welsh Government's short, medium and long-term strategies with regard to maintenance and development of orthodontic provision, specifically dealing with the backlog of patients currently in the system and meeting future patients needs;
- arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector.

Methods

3. The inquiry was held between 22 September 2010 and 3 November 2010, and a call for evidence was issued on 22 July 2010. Sixteen submissions were received, which can be found at Annex C.

4. Six sets of witnesses were invited to give oral evidence during four Committee meetings. A list of meeting dates, details of the witnesses who appeared, written papers provided to the Committee, and links to transcripts are provided at Annexes A and B.

5. Agendas, papers and transcripts for each meeting are available in full on the Committee's pages on the National Assembly for Wales' website, which can be found at http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/bus-committees-third-hwlg-agendas.htm.

2. Background

6. Orthodontics is a type of dental treatment that is used to improve the appearance, position and function of crooked or abnormally arranged teeth. An orthodontist is a dental surgeon who specialises in orthodontic treatment and makes use of a range of appliances, such as braces. These are used to correct the position of teeth over a period of time, usually between 18 months and two years.

7. Most orthodontic treatment is carried out by specialist orthodontists working in local practices, who have done an additional three years of specialist training. They usually see their patients on referral from a general dentist. Straightforward orthodontic cases can also be treated by dentists with a special interest in orthodontics. The very complex cases, often requiring surgery, are referred to a Consultant Orthodontist in hospital. Orthodontists in the Community Dental Service also provide a supporting service mostly to the staff in their clinics and treat patients with special requirements.

8. Figures published by the British Orthodontic Society in November 2009 show that one in three children has a significant derangement of the teeth and needs orthodontic treatment[1]. This figure is based on the Index of Orthodontic Treatment Need (IOTN), which is used to assess the need and eligibility of individual cases. It is made up of five grades, which are listed below:

- Grade 1: almost perfect teeth;
- Grade 2: minor irregularities with the teeth, such as slightly protruding upper front teeth;
- Grade 3: greater irregularities with the teeth, which do not require treatment for health reasons, for example, upper front teeth that protrude 4mm (0.15 inches) or less;
- Grade 4: a severe degree of irregularity with the teeth, which requires treatment for health reasons, for example, upper front teeth that protrude more than 6mm (0.25 inches);
- Grade 5: severe dental health problems, for example, upper front teeth that protrude more than 9 mm (0.35 inches).

9. NHS treatment is available for grade four or five cases. Grade three cases are usually judged on a case-by-case basis, and treatment may be made available if the appearance of the teeth is particularly unattractive. Referrals to an NHS orthodontist are made by local dentists via the Local Health Board.

[1] British Orthodontic Society, A few facts about orthodontists, November 2009

10. The NHS makes some provision for adult orthodontic treatment but only the more severe cases are covered under current regulations. In cases where it can be offered, the standard NHS charge for complex dental treatment applies - this is currently just under £200. However, in some areas there are no orthodontists at all with NHS contracts to treat adults. Recent British Orthodontic Society figures show that 18 per cent of orthodontic patients are adults.[2]

11. The cost of private treatment depends on the type and duration of the treatment required. Figures published by NHS Direct state that the average cost for a course of treatment is around £2,000-£2,500.[3] However, the costs for private treatment can vary depending on the locality, the facilities of the practice, the age of the patient and the extent of treatment required.

12. Private treatment may be legitimately offered as the only option to patients who do not fulfil the criteria for NHS care. Private treatment can also offer patients a wider choice of braces, including clear brackets or invisible braces, and often more convenient appointment times. Treatment under private contract is not monitored in the same way as care under a NHS contract. However, all practitioners must abide by the profession's ethical guidance; 'Standards for Dental Professionals'.

13. According to the British Orthodontic Society, the UK has fewer orthodontists relative to its population than almost all European counties.[4] The Society argues that the shortage of orthodontists in the UK is due in part, to insufficient training places, with approximately 35-40 trainees qualifying each year. Further, more orthodontists are retiring each year than are qualifying; around 40-45 specialist orthodontists are expected to retire each year over the next ten years.[5]

14. The new NHS contracts for dentists in England and Wales, introduced in April 2006, have had an impact on orthodontic provision. The contract enabled dental services to be funded and organised at a local level, with Local Health Boards having responsibility for commissioning services in their area. Only practices with contracts can provide NHS treatment. There is a perception that provision has decreased under the new dental contract.

