NHS England

Transitional commissioning of primary care orthodontic services

Single Operating Model

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Transitional Commissioning of Primary Care Orthodontic Services

Standard operating policies and procedures for primary care

Issue Date: November 2013

Document Number: OPS_1025

Prepared by: NHS England

Information Reader Box

Directorate	Purpose
Medical	Tools
Nursing	Guidance
Patients & Information	Resources
Finance	Consultations
Operations	
Commissioning Development	
Policy	
Human Resources	

Publications Gateway Reference	00642
Document Purpose	Standard operating policies and procedures for primary care
Document Name	Transitional Commissioning of Primary Care Orthodontic Services
Publication Date	November 2013
Target Audience	All NHS England Employees
Additional Circulation List	n/a
Description	Standard operating policies and procedures for transitional commissioning of primary care orthodontic services
Cross Reference	n/a
Superseded Document	n/a
Action Required	To Note
Timing/Deadlines	n/a
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Document Status

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Contents

Purpose of policy

1 NHS England is responsible for direct commissioning of services beyond the remit of clinical commissioning groups, namely primary care, offender health, military health and specialised services.

2 This document forms part of a suite of policies and procedures to support commissioning of primary care. They have been produced for use by NHS England's area teams (ATs).

3 The policies and procedures underpin NHS England's commitment to a single operating model for primary care – a "do once" approach intended to ensure consistency and eliminate duplication of effort in the management of the four primary care contractor groups from 1 April 2013.

4 All policies and procedures have been designed to support the principle of proportionality. By applying these policies and procedures, Area Teams are responding to local issues within a national framework, and our way of working across NHS England is to be proportionate in our actions.

5 The development process for the document reflects the principles set out in *Securing excellence in commissioning primary care*[1], including the intention to build on the established good practice of predecessor organisations.

6 Primary care professional bodies, representatives of patients and the public and other stakeholders were involved in the production of these documents. NHS England is grateful to all those who gave up their time to read and comment on the drafts.

7 The authors and reviewers of these documents were asked to keep the following principles in mind:

- Wherever possible to enable improvement of primary care
- To balance consistency and local flexibility
- Alignment with policy and compliance with legislation
- Compliance with the Equality Act 2010
- A realistic balance between attention to detail and practical application
- A reasonable, proportionate and consistent approach across the four primary care contractor groups.

8 This suite of documents will be refined in light of feedback from users.

[1] *Securing excellence in commissioning primary care http://bit.ly/MJwrfA*

Background

9 This policy provides area teams (ATs) on behalf of NHS England, with the process required for transitional commissioning of primary care orthodontic services.

10 The policy also refers to the specific clauses in the contracts and agreement and crosschecks where applicable with the regulations, the Health and Social Care Act (2012) and the statement of financial entitlements (SFE)

11 The policy looks at how ATs should manage the transitional commissioning of primary care orthodontic services process.

12 The policy removes any deviation from the regulations and provides a fair and equitable process for all contract holders. It also provides an element of proportionality when dealing with contractors.

13 All dental contracts, including primary care orthodontic PDS agreements, transferred to NHS England in April 2013. Some of these orthodontic agreements will reach an end date in this transition period. Before any procurement process can be considered area teams (with input from a consultant in dental public health) need to complete a population orthodontic needs assessment, which should include analysis of performance of current service provision and describe available resources.

14 This commissioning guide provides methods and examples of developed good practice in population orthodontic needs assessment and a quality audit framework for analysis of existing service providers to identify gaps and describe expected standards of service delivery and VFM. It is intended to support area team commissioners manage orthodontic contracts in transition and stimulate improvements in quality and efficiency.

Scope of the policy

15 NHS England National Dental Commissioning Group will develop care pathways and commissioning guides for each specialty as set out in SEICD[2]. The development of a national guide for orthodontics may not meet the timescales associated with some PDS contract expiration dates. The key priority during this transitional period is to avoid any destabilisation of existing service provision. It is also important that costly procurement exercises are avoided until the orthodontic pathway work, population needs assessment and development of a single commissioning model is completed.

16 Area teams need a robust evaluation process of existing contracts for analysis of existing services for needs assessment and to ensure any extension to PDS agreements are only awarded to those providers who demonstrate they are providing a high quality, effective and efficient service. Where this is not the case and providers are not able to demonstrate sufficient improvement against national criteria, further

[2] Securing Excellence In Commissioning NHS Dental Services. NHS Commissioning Board. February 2013

quality improvement and/or procurement may be required

17 Area teams need to ensure they have:

I. Completed a population orthodontic needs assessment to underpin orthodontic commissioning decisions with input from Consultant in Dental Public Health (PHE)

II. Undertaken a review of existing providers and their services by benchmarking against the quality and value framework

III. Considered contract extensions and/or procurement exercises in light of a number of key principles including the need to maintain continuity of care for patients

18 Following this guide will assist area teams:

- Recognise excellence in existing orthodontic primary care services
- Support quality improvement and put a performance management spotlight on providers who need to make changes
- Limit procurement exercises associated with existing providers where these are not necessary
- Ensure continuity of care for current orthodontic patients
- Contribute to the development of a single NHS England operating model and national quality and value framework

These are considered in more detail in the following sections.

