Health, Wellbeing and Local Government Committee
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Inquiry into Orthodontic Services in Wales – Evidence from the Minister for Health and Social Services

Purpose

1. This paper outlines the background to the introduction of the current contractual arrangements for dentistry, the current pressures on the service, and the work being carried out to address orthodontic capacity concerns. It should be read alongside the Welsh Assembly Government commissioned independent review of orthodontic provision in Wales (annex A of this paper).

Background

2. From the early 1990s the provider driven system in operation left all dentists, including orthodontists, to decide where and what level of NHS service they would provide. As dentists drifted away from the NHS, service commissioners had no powers to seek alternative providers and the resources were not safeguarded for replacement dental services.

3. The system in operation prior to 2006 also saw orthodontics consuming high levels of NHS funding and the percentage year on year increases in orthodontic spend was well above that of other dental service treatments. Some of the cases treated were on the lower end of treatment need. Orthodontics continues to make up a significant proportion of the total expenditure on dental services for children.

4. In 2006 new contractual arrangements were introduced which saw three important changes in relation to orthodontics:
- They gave Local Health Boards (LHBs) power to commission services to meet local needs;
- There was a move away from a non-cash limited centrally held budget to a cash limited allocation to LHBs; and
- The introduction of the Index of Orthodontic Treatment Need (IOTN).

5. The previous system of dentistry had led to huge variations in the provision of orthodontic services, because (like other dentists) orthodontists could decide for themselves where to set up practice and how much work to do for the NHS. The new arrangements gave LHBs responsibility for the provision of dental care to meet local needs and for the control and accountability of their dental budget. It allowed LHBs to develop services based on local needs.

6. Orthodontic budgets, like other dental budgets, were constructed for 2006/07 on the basis of the LHB where the service is located. For orthodontic

services LHBs were encouraged to work jointly across areas in order to ensure services were commissioned that took into account the needs of patients regardless of the LHB in which they are resident.

7. Where an orthodontist's activity had been growing, and the new contract value did not reflect the volume of work being undertaken prior to the new contract, the LHB were asked to take into account the completion of all current cases. However, this did not commit the LHB to the same level of future activity, which would be a matter for local decision.

8. A key change was the introduction of IOTN into NHS practice which differentiates between dental health needs and cosmetic improvements, acting as a selector for NHS treatment.

9. In the past, there was often little consistency in the way that orthodontic needs were assessed. Under the new arrangements, all assessments are made using IOTN which provides a much fairer and more consistent way of assessing clinical need and defines the groups of patients for whom NHS orthodontic services treatment is considered necessary to secure their oral health.

Demand for orthodontic treatment

10. In the last decade the focus of a significant proportion of patients has moved from wanting to ensure their teeth are healthy and pain free, to a growing wish that they should also be cosmetically pleasing. This presents new challenges about where the boundaries should lie between clinically needed treatment - available for all who want it from the NHS - and cosmetic treatment.

11. Demand for orthodontic treatment has increased across the UK, and undoubtedly there are some social and cultural factors involved. Demand for orthodontic treatment can also be driven by requests from more affluent families, and some of this demand can have little health gain attached. Demand can also be driven up by the presence of Specialist (High Street) providers themselves.

12. The Welsh Assembly Government and LHBs also face spending pressures and orthodontic provision has to be placed in context with other dental health priorities. Total expenditure on orthodontics within primary care dentistry already makes up a significant percentage of the total funding of dental services. It is therefore vital that continued funding is based upon sound needs assessment, prioritisation and an integrated approach between the orthodontic dental service providers.

13. It has been shown that the public have clear preferences when it comes to funding priorities for different dental treatments. A study carried out by the Clinical and Applied Public Health Research Cardiff University Dental School in May 2008 showed the public placed check-ups and emergency treatment as more important than orthodontics or cosmetic treatment. Respondents

were provided with a list of dental treatments and asked to rank these in order of importance.

14. Check-ups and x-rays were ranked as most important followed by emergency treatment. Orthodontic appliances (braces) and cosmetic treatment were scored as least important. The study also showed that only half of respondents thought that orthodontic appliances should be provided free as is currently the case.