15. The system of NHS contracts places a quota on the number of patients each orthodontist can treat. This means that the contract has reduced the number of cases that can be treated within the NHS; practices who want to expand need to secure enhancements to their contracts from the Local Health Board. Many

[2] British Orthodontic Society, A few facts about orthodontists, November 2009
[3] NHS Direct website: http://www.nhsdirect.wales.nhs.uk/encyclopaedia/o/article/orthodontics/
[4] British Orthodontic Society, A few facts about orthodontists, November 2009
[5] Ibid

practices now provide both private and NHS care for children. According to the Orthodontic Subgroup, service capacity in relation orthodontic treatment is variable across Wales, with patients in rural areas being affected by inequity of access to services.[6]

16. There are shortages of NHS orthodontic practitioners in some areas and it can sometimes be difficult to access NHS orthodontic treatment. Waiting lists for treatment can be as long as three years in some parts of the country.[7] Evidence suggests that, in some areas, increases in demand and patient expectation have added to existing waiting lists, along with many children being referred in advance of need.[8]

17. There are also concerns that a lack of co-ordination of waiting lists (a patient may be on more than one list), is contributing to increased waiting times for treatment. There is a need to examine cross-border flows of patients and the impact on waiting times.

[6] Orthodontic sub-group of the Dental Contract Review Group, Note of the 1st Meeting, 9 September 2009
[7] Ibid
[8] Ibid

3. Availability of NHS Treatment

18. The new NHS dental contract implemented in April 2006 impacted on orthodontic care by means of the contract for orthodontic treatments with Units of Orthodontic Activity (UOA). The contract enabled dental services to be funded and organised at a local level, with Local Health Boards having responsibility for commissioning services in their area. Only practices with contracts can provide NHS treatment.

19. The system of NHS contracts places a quota on the number of patients each orthodontist can treat. The Committee was told that the UOA contracts were awarded based on remuneration for clinical work completed between October 2004 and September 2005 and that the number of UOAs, and the number of patients treated, has remained fixed since 2006.

20. There is a perception that provision has decreased under the new dental contract. The Committee heard that whilst demand has increased, the need for orthodontic treatment cannot be met, leading to long waiting lists for treatment in some specialist practices. The Committee also heard that, since the introduction of the new contract, there has been an increase in the number of referrals to the hospital service resulting in an increase in hospital waiting times.

21. The Committee was told that access to orthodontic treatment can be difficult in some parts of Wales, particularly in rural areas. There was a general consensus among witnesses that the new dental contract, based on historical activity is an inefficient use of resources. Witnesses largely agreed that the new contract has led to an overall reduction in the provision of orthodontic care, with some practices having more capacity to deliver than the contract value. Peter Nicholson of the British Orthodontic Society said:

> "I have spoken to colleagues over the past few weeks…and some practices are telling me that they are not starting any new patients because they have used up their UOA allocation for this year…

> "Some of them have told me that, even assuming a normal uptake, they have more patients waiting than next year's contract will cover. So, it is a serious issue."[9]

Improving the current system

Commissioning

22. Most witnesses supported the view that efficiencies could be made to the current system. Representatives from the National Public Health Service suggested that the Local Health Boards should improve the effectiveness and efficiency of their commissioning process to enable orthodontists to plan their treatment load more effectively.

> "Certainly, you will find that, in the Government review, one of the big recommendations to all local health boards is to improve the effectiveness and efficiency of their commissioning process... I would agree that, given that orthodontic treatment can take up to two years to complete, it makes sense to be more flexible in the commissioning of services so that it would allow orthodontists to plan their treatment load much more effectively."[10]

23. They also suggested that there should be greater clarity within the contract to prescribe the number of treatments and completions an orthodontist carries out.

