STRATEGIC COMMISSIONING OF PRIMARY CARE ORTHODONTIC SERVICES

1. INTRODUCTION

1.1 Recent guidance and support on orthodontics has focused on transitional and short term issues associated with the implementation of the new contract arrangements from 1 April 2006.

1.2 In this guidance we are moving on to providing advice and support to PCTs in relation to strategic commissioning of orthodontic services. Some transitional issues are included where PCTs have sought further refinement of existing guidance.

2. NEXT STEPS

2.1 As the most immediate priority, this guidance recommends:

- Reviewing the 'Unit of Orthodontic Activity' values for current contracts to make sure that Regulations have been followed (see section 8 and Annex 2). The Department is aware of a high number of cases where this is not the case.

- Ensuring that negotiations with new or growing practices about disputed contract values take the correct factors into account in assessing the costs involved in completing current courses of treatment (see section 9).

These are both complex areas, where failure to apply regulations and guidance could potentially result in additional service pressures and poor value for money.

2.2 The guidance also recommends a range of actions to help PCTs establish a more strategic and effective approach to orthodontic commissioning for the future, including (where PCTs have not already done so):

- moving to a sector-wide approach to commissioning orthodontics across primary and secondary care (see section 3)
- assessing levels of orthodontic need, as the basis for planning appropriate future capacity (sections 4 and 5, and Annex 1)
- establishing arrangements to route orthodontic referrals through a central point to ensure optimum use of provision (section 6)
- developing clinical governance (section 7).
3. SPECIALIST COMMISSIONING OF ORTHODONTIC SERVICES

3.1 Orthodontics is a specialised service within primary care dentistry. As with other specialised services in both primary and secondary care, PCTs are advised to work with other PCTs, including where appropriate those outside the SHA area, to commission more effectively across significant populations. This will enable PCTs to facilitate wider access to orthodontic services for their populations so that mismatches between need, demand and capacity can be evened out more easily.

3.2 Such an approach potentially facilitates practices serving a number of PCTs on a planned basis and achieving, individually, a scale that enables full use of the skill mix changes and new technologies that have already started and are expected to continue in specialist orthodontics. In future, these skill mix changes may include the use of orthodontic therapists. This is a new category of dental care professional that will be recognised for the first time in the UK, and the General Dental Council (GDC) is presently working with training providers to develop courses in orthodontic therapy. Orthodontic therapists will assist dentists in carrying out orthodontic treatment and provide some aspects of the treatment themselves.

3.3 Commissioning for a larger population also makes it easier for PCTs, working together, to apply the specialised commissioning expertise required for commissioning effectively, and to benchmark good provider performance over a wider area. Much of the guidance in this document can be implemented jointly by PCTs and should encourage multi PCT commissioning strategies for orthodontics. PCTs may also wish to seek the views of any established orthodontic clinical networks, where they exist locally. New SHAs are encouraged to facilitate PCTs to work together, where this is not already happening, to enable this specialist commissioning expertise to develop fully.

3.4 An integrated commissioning approach will also enable PCTs to engage more effectively with the range of orthodontic providers across primary and secondary care. As part of integrated commissioning strategies, PCTs may wish to consider the scope for orthodontists working in primary care, including dentists with a special interest, to provide some services that have traditionally been provided in hospitals. Equally, where PCTs are tendering for primary orthodontic services (through PDS agreements), hospital orthodontic departments in NHS Trusts or NHS Foundation Trusts could consider bidding for this work.

4. ASSESSING NEED

4.1 Orthodontic capacity varies around the country and reflects historical decisions by practitioners about where to practice. As in other areas of
health services commissioning, PCTs should undertake needs assessment to inform priority setting and planning. This should take into account appropriate dental public health advice (see Annex 1).

