

**Guides for  
commissioning dental  
specialties - Orthodontics**

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<b>Description</b>	This document is to be used by commissioners to offer a consistent and coherent approach. They describe the direction required to commission dental specialist services. They will improve dental care and outcomes for patients, ensure they receive the highest quality dental care in the most appropriate setting, by professionals with the required skills, whilst ensuring value for money.	
<b>Cross Reference</b>	This document should not be read in isolation and is part of suite of documents including; Guide for Commissioning Specialist Dentistry Services Introduction, Guide for Commissioning Oral Surgery/Oral Medicine, Guide for Commissioning Special Care Dentistry, Equality & Health Inequalities supplement	
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## 1 Foreword

NHS England produced the Five Year Forward View to set out a shared view of the challenges ahead and the choices about health and care services in the future; it applies to all services, including dentistry.

This consensus on the need for change and the shared ambition for the future is the context in which these Commissioning Guides for Dental specialties have been produced. Clinicians, Commissioners and patients have contributed to this work to describe how dental Care Pathways should develop to deliver consistency and excellence in commissioning NHS dental services across the spectrum of providers to benefit patients.

In order to deliver this vision and implement the pathway's 'a coalition of the willing', NHS England partners, HEE and PHE, specialist societies and others who have contributed to their development will need to respond in the implementation phase by unlocking structural and cultural barriers to support transformational change in dental service delivery.

It's a future that will dissolve the artificial divide between primary dental care and hospital specialists; one that will free specialist expertise from outdated service delivery and training models so all providers can work together to focus on patients and their needs.

These guides set out a framework and implementation and the pace of change will vary across England. This will be an iterative process; therefore, it will be necessary to review and update these guides regularly. However, implementation will require energy, brave decisions and momentum, together with a willingness to share good practice, innovation and learning, as it emerges, to accelerate the speed and impact of change to improve patient care.

## 2 Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

### 3 Executive summary

It is now widely recognised that the NHS needs transformational change to services, in order to promote health and deliver better outcomes for patients and ensure that we commission effectively.

Progress has been made in improving oral health and access to services in general. However, inequality in oral health experience and inequity in access to primary and specialist care exists. These guides focus on the commissioning and delivery of specialist Care Pathways; however, the gateway to specialist care relies on access to efficient and effective primary dental care services. Whilst there has been some improvement in general access over the past few years, Commissioners need to ensure that they continue to meet their duties to commission primary care services appropriate to the needs of their populations. This means making effective use of available resources by challenging primary care providers to deliver care to those who need it most and, by adopting appropriate recall intervals for those who can be seen less frequently, freeing capacity for access by new patients. Achieving improvements in access to primary care will widen access to specialist care for those who need it.

NHS England has developed these guides for commissioning dental specialties to be used by Commissioners to offer a consistent and coherent approach. They describe the direction required to commission dental specialist services. This will reflect the need and complexity of patient care and the competency of the clinician required to deliver the clinical intervention, rather than by the setting within which the care is delivered. Care will be delivered via a pathway approach which will provide clarity and consistency for patients, the profession and Commissioners. There will be nationally agreed minimum specifications for each service, including how quality and outcomes are to be measured, which can be enhanced locally.

They will ensure there is national consistency in the NHS commissioning offer for dental specialist services and how they are delivered. The pathway will also provide consistency across England in agreeing, at a national level, as much of the detail around commissioning; this includes referral criteria, core data set required on referral, quality of environment and equipment, contractual frameworks etc., as well as consistent measures of quality and outcomes. The frameworks describe the concept of clinical engagement and leadership through Managed Clinical Networks (MCNs) which will work closely with Commissioners, Dental Local Professional Networks (LPNs) and will describe and monitor the patient journey from primary care to specialist care.

The first phase of this work during 14/15 has included developing frameworks for the following specialties: Orthodontics, Special Care Dentistry, Oral Surgery/ Oral Medicine and Restorative dentistry. Further work on Restorative Mono-specialties, Paediatric Dentistry and Supporting Specialties (Oral Radiology, Oral Microbiology and Oral Pathology) will follow. This document provides a focus on Orthodontics and should be read within the context of the overarching introductory guide as this

highlights the concepts and principles and common challenges and solutions for all dental specialties.

NHS England is committed to working and engaging with patients, carers and the public in a wide range of ways. Throughout this process we have ensured that people's views are heard through having patient representatives on every group and by convening a patient review group, who have helped us develop the content. This is outlined in detail in the patient engagement and stakeholder engagement appendices, in the overarching guide.

Moreover, it must be understood that ultimately it is the patient who should make the decision about what treatment, if any, to undergo. The practitioner's role is to advise on treatments and options, and benefits and risks. This discussion between patient and practitioner should form the beginning of every patient journey and every specialist care pathway. That includes patient consent to the information sharing needed for their journey along a pathway.

The process of developing these patient involvement frameworks has also included engagement with every stakeholder group that has an interest in dentistry, as outlined in the acknowledgments, stakeholder engagement appendix and governance model in the appendices.

This is the beginning of a process. Locally, Commissioners need to undertake work to understand the specialist services that are currently being provided, by who and where. The quality and quantity of those services, together with the impact and cost, need to be identified before any change or procurement takes place. Many Commissioners and clinicians have already made progress on aspects of this approach locally. However, they need to measure themselves against the enablers within each of the guides to understand what needs to happen next and agree local priorities. Commissioners need support to identify current dental resources, to allow flexibility locally, so decisions can be made, for example, in establishing MCNs that may require investment or flexibility in contracting, such as the use of Commissioning for Quality and Innovation payments (CQUIN). The work of developing the commissioning guides has identified a number of examples of innovative solutions and exploiting flexibility in current contracting forms. Locally, Commissioners will need to consider investment and contractual flexibility to support the implementation of new Care Pathways. The implementation of Care Pathways could deliver efficiency gains in some areas; however, there may be a need to consider the use of these savings as investment to pump prime change in other areas of dentistry. The next phase of this work could support the validation and sharing of solutions to harness and communicate examples of good practice and innovation. Some of the identified enablers will be more difficult to implement at a local level; however, NHS England could support identified enablers to become a reality at a national level. An example would be expanding the use of the NHS number within dentistry.

There will be a particular emphasis on helping Commissioners to understand the financial impact of implementing the commissioning guides, to provide an estimate for the associated upfront costs along with any expected financial savings to the NHS. The initial work will involve needs assessment, understanding current



provision, enabling consistent data collection and coding. Implementation support will include the development of a commissioning pack to encourage effective and consistent commissioning to benefit patients. Work on an additional set of guides will also take place during this phase, focusing on Paediatrics, the Supporting Specialties (Radiology, Oral Microbiology, Oral Pathology) and further detail on Restorative mono-specialties (Endodontics, Periodontics, Prosthodontics).

An implementation phase will include supporting Commissioners to identify what could and should be undertaken nationally or regionally, and what should be supported by the Commissioning Support Unit locally. However, the first steps for Commissioners on the release of these first four strategic specialist commissioning guides will be to review current local progress against the frameworks and pathways, to assess local priorities, and agree what enablers need to be put in place, such as establishing clinical networks and referral processes.

Commissioners need to be aware that the effective implementation of needs-led dental specialist Care Pathways relies on maintaining and ensuring access to effective primary dental care services, particularly for those groups in the population who do not access care routinely or have additional needs. Producing these guides is the first step in what is intended to be an iterative process. The Commissioners who need to procure services in this transition can use the guides to complete needs assessment, set minimum standards and service direction and ensure that proposed outcomes and quality measures are included in service specifications. The guides, including the accompanying overarching introductory framework, can be made available to potential bidders. Tendering providers will need to include a statement in their submissions on how they will work with Commissioners to comply with the requirements of the guides.

Commissioning the new pathways is intended to ensure improved access and quality.

## 4 What is Orthodontics?

### 4.1 Description of the speciality

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

### 4.2 Description of the national picture

Orthodontic care includes the provision of advice and education for patients, parents and other health-care professionals. It includes monitoring the development of teeth and providing interceptive measures, with appliances where appropriate. The majority of Orthodontic work is carried out with removable and fixed appliances when all the deciduous teeth have been lost. In certain situations, input from other disciplines is required, such as Restorative/ Paediatric dentistry (patients with missing or damaged adult teeth), or Maxillofacial and Oral Surgery (to manage impacted teeth or significant jaw discrepancies beyond the scope of correction with braces alone). Additional support services for complex multi-disciplinary treatments, such as management of patients with cleft lip and palate, facial deformities or syndromes may be required.

The Index of Orthodontic Treatment Need (IOTN) is a clinical assessment of malocclusion severity utilised within the NHS to select those individuals who would benefit most from Orthodontic treatment. The majority of NHS Orthodontic treatment above IOTN 3.6 is supervised or carried out by specialists.

Specialists will frequently operate a team approach to Orthodontic care with the support of primary care practitioners, Orthodontic therapists and Orthodontic nurses working under their supervision.

The distribution of service providers at all levels will differ across NHS England. Care Pathways should reflect need and local patient flows. They may look different across NHS England, due to the current distribution of skills across primary and secondary care.

### 4.3 Description of the workforce and training

Dental undergraduate training takes five years in the UK, following which, newly qualified dentists are able to register with the General Dental Council (GDC). They are required to undertake a twelve month period of Dental Foundation Training (FD) in the NHS in order to acquire a NHS performer's number.

Training in Orthodontics, at both undergraduate level and during FD, is focussed on diagnosis, assessment of treatment need and appropriate referral. Contemporary teaching in Orthodontics at this level rarely includes the delivery of treatment. Consequently, post FD, dentists will not have the required competencies to provide Orthodontic care without further training.

#### **4.3.1 General Dental Practitioners (GDP)**

On completion of FD, a GDP should have the skills to monitor the developing occlusion and recognise a malocclusion. A GDP should be familiar with the use of IOTN and be able to determine the suitability and commitment of a patient in order to support the Orthodontic referral decision to a specialist. A GDP should have the competency to manage the patient's oral health during and following Orthodontic care, including maintenance of patients' post Orthodontic treatment.