Standardising the UOA rate

24. One of the outcomes of the Government's national review was the finding that there is a disparity in the UOA value among different practices – which means that some practices are paid less than others for providing exactly the same treatment.[11]

25. The Committee heard that standardising the UOA rate might be helpful in delivering orthodontic care. Whilst several witnesses including the British Orthodontic Society, Professor Richmond from Cardiff University School of Dentistry and the Orthodontic National

---

[9] RoP [para 8-10], 22 September 2010, Health, Wellbeing and Local Government Committee
[10] RoP, [para. 201], 6 October 2010, Health, Wellbeing and Local Government Committee
[11] RoP [para. 281], 6 October 2010, Health, Wellbeing and Local Government Committee

Group supported this, others were more cautious. Dr Bennett of Public Health Wales stated:

> "There is no doubt that, if you could do that, it would help the situation. It is probably more difficult to implement than appears at first sight, because the original values were based on the activity of the practices. Each orthodontic practice might have different on-costs, depending on the area in which they worked, to produce similar levels of activity."[12]

Repeat Review and Assess appointments

26. The Committee heard that the current arrangements under which orthodontics receive funding means that sometimes money is given to practices where little or no orthodontic treatment is provided. The orthodontist Dr David Howells told Committee:

> "The practices…were largely general practices, which, under the old contract, would quite frequently make an orthodontic assessment and be funded for that before referring the case onwards. There are several practices that are still making orthodontic assessments and then referring cases to a specialist, and therefore undertaking no treatment."[13]

Professor Richmond added to this stating that,

> "there are lots of practitioners who are not treating patients. They are doing what we call review and assessing, or reviewing and refusing treatment."[14]

27. Dr Thomas representing Public Health Wales also raised concerns about the number of patients being recycled and reassessed under the current system. He suggested that more needed to be done to reduce the number of repeat assessments and encourage more treatment,

> "at the moment, each provider of orthodontic services gets a contract that says, 'Mr Snooks, please provide 7,000 units of orthodontic activity'. You get a total of 21 units of activity to do

[12] RoP, [para. 203], 6 October 2010, Health, Wellbeing and Local Government Committee
[13] RoP, [para.251-252], 20 October 2010, Health, Wellbeing and Local Government Committee
[14] RoP, [para.151], 3 November 2010, Health, Wellbeing and Local Government Committee

> an assessment and treatment of that patient or you get one unit just to assess that patient. Theoretically, you could just do 7,000 assessments, if you wanted to. However, obviously, orthodontists do not. It seems to me that, logically, we need some more information within the contract. Would it not be useful to know how many patients we started to treat, how many patients completed treatment, and for that to be included within the contractual mechanisms?" [15]

28. Witnesses were concerned that there are too many assessments being carried out, creating inefficiencies. Dr Thomas of Public Health Wales stated:

> "One of the problems that we have—again, the evidence is in the national review and also my specialist registrar review—is the amount of recycling in terms of assessments that takes place. Another efficiency would be to disallow repeat assessments of children so that that would encourage people to do more treatment." [16]

Inappropriate and Early Referrals

29. The Committee was told that there is insufficient activity to deliver on demand within specialist orthodontic practices, resulting in high waiting times. The Health Boards said that this has led to an increase in the number of early referrals because of the delay in waiting for an initial consultation. Representatives from the National Public Health Service explained that GDPs tend to refer patients earlier to get on to the list, or they refer the patient to more than one orthodontic practice making multiple referrals. This, they said, does not represent value for money. Dr Bennett of Public Health Wales stated:

> "In my view, you are not getting value for money. There is also some evidence of multiple referrals. We are in a catch-22 situation. If you are a referring dentist and you know that there is a waiting list, you tend to do one of two things. You may refer patients earlier to get on to the list, further compounding the problem, or there is some evidence to suggest that dentists

[15] RoP, [para 228], 6 October 2010, Health, Wellbeing and Local Government Committee
[16] RoP, [para 242], 6 October 2010, Health, Wellbeing and Local Government Committee

> are referring to more than one orthodontic practice. So, there are definitely inefficiencies that have grown within the system because of the nature of the new contract."[17]

30. It was also suggested that such cases are inflating the waiting list figures. The British Orthodontic Society told the Committee that there are 5,498 patients on specialist practitioners' waiting lists in South-East Wales but suggest that these figures might be inflated because there will be duplicate referrals and inappropriate referrals and a number of those patients will not need treatment.