4.2 The Index of Orthodontic Treatment Need (IOTN) is used to assess a patient’s need for orthodontic treatment and the Peer Assessment Rating (PAR) to quantify the severity of a malocclusion both before and after treatment so that the quality of the outcome of treatment can be measured. The need for orthodontic treatment is evaluated both in terms of dental health and aesthetics. There are two components to the IOTN index:

- Dental health component (DHC)
- Aesthetic component (AC)

4.3 The NHS regulations expect that NHS treatment will normally be limited to patients with a DHC of 4 or 5 (1 being no need for treatment and 5 being great need) and patients with a DHC of 3 with an AC of 6 or more (the AC is based on a 10 point scale). Unlike with dental decay, there is no significant difference in orthodontic need between deprived and non-deprived areas.

4.4 There has been a major change in treatment methodology for orthodontics over the last 10 years. Removable appliances have traditionally been used in the UK for the majority of orthodontic treatment; however they are now considered to be less effective than fixed appliances as they tilt teeth rather than moving teeth bodily through bone. During the last 10 years improved technology and techniques have enabled fixed appliances to become the treatment of choice for the majority of patients. Fixed appliances, whilst providing the highest quality treatment do have the potential to increase the risk of dental decay unless the patient has good dental hygiene.

4.5 In planning orthodontic services, PCTs should be aware that the 2003 National Child Dental Health Survey found that 35% of 12 year olds are likely to have a need for treatment (8% of children surveyed were receiving active treatment already). Not all parents and children agree with a professionally assessed need for treatment and, conversely, a smaller proportion feel that treatment is needed when clinically no need is recognised. The 2003 survey estimated that 58% of the parents of 12 year old children with a clinical need (and not already under treatment) felt that their children did not need orthodontic treatment.

4.6 Some PCTs, or groups of PCTs working together, may find that current services in orthodontics fall short of those indicated to meet local needs, others that they have more than are required long term to meet needs. The priority to be given to adjustments to the resources devoted to orthodontics should be determined in the light of oral health in general in the PCT and the availability of resources for dentistry. Orthodontics should not be undertaken on patients with poor oral
health. In areas of high oral health need PCTs may therefore wish to consider the appropriateness of dedicating additional resources to orthodontics at the expense of allocating resources to population based preventive programmes aimed at improving oral health.

4.7 For orthodontic treatment to be considered, children have to attend a dentist first. Registration data at March 31st 2006 showed that 75% of 12 year old children had attended a dentist in the previous 15 months. Planning for orthodontic services needs to take this into account and PCTs’ first priority for children without regular access to a dentist should be to facilitate that access and ensure improved oral health.

5. COMMISSIONING APPROPRIATE CAPACITY

5.1 PCT commissioning of orthodontic services should, over time, be adjusted to reflect an assessment of needs and planning priorities. Whilst dental financial allocations are made separately, setting priorities and adjusting commissioning as a result will be undertaken within the dentistry budget as a whole. Ultimately, this will take place within PCT priorities in general when, as envisaged, dental resources become part of the unified allocation to PCTs. Primary care orthodontic services should not be commissioned in isolation and the availability of secondary care orthodontic services is also relevant.

5.2 There are already examples of PCTs expanding current orthodontic contracts where this is appropriate and local capacity can be increased. Where significant investment is involved or local capacity is not easily available, PCTs should consider tendering for new providers so that they can be assured of value for money and the best deployment of service to meet local requirements. The national regulations for orthodontics provide a firm quality framework to ensure that quality considerations are taken into account fully in new as well as existing services.

5.3 Where PCTs wish, over time, to redeploy resources from local orthodontic services to other services in accordance with local requirements and priorities, they will need to pay close regard to the current contracts in place and associated notice periods. The average treatment length in orthodontics is 18 months to two years followed normally by supervised retention, so PCTs will need to decide how current patients under treatment and supervision will continue to be treated.

5.4 It should be noted that the orthodontic contract has moved away from the pre-April 2006 item of service basis whereby individual components of treatment were reimbursed separately. Now the contract involves monthly payments of one-twelfth of the annual amount, for which the contractor undertakes case assessments, case starts and the continuing care of orthodontic patients until satisfactory completion of
treatment is achieved, including repairs, diagnostic records and supervision of retention. The service for each patient includes early or interceptive treatment and any continued orthodontic treatment until the permanent dentition is established and the goals of treatment achieved. The workload measures for the contract are units of orthodontic activity (UOAs) with 1 for a case assessment and 21 for a case assessment followed by a case start. Although these measures mark particular stages in the treatment process they do not trigger reimbursement as contracts are paid in even monthly amounts. UOAs, therefore, give a measure of performance against the contract and indirectly reimburse the whole range of orthodontic activity undertaken by a contractor.