#### **4.3.2 Dentists with Enhanced Skills and Experience**

Dentists with enhanced skills and experience have undertaken additional training to develop further competencies. There is a wide variation among individual practitioners of additional experience, qualifications and training undertaken.

#### **4.3.3 Specialists**

The award of the certificate of completion of specialty training (CCST) is the responsibility of the General Dental Council (GDC). A CCST is awarded to a trainee who has been allocated a national training number (NTN) by open competitive appointment to a training programme approved as leading to the award of a CCST and who has successfully completed that programme.

Training currently takes place in secondary care, in dental hospitals and Orthodontic units in District General Hospitals. Registered specialists can provide a full range of treatments within the competencies defined by the Curriculum of Specialist Training. Some provide this treatment themselves but some also provide the treatment as part of a team utilising dentists with enhanced skills and experience and/ or Orthodontic therapists. Some specialists train outside the UK, but may be eligible to work in the UK; they will need to satisfy the GDC that they meet the requirements to be registered as a specialist in the UK.

#### **4.3.4 Consultants**

Orthodontic treatment, in certain situations, may require a multidisciplinary team approach and this is often more appropriately offered by an individual at Consultant level. Currently, this service is offered in a secondary or tertiary care setting in a Dental Hospital or a District General Hospital. Such patients may be those with a cleft lip and palate or other facial deformity that requires corrective treatment, often involving surgery; complex restorative cases with multiple missing teeth may also require such a multidisciplinary team approach. Such treatment is usually Consultant-led and forms the basis for the centres for specialty training. Specialists who wish to become Consultants in Orthodontics require a further two years training beyond their specialty training. During this period, trainees are required to achieve additional competencies in specific areas such as complex multidisciplinary care, leadership and training, not encountered during the three year specialty training programme. Entry to this additional period of training is competitive. Completion of training is marked by passing the Intercollegiate Specialty Fellowship Examination (ISFE) awarded by The Royal College of Surgeons (RCS) and satisfactory completion of all Annual Review of Competence Progression (ARCPs).

#### **4.3.5 Orthodontic Therapists**

Orthodontic therapists are members of the Orthodontic treatment delivery team and work under the guidance of a dentist or specialist. The GDC qualification for

registration is the Diploma in Orthodontic Therapy. Orthodontic therapists can work in primary and secondary care and require treatment prescriptions with continuing supervision throughout delivery of a Care Pathway. Orthodontic therapists cannot undertake treatment planning and, at decision-making appointments, direct accessible supervision must be available to Orthodontic therapists.

#### **4.4 Description of the complexity levels**

There are several factors which need to be considered when describing the complexity level of an Orthodontic case. These include the type of malocclusion, technical difficulty in improving function and aesthetics, together with any patient modifying factors.

##### **4.4.1 General Principles**

- Orthodontic treatment should only be undertaken in situations where it is believed to be in the patient's best interests in terms of their oral health and/ or psychosocial wellbeing.
- In all situations, the clinical advantages and long-term benefits of Orthodontic treatment should justify such treatment and outweigh any detrimental effects.
- Patients will only be offered one course of NHS-funded routine Orthodontic treatment, unless there are exceptional circumstances. Such cases include where interceptive or growth dependent treatment has been undertaken and IOTN remains greater than 3.6. Any patient not meeting these circumstances would need to apply via their Commissioner who will seek clinical advice from either their dental LPN or MCN to approve a second course of treatment. There may be occasions when an appliance has to be removed during a course of treatment to allow a patient to undergo other procedures such diagnostic services. Recommencing treatment would not constitute a new course of treatment.

##### **4.4.2 General patient factors**

The clinician should ensure that the co-operation, motivation, aspirations and general health of the patient are consistent with the provision of Orthodontic treatment, particularly their ability to maintain good oral hygiene to ensure no harm is done. They should also ensure that the patient and carer are willing and able to commit to frequent attendance, which may be during school hours, over the course of Orthodontic treatment and are aware of the need to wear appliances. The exception to this is patients requiring assessment for interceptive extractions or advice only.

##### **4.4.3 Patient's oral environment**

The clinician should ensure that an oral health assessment/ review has been carried out and that the information collected and the risks identified are reviewed and shared with the patient before entering treatment.

It is not generally in the patient's best interest to plan and deliver Orthodontic treatment in the absence of a stable oral environment when the risk of dental disease is high.

#### **4.4.4 Clinically feasible and beneficial**

Finally, the detailed clinical aspects of the proposed Orthodontic treatment should be considered to ensure that it will be beneficial to the patient.

#### **4.4.5 Complexity Descriptors**

##### **Level 1:**

Treatment and care undertaken in NHS primary dental care mandatory contracts and NHS England commissioning expectations of care provided.

##### **Level 2:**

Treatment undertaken by practitioners, under specialist supervision and with a formal link to a consultant-led MCN. This includes dentists who have enhanced skills and/ or experience; non-specialists who have demonstrated the competencies detailed in the Curriculum for the Primary Care Dentist with a Special Interest in Orthodontics, either by obtaining the Diploma in Primary Care Orthodontics or by demonstrating equivalence.

##### **Level 3a:**

Treatment undertaken by practitioners who are on the Specialist List for Orthodontics with a formal link to a consultant-led MCN. This is predominantly primary care treatment which could be delivered in either a primary care or secondary care setting.

##### **Level 3b:**

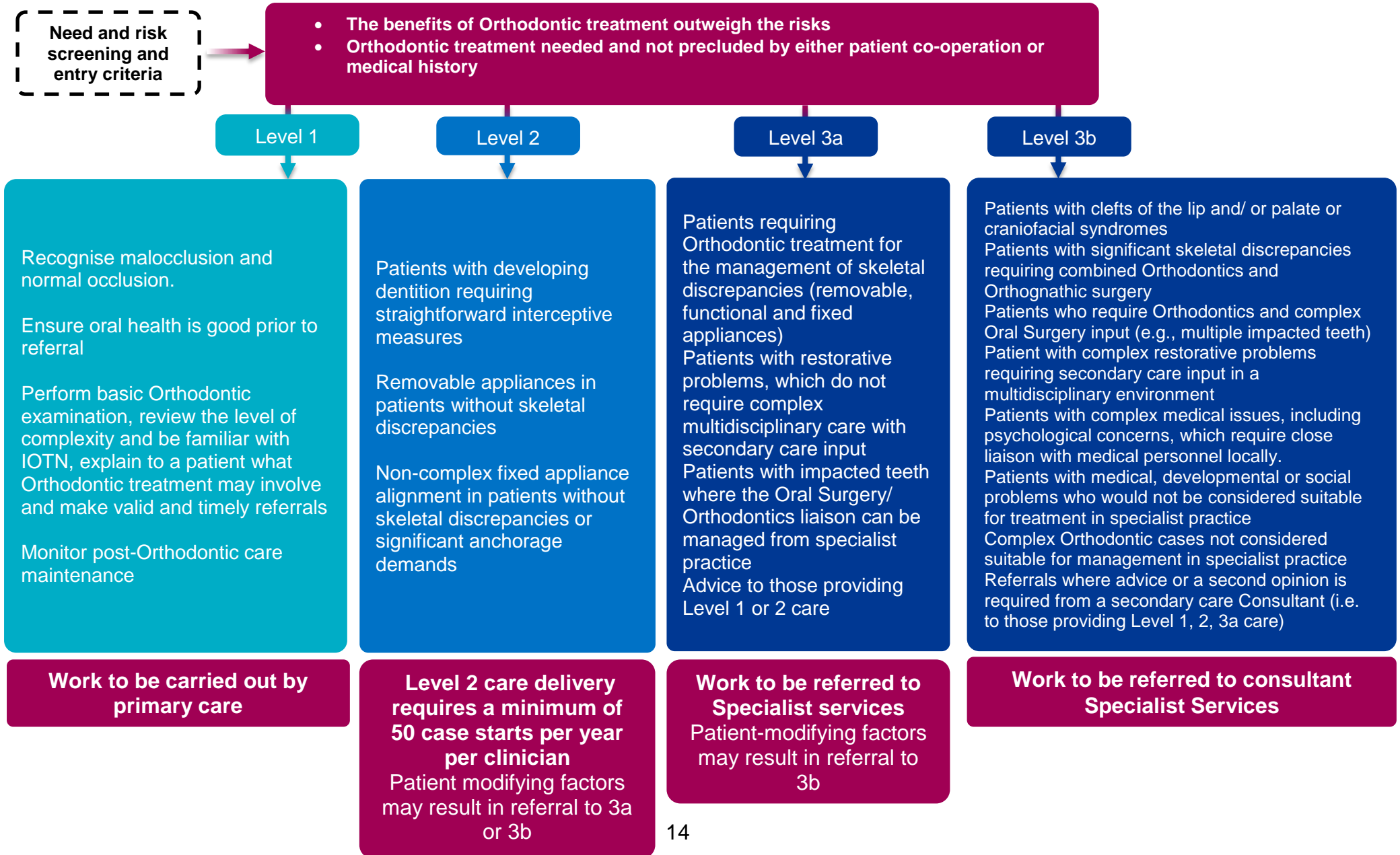
Treatment undertaken by practitioners who are on the Specialist List for Orthodontics and have undergone an approved period of further post-specialist training or who can demonstrate equivalence. Level 3b Orthodontic treatment is generally delivered within a secondary care setting.

NB - The present curriculum was introduced in September 2010 and, therefore, the above criteria should be interpreted with that in mind.