NHS orthodontic contracts

19 The contracting framework for NHS orthodontic services came into being on April 1 2006. Dentists providing orthodontic services were transferred to either a Personal Dental Services (PDS) agreement or General Dental Services (GDS) contract in April 2006. Those providing both general dental services and orthodontic services were, in general, transferred to PDS agreements with recommended minimum contract duration of 5 years. The majority of these agreements are likely to have reached the end of their agreed term.

20 In the former General Dental Services (GDS), orthodontists were paid the majority of fees when the treatment was completed. Dentists were able to claim an interim payment when the appliance was fitted (amounting to approximately 20% of the total payment).

21 Current payment arrangements for orthodontic treatment differ significantly. Under PDS and GDS agreements, the total annual sum due to the provider is paid in twelve monthly installments, one month in arrears in line with their calculated annual

contract value (CACV). There is no payment for completing an individual orthodontic case; instead the contractor receives monthly payments to provide a complete orthodontic service to a group of patients over that period of time. This includes assessments, treatment starts, repairs, retainer checks and continuing care of an on-going caseload.

22 Units of Orthodontic Activity (UOAs) are attributed to an orthodontist as follows:

1 UOA – full and comprehensive orthodontic assessment
21 UOAs – orthodontic assessment and case start (patient aged 10 -17)
4 UOAs – orthodontic assessment and case start (patient aged below 10)
23 UOAs – orthodontic assessment and case start (patient aged 18+)

23 Whilst other clinical obligations such as validation of referrals, continuing care and retention, do not trigger UOAs, contractors are required to undertake these as part of the orthodontic care package to their patients.

24 Orthodontic courses of treatment normally take between 18 months to two years to complete.

25 As UOAs are mainly attributed to a contractor at the commencement of treatment, this is often mistaken to equate to the provider being paid in advance of the treatment for the patient being completed. This is not the case.
UOAs are an activity indicator to ensure that the contractor maintains a constant level of service in line with their contracted activity. It is expected that, as courses of treatment are completed, the practitioner will take on new patients in accordance with their contract to meet the annual UOA requirements. In order for a clinician to maintain steady state - the number of case completions would need to broadly equal new cases commenced each month.

26 The current orthodontic contracting arrangement requires dental providers to provide a minimum of three months' notice when terminating their contracts. Whether the contractor gives notice or the agreement expires, as orthodontic treatment can take more than two years to complete this means that there is likely to be a cohort of patients who will be part way through treatment at the end of the contractual period. Continuity of care for these patients is essential and should be considered as part of any future orthodontic commissioning decisions.

27 Prior to the introduction of the new orthodontic contract in April 2006, the Department of Health issued guidance to support PCTs understand the transitional and short term issues associated with the new arrangements. Further guidance then focused on providing advice to PCTs in relation to the strategic commissioning of orthodontic services including the assessment of orthodontic need.

28 During November 2010, the Department of Heath issued PCTs with advice on how to approach the review of existing NHS orthodontic contracts. Available via the Department of Health web site, links to these publications can be found below:

http://www.dh.gov.uk/assetRoot/04/13/03/20/04130320.pdf

http://www.dh.gov.uk/assetRoot/04/13/91/77/04139177.pdf
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121386

Assessing orthodontic treatment need

29 Published data, of the need in11-12 year olds in the UK population, identifies that approximately one third of this age cohort will need and want orthodontic treatment. This is consistent across population and ethnic groups.

Undertaking population orthodontic needs assessment and reviewing existing service provision is essential and, as a minimum, should include:

- an audit of current providers and their service delivery by benchmarking against a quality and value framework of what 'excellent' looks like (see section 4)
- 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

There are two main elements to assessing orthodontic treatment need.

- Normative need - the actual professionally judged need in a population cohort as defined following a clinical examination using a standardised clinical index such as IOTN or benchmark and/ or need defined by applying a validated formula. This represents the capacity to benefit from healthcare.

- Demand - expressed need that is presented for treatment.

Orthodontic needs assessment exercises have been undertaken across the country and many good examples are available. See method as set out in **Annex 2.** An assessment of the need for orthodontic services is necessary to inform long-term decisions on the future of orthodontic contracts. The input of a consultant in dental public health will ensure expert advice is available during this process.

Review of existing providers

30 Area teams need to be aware of any orthodontic contracts that will end soon and will need to undertake reviews to quality assure service providers. A review should include an audit of current providers and their service delivery by benchmarking against the quality and value framework describing what 'excellent' looks like.

Area teams need to:

- Assess current providers and the service being delivered against the Quality and Value Audit Framework Annex 3.

31 If current providers are performing well against the quality standards, an area team might consider renewing/extending contracts, or agreeing a single tender action, but should not do so if the standards are not met to an acceptable level. The quality and value audit opens the way for local discussions with current providers about these expected standards.

- Support procurement processes and decisions
- Support NHS England area teams in this transition period to ensure stabilisation and to support a standard approach to performance and quality arrangements across England.