5.5 When notice is given on a contract whether by the contractor or PCT, careful attention needs to be paid to an agreement about what happens to existing patients who are under treatment, or have been assessed and an indication given that treatment will be started at a future date. Where a practice-based contract has changes in personnel the continuing caseload will continue to be the responsibility of the practice with no additional payment for completion as long as the UOA value of the contract remains comparable. Where this is not appropriate, or a contractor leaves who is not part of a practice-based contract, PCTs will need to make special arrangements for current cases to be taken forward by alternative clinicians and the appropriate reimbursement will need to be agreed in the light of the cases involved.

6. REFERRAL MANAGEMENT

6.1 Primary care orthodontics has become more specialised, and once a case has been started commits significant resources to individual patients. PCTs will want to ensure that the orthodontic resources they commission, whether in primary or secondary care, are used effectively so that their benefits are maximised for patients. PCTs are advised to agree local referral protocols and issue explanatory packs to all local dental practitioners to assist in identifying appropriate referrals for orthodontics.

6.2 PCTs are advised to put in place a central arrangement to receive referrals for orthodontic treatment. These arrangements need to monitor whether referral protocols have been followed. Appropriate referrals can then be directed to the most appropriate service, whether in primary or secondary care. A clinical assessment may need to be made before the appropriate service can be identified. PCTs should also take the opportunity to review waiting lists for treatment. Where this has been done PCTs have found widely varying waits for treatment at different providers and also cases of multiple referral of the same patient. Where referral management processes are not put in place, PCTs should ensure that the number of patient assessments per case start are kept under review so that resources are not disproportionately directed to multiple assessments on the same patient or assessments.
that do not proceed to treatment. They will also want to monitor the number of case starts that fall outside the IOTN indicated within the regulations. Clinicians are able to start cases that fall outside the stated criteria, but PCTs will want to discuss the factors involved with the practice if this becomes other than exceptional.

7. QUALITY FRAMEWORK

PCTs will want to build the quality assessment and outcome framework prescribed by national regulations into their clinical governance processes for orthodontics. Contractors need to apply IOTN as part of their case assessments and the outcomes of the first 20 cases need to be peer assessed and then 10% of cases in excess of 20 (PAR scoring). PCTs should consider running Section 63 courses on the application of IOTN and PAR scoring where their local contractors would find this helpful. PCTs should make clear within their clinical governance processes what evidence they will seek from contractors about compliance with the national regulations. Where necessary, PCTs can access specialist expertise within the Dental Reference Service (part of the NHS Business Services Authority Dental Practice Division (BSA)) to assist with orthodontic clinical governance issues.

8. UOA VALUES

8.1 Transitional Regulations required that, for specialist orthodontic practitioners transferring into the new arrangements at 1 April 2006, the calculated annual contract value should be divided by 55 in order to determine the number of UOAs appropriate for the contract. This means that, for transitional purposes, the ‘unit price’ is effectively £55 per UOA (at 2005/06 prices); the BSA has since adjusted contract values to reflect 2006/07 prices, so the transitional ‘unit price’ is now higher.

8.2 PCTs are advised to check that the Regulations have been applied accurately in all instances as it appears from records held at the BSA that in some cases the UOAs entered by the PCT in the BSA system bear no relationship to what is required by the Regulations.

8.3 In some cases, this may be because PCTs have reduced the number of UOAs required (or increased the contract value) in the belief that this is necessary to allow for completion of cases underway before 1 April 2006. This will have deflated the number of patients who can be assessed and have treatment started under the new agreement. Except for the growing practices discussed in section 9 below, this approach is incorrect and puts local services under additional pressure. For stable practices, the calculated annual contract value will already fully cover the cost of completing all current patients. Because UOAs are based on case assessments and case starts (rather than case
completions), the annual contract value will always be paying for some incomplete courses carried over from the previous year.