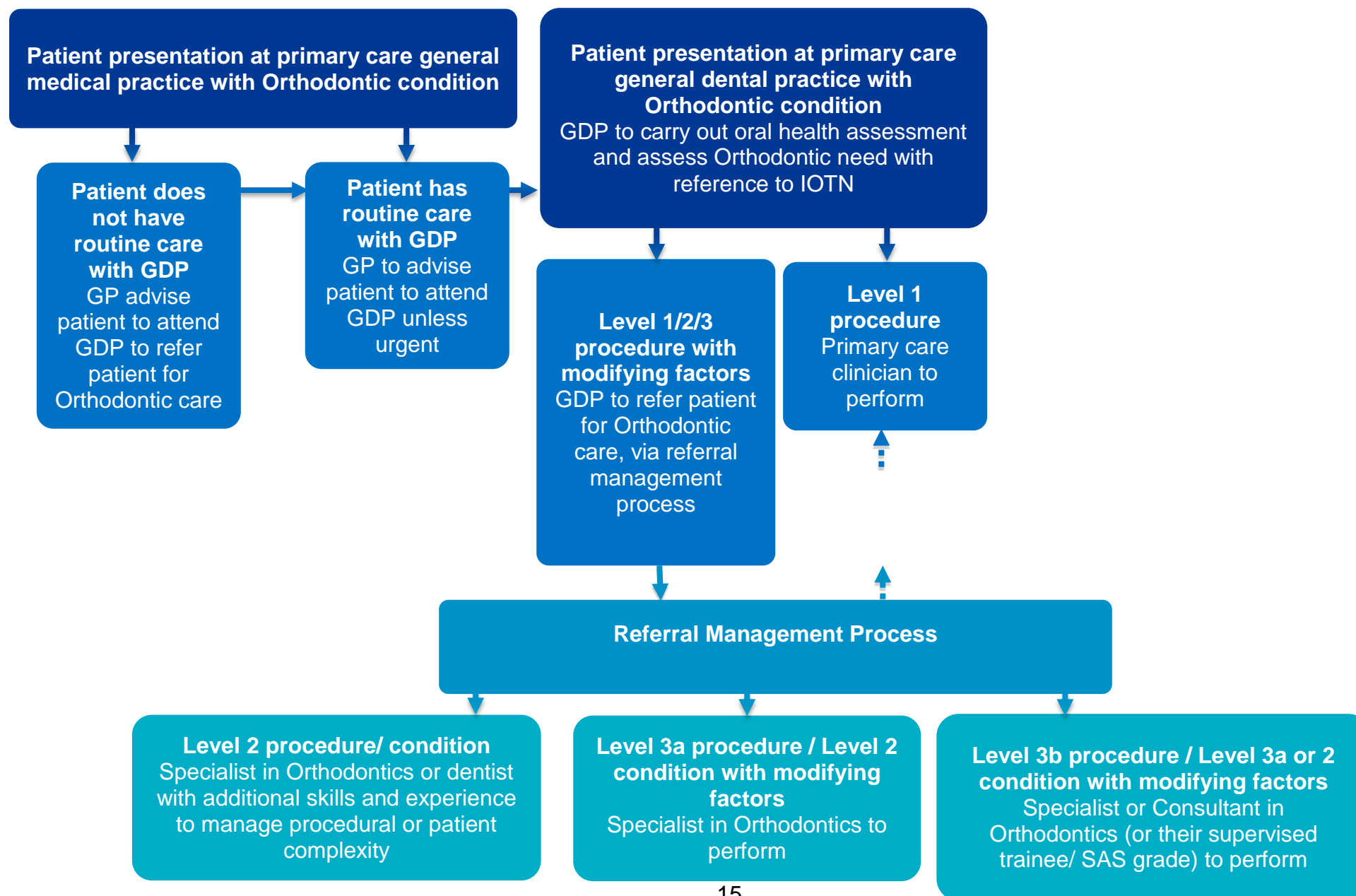
The level of complexity may change depending on one or more of the following factors:

- Medical History
- Social Factors
- Patient anxiety
- Other patient-associated modifiers

# COMPLEXITY ASSESSMENT – ORTHODONTIC TREATMENT



## 5 Summarised illustrative patient journey



## 6 Assessing need

### 6.1 Population

Measuring Orthodontic treatment need is an essential component of any commissioning cycle. Commissioners should seek assistance from Public Health England (PHE) Consultants in Dental Public Health to complete Orthodontic needs assessments.

This section offers a skeleton outline of the process. Understanding need is not an exact science, and data including local demographics, patient views and current service impact, need to be triangulated to give best estimate and reflect population changes.

There are three main elements to assessing Orthodontic treatment need.

- Normative need – the professionally-judged need in a population cohort using a standardised clinical index such as IOTN. This represents the capacity to benefit from healthcare.
- Expressed need – patients with need presenting for treatment.
- Demand – felt need – a patient’s perception of need. This is generally a poor proxy for need and often reflects supply.

Undertaking population Orthodontic needs assessment and reviewing existing service provision to meet the need is part of the process and, as a minimum, should include:

- an audit of current providers and their service and contract delivery performance
- an assessment of whether local Orthodontic services are sufficient to serve the population and are currently in the right locations

The purpose of assessing Orthodontic treatment need is to determine if sufficient effective Orthodontic care is currently commissioned for the local population and if population projections will alter this needs assessment over the coming years. An assessment of the need for Orthodontic services is necessary to inform long-term decisions on the future of Orthodontic contracts.

#### 6.1.1 Quantification of need for Orthodontic treatment

In 2008/9 an NHS epidemiological oral health survey of 12 year old children was undertaken across England. As well as surveying oral health, Orthodontic need was also assessed, giving for the first time a PCT-based epidemiological Orthodontic needs assessment. The examiners were all calibrated with a Regional and National standard and trained in IOTN assessment. The defining level for identifying Orthodontic need to be present was a Dental Health Component (DHC) IOTN score of 4 or above (the same level used in the 2003 National Child Dental Health Survey) and/ or an Aesthetic Component (AC) of 8 to 10.



The survey shows the amount of normative need. The population representative sample indicated that the prevalence of Orthodontic clinical need is between 30.5% & 33% of the population. The range is wide, but includes prevalence levels that have been found from previous research. Children with poor oral hygiene or active caries were included in the assessment.

There are a number of methods for assessing need; however, published studies and surveys have consistently reported that around one third of children, in any given population, will need and want Orthodontic treatment. Demand is rising as the health and expectations of the population improve. Commissioners need to know the demographics and views of their 12 year old population and assess if there are any changes in planning and developing services.

## 7 Understanding current provision

Currently, Orthodontic services are largely provided by specialist practitioners operating within primary care. As well as specialist primary care services, there are providers in primary care who provide Orthodontic services as part of a mixed contract under general dental services. Orthodontic services are also provided in secondary care for complex cases and the provision of training. As well as the NHS, there is a growing private market for the provision of services, particularly for adults.

Orthodontic services are in the main provided to children and adolescents. The Index of Orthodontic Treatment Need (IOTN) is the criteria by which clinical need is assessed. This is currently set at IOTN 3.6 or above for NHS eligibility; however, the requirement for a patient to have excellent oral hygiene, want care and be prepared to commit to the demands of treatment are as important.

Under current arrangements, it is largely the referring GDP who determines if, where and when a patient is referred. This is usually based on historic arrangements and primary care dentists are sometimes under pressure from patients and their parents to make a referral to specialist services even when clinical conditions are not ideal. Commissioners report that long lists of referrals awaiting assessment have developed in some locations. This can result in early referrals being made, making it difficult for Orthodontic providers to prioritise need and identify cases which require early intervention. These waiting lists for assessment perpetuate primary care providers' behaviour to refer too early to ensure their patients reach the top of the waiting list at the optimum time for treatment to commence. As a result, some Orthodontic providers are using commissioned units of Orthodontic activity (UOAs) for assessing unsuitable referrals and repeat reviews, rather than directing this resource to new case starts.

Most recent service data trends from the NHS Business Services Authority (NHSBSA) FP 170 returns suggest the Orthodontic clinical community, working with Commissioners and public health, have made progress in addressing this issue in many localities. In the past year, assessment types altered, the assessment to review reduced and assessment to accept increased. This is a good example of system changes, clinical, public health and Commissioner partnerships working to benefit patients and increasing capacity of services within existing resources.

When patients do receive care there is evidence that they are satisfied with the care that they have received. However, this element of information is generally collected at treatment start and before patients have experienced care. Improved clinical outcomes are reported in the majority of Orthodontic contract delivery through requirements of Peer Assessment Review (PAR) scoring. PAR scoring is undertaken on a sample of patients; therefore, outcomes of care and scores are not routinely collected or reported.

## 7.1 Service analysis

### 7.1.1 Primary care Orthodontic services in England

There were 1109 primary care contracts open in England during 2013/14 that included Orthodontic activity. There is a mix of Personal Dental Services (PDS) Orthodontic agreements and General Dental Services (GDS) general and Orthodontic contracts. Table 2 below illustrates the estimated budgets/ contracted UOAs for primary care Orthodontic services in England.

**Table 2. Contract values, contracted UOAs and mean UOA values. Source: NHS BSA Vital Signs (Dec '13)**

	Contract Value (PDS only)	ALL Contracted UOAs 2013/14 (PDS and GDS)	Mean UOA value (PDS only)
<b>REGION: NORTH</b>	<b>£56,259,842.78</b>	<b>1,094,583</b>	<b>£59.62</b>
<b>REGION: MIDLANDS AND EAST</b>	<b>£66,951,667.50</b>	<b>1,349,766</b>	<b>£60.93</b>
<b>REGION: LONDON</b>	<b>£34,372,187.69</b>	<b>610,228</b>	<b>£62.89</b>
<b>REGION: SOUTH</b>	<b>£60,066,855.02</b>	<b>1,072,476</b>	<b>£60.82</b>
<b>England TOTAL</b>	<b>£217,650,552.99</b>	<b>4,127,053</b>	<b>£60.38</b>

In addition to the activity commissioned through PDS agreements, there are 571,619 UOAs that are contracted through GDS mixed contracts. The range of values for UOAs in these contracts is £15.17 to £80.19. Some of this range can be attributed to the fact that not all activity type costs are separated in blended contracts. The actual value will need to be determined by Commissioners to contribute to their local Orthodontic needs assessment.

### 7.1.2 Hospital Orthodontic services

A recent needs assessment, carried out in Greater Manchester, estimated an annual spend in secondary care for Orthodontic services of £3.6M (based on available 6-month data). Commissioners in London estimated an annual cost across the London region of £12.6M for secondary care. Data collection and costs accrued in the provision of orthodontic services by Trusts is an area that needs significant for improvement. We will need Trusts to work closely and transparently with Commissioners in order to accurately report actual hospital based orthodontic activity and costs if we are to formulate a true picture of this area of Orthodontic needs.