31. Some witnesses such as the British Orthodontic Society and National Public Health Service commented that if the issue of inappropriate referrals was addressed, waiting times for new patient appointments would decrease and there would be sufficient capacity in Wales to meet the demand for orthodontic care. Dr Thomas of Public Health Wales stated:

> "I cover south-east Wales, and it is very interesting to hear that there are long waits there, because we believe that there is sufficient service in south-east Wales to meet all the needs of all the children. Therefore, we believe that it is the inefficiency in the referral system that is clogging up these waiting times."[18]

Managed Clinical Networks

32. The majority of witnesses agreed that setting up Managed Clinical Networks (MCNs) could lead to better referral management processes and reduce the number of inappropriate referrals, though Dr. Howells disagreed with this view. The Committee was told that there is an established MCN in West Wales, a developing MCN in South East Wales and one to be developed in North Wales.

Community Dental Service

33. The importance of managed clinical networks in making better use of the community dental service was an issue raised by many witnesses including the National Public Health Service and the Health Boards.

---

[17] RoP, [para 182], 6 October 2010, Health, Wellbeing and Local Government Committee

[18] RoP, [para 191], 6 October 2010, Health, Wellbeing and Local Government Committee

34. Several witnesses recognised the important role of the community dental service in treating disabled and other patients. However, the National Public Health Service explained that there is no established orthodontic budget within the community dental service. Some witnesses were concerned about this. For example, ABM University Health Board raised some concerns in their written submission about the increase in orthodontic activity within the community dental service and its associated costs.

Backlog of patients

35. Another issue raised by witnesses was the backlog of patients waiting for orthodontic treatment. The British Orthodontic Society told the Committee that even with adequate contracts to cope with the current demand and workload, there is a big backlog in the system. Many witnesses stated that a one-off waiting list initiative was needed to address the problem. Dr Bennett of Public Health Wales stated:

> "I think that you have to put some one-off funding in to get rid of that backlog."[19]

36. The British Orthodontic Society stressed the importance of this being a two-year commitment to ongoing treatment related to treatment starts, and not new patient assessments. Mr Nicholson of the British Orthodontic Society stated:

> "It is not a matter of introducing a one-off new patient waiting list initiative that can quickly sweep the backlog under the carpet with a bit of money in time for 31 March, as has been done in the health service, as we know. This is a two-year commitment to ongoing treatment for quite a lot of kids to catch up."[20]

Minister's View

37. The Minister told Committee that she expects Local Health Boards to use their local oral health planning processes in commissioning dental services, and that they should look at cross-LHB provision to do this,

---

[19] RoP, [para. 238], 6 October 2010, Health, Wellbeing and Local Government Committee
[20] Rop [para. 84], 22 September 2010, Health, Wellbeing and Local Government Committee

> "there are areas where there is no difficulty in accessing orthodontic services. It is important that we recognise that local health boards should look at the cross-boundary issues in terms of orthodontics, and at how you perhaps need to cross boundaries in order to provide the service."[21]

38. On the issue of whether additional, one-off funding should be provided to address the backlog of patients waiting for treatment, the Minister indicated that, in her view, the first step to address the backlog is to consider the report submitted by the Task and Finish Group that she set up to review the main NHS Dental Contract, and to identify inefficiencies in the system from that. She told Committee that this an 'ongoing process'.

39. The Minister accepted that there has been a lack of strategic planning with regard to orthodontic care, and told Committee that this was one of the reasons for her commissioning of the national review. The Minister told committee that the development of the managed clinical networks will improve the referral management process and will reduce early, multiple and inappropriate referrals.

40. The Minister told Committee that she will be considering the recommendations of the Task and Finish Group in detail and that some are already being implemented, such as the recommendation that dental practices should be allowed to charge for missed appointments. The Minister also told Committee that she would need to consider the cost implications of the recommendations, but that she would keep the Committee informed of her final decisions in this regard.

41. The Committee was told that the group looking at the implementation of the Task and Finish Group's recommendations will also take account of the Committee's report.

Recommendations

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.

[21] RoP, [para. 264], 3 November 2010, Health, Wellbeing and Local Government Committee

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.

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.

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.

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

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.

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.

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.

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.

4. The Hospital Service

42. Much of the evidence gathered by the Committee refers specifically to specialist orthodontic practices. However, the Committee was keen to inquire into the provision of orthodontic care across the various orthodontic providers in Wales, including hospital orthodontic departments. In their written submission to the Committee, the Welsh Consultants Orthodontic Group stated that there has been an increase in the number of referrals to the hospital service resulting in an increase in waiting times.