8.4 Where PCTs find that contracts are not consistent with the Regulations, Annex 2 gives advice on handling.

8.5 Where a PCT wishes to commission an increased number of orthodontic cases from a practitioner (i.e. more than the UOAs associated with the calculated annual contract value), or wishes to enter into a new contract, these commissioning decisions are not covered by the Transitional Regulations and it is for the PCT and the contractor to agree the appropriate value for the contract. £55 is not a national ‘going rate’. PCTs are reminded that the quality framework prescribed in national regulations provides a firm foundation for the assurance of the quality of services.

9. GROWING PRACTICES: TRANSITIONAL ISSUES

9.1 As set out in section 8, the annual contract value is designed to pay both for the remaining work associated with courses of treatment carried over from the previous year and for the work associated with in-year assessments and case starts. However, where a practice has been growing, its current case load and its calculated annual contract value will be out of balance. This means that, for the first 18 months or so, the contract value cannot fully accommodate the number of new assessments and case starts that would normally be required at the same time as funding case completions. This section gives further advice on how these cases should be handled.

9.2 As explained in Factsheet 11 (Gateway Reference 5917), the practices in question are those where the total value of outstanding cases at 1 April 2006 exceeds 150% of the contract value (based on the assumption of a typical 18 month treatment period). To allow for existing cases to be completed, the PCT either needs to make a temporary reduction in the annual UOA total (corresponding to the value of this ‘excess’), or make a temporary increase in the contract value. However, the calculation of this ‘excess’ can only be completed when all outstanding claims for cases in progress at 31 March 2006 have been submitted to the BSA by the deadline of the 30 September 2006.

9.3 For practices that have grown sharply in the lead up to the implementation of the new contract arrangements, there may be an additional factor not reflected in Factsheet 11. The claims history of the dentist may not include claims that would (under the old system) have occurred towards the end of, or after, the 18+ month treatment period. The specific items are supervision of retention and breakages. In identifying whether a supplementary calculation needs to be made
(over and above that set out in Factsheet 11), PCTs need to take the following factors into account:

- only the caseload not covered by the contract value should be considered.
- the valuation of UOAs for transitional purposes (i.e. the £55) was set at a level that enables flexibility during the transition into the new arrangements. The average case cost under the old arrangements was approximately £800, and this has moved to approximately £1,200. This should enable not only the new IOTN and quality requirements to be met, but should also give flexibility to reflect transitional effects such as the issue about supervision and breakages. This may not, however, be the case for low continuing contract values.

9.4 The process PCTs should follow is:

- undertake the calculation set out in Factsheet 11 using the final value of outstanding caseload as confirmed by the BSA, namely:

  \[
  [(\text{Total Value of Transitional Claims}) - (1.5 \times \text{the contract value})] \times 30\%.
  \]

- where having applied this formula, the figure has a negative value, the orthodontic contract value covers the outstanding treatment needed for patients whose treatment was commenced prior to April 2006. The PCT therefore does not need to reduce the activity required as part of the new contract to compensate for the completion of these cases. A practice is only a growing practice where the application of the formula results in a positive figure.

- where a practice is confirmed as growing and may not have a full claims record in its reference period that reflects actual supervision of retention and breakages, PCTs should consider whether the flexibility inherent in the transitional UOA valuation enables the contractor to cover the cost of the additional items from the contract value.

- where a PCT believes, having undertaken the above assessment, that there needs to be an additional (temporary) reduction in UOAs, or a (temporary) increase to the contract value, it should aim to come to an agreed settlement with the contractor.

- in calculating the amount needed the PCT should bear in mind that the national average cost of such additional items was £50 per case in 2004/05 (uprated to £51.70 for 2005/06).

- one way of calculating these additional items (£51.70 per case) is to first undertake the formula set out above and then, only when the
resulting figure is positive, uprate the positive figure produced by the formula by a further 23%

- if a contractor seeks more than this amount the PCT should consider asking the BSA to undertake a review of the supervised retention and repair claims history for the contractor to verify the appropriate sum to be paid.