Table 3 below shows Orthodontic activity within secondary care between April 2012 and November 2012 for treatment function code 143 as a regional level summary of the percentage of Orthodontic activity within dental secondary care specialist outpatient activity.

**Table 3: Source: Orthodontic outpatient activity as a percentage of secondary care dental outpatient activity.**

North	Midlands and East	London	South	England
25%	27%	24%	34%	27%

### **7.1.3 Matching need to capacity**

It is necessary to determine whether commissioned capacity is meeting need. This can be estimated by dividing the total contracted level of UOA activity by 21 (the number of UOAs per course of treatment) to provide an estimate of the number of case starts available in primary care. It is recognised that methods of assessment of capacity require updating, particularly for secondary care. In areas where mature contracting arrangements with validated waiting list management processes in place, there is still an apparent mismatch of capacity and expressed need. Until a more appropriate method of assessing capacity is developed, it is suggested that the current resources allocated to Orthodontics (across PDS contracts, GDS contracts and within secondary care) should be maintained.

The use of a referral management process would allow Commissioners to better understand the need for specialist Orthodontic care, the level of care at which treatment needs to be provided and where this care needs to be located. A local referral management process would also identify where patients are being referred from, so demand can be managed better and resources directed to those who need care the most.

Commissioners will need to assess their local need and demand against available resources and commissioned activity so they can understand and address any variance.

## **7.2 Quality and effectiveness**

This guide has been produced to promote consistent value and quality of specialist Orthodontic care provision to patients in England. There are inefficiencies in the system, such as long lists of patients referred awaiting assessment, incomplete courses of treatment and cases of unnecessary referrals to secondary care. This commissioning guide is intended to provide a better understanding of these issues and ways to release resource and use it more effectively. It is intended to support a system change. Use of this guide, in conjunction with the accompanying overarching introductory framework, encourages Commissioners and Orthodontists to work together to ensure that resources invested by the NHS in specialist care are used in the most effective way, provide the best possible quality and quantity of care for patients, and meet need rather than serve demand.

Value is not a short-term cost reduction, but it describes the optimum patient outcome for a given investment. In Orthodontic contract terms this can be described as achieving the greatest number of case completions with improved PAR scores within a provider's contract value. For Orthodontic service provision this means directing much of the available resource for the completion of cases to a primary care setting, ensuring that only those patients with greatest complexity are referred for care within a secondary care setting (taking account of training requirements).

During transitional phases it may be necessary to consider current geographic provision, as care may not be locally available in a primary care setting and patient access needs to be maintained. It also means ensuring that the system does not use resource to manage referrals that are not valid for specialist care because they have, for example, been referred too early, do not meet IOTN criteria, or are unsuitable.

As responsible clinical stewards, Orthodontic specialists can assist in leading change and provide a more effective use of constrained resources by broadening their influence within a MCN with primary care clinicians and other specialist providers to ensure that referrals are timely and valid and Orthodontic care is delivered effectively and efficiently.

### 7.3 Outcomes

Orthodontics is one specialty where a clinical outcome measure has been developed and is in use in both primary and secondary care. The PAR index is a fast, simple and robust way of assessing the standard of Orthodontic treatment that an individual provider is achieving.

The PAR index is primarily designed to look at the results of a group of patients, rather than an individual patient, as there are always a small number of patients where the index does not fully represent the result obtained. However, only a sample is collected and for its use to be accurate and reproducible, any individual completing PAR scoring service must be trained and calibrated.

As individual patient outcomes may be influenced by many factors, it has been proposed that an appropriate quality standard would be that 75% of completed cases should exhibit a reduction in PAR score greater than 70%, with 3%, or fewer, completed cases having a reduction in PAR lower than 30%<sup>1</sup>. Other PROMs and PREMs should also be used to assess the quality of patient care.

There is a need to develop and validate a measure of impact of Orthodontic care on a patient. Eastman and Sheffield academic units and the British Orthodontic Society (BOS) are currently working on this.

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<sup>1</sup> McMullan R E, Doubleday B, Muir J D, Harradine N W, Williams J K 2003 Development of a treatment outcome standard as a result of a clinical audit of the outcome of fixed appliance therapy undertaken by hospital-based consultant Orthodontists in the UK. British Dental Journal 194: 81 – 84

## 8 Transforming services

### 8.1 Current models

The following bullet points summarise the current models of care operating for the provision of Orthodontic services and have been discussed previously in the guide.

- GDPs decide where and when to refer a patient.
- Service provided in primary and secondary care settings.
- IOTN used to determine access to NHS-funded Orthodontic treatment.
  - Primary care: IOTN 3.6 and above
  - Secondary care: usually IOTN 4 and above
- Variable local referral pathways used with no national agreed Care Pathway.
- Specific factors influence where patients are referred including:
- General and available access to primary dental care
  - Historic referral patterns/ local Care Pathways
  - Patient satisfaction/preference
  - Geography (transport links) and availability of Orthodontic services
  - Teaching needs e.g. postgraduate and undergraduate programmes
  - Contracts and available resources (primary and secondary care)
  - Care and delivery is dependent upon access to services, experience and knowledge of GDPs.
- Specialty partnerships in place through local MCNs/ LCNs, but specific management/ effectiveness of these differ from region to region.
- Sample PAR outcome not routinely reported and cases are selected by providers
- Patient satisfaction collected and reported at case starts in primary care.

### 8.2 Current challenges

Commissioners and clinicians have identified a number of challenges in current contracting and service delivery:

- Contract regulations assign 21 UOAs on a case start
- No incentive to complete cases or robustly follow-up case abandonments
- No formal method of contracting for advice only service
- Referrals that are not valid utilising specialist resource to 'assess and review' and 'assess and refuse'.
- Perception that referrals for assessment are waiting lists
- New process required to more effectively manage 'transfer' cases
- Process required to manage contract close downs and transfer care to a new provider on block
- Process required for facilitating new entrants to the market
- Relatively short-term contracts
- Procurement rules and length of process
- Skills and resources to complete accurate needs assessment
- Performance management
- Benefits of skill mix to all: patients, providers and Commissioners
- Activity coding issues in secondary and primary care

- Lack of use of NHS number as patient identifier makes tracking patients and validating multiple referrals difficult.
- Addressing current 18 weeks issues with 'waiting lists' in primary care

### **8.3 Current Workforce model**

- Primary care setting:
  - GPs
  - Dentist with additional enhanced skills and experience
  - Specialist Practitioners
- Secondary care setting: Consultant-led Hospital Service (Consultant, Specialty Doctors and StRs)
- Therapists
  - Work in both primary and secondary care setting

## 9 Service redesign

The bullet points below set out the vision for the longer-term provision of Orthodontic care. There are many of these which Commissioners can be progressing now, creating and testing solutions which could be shared nationally. However, some elements will require agreement, validation and support at a national level before whole scale implementation. The establishment of MCNs for Orthodontics will allow clinicians to shape and influence service redesign by working with Commissioners and patients. In developing, redesigning, procuring and monitoring services, arrangements should be made to involve patients, carers and the public, and the organisations that advocate for them including HealthWatch. See Appendix 2.

- Single point of entry to Orthodontic services
  - Referral management process
  - Agreed minimum data set in which all practitioners have received appropriate training in making valid referrals (including use of IOTN, importance of good oral hygiene and suitability of patient).
  - Greater use of IT to allow use of NHS mail and NHS number
- Agreed standards for waiting times both for assessment, advice and treatment 'starts' from optimum treatment time.
- Use of a nationally agreed Care Pathway to take into account:
  - Population and Geography
    - Provision for freedom of movement and choice for patient, including the opportunity for second opinions.
    - Needs-led procurement and planning
  - Complexity descriptors in:
    - Level 2
    - Level 3a
    - Level 3b
  - Use of IOTN:
    - Useful accepted standardised tool
    - Use of extended IOTN (functional treatment need) for patients who have dentofacial deformity
    - Referrers will require training in use of IOTN
  - Training of future workforce: undergraduates, Dental Care Professionals (DCPs), GDPs, Dentists with enhanced skills, and experience, Specialists, Consultants
  - Opportunities to develop and enhance the use of skill mix in Orthodontic care delivery to increase capacity within resources
  - Maintenance of core skills and enhanced Continuing Professional Development for all members of the Orthodontic team
  - Quality assurance
    - Use of quality measures for all patients e.g. PAR, Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs), repeat PAR score at end of treatment
    - Minimum number of cases treated per year
    - Peer review and audit within the MCN
    - Update the quality assurance framework



- Contract
  - Use of alternative contracting frameworks
  - Stepped activity credits and alternative structures for allocation of UOAs throughout course of treatment. This could include some UOAs allocated at case completion.
  - Use of KPIs for quality improvement
  - Agreed rate of activity credit and payment for interceptive care and second opinion/ advice
  - Increase length of contract beyond current SFI limits and consider staged procurement to ensure some level of stability
  - Unified activity coding
  - Minimum case starts by a single performer delivering Level 2 pathways (suggested 50 case starts per annum; however, this will require further consultation)
- All Orthodontic providers must have a formal link to an MCN and be required to take an active role within them. All referrals must go through the local referral management process and quality assurance.

## 9.1 Workforce implications

- Multidisciplinary care managed through local MCNs
  - Consultant-led with administrative support required
    - Cleft (already established)
    - Orthognathic (secondary care)
    - Oral Surgery
    - Restorative
    - Paediatric Dentistry
- Appropriate workforce available to deliver care (e.g. for hypodontia patients)
- Effective communication with Commissioners and dental LPN through Orthodontic MCN to ensure high quality patient care
- Development of training models to improve quality and cost effectiveness to deliver additional benefit to patients
- Framework for maintenance of core skills and enhanced CPD.

## 9.2 Data collection implications

The illustrative patient journey below describes a number of performance data collection items which providers will need to generate themselves. This will require local performance management from Commissioners, with support and engagement from a managed clinical network. Commissioners can also, with support from an MCN, generate much of the needs assessment information required. See Section 12 of the accompanying overarching introductory framework.