A standardised framework to review existing orthodontic services is set out in **Annex 3**.

Contract extension and procurement

32 **Contract extensions**

33 Area teams should not just roll existing contracts forward without looking at value for money and quality. An assessment using the framework will support considerations and decisions.

34 As part of VFM reviews, area teams should not just consider UOA cost in isolation (though this remains important). Other quality factors, such as high achievement against the example framework, are also indicators of good value for money.

35 The competence and quality of current providers should be assessed and any new contract offered on re-negotiated terms if needed – as the quality and VFM framework can be used to assure quality.

36 Some extensions to contracts have been applied with variable lengths, which means, contracts across the same area will end at different times. Apply the same quality and value framework and audit to ***all*** providers. Area teams can facilitate clinicians establishing a managed clinical network / peer review approach via the dental LPN to drive up quality

37 Some orthodontic contracts do not have end dates however the framework can be used to quality assure and to re-negotiate with incumbent providers

38 Some GDS contracts include orthodontic activity and it is possible that some of these may not being treated equitably. So all orthodontic practices are to take part.

39 **Procurement**

40 May be necessary if resources are available and/or if a provider gives notice:

41 Contract extension and single tender actions can open commissioners to a risk of challenge if there is interest from the market that is not explored

42 Completing an orthodontic population need assessment is part of the commissioning cycle, this involves an assessment of existing services and this must be completed first as a necessary part of the procurement process.

Annex 1: abbreviations and acronyms

AT	Area team (of NHS England)
GDP	General dental practitioner
GDS	General Dental Services
LPN	Local professional network
NHS CB	NHS Commissioning Board (NHS England)
NHS DS	NHS Dental Services
PCC	Primary Care Commissioning
PCT	Primary care trust
PDS	Personal dental services
POL	Payments online
UDA	Unit of dental activity
UOA	Unit of orthodontic activity

Annex 2

Assessing Population Orthodontic Need

Measuring treatment need

Published data regarding orthodontic treatment need in11-12 year olds in the UK population, identifies that approximately one third of this age cohort will need and want orthodontic treatment. This is consistent across population and ethnic groups.

There are two main elements to assessing orthodontic treatment need.

- Normative need - the professionally judged need in a population cohort as defined following a clinical examination using a standardised clinical index such as IOTN. This represents the capacity to benefit from healthcare.

- Demand - expressed need that is presented for treatment.

There will be a proportion of people who may be assessed as requiring treatment but cannot comply and decline treatment, others with a need may be unsuitable for orthodontic care because they have active caries and/or poor oral hygiene and cannot be accepted for treatment. There will be others whose IOTN will be below 3.6 who demand treatment to correct mild imperfections.

Information to referrers on criteria and/or a referral management system will support commissioners to ensure that only good quality referrals are directed to specialist orthodontic services. Orthodontic providers will also need to validate referrals.

Full Orthodontic Assessment should only be carried out when the referral is validated as having an IOTN 3.6 or above, good OH and stable oral environment, patient aware of what is involved and willing to comply. Primary care providers are responsible for ensuring referrals are appropriate. UOAs should not be used for repeat assessments or to validate a referral.

Method

The need for Orthodontic treatment can be estimated using the results of the most recent 12-year old survey (2008/9). These tables include the most recent available data from the Office for National Statistics (ONS) estimates of the 12-year-old population in your area. These measures will not vary much from year to year.

It is available by following this link and then click on the excel workbook indicated by the arrow.

http://www.nwph.net/dentalhealth/survey-results-12.aspx

The workbook contains an overview, which explains the results worksheet and survey method.

Scroll up to find your area details. Column O lists the number of 12 year old children in the current population who will be eligible i.e. 'need and want' orthodontic care for each previous PCT area. The represents an approximation of the likely number of new case starts in any given year from previously published data it is consistently around one third. Area Teams can use this `close approximate third' or collate these figures for a population overview of need in their area team footprint. Column P is the number of children in treatment i.e. existing cases.

Together the total number will give a close estimate of the number of Orthodontic treatments required to be commissioned to meet the estimated normative needs of your current resident population in a year. How does capacity match normative need? How many case starts can there be in a given year?

For example in your area you should know and list in the population orthodontic needs assessment:

- How many Orthodontic contracts are open?

- How many are limited to Orthodontics and how many are mixed (GDS).
- The existing capacity i.e. the total number of Units of Orthodontic Activity (UOAs) contracted across the area
- The total financial value, and
- The average and the range of UOA values.

You will need to factor in an estimate of un-quantified private market and in addition the NHS Hospital Orthodontic service provision. It may be necessary to consider factors such as cross-boundary patient flows and waiting times within localities.

The orthodontic needs assessment of the population should include the results of the quality benchmark in Annex 2 - giving details of existing service provision.

This method provides an evidence base for informed commissioning decisions and further strategic planning relating to orthodontic provision. Commissioners can conclude how well existing provision is meeting need and/or providing value for money and it will assist further mapping and more detailed understanding of need.

Completing this exercise provides a basis for more detailed needs assessment