September 2006
ANNEX 1

Identifying Orthodontic Treatment Needs – Guidance for PCTs

1. **Aim of Orthodontic Treatment**

The aim of orthodontic treatment has been defined as producing improved function by the correction of occlusal irregularities (malocclusions) creating not only greater resistance to disease, but also improving personal appearance, which later will contribute to the mental as well as the physical well-being of the individual.

2. **Defining Needs**

In analysing health needs, three dimensions need to be considered:

- **Objective or clinical need**: the actual clinical need in a population cohort as defined following a clinical examination using a standardised clinical index as a benchmark. This represents the “capacity to benefit” from health care.

- **Subjective or perceived need**: the amount of clinical need that is recognised by the patient (or parent/guardian) as requiring treatment within the population cohort.

- **Demand**: the amount of subjective need that is presented for treatment within a cohort (estimated by those currently undergoing treatment).

This paper analyses orthodontic treatment need in England in each of these three dimensions using data obtained as part of the National Child Dental Health Survey 2003 using a modified version of the Index of Orthodontic Treatment Need (IOTN) as the benchmark index.

3. **Measuring Orthodontic Treatment Need**

The Index of Orthodontic Treatment Need (IOTN) and the Peer Assessment Rating (PAR) were developed following the 1986 Schanschieff report into unnecessary dental treatment, which drew the NHS and the profession's attention to the varied standard of orthodontic care in the general dental services.

IOTN is designed so that a malocclusion may be quickly assessed clinically or from clinical models, but it is most widely used clinically and epidemiologically. The PAR index is a method of quantifying the severity of a malocclusion on study models. If this is done before and after treatment, then the change can be measured and thus the quality of the outcome of care measured. The two indices are used in different ways for different purposes.
As orthodontic treatment needs to be justified on either dental health or aesthetic needs, there are two components to the IOTN index:

- The Dental Health Component (DHC)
- The Aesthetic Component (AC)

The Dental Health Component of the IOTN has five categories ranging from 1 (no need for treatment) to 5 (great need) which may be applied clinically or to a patient’s study casts. The Aesthetic Component of the IOTN consists of a ten-point scale illustrated by a series of photographs which in development were rated for attractiveness by a lay panel and selected as being equidistantly spaced through the range of grades. The patient is involved at this stage of the assessment and compares their appearance with the series of photographs. The final AC value therefore reflects the treatment need on the grounds of perceived aesthetic impairment and by implication the socio-psychological need for orthodontic treatment.²,³

In terms of the provision of primary care orthodontic treatment within the NHS regulations, patients can be treated who have a DHC score of 4 or 5 with any AC score or a DHC score of 3 with an AC score of 6 or more. Within secondary care services there seems to be a general agreement that a DHC of less than 4 and an AC score of below 7 do not justify treatment by a hospital based consultant led team except for teaching or research purposes.

4. The National Child Dental Health Survey

The 2003 National Child Dental Health Survey⁴ is the fourth in a series of surveys carried out every ten years since 1973. The 2003 survey was jointly commissioned by the Health Departments from the UK countries. The Office for National Statistics won the tender to undertake the survey in collaboration with five universities who developed the criteria for the examinations and arranged for the calibration of examiners. The surveyed population were representative samples of 5, 8, 12 and 15 year old children attending state and independent primary and secondary schools throughout the United Kingdom.

5. Objective or Clinical Need

The National Child Dental Health Survey collected information relating to orthodontic conditions of 12 and 15 year old children across the UK from both a clinical examination and questionnaire. In assessing orthodontic need the survey used a modified version of the IOTN whereby the IOTN DHC components of 1 to 3 were defined as not requiring treatment and the DHC component 4 and 5 were identified as needing treatment. The DHC and AC components were examined separately and children were assessed to be in need of treatment on either of these scales alone or combined. By excluding the DHC 3 AC 6 + the clinical need identified in this survey will underplay somewhat the clinical need which can be treated within NHS regulations.
In England in 2003 of 1,249 children examined who were not undergoing orthodontic treatment at the time of the survey 35% of 12 year olds and 19% of 15 year olds were identified as needing orthodontic treatment on DHC or AC grounds. (Table 1 & Figure 1). These levels of objective need in 15 year olds reflects unmet need because treatment would usually be completed by this age and this unmet need is greater in males than females.