## 10 Illustrative journey of a patient

The suggested metrics and enablers throughout the illustrative patient journey should be considered locally:

### Identifying Care Pathway for Patients - Orthodontic Level 1/ Level 2/ Level 3 Complexity

Primary Care Dentist			
Illustrative Patient Journey	Standards	Metrics	Enablers
<p>Providers of GDS/ PDS primary care should ensure that Level 1 care (Procedure/ conditions to be performed or managed by a dentist commensurate with level of competence as defined by the Curriculum for Dental Foundation Training or its equivalent) is provided to the expected standard within the contract.</p> <p>Recognise malocclusion and normal occlusion. Understand the importance of monitoring the developing occlusion</p> <p>Evaluate the potential need for Orthodontic treatment and be familiar with the Index of Orthodontic Treatment Need (IOTN) in order to support referral decision making and advice to patients on alternative options if they do not meet IOTN criteria.</p>	<ul style="list-style-type: none"> <li>All other expected standards. Adherence to NHS England Orthodontic referral guidance (to be produced)</li> <li>Timely valid referrals</li> <li>Timely accurate extractions as requested by Orthodontic provider</li> <li>Effective primary care management with regard to oral hygiene during Orthodontic care and in maintenance post-treatment</li> <li>Patients referred need, want and are suitable for Orthodontic treatment or advice.</li> </ul>	<ul style="list-style-type: none"> <li>Data submissions aligned with that expected of GDS contract</li> </ul> <p>Referral quality and validity:</p> <ul style="list-style-type: none"> <li>Caries controlled at referral unless special circumstances</li> <li>Good oral hygiene unless special circumstances</li> <li>Referrals should relate to a knowledge of IOTN and (PwLD) or other special needs/ modifying factors</li> </ul>	<p>Consultant led local Orthodontic MCN communicating with GDS/PDS primary care contractors under the umbrella of a local professional network.</p> <p>Accessible IOTN update training to ensure primary care practitioner competency</p> <p>Contract reform:-</p> <ul style="list-style-type: none"> <li>Consultant led MCN</li> </ul> <p>Retainer replacement guidance produced. See Appendix 3</p> <p>NHS England Orthodontic referral guidance to be developed</p> <p>NHS England approved patient information leaflet to be developed.</p>

<p>Ensure patient is:-</p> <ul style="list-style-type: none"> <li>• Caries free unless opinion is being sought with regard to special circumstances.</li> <li>• Aware of the importance of maintaining good oral hygiene throughout Orthodontic treatment.</li> </ul> <p>Primary care dentists should explain to patients what Orthodontic treatment may involve including:</p> <ul style="list-style-type: none"> <li>• removable appliances and/ or fixed appliances and what these might entail</li> <li>• possible length of treatment and required commitment to attend and complete treatment</li> <li>• the risks and benefits of Orthodontic treatment</li> </ul> <p>Be able to make valid and timely referrals adhering to NHS England Orthodontic referral guidelines (to be produced)</p> <p>Monitoring post-Orthodontic care maintenance</p>	<ul style="list-style-type: none"> <li>• NHS England approved patient information leaflet to be issued to the patient at the point of referral.(to be produced)</li> <li>• Retainer replacement guidance to be available</li> </ul>		
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Referral			
Illustrative Patient Journey	Standards	Metrics	Enablers
<ul style="list-style-type: none"> <li>• Referrer completes the referral form ensuring consistent required data set is complete (to be developed)</li> <li>• The referral must include all relevant medical history</li> <li>• The referral must include any available relevant radiographs</li> <li>• It is explained to patients referred for Orthodontic assessment that they may not meet criteria for NHS treatment where need is borderline</li> <li>• Relevant information is provided to the patient – standard, age-appropriate NHS England approved leaflet (to be produced)</li> <li>• Patient choice of preferred providers for the appropriate level of specialist care required.</li> <li>• Dentist referring within one week of the decision to refer being made</li> </ul>	<ul style="list-style-type: none"> <li>• Only refer patients who want Orthodontic care</li> <li>• Referrals adhere to Orthodontic referral guidance, including timely referral requirements</li> <li>• Consistent and accurate data set of referrer details</li> <li>• Consistent and accurate data set of patient demographics and contact details</li> <li>• Specific relevant medical history communicated to Orthodontic provider</li> <li>• Patient has good oral hygiene or, if complex, Orthodontic need or other special difficulties (e.g. PwLD)</li> <li>• Patient receives information on Orthodontic care and understands level of commitment on entering specialist Care Pathway</li> </ul>	<ul style="list-style-type: none"> <li>• % of referrals received that have complete referrer details</li> <li>• % of referrals received that have complete patient demographic and contact details</li> <li>• % of referrals that are valid with regard to OH</li> <li>• % of patients who are informed and understand what Orthodontic therapy may entail</li> <li>• % of patients who meet NHS criteria, want and are suitable for Orthodontic care or advice</li> <li>• % of patients who are referred within 1 week of decision to refer.</li> </ul>	<p>Electronic pro-forma and referral processes</p> <p>Agreed data set and national Orthodontic referral guidance</p> <p>Accessible IOTN update training to ensure primary care practitioner knowledge of Index and awareness of NHS England Orthodontic referral guidelines and expectations</p> <p>Nationally agreed Orthodontic information for patients available</p> <p>Orthodontic providers' patient preparation information and maps available to referrers</p> <p>Waiting lists, Outcome and performance indicators of all specialist providers available to referrers</p>

Assessing the referral			
Illustrative Patient Journey	Standards	Metrics	Enablers
<p>Patients who do not meet NHS criteria or are unsuitable for treatment should be referred back to dentist.</p> <ul style="list-style-type: none"> <li>• Patient and referrer informed of decision within 1 month of Orthodontic provider receiving the referral</li> <li>• Patient to be informed of waiting times for all eligible Orthodontic providers</li> <li>• Primary care dentist only allowed to refer once to a selected specialist provider unless malocclusion changes. Multiple referrals to multiple providers are not acceptable.</li> </ul> <p>Dental Hospitals in acute setting and District General Hospitals will require Level 2/3a cases for training</p>	<ul style="list-style-type: none"> <li>• Relevant medical and social history details included with any other relevant patient factors</li> <li>• Appointment offered to patient within 1 month of decision for full Orthodontic assessment</li> </ul>	<ul style="list-style-type: none"> <li>• % of referral forms that are deemed valid</li> <li>• % of referrals forms received that confirm patient need, want and are suitable for specialist Orthodontic care or advice</li> </ul>	<p>All dental providers to have access to NHS numbers as the unique reference number across the pathway</p> <p>Referral decision can be tracked electronically by both referrer and patient</p> <p>Validation of referrals for full Orthodontic assessment</p> <p>Direct booking procedures</p> <p>Responsive Level 3b services available in secondary care setting (Multi-disciplinary team - MDT)</p> <p>Contract Reform – Volume and cost Service Level Agreement for validation/assessment</p> <p>UOA spread more evenly throughout the course of treatment with some being reserved for completion of treatment</p> <p>Cost for treatment in either primary or secondary care setting should be equalised for Level 2</p>

			<p>care</p> <p>Transform PG training so that Level 3a care training is provided and supported in a primary care setting where it makes sense to do so.</p> <p>Greater use of technology to support electronic transfer of information</p>
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**Patient seen – assessment  
Specialist care level 2/3**

<b>Illustrative Patient Journey</b>	<b>Standards</b>	<b>Metrics</b>	<b>Enablers</b>
<ul style="list-style-type: none"> <li>• Patient has all information about Orthodontic assessment, treatment options, average length of treatment and what committing to care will involve.</li> <li>• Information will include waiting times by Orthodontic provider</li> <li>• Patient has all necessary maps and information about setting</li> <li>• Ensure valid consent</li> <li>• Information on appliance and out-of-hours care after procedure</li> <li>• Patients are fully informed about the risks and benefits of Orthodontic treatment including the likely need for long-term retention to maintain complete alignment.</li> <li>• Referral process includes assessment for advice on on-going management, such as the need for extractions.</li> </ul>	<ul style="list-style-type: none"> <li>• Competence and qualification of Orthodontic team meets the level of care provision</li> <li>• Formal appraisal, peer review and outcome measures (e.g. audited PAR scores) in place for all clinicians through a managed clinical network</li> <li>• Access to appropriate premises and equipment such as radiographic facilities Dental Panoramic Tomography, Lateral Cephalometric radiograph and any drugs and equipment made available as recommended by Research Council UK</li> <li>• Disability Discrimination Act, Equality Act and CQC compliant</li> <li>• Patient has choice of appointment time subject to availability of provider, but all providers should be able to offer appointments outside of school times</li> <li>• All providers are working within an MCN and not</li> </ul>	<ul style="list-style-type: none"> <li>• % of referral forms that are deemed valid</li> <li>• % of referrals forms received that confirm patient need, want and are suitable for specialist Orthodontic care or advice</li> <li>• % of DNAs/ cancellations by patient</li> <li>• Provider CQC compliance</li> <li>• % of appointments available outside of school hours and term time.</li> </ul>	<p>Appropriate contracting mechanisms</p>

	working in isolation		
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Level 2 and 3 care			
Illustrative Patient Journey	Standards	Metrics	Enablers
<p>Ensure good communication with patient's GDP throughout treatment. Referral to MDT e.g. Restorative, Oral Surgery, Maxillo-facial Surgery, Paediatric Dentistry, Plastic Surgery if necessary Monitor patient's compliance of oral hygiene throughout treatment and inform patient/ carer and GDP if support is necessary. Undertake Orthodontic treatment to a high standard and in a time efficient manner. Patient has all necessary information on advised self-care and who to contact during treatment should there be a problem.</p>	<ul style="list-style-type: none"> <li>• Start treatment within 18 weeks of initial assessment if patient meets necessary referral criteria</li> <li>• Timely management of problems during treatment</li> <li>• Consistent and accurate record keeping</li> <li>• Patients able to contact the Orthodontic providers during surgery hours throughout the course of treatment and maintenance period</li> <li>• Inter-visit length i.e. length between appointments should be appropriate to meet optimal clinical standards</li> <li>• Ensure valid consent for treatment is obtained throughout the course of treatment</li> <li>• Appropriate supervision of Orthodontic therapists and other non-specialist providers</li> </ul>	<ul style="list-style-type: none"> <li>• % of patients who are ready for treatment and commence within 18 weeks or decision to treat</li> <li>• % of incomplete or abandoned treatments</li> <li>• PAR scoring recorded for every completed case.</li> <li>• Robust external audit of PAR and outcomes reported and reviewed through the managed clinical network</li> <li>• % of completed cases</li> </ul>	<p>Effective use of resources e.g. skill mix</p> <p>Consistent diagnostic and procedure used by all Level 2 and 3 care providers</p> <p>The workforce with the relevant training to deliver care</p> <p>Access to appropriate MDT where required.</p> <p>Clear distinction between levels of care</p>