43. Unlike waiting lists in specialist practices, where there are long waiting lists for patients to be assessed (but once they have been seen by the orthodontist they start treatment straight away), the hospital service takes a different route to seeing their patients. Hospital new patient waiting lists tend to be short – around 10 to 12 weeks. This means that those on hospital waiting lists have a proven need (they have had a new patient appointment with a consultant and they have been assessed as requiring hospital treatment) and are waiting for treatment. The Committee was told that there are around 2,000 patients waiting for hospital treatment, representing a wait to start treatment of between 14 to 27 months.

44. Ms Stephenson, representing the Welsh Consultants Orthodontics Group, told the Committee that more consultants need to be recruited into the service in order to increase hospital treatment capacity. The Committee was told that much of the treatment is carried out within hospital units with specialist trainees and that there is a fallow year in that the University takes in trainees for only two years out of three. Waiting lists tend to be longer during this fallow year. Ms Stephenson suggested that the number of specialist registrars training to be orthodontists should be increased,

> "it would be beneficial to recruit more specialist registrars who are training to be orthodontists. At the moment, within our area, we have five trainees and we would like to see that number increase to six trainees at any one time. That would start the process of their becoming eligible for their further training to become a consultant. So, if we can get more

specialist trainees locally, they are more likely to stay within the area and then apply for consultant positions within Wales."[22]

45. The Committee received evidence of particular recruitment problems within the hospital service in North Wales:

> "Recruitment across all dental services and orthodontics in North Wales appears less attractive than many other parts of Wales and the U.K. This may be exacerbated by large travelling distances and multiple site working."[23]

46. Hospital Orthodontic Services are exempt from the Referral to Treatment Time (RTT) targets and treatment waiting lists are usually not recorded on any centrally held administration system. The British Orthodontic Society suggested that it would be appropriate to have a referral-to-treatment target for orthodontics, but representatives from the National Public Health Service said it was important that any targets should be focused on primary care.

47. The evidence submitted to the Committee by the Local Health Boards suggests that while some hospital departments have waiting lists, others do not, depending on the care model that has been implemented.

Minister's View

48. On the inclusion of orthodontics into the referral-to-treatment time targets, the Minister confirmed that discussions have taken place between the Welsh Government, the Chairman of the Welsh Dental Committee and the Welsh Consultant Orthodontic Group. The Minister was clear that it would not be realistic to have a RTT of 26 weeks for orthodontics. The Acting Chief Dental Officer stated in relation to this:

> "There is an issue about when treatment is necessary and obviously if patients—certainly child patients—are being referred early, that would be completely inappropriate because

[22] RoP, [para 86], 22 September 2010, Health, Wellbeing and Local Government Committee
[23] Health, Wellbeing and Local Government Committee Paper, Inquiry into Orthodontic Services in Wales; Evidence from North Wales Consultants Group

they need to wait two or three years for the teeth to come through in their mouths to be treated anyway."[24]

[24] RoP, [para 154-155], 3 November 2010, Health, Wellbeing and Local Government Committee

5. The Orthodontic Workforce

49. The orthodontic workforce includes: General Dental Practitioners (GDPs); Dentists with a Special Interest (DWSIs); Specialist Orthodontic Practitioners; Specialist Orthodontic Practitioners working in the Community Dental Service; Hospital Consultants; and Orthodontic Therapists.

General Dental Practitioners

50. Referrals to an NHS orthodontist are made by local dentists via the Local Health Board. Historically some GDPs carried out simple orthodontic treatments on advice from their local consultant, but the British Orthodontic Society explained in their written submission that this has largely disappeared with the new dental contract. Most orthodontic treatment is carried out on referral from GDPs and, as such, they are the gatekeepers of the service. The Committee heard that, to be effective in this role, GDPs need training in the application of the Index of Orthodontic Treatment Need (IOTN). The IOTN is used to assess the need and eligibility of individual cases.

51. Witnesses generally agreed that the introduction of the IOTN had been positive, leading to better targeting of orthodontic treatment by the elimination of mild cases under treatment. However, several witnesses, including the British Orthodontic Society, stated that:

> "GDPs generally have a poor understanding of the system and tend to be 'one stop' rather than discerning referrers."[25]

The Committee was told that this has led to an increase in the number of inappropriate referrals to specialist practices and hospital departments.