Table 1: Orthodontic condition in 12 & 15 year olds in the United Kingdom

<table>
<thead>
<tr>
<th>Orthodontic condition</th>
<th>England</th>
<th>Wales</th>
<th>Northern Ireland</th>
<th>United Kingdom*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children undergoing orthodontic treatment at the time of the survey</td>
<td>0</td>
<td>14</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Children not undergoing orthodontic treatment at the time of the survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In need of orthodontic treatment on Dental Health grounds alone</td>
<td>20</td>
<td>15</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>In need of orthodontic treatment on aesthetic grounds alone</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>In need of orthodontic treatment on grounds of both dental health and aesthetics</td>
<td>9</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>No orthodontic treatment need</td>
<td>58</td>
<td>68</td>
<td>56</td>
<td>60</td>
</tr>
</tbody>
</table>

Unweighted sample size
England: 1356, Wales: 1116, Northern Ireland: 558, United Kingdom: 492

* Weighted basis shown for United Kingdom

Source: National Child Dental Health Survey 2003 (reference 4)

This clinical need is higher than that found in the 1993 survey (27%) but compares favourable with previous studies of 32.7% Brook and Shaw1. In fact, the prevalence of objective need for orthodontics seems to have been reasonably consistent over the last 30 years.

Figure 1: Orthodontic condition in 12 & 15 year olds in the United Kingdom

In order to obtain a social parameter, the survey compared the needs between children in deprived areas and those in non-deprived areas based on
the number of free school meals taken at the school in which the child was examined.

Unlike dental decay, there was no significant difference in orthodontic need between deprived and non-deprived areas and orthodontic treatment need therefore does not display a major social class gradient (see Table 2).

Table 2: Orthodontic Condition in 12 & 15 year old children by school deprivation status

<table>
<thead>
<tr>
<th>Orthodontic condition</th>
<th>Non-deprived schools Age</th>
<th>Deprived schools Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Percentage of children:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children undergoing orthodontic treatment at the time of the survey</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Children not undergoing orthodontic treatment at the time of the survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In need of orthodontic treatment on Dental Health grounds alone</td>
<td>26</td>
<td>15</td>
</tr>
<tr>
<td>In need of orthodontic treatment on aesthetic grounds alone</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>In need of orthodontic treatment on grounds of both dental health and aesthetics</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>No orthodontic treatment need</td>
<td>56</td>
<td>65</td>
</tr>
</tbody>
</table>

Unweighted sample size: 2030 1741 565 401

Source: National Child Dental Health Survey 2003 (reference 4)

6. Subjective or Perceived Need

Assessing subjective need for orthodontics is very complicated and difficult to predict. Not all children with an objective need have a subjective need and will seek or accept treatment. Some children with a very high objective need are unconcerned whilst others with a near perfect occlusion desire treatment. Subjective need does not vary with race, or social class although it is thought that the negative impact of malocclusion and the desire for treatment is in fact greater in children from ethnic minorities and from deprived areas.

Discrepancies were evident between the subjective needs of parents with regard to their child's need for orthodontic treatment and objective clinical need as assessed by the simplified index of treatment need.

In 12 year old children where a clinical malocclusion was judged to be present 58% of parents believed that their child's teeth did not need orthodontic treatment (see Table 3).
Table 3: Parental views on the need for orthodontic treatment by simplified IOTN DHC for 12 & 15 year old NOT undergoing active orthodontic treatment

<table>
<thead>
<tr>
<th>Parental assessment</th>
<th>Malocclusion present</th>
<th>Malocclusion absent</th>
<th>Percentage of children:</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 year olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth need straightening</td>
<td>42</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Teeth alright</td>
<td>58</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Weighted base</td>
<td>365</td>
<td>700</td>
<td></td>
</tr>
<tr>
<td>15 year olds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth need straightening</td>
<td>21</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Teeth alright</td>
<td>79</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Weighted base</td>
<td>203</td>
<td>776</td>
<td></td>
</tr>
</tbody>
</table>

Source: National Child Dental Health Survey 2003 (reference 4)

Conversely 12% of parents of 12 year olds who were judged not to have treatment need said that they would like their child’s teeth straightening.