Discharge Maintenance			
Illustrative Patient Journey	Standards	Metrics	Enablers
<p>Patient has all necessary information at end of active treatment on retention regime and who to contact should there be a problem</p> <ul style="list-style-type: none"> <li>what to expect in the <b>retention</b> period</li> </ul> <p>At discharge from the Orthodontic provider, following the supervised retention period, the patient is given all the necessary information regarding on-going management of retention and what they can expect from their GDP. Relapse is often minimal, but all patients differ to the extent that it occurs.</p>	<ul style="list-style-type: none"> <li>Patient-friendly information available in a number of formats including information on what to expect and who to contact and what to do if problems occur</li> <li>GDP informed of patient's discharge within 1 month</li> <li>GDP and patient given discharge and retention plan</li> </ul>	<ul style="list-style-type: none"> <li><b>PROMs collected and reported on routinely within one month of completion of care</b></li> </ul> <p>Through provider home check reporting and surveys</p> <ul style="list-style-type: none"> <li>Did you get what you needed?</li> <li>Did you have any problems over course of treatment?</li> <li>Did you need to seek advice or assistance outside of scheduled appointments?</li> <li>If the problem you were referred with caused you to be unable to eat comfortably or socialise with confidence – is that now resolved?</li> <li>Would you recommend this provider to a friend?</li> </ul>	<p>Provider has all details of referring dentist correct from initial referral data</p> <p>Discharge information to referrer</p> <p>Responsive administrative support</p>

## 11 Procuring services

### 11.1 Minimum standard specification

#### Minimum Service Specification

All Level 2 and Level 3 care must meet the minimum service specification as detailed in the introductory guide for all Level 1 care together with the additional elements as described below.

Level 2 Care	Level 3 Care
<p><b>Staff Composition/ Workforce</b>            The staff composition will be as follows:</p> <ul style="list-style-type: none"> <li>• Dentists with additional skills and experience to manage the procedural or patient complexity in Orthodontics</li> <li>• Suitably trained and experienced dental healthcare professionals i.e. dental nurses/ hygienists</li> <li>• A qualified dental nurse who will support the Orthodontist at all times.</li> </ul> <p>The provider will ensure:</p> <ul style="list-style-type: none"> <li>• That robust practice management is in place to address issues arising from the patient pathway e.g. validation of patient data, management of patient complaints and issues, management of clinical information.</li> <li>• That all dental/ Orthodontic staff must have the appropriate clinical indemnity, either through an approved defence organisation or through their employment</li> <li>• That all staff supplied have valid registrations and evidence of continuing professional development for on-going registration including participation in peer review and audit</li> <li>• That the performers have the skills to manage vulnerable patients who may have addiction, mental health illnesses and anxiety/ phobia.</li> </ul>	<p><b>As Level 2 care, but to include</b></p> <ul style="list-style-type: none"> <li>• Suitably experienced and qualified specialist Orthodontists with the following qualifications: FDS(Orth)RCS (Level 3b)/ MOrth (Level 3a) or equivalent and must be on the GDC Orthodontist specialist list.</li> </ul>
<p><b>Days/ hours of operations</b>            The service must be provided at times most convenient to patients, including early mornings and late afternoon appointments to ensure school children are not discriminated against. Consideration should be given to evening or weekend appointments and it is expected that a minimum number of after school sessions should be made available per week.</p>	<p>As Level 2</p>
<p><b>Patient Focus</b>            Providers will ensure that patients are provided with relevant verbal and written</p>	

<p>information in a variety of formats, where necessary utilising a translator service, outlining the service. They will also be required to provide information concerning the outcome of the assessment, such that the patient is clear why a specific treatment opinion has been selected.</p> <p>Prior to initiation of treatment, the patient and/ or carer should be provided with the following information verbally and in writing:</p> <ul style="list-style-type: none"> <li>• Treatment plan including length of treatment and frequency of visits</li> <li>• What to expect during treatment</li> <li>• What is expected of them including self-care, compliance and under what circumstances treatment will be terminated e.g. poor attendance, poor oral hygiene, abusive behaviour</li> <li>• Any additional costs the patients may experience e.g. payment for replacement of broken appliances under Regulation 11 and equipment such as wax, toothbrushes etc.</li> </ul> <p>The information should be given in such a way that it supports the patient's ability to give formal consent to initiate treatment.</p> <p>Providers will be required to:</p> <ul style="list-style-type: none"> <li>• Ensure the patient has a clear understanding in advance of what will happen to them during the treatment, who will be responsible for delivering each element of care and why, for example, the patient may be returned to their GDP for extractions</li> <li>• Ensure valid consent is gained from all patients prior to initiating assessment and/ or treatment</li> <li>• Have effective and robust arrangements in place to promote and safeguard the health and wellbeing of young people and vulnerable adults</li> <li>• Have in place a policy that meets the Commissioners' and CQC requirements for Safeguarding Child/ Young Person</li> </ul>	
<p><b>Equipment/facilities</b></p> <ul style="list-style-type: none"> <li>• Ensure that all equipment conforms with health and safety regulations and nationally accepted standards and is maintained regularly in line with national and manufacturers</li> </ul>	

<p>guidelines – providing annual reports to the Commissioners detailing compliance</p> <ul style="list-style-type: none"> <li>• Be responsible for the funding of consumables, laboratory work and dental appliances</li> <li>• Ensure any dental laboratory services used meet with GDC guidance and EU legislation</li> <li>• Ensure that safe processes and working environment are in place. This will include training of staff in relevant processes and procedures</li> <li>• Ensure all legal requirements relating to radiological guidance are met.</li> <li>• Appropriate premises and equipment such as radiographic facilities e.g. Dental Panoramic Tomography, Lateral Cephalometric radiograph and any drugs and equipment made available as recommended by Research Council UK</li> </ul>	
<p>Other All providers will be required to become active members of their local MCN</p>	

## 11.2 Enablers and minimising barriers to transformation

The minimum standards that Commissioners will include within a specification have been described. This will include the local population need, the aims and objectives of this service, a description of the patient journey, service standards, key service outcomes, location of provider premises, data collection and reporting, and tariff costs. The enablers that would assist Commissioners and clinicians in implementing transformed services are outlined above. The risks and barriers will be explored and hints and tips to overcome these. Innovation is about using the flexibility in the regulations to allow better value and outcomes for the investment made.

Meeting the needs and access of vulnerable groups need to be considered and the process for monitoring access and outcomes agreed to align with the pathway.

## 12 Quality and outcome measures

The illustrative patient journey suggests metrics that can be applied across the Orthodontic Care Pathway. It is expected that Commissioners and local MCNs will select and develop reporting mechanisms for locally relevant metrics along with the required PAR scoring, and PROMs and PREMs measures, as detailed below.

High-level assurance relating to contractual delivery is monitored via the current Orthodontic indicators of NHS England's Dental Assurance Framework.

### 12.1 Patient reported outcome measures (PROMs) and Patient reported experience measures (PREMs)

The use of appropriate PROMs and PREMs will be essential to benchmark services. The measures should be patient-focused and consider potential inequalities throughout the patient journey. Appropriate tools should consider the different ways in which service users can provide feedback and different service users' communication needs.

PROMs/ PREMs should include data which can be collected by services at a local level, as well as data which can be collected centrally using national surveys and, where possible these data should be triangulated. There should be evidence to demonstrate that PROMs/ PREMs are representative of the patient groups treated and not just those who can easily provide feedback.

There is a requirement for NHS services to implement the 'Friends and Family' test. Commissioners need to understand and recognise that, given the patient base for Orthodontic services, the question is unlikely to be consistently interpreted within the intended context since those services may not be appropriate or applicable to other family members or friends of the patient.

Generic PROMs & PREMs have been developed for all specialist services and these can be referenced in Section 16 of the Guide for Commissioning Specialist Dentistry Services.

Whilst an Orthodontic-specific PREM has been developed, work is still on-going to develop and agree an Orthodontic-specific PROM. The age group of people undergoing Orthodontic treatment will be a specific factor in how these develop.

The specialty-specific PREM for Orthodontics is:

- Were you able to book an appointment with your NHS Orthodontist at a time that suited your schedule? e.g. able to book an appointment outside school hours if necessary, etc.

1 Yes, I was able to book an appointment at a convenient time for me

2 No, I had to book an appointment at an inconvenient time for me

3 N/A

4 *Additional comments*

With regard to this additional specialty-specific PREM, many service users may particularly value other more qualitative aspects of the service provided such as having adequate time to understand and for delivery of their care, feeling valued as a service user and the attitude and approach of staff members.

As a more qualitative measure it may also be helpful for services to show how they have evaluated, reflected upon, responded to, and acted upon feedback and how services are being developed to improve patient experience as a result of the feedback received.

**12.2 Clinical outcome measures**

MCNs in Orthodontics can begin to use PAR results to audit and review clinical outcomes to support improved quality.

**12.3 Dental Assurance Framework – Orthodontic indicators**

NHS England’s Dental Assurance Framework provides a set of indicators that provide high level assurance for Commissioners, whilst recognising that no one set of indicators could, in itself, provide absolute assurance of quality, nor could it necessarily identify best practice. It is designed to assure Commissioners that contract holders and providers are on course to meet their obligations under their contract/ agreement. The current Orthodontic indicators are detailed below and are measurable via existing datasets.