52. Witnesses were also concerned that pressure from parents means that some GDPs are referring patients inappropriately. According to the National Public Health Service, there is a significant proportion of patients who are being assessed that probably do not need to be. The British Orthodontic Society said it was important that GDPs should be better educated at university, including at undergraduate and postgraduate level, and through continuing professional development:

[25] Health, Wellbeing and Local Government Committee Paper, Inquiry into Orthodontic Services in Wales; Evidence from Paper British Orthodontic Society, p.6

> "Speaking as an orthodontist, I would love for IOTN training to be mandatory for general dental practitioners, but it is not. There are some things that they have to do: they have to do cross-infection and various other aspects that are a requirement of their continuing professional development; training in IOTN is not one of them."[26]

Professor Richmond representing Cardiff University School of Dentistry did not agree that this is necessary for all practitioners:

> "I run courses every year for practitioners on the index of treatment need, and most of the orthodontists will be very familiar with the index, and some of them will be calibrated. I do not think it is necessary for all practitioners to calibrate, but the practitioners should be aware of how it is done. The way that I do it, and I have recently done stuff for Ireland and Holland, is to train the key people and then they cascade it down. That is the way it is done."[27]

53. Some witnesses suggested that GDPs should be fined for making inappropriate referrals, stating that this would act a disincentive to them making early or inappropriate referrals.

Dentists with a Special Interest (DwSIs)

54. The Committee heard that DwSIs have an important role to play in improving access to orthodontic treatment. The Welsh Consultant Orthodontics Group stated in written evidence that, especially in rural areas,

> "consideration should be given to recruiting suitably trained DwSIs to work under the supervision of a Consultant, although the ultimate goal is to improve access to care by attracting specialist practitioners to rural areas."[28]

---

[26] RoP, [para 40-47], 22 September 2010, Health, Wellbeing and Local Government Committee
[27] RoP, [para 154-155], 3 November 2010, Health, Wellbeing and Local Government Committee
[28] Health, Wellbeing and Local Government Committee Paper, Inquiry into Orthodontic Services in Wales; Evidence from the Welsh Consultations Orthodontics Group, p.3

The Committee heard that attracting DwSIs to rural areas is particularly important given the difficulties in attracting specialist practices to rural areas and that the current level of orthodontic provision is insufficient. However, the Local Health Boards explained that DwSIs can be expensive in comparison to specialist practices and suggested that there might be better ways to improve access for patients.

Orthodontic therapists

55. Orthodontic therapists are trained dental nurses who undergo an additional, largely work-based, one-year training programme. They are trained in many of the manual skills of an orthodontist but not diagnosis or case management.

56. There appeared to be a general consensus among witnesses that orthodontic therapists are a welcome addition to the orthodontic workforce. Most clinicians, for example, said they could help to increase orthodontic provision and reduce costs, though they are a relatively new addition to the orthodontic workforce. Specifically, Professor Richmond representing Cardiff University School of Dentistry highlighted the importance of orthodontic therapists in addressing the shortfall in orthodontics through retirements in future years. He also stated that improving the skills mix among orthodontics was important.

57. A number of witnesses, including the British Orthodontics Society and Orthodontic National Group raised some concerns about the role of orthodontic therapists in orthodontic treatment, particularly that the legislation in this area is too vague. Witnesses expressed concern about the fact that therapists can be supervised by any dentist, which they argue could lead to poor supervision of therapists.

Minister's View

58. On inappropriate referrals, the Minister told Committee that it is clear that the number of people receiving orthodontic treatment has increased considerably over the last decade and that the proportion of spend in terms of the total dentistry budget that local health boards have is also increasing. The Minister accepted that work is needed to improve the awareness among patients of the assessment criteria for NHS treatment, and said:

> "I think that we all need to be involved, from practitioners to the local health boards, and Assembly Members also need to be aware of it so that we can advise when we get queries from our constituents."[29]

Recommendations

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.

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.

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.

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

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

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.

[29] RoP, [para. 279], 3 November 2010, Health, Wellbeing and Local Government Committee

6. Monitoring standards for delivery and outcomes of care

59. Orthodontics as a profession uses the Peer Assessment Rating (PAR) Index to assess the quality of care for their patients and to monitor outcomes. There was a general consensus among witnesses that with the advent of new orthodontic providers such as DwSIs and Orthodontic Therapists, it is particularly important to monitor the quality of treatment. Witnesses generally agreed that more emphasis should be placed on monitoring quality of care and patient satisfaction. It was also felt that Health Boards should be encouraged to ensure that sufficient time is taken to teach and train all grades of staff to ensure quality and consistency of care.