Amongst 15 year olds, 79% of parents whose children were assessed as needing treatment felt that their child’s teeth did not need treatment and 10% felt that their children needed treatment when clinically they didn’t.

In terms then of converting objective need into a subjective need for treatment, we can say that based on the national survey findings it is likely that the parents of over 50% of those children with a clinical need do not feel that their children need treatment. They could, of course, be persuaded that there was need by their dentist – but there still may be a significant reduction in demand for treatment compared with objective or clinical need. In addition, not all those children with a clinical need for orthodontic treatment will have oral health good enough to proceed with treatment.

7. Demand

Demand cannot be predicted by objective or subjective need as those who experience a subjective need for orthodontics will not necessarily express it. At the time of the National Child Dental Health Survey (2003), of 1,356 12 year olds children surveyed, 8% were undergoing active orthodontic treatment and 14% of 15 year olds in the 1116 surveyed in this age group. This will underestimate the demand because some children at the date of examination could have been awaiting an appointment with an orthodontist for an initial assessment or having been assessed, awaiting active treatment to commence.

8. The Need Gradient

Even given the cautionary caveats a need gradient can be demonstrated from the National Survey data. At its most extreme, for every one hundred 12 year old children examined, at the time of examination:
• there was an objective *clinical* need in 35 children

• of these, there *could* be a *subjective need* for treatment by the parents of 15 children

• 8 children out of 100 children examined were actually receiving active treatment at the time of the survey although this does not include those awaiting assessment or treatment.

PCTs will therefore need to take into consideration the need gradient in deciding the capacity of an orthodontic service that is needed and the resources required.

9. **Type of Treatment Undertaken**

There has been a major change in treatment methodology for orthodontics in the last ten years. Removable appliances have traditionally been used in the UK for the majority of orthodontic treatment. These appliances are usually made off site by an orthodontic technician in a dental laboratory. They have the advantage that generalists can use them often under prescription from a specialist or consultant. They are relatively cheap and can be taken out by the patient to clean. Conversely, the fact that they can be removed means that they can be lost or deliberately not worn by a reluctant child! In addition, as they tilt teeth rather than moving teeth bodily through bone the final result is not considered to be as good clinically as with a fixed appliance. During the last ten years, the use of these has declined considerably and fixed appliance treatment is now the treatment of choice in the majority of cases.

Fixed appliance treatment was once the sole province of the specialist orthodontist. Now, more generalist practitioners are undertaking training to use these appliances. However, they should only be used by practitioners who are appropriately and adequately trained in their use unless treatment is being undertaken under the direct supervision of a specialist or a PCT accredited dentist with a special interest in orthodontics. Fixed appliance therapy, whilst providing the highest quality of treatment, does have the potential for increasing the risk of dental decay unless the patient has good oral hygiene. It can also be more time intensive within the surgery.

Figures from the 2003 survey show that the percentage of 12 year old children undergoing treatment with fixed orthodontic appliances has risen from 49% in 1983 to 72% in 2003, with a converse fall in the proportion having treatment with removable appliances.

Whichever the treatment methodology, it is considered to be difficult to achieve a greatly improved result in cases with a DHC of Grade 3 or below which supports the notion that not all treatment will necessarily benefit the patient and therefore not all malocclusions necessarily require correction.
10. **Attendance at a Dentist**

Another component to take into consideration in assessing the conversion of clinical need into demand is the fact that for orthodontic treatment to be initiated, children have to attend a dentist first. Likely attendance patterns can be estimated from the registration data as at 31 March 2006. 75% of 12 year olds children were registered (meaning that they had attended the dentist at least once in the previous 15 months).

11. **Orthodontics within Overall Commissioning Priorities**

PCTs will want to consider the need for and provision of orthodontic treatment within their overarching oral health needs assessment. In particular, they will want to consider how orthodontics fits into their commissioning priority with respect to other oral health needs.