<b>Indicator</b>	<b>Metric</b>
<b>Assessment</b>	
O1. Assessments by category	% of assessments that are: Assess and accept Assess and refuse Assess and review
O2. Age at assessment	% of reported assessments and review where patient is aged 9 years or younger
<b>Treatment</b>	
O3. Cases reported concluded as a function assess and fit appliance	Ratio of reported concluded (completed, abandoned or discontinued) courses of treatment to reported assess and fit appliance.
O4. Type of appliance used	% of concluded (completed, abandoned or discontinued) courses of treatment reported as using removable appliances only (all outcomes, including completed, abandoned or discontinued)
<b>Outcomes</b>	
O5. UOAs reported per completed case	Ratio of the number of UOAs reported per reported completed case (not including abandoned or discontinued cases)

O6. Reported PAR scoring	Expected number of cases PAR scored based on completed courses of treatment reported versus actual number of cases reported PAR scored (year to date).
O7. Abandoned or discontinued care	% of concluded (completed, abandoned or discontinued) courses of treatment where treatment is reported as abandoned or discontinued

## 13 Next steps

This guide provides a strategic framework for commissioning Orthodontic services in the future. Following publication there will be further work on implementation; however, the enablers, direction and tools are articulated and can be used by Commissioners to make progress locally and begin to set the groundwork for change.

Commissioners, as a minimum, should ensure that they have completed a needs assessment and review current service provision. Establishing MCN networks linked to Dental LPNs and Commissioners would also assist in making progress to achieve the aims of this guide and develop partnership working with clinicians.



## Appendix 1 - Normative Need

		<b>Normative Need</b>	<b>Estimated Need and Demand</b>	<b>Estimated 12-year population already wearing an appliance</b>	<b>Total</b>
<b>NHS England Region</b>	<b>12-year-old Population (Mid-2008)</b>	<b>% of children examined</b>	<b>Number</b>	<b>Number</b>	<b>Number</b>
North	190,263	32.9%	37,637	11,325	48,962
Midlands and East	187,215	33.0%	35,804	14,707	50,511
London	81,522	30.4%	10,685	5,853	16,538
South	162,232	30.5%	29,766	14,620	44,386
<b>ENGLAND</b>	<b>621,232</b>	<b>31.7%</b>	<b>113,892</b>	<b>46,505</b>	<b>160,397</b>

**Table 1: Normative (Clinically Defined) Orthodontic Need in England**  
**Source: NHS Epidemiological Survey of 12 year old children 2008/9 – NW Public Health Observatory 2010<sup>7</sup>**

## Appendix 2 - Patient Engagement

### **Orthodontics Commissioning Guide: participation report**

#### **Analysis of feedback from children and young people's participation in the development of the framework for Orthodontics commissioning and actions to be taken by dental Commissioners**

##### **1. Introduction**

During 2014-15, NHS England has produced a strategic framework for commissioning Orthodontics, one of a series of planned commissioning guides to support more effective commissioning of dental services. As Orthodontics services are heavily used by children and young people, it was important to get insights from this group on the services, and some participation activity was designed to support this. This targeted activity complemented the wider patient and public voice (PPV), obtained via the PPV representatives on the working groups which produced the guides, and the overall Patient Review Group.

Insights were intended to support a patient focus in the framework, especially in relation to influencing patient experience measures and implementation approaches. In addition, we wanted to test a participation approach that could be used by NHS England colleagues more widely to support a patient-focused approach to commissioning Orthodontics. There is considerable scope to increase the involvement of patients and public, particularly young people, in commissioning dental services, both nationally and locally, and at all stages of the commissioning cycle from needs assessment through to service procurement and monitoring. This relatively small piece of engagement has yielded a rich range of insights and potential service improvement ideas that can be built on in future work.

##### **2. Participation approach**

A combination of digital engagement and face-to-face focus groups was used to involve children, young people and their parents/ carers in a dialogue about Orthodontics. The digital engagement comprised two evening tweetchats using #orthodontics. These attracted small numbers of young people and their parents, but yielded some useful insights that were then drawn out in the focus group discussions. The two Storify's of the tweets can be viewed at:

<https://storify.com/bethjp/o>  
<https://storify.com/bethjp/orthodontics>

We then ran two focus groups in different parts of the country, with about 16 children and young people participating in total, aged between 9 and 21 and coming from a wide variety of locations. Annex A below includes the discussion guide used.

The activity was supported by two voluntary sector organisations that are part of NHS England's Voluntary Sector Strategic Partnership: NCB (National Children's Bureau) and NCVYS (National Council for Voluntary Youth Services). They helped plan the engagement and organise the focus groups including recruitment, hosting, organising travel and expenses, supporting facilitation, and ensuring safeguarding and risk assessment processes were adhered to. Members of the Orthodontics guide working group supported both the tweetchats and the focus groups, and NHS England's public voice team helped design the engagement, linked up with partners, developed a discussion framework, and facilitated digital and face-to-face dialogue.

### 3. Feedback and actions

Feedback	Actions to consider
<p><b>1. Communications - general</b></p> <ul style="list-style-type: none"> <li>• Needed throughout patient journey – not just at start of treatment. Discharge/follow up important too</li> <li>• Participants wanted information in a way they could understand, that answered their questions and focussed on how it will feel</li> <li>• Comments related to verbal and written communication</li> <li>• Need to take into account that it can be hard to retain information during a long treatment period</li> <li>• Skills to communicate with teenagers; not patronising, speaking to young person, not their parents</li> <li>• Clear advice and explanations e.g. of NHS scoring system for treatment eligibility, what to eat, what treatment choices are</li> <li>• Manage expectations and provide clarity and honesty on issues such as how painful treatment will be, length of treatment, when treatment can begin</li> </ul>	<ul style="list-style-type: none"> <li>• Develop Patient Related Experience Measures (PREMs) relating to verbal and written communication by Orthodontist service</li> <li>• Specifications for new Orthodontics contracts to include requirement for Patient Related Experience Measures (PREMs) on communication</li> </ul>
<p><b>2. Communications – written/video/online</b></p> <ul style="list-style-type: none"> <li>• Existing British Orthodontic Society leaflets not felt to be very children and young people friendly (lots of words!)</li> <li>• Any information given to young people should be co-produced with young people to make the language and appearance more appropriate.</li> <li>• Information and leaflets could be more direct in presenting the facts; rather than saying 'Y could happen if you don't eat the right things' being more direct and saying 'don't eat x, y, z..'</li> <li>• They did not want to be presented with worst case scenarios in the literature given, and wanted information to be helpful and not repeating things they already know.</li> <li>• Preference for take away information to be in more useable formats, such as business card sized.</li> <li>• Did not find video with advice on what</li> </ul>	<ul style="list-style-type: none"> <li>• British Orthodontic Society to be asked to consider developing some children and young people focused information, using the contacts from the participation activity to support co-production (children and young people who took part, NHS England Youth Forum, voluntary sector organisations)</li> <li>• Also consider what online information is available on Orthodontics via NHS Choices</li> <li>• Specifications for new Orthodontics contracts to include requirement for patients starting treatment to be given verbal and written information on where to find more information, what to do if not happy with treatment, how to get a second opinion</li> </ul>

<p>to eat etc. helpful – soon forgotten. Preference to written information which Orthodontist talks through</p> <ul style="list-style-type: none"> <li>• Request for online one-stop shop or Orthodontics information – young people currently don't know where to go for information in relation to: choice of practice; knowing what practices do what treatments; finding out the rules on second opinions; what you are entitled to and what is different in different places; difference between NHS and non NHS services; what to do if not happy with treatment</li> </ul>	
<p><b>3. Waiting times</b></p> <ul style="list-style-type: none"> <li>• Variation in experience on this</li> <li>• Need clarity on waiting times, once referred</li> <li>• Need clarity if required to wait for treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Consider measuring waiting time performance of Orthodontic providers as part of contract monitoring and comparing different areas</li> </ul>
<p><b>4. Timing of appointments</b></p> <ul style="list-style-type: none"> <li>• Access to emergency appointments a concern for some</li> <li>• Request for appointment availability outside school times for NHS as well as private patients: more early morning, evening and weekend appointments</li> <li>• Schools not always supportive about time out for Orthodontic treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Specifications for contracts could require Orthodontics practices to give patients written information on how to access emergency appointments</li> <li>• Availability of appointments outside school times should be a key criterion when reviewing contracts in tender processes</li> <li>• Dental Local Professional Networks could take shared action to communicate with schools in their area about supporting young people to attend for Orthodontic treatment</li> </ul>
<p><b>5. Continuity of care and follow-up</b></p> <ul style="list-style-type: none"> <li>• Some experienced different Orthodontists throughout treatment</li> <li>• Affected continuity of care</li> <li>• Some participants not happy with discharge and follow-up arrangements</li> </ul>	<ul style="list-style-type: none"> <li>• Develop Patient Related Experience Measures (PREMs) relating to continuity of care and discharge arrangements</li> </ul>
<p><b>6. Consistency on costs and payments</b></p> <ul style="list-style-type: none"> <li>• Variation in whether patients pay when braces break, or get replacements free</li> <li>• Varying range of 'extras' that have to be paid for, including storage box, starter pack</li> </ul>	<ul style="list-style-type: none"> <li>• Include recommendation in commissioning guide that storage boxes should be provided as standard</li> <li>• Specifications for new Orthodontic contracts to include requirements</li> </ul>

	on what items should be provided free of charge
<p><b>7. Participants generally happy with Orthodontics services</b></p> <ul style="list-style-type: none"> <li>Majority of those who participated in this engagement were positive about the outcomes of their treatment</li> <li>Positive outcomes mentioned were: straight teeth; improved self-esteem; eating and speaking improvement</li> </ul>	<ul style="list-style-type: none"> <li>Develop Patient Related Experience Measures (PREMs) to include these positive outcomes</li> </ul>

#### 4. Next steps

- Use feedback to inform on-going Orthodontics commissioning work throughout England especially in relation to informing specifications, tender and monitoring processes, and development of Patient Related Experience Measures
- Share this report and the Annex detailing the participation methodology with dental Commissioners and providers using channels such as dental Local Professional Networks, Managed Clinical Networks, NHS England dental leads meetings, NHS England National Dental Commissioning Group.