Current issues

15. I am aware of difficulties encountered by patients seeking orthodontic treatment in some parts of Wales and the reports of increased waiting times for treatment. There will be a number of reasons for this and I know that LHBs have been working to address on-going capacity issues in both the secondary and primary care orthodontic services.

16. Recruitment and retention has also been an issue for secondary care and specialist services in some rural areas.

Orthodontic review

17. In September 2009 I established an expert group, chaired by Professor Stephen Richmond, Professor of Orthodontics at Cardiff University School of Dentistry, to look at the provision of orthodontics in Wales. This was in response to reported difficulties and also follows a recommendation made by the NHS Dental Contract Task & Finish Review Group who highlighted orthodontics as an area requiring further consideration.

18. Membership of the Group included representatives of the dental profession, British Orthodontic Society, British Dental Association (Wales), specialist orthodontists, patient groups, Local Health Boards, and other key stakeholders. The aim of the review was to produce recommendations that would improve and enhance the provision and delivery of services.

19. I received the Group's report last month. It has been made available to dentists in Wales who provide NHS care, to Local Health Boards and other interested parties including Assembly Members. A copy is included as an annex to this paper.

20. The report reaches some interesting and challenging conclusions. In such difficult economic times it is encouraging that the group believe current spending on orthodontics in Wales – some £12.7 million annually – is capable of largely meeting the orthodontic needs of Welsh patients. The report also makes clear there is little unnecessary treatment undertaken, although there is a need for improved validation and further confirmation regarding the quality of services provided.

21. What also comes over clearly is that the current system of provision and management of orthodontic services in Wales contains inconsistencies and

inefficiencies. In addition access to services is not uniform. These need to be addressed and the report suggests this can be done through better procurement, contract/service management and skill mix while also achieving higher cost-efficiencies.

Key findings of the orthodontic review

- Currently 27% of the 12-17 year old population receive active orthodontic treatment in Wales.
- With effective commissioning current funding is capable of meeting the orthodontic needs of Welsh patients - however a small proportion of funding (7.5%) should be reinvested to facilitate modernisation, detailed management and support.
- Orthodontic care is provided for children by the General Dental Service /Personal Dental Service (82%), Hospital Dental Service (15%) and the Community Dental Service (4%).
- In 2008/09 there were 8,991 GDS/PDS orthodontic treatments undertaken.
- There are inconsistencies in the length of orthodontic contracts between LHBs and orthodontic providers, ranging between 3 and 7 years.
- There is a high proportion of “Assess and review” activity being undertaken with little resulting treatment.
- There is a large number of early referrals below 9 years of age, which is not uniform across Wales or LHB areas but appears to be practitioner specific.
- There are 135 practitioners providing orthodontic care in Wales.
- The orthodontic workforce is likely to be challenged due to retirements and changes in working practices. There are also workforce issues around training and skill mix.
- There appears to be little unnecessary treatment undertaken in Wales but the IOTN data is self reported and should be validated.
- There are waiting lists for treatment in all services and some interim funding may be required to clear this backlog of patients following waiting list validation.
- The system of provision and management of orthodontic services in Wales is largely inefficient and access to services is not uniform. Higher cost-efficiency can be achieved through better procurement, contract/service management and skill mix.

22. The report also includes 17 recommendations for consideration by the Welsh Assembly Government, LHBs and the dental profession. These include work around service development, changes to legislation, improving efficiency and effectiveness, along with better referral and monitoring.

23. I will be establishing a group to support implementation of these recommendations and to report annually on orthodontic services in Wales. Assistance will be provided by the Welsh Dental Committee and Public Health Wales. The Implementation Group will also address any additional issues identified by the Health, Wellbeing and Local Government Committee’s inquiry into orthodontics.

Conclusion

24. I have put in place a review, and an implementation process, to improve the provision of orthodontics in Wales. This is based on advice from clinicians.

25. With the current financial pressures facing LHBs and the wider NHS it is essential that the planning of NHS orthodontics is based upon assessed need and potential health gain. This is a challenging plan of work and it will be important to ensure that orthodontic services prioritise cases appropriately and that if treatment is undertaken that the patients benefit from the intervention.

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