60. It was felt by many witnesses that Local Health Boards need to be better at monitoring PAR scores. Some witnesses suggested that primary care outcomes are variable and that PAR scores are not always accurate. Several witnesses felt that an independent method of measuring this was needed. Professor Richmond told Committee:

> "When you measure your own cases, you tend to be favourable, and when you measure other people's cases, you tend to be more stringent. So, the idea is to have an independent assessor."[30]

Minister's View

61. The Acting Chief Dental Officer for Wales told committee that orthodontics' contracts include the peer assessment rating index to measure quality of treatment.

Recommendations

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).

[30] RoP, [para 135], 3 November 2010, Health, Wellbeing and Local Government Committee

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.

Annex A - Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/bus-committees-third-hwlg-agendas.htm

Wednesday 22 September 2010	
Pamela Stephenson	British Orthodontic Society
Peter Nicholson	British Orthodontic Society
Wednesday 6 October 2010	
Dr David Thomas	Consultant in Dental Public Health, Public Health Wales
Dr Hugh Bennett	Consultant in Dental Public Health, Public Health Wales
Professor Jeremy Knox	Consultant Orthodontist, Abertawe Bro Morgannwg University Health Board
Emma Proctor	Head of Primary Care, Aneurin Bevan Health Board
Wednesday 20 October 2010	
Janet Robins	Chief Executive, The Orthodontic National Group
Dr David Howells	Orthodontist
Wednesday 3 November 2010	
Professor Stephen Richmond	Professor in Orthodontics, Cardiff University School of Dentistry
Edwina Hart AM	Minister for Health and Social Services
Andrew Powell-Chandler	Head of Dental Policy, Welsh Assembly Government
Dr David Thomas	Acting Chief Dental Officer for Wales

Annex B - Written evidence

The following people and organisations provided written evidence to the Committee in support of oral evidence. All written evidence can be viewed in full at:
http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/business-hwlg-inquiries/hwlg3-orthodontics/orthodontics_papers_transcripts.htm

Name	Organisation	Reference
Peter Nicholson	British Orthodontic Society	HWLG(3)-14-10 : Paper 1
Dr Hugh Bennett	Public Health Wales	HWLG(3)-15-10 : Paper 4
Professor Jeremy Knox Emma Proctor	Local Health Boards in Wales	HWLG(3)-15-10 : Paper 5
Janet Robins	The Orthodontic National Group	HWLG(3)-16-10 : Paper 4
Dr David Howells	Orthodontist	HWLG(3)-16-10 : Paper 5
Professor Stephen Richmond	Orthodontic sub-group Welsh Assembly Government	HWLG(3)-17-10 : Paper 2
Edwina Hart AM	Minister for Health and Social Services	HWLG(3)-17-10 : Paper 5

Annex C - Consultation Responses

The following people and organisations provided written evidence to the Committee as part of its public consultation. All consultation responses can be viewed in full at: http://www.assemblywales.org/bus-home/bus-committees/bus-committees-scrutiny-committees/bus-committees-third-hwlg-home/business-hwlg-inquiries/hwlg3-orthodontics/orthodontics_consultation_responses.htm

Name	Reference
Dr Byron Jones	HWLG(3)-OS001
Hospital Orthodontic Consultant Services across Betsi Cadwaladr University Health Board	HWLG(3)-OS002
Cliff Croft	HWLG(3)-OS003
Community Dental Service, Cardiff and Vale University Health Board	HWLG(3)-OS004
Welsh Consultant Orthodontic Group	HWLG(3)-OS005
Orthodontic National Group	HWLG(3)-OS006
Healthcare Inspectorate Wales	HWLG(3)-OS007
Dental School at Cardiff University, and Cardiff and Vale University Health Board	HWLG(3)-OS008
Cwm Taf Local Health Board	HWLG(3)-OS009
South East Wales Managed Clinical Network for Orthodontics	HWLG(3)-OS010
Rhys Birks	HWLG(3)-OS011
British Dental Association	HWLG(3)-OS012
Colin Sanders	HWLG(3)-OS013
Mr Dylan Lewis	HWLG(3)-OS014