#### **Annex A: Discussion guide – for reference and future use/ adaption in primary care commissioning**

This discussion guide was produced by the Public Voice team at NHS England to support engagement of children and young people in Orthodontics commissioning. It was used in February 2015 for focus group discussions organised with support from voluntary sector partners. The discussion guide is reproduced here so that it can be adapted for use for engaging children and young people in commissioning: locally, nationally, in dental services or more broadly across other service areas.

##### **When might this approach be used?**

- To seek insights from children and young people when carrying out a needs assessment in relation to a particular service
- To get insights that can shape service specifications and subsequent procurement and monitoring of a contracted service; for example, Orthodontics, general dentistry.

For more information and advice on using this focus group guide, contact: NHS England Public Voice team: [england.nhs.participation@nhs.net](mailto:england.nhs.participation@nhs.net)

##### **Background notes**

The purpose of the focus groups was to get insights from children and young people that could support a patient focus in the commissioning guide for Orthodontics, and influence patient experience measures and implementation approaches.

Focus group participants were children and young people who had self-selected for the focus groups, but with the requirement that they were aged between 9 and 18 and had recently had Orthodontics treatment. We ran 1-2 groups divided by age, with an additional separate group for parents/ carers to share experience.

The groups were recruited to and hosted by voluntary sector partners NCB (National Children’s Bureau and NCVYS (National Council for Voluntary Youth Services). Members of the public voice team supported overall facilitation. Members of the Orthodontics working group introduced the project, asked questions, and captured comments.

### Session outline

Time	Activity	Who	Comments
1030am	Prebrief for staff involved in focus groups		
11am	Sign in and welcome attendees	Hosts (NCB/ NCVYS) to sign in, check paperwork	NHS E/ working group staff to welcome, chat to participants. Need to make sure we get participants’ ages and areas where received treatment
11.20am	Introductions	Led by hosts (NCB/ NCVYS)	Suitable ice breaker can be used e.g. human bingo
11.30am	Setting the scene (adapt as appropriate) <ul style="list-style-type: none"> <li>• What is Orthodontics?</li> <li>• We are looking at how we manage Orthodontics services in England</li> <li>• This is about getting good NHS Orthodontics services, that provide excellent treatment wherever you are in the country, communicate clearly what’s being done and why, and what the patient needs to do, gives people the support that they need, is good value for money</li> <li>• Group of people are producing a guide to how we plan and buy Orthodontics in England. Will be used by managers and Orthodontists to develop and improve services</li> <li>• On the group are Orthodontists, managers of</li> </ul>	Dental Commissioner or provider	Using visual props – leaflets, photos and appliance models

	<p>dental services, and 3 patient representatives</p> <ul style="list-style-type: none"> <li>• Orthodontics services are mostly used by children and young people, so we wanted to talk to you and get your views and ideas to influence the work we are doing</li> </ul>		
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11.40am	General questions and answers	Facilitators manage and ensure group keeps to time	This may be very short if people are quiet, in which case move straight to group discussion
11.50am	Split into groups	Facilitators organise participants into groups	2 or 3 groups based on age: 11 and under, 12 and over, plus group for parents/ carers depending on resource to facilitate this
12 noon	<p>Focus group questions:</p> <ol style="list-style-type: none"> <li>1. Who has had a brace fitted or something similar? When did you have it? (show photo of brace)</li> <li>2. If you are waiting for treatment or at the beginning of treatment, what do you hope Orthodontics can do for you? Prompts – make you feel differently about your appearance? Make eating easier?</li> <li>3. How did you feel when you were at the Orthodontist? (show photo of Orthodontist with patient) Prompts: Were you happy with how it went? Were the staff kind? What were the best bits? What were the worst bits? E.g. being able to choose colours, missing school, pain, length of</li> </ol>	Agree on day who does what	<p>Need to have someone in each group asking questions. Be aware of striking a balance between making sure everyone has opportunity to contribute and putting people on the spot, as children will not like the latter! Need to assess on the day and make a judgement. Try to ensure that the dialogue is not dominated by one or two individuals and bring dialogue back to the key topics if people start to digress. Need a notetaker in each group or other</p>

	<p>treatment, feeling self-conscious? What made you feel that way?</p> <p>4. Did the Orthodontist explain the treatment clearly to you? Prompts: did you understand the explanations? Could you ask questions? Did they listen to you? Did you know how you might feel during the treatment, how long it would last?</p> <p>5. What have the benefits been to you of wearing a brace (or whatever else you had done) – are you glad you had the treatment? Prompts: has it changed how you feel about yourself?</p> <p>6. <i>May need to miss this one out for younger group if attention is flagging, and have a longer comfort break</i> [What could be done differently/ better when you go to the Orthodontist? Prompts: If you were in charge of treating people your age – what would you do? What about waiting for treatment; what the staff are like; how you are told about what to expect; what the environment is like at the Orthodontist</p>		<p>way of capturing comments e.g. participants write notes for sticky wall</p> <p>Note; if you run a separate group for parents/ carers, these questions will need to be tweaked so they are appropriate. May want to add a question about waiting time for seeing an Orthodontist and starting treatment.</p>
12.35pm	<p>Stretch legs – 5 min break Bring everyone back together Explain how we will use the things you told us today Commit to come back to participants and tell them what we did about what they told us. Tell them about other relevant engagement activities, especially relating to children</p>	Commissioners and facilitators	<p>If any of participants are already engaged in health and social care (e.g. on NHS England Youth Forum), useful to get them to speak briefly about this</p>



	and young people, both national and local. Mention NHS England Youth Forum (Facebook page – regular events)		
12.50pm	Hand out thank you vouchers/ travel and have lunch/ light refreshments		

## Appendix 3 - Guidance on the Provision of Replacement Orthodontic Retainers

The purpose of this guidance is to set out NHS England's policy regarding the management of patients who require (or request) the repair or replacement of NHS-funded Orthodontic retainers.

### 1. NHS Orthodontic contract holders:

#### 1.1 Retainers lost or broken beyond repair by an act or omission by the patient:

Where a retainer is lost or broken beyond repair by an act or omission by the patient this should be managed using Regulation 11 of the NHS Dental Charges Regulations 2005 (30% of a Band 3 patient charge per retainer). No UOAs are credited, but the contract holder is entitled to retain the patient charge.

#### 1.2 Repair or replacement necessitated by 'fair wear and tear':

##### 1.2.1 During the supervised retention period (normally a minimum of 12 months):

The repair or replacement should be provided free of charge to the patient (with no UOAs credited).

##### 1.2.2 After discharge:

Refer to the British Orthodontic Society guidance 'Liability of Practitioners for continuing care after completion of active treatment'.

### 2. NHS contract holders with no Orthodontic element within their contract:

Contract holders with no Orthodontic element within their contract should manage patients who request the repair or replacement of Orthodontic retainers in the following way:

#### 2.1 Within the supervised retention period (up to 12 months after active treatment):

Refer back to the Orthodontic contractor where treatment was provided.

#### 2.2 Beyond the supervised retention period:

Refer back to the Orthodontic contractor where treatment was provided.

The NHS GDS Regulations (2005) do not permit holders of mandatory services contracts to claim UDA activity for the repair/ replacement of Orthodontic retainers.

## Appendix 4 – Glossary of terms and acronyms

AC	Aesthetic component
ARCP	Annual Review of Competence Progression
CCST	Certificate of Completion of Training
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework enables Commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
DES	Dentist with Enhanced Skills
DGH	District General Hospital
DHC	Dental health component
DNA	Did Not Attend
FDS	Faculty of Dental Surgery
FT	Foundation Trainee
GDC	General Dental Council
GDP	General Dental Practitioner
GDS	General Dental Services
IFR	Individual Funding Request
IOTN	Index of Orthodontic Treatment Need
ISFE	Intercollegiate Specialty Fellowship Examination
LDN	Local Dental Network – <i>Also known as Dental Local Professional Network</i>
LPN	Local Professional Network
MDT	Multi-disciplinary Team
NTN	National Training Number
ONS	Office of National Statistics
PAR	Peer Assessment Review
PDS	Primary Dental Services
PREM	Patient Reported Experience Measure
PROM	Patient Reported Outcome Measure
RCS	Royal College of Surgeons
UOA	Units of Orthodontic Activity

## Appendix 5 – Orthodontic Commissioning Guide Working Group Membership

Alice Benton	Chair of the Working Group and Regional Lead for Dentistry & Optometry, London
Nikki Atack	Faculty of Dental Surgery
Dirk Bister	Association of Dental Hospitals
Colette Bridgman	Consultant in Dental Public Health (Guides Support)
Donna Campbell	Orthodontic Therapist
Paul Cook	COPDEND
Eddie Crouch	Primary Care
Richard Cure	Faculty of General Dental Practice
Rob Dalziel	Healthwatch Dudley
Guy Deeming	British Orthodontic Society, Chair BOS Specialist Group
Pauline Fletcher	Primary Care Commissioning Manager (Dental), Cumbria and North East
Ruth Gasser	NHS Business Services Authority, Head of Dental Policy
Rob Haley	Primary Care Commissioning (Commissioning Guides Support)
Nick Hall	Primary Care
Jim Harris	Patient / public representative
Dionne Hilton	NHS England, Dental Pathways Programme Manager
Natalie Jones	Primary Care Contract Manager, Wessex
Serbjit Kaur	NHS England, Deputy Chief Dental Officer
Brian Kelly	NHS Business Services Authority
Fraser McDonald	Association of Dental Hospitals
Mike McGrady	Public Health England, Specialist Training Registrar in Dental Public Health
John Milne	British Dental Association
Jane Moore	Dental Local Professional Network
Carol Reece	NHS England, Senior Programme Manager, Dental, Pharmacy and Optical
Lucy Ridsdale	Foundation training representative
James Spencer	COPDEND
Julie Theaker	Contract Manager (Dental and Optometry), Derbyshire and Nottinghamshire
Helen Tippet	Secondary Care
Colin Wallis	British Orthodontic Society
Mark Welch	Patient / public representative