For example, it is clinically inappropriate for orthodontic treatment to be carried out on children who have poor oral health and oral hygiene. Therefore, in areas of poor oral health the use of resources to meet the need and demand for orthodontic treatment may need to balanced against those required to promote prevention, improve oral health and also provide treatment for oral disease. In making these commissioning decisions PCTs they will need appropriate dental public health advice.

12. **Conclusion**

This Annex has aimed to provide PCT commissioners with an overview of orthodontic needs identified in a representative sample of the UK/English population as part of the National Child Dental Health Survey 2003. In terms of providing more local data, PCTs may wish to consider commissioning a survey of local orthodontic needs as part of the on-going NHS child dental health surveys.

Key issues to be considered are that:

- Unlike dental decay, there is no social gradient with respect the objective or clinical need for orthodontic treatment and so we would anticipate the same prevalence of malocclusion in socially deprived areas as in non deprived areas. However, there is likely to be a social gradient when translating the clinical need into subjective need and demand not least because of the lower attendance rates in deprived areas.

- In commissioning orthodontic services PCTs should take into consideration the overall levels of oral health in their population because orthodontic treatment is inappropriate in patients where oral health is not under control.

- Changes in the commissioning of orthodontic services like all the other dental services should only take place after a full oral health needs
assessment of the population is undertaken. Guidance on how to undertake this is given at:

http://www.pcc.nhs.uk/135.php

13. References:


7 De Oliveria CM, Sheiham A. the relationship between normative orthodontic need and oral health related quality of life. *Community Dentistry and Oral Epidemiology* 2003; 31(6), 426-436


Annex 2

Orthodontic Divisor

The transitional value of orthodontic contracts and the required level of UOAs should have been determined by PCTs in accordance with national regulations. A number of PCTs have not used the divisor of 55 specified in the Transitional Regulations (A below) and the Statement of Financial Entitlement (B) to calculate the number of units of Orthodontic activity expected from contractors.

This error now needs to be corrected by these PCTs to bring contracts into line with statute. The mechanism for PCTs to do this is via the regulations which contain a clause that allows PCTs to vary contracts, without the contractor’s agreement, to bring the contract into line with Regulation and statute (C).

A dispute against this action would be difficult to pursue, as it is an implementation of the statutory national framework, although the PCT would clearly need to discuss with the contractor how it proposed to amend the contract to enable it to meet national requirements.

(A) 3.7 If a contractor has entered into a PDS agreement on the basis of entitlement under article 16 or 17 of the First Transitional Provisions Order (that is, contractors that were providing orthodontic services only under section 35 arrangements and will be providing orthodontic services only under their PDS agreement), their NAAV must be 55 times the number of units of orthodontic activity to be provided under their PDS agreement (see article 23(6) of the First Transitional Provisions Order) and so the RB and the contractor will have to agree the number of units of orthodontic activity to be provided under the agreement and the NAAV simultaneously.

(B) together with the transitional regulations (The General Dental Services and Personal Dental Services Transitional Provisions Order 2005, Part 3 Personal Dental Services, Chapter 2, Agreements: Required Terms (6), which state:

(6) In the case to which paragraph (1)(c) applies, the number of units of orthodontic activity to be provided under the personal dental services agreement shall be one fifty-fifth of the negotiated annual agreement value of that agreement, as determined in accordance with directions under section 28E(3A) of the 1977 Act (personal dental services: regulations)[20] (so the contractor and the Primary Care Trust must agree the number of units of orthodontic activity to be provided and the negotiated annual agreement value simultaneously).

(C) Part 9 Variation and termination of agreements, para 60 (2)

In addition to the specific provision made in paragraph 73, the Relevant Body may vary the agreement without the contractor’s consent where it —
(a) is reasonably satisfied that it is necessary to vary the agreement so as
to comply with the Act, any regulations made pursuant to that Act, or
any direction given by the Secretary of State pursuant to that Act; and

(b) notifies the contractor in writing of the wording of the proposed
variation and the date upon which that variation is to take effect, and,
where it is reasonably practicable to do so, the date that the proposed
variation is to take effect shall be not less than 14 days after the date
on which the notice under paragraph (b) is served on the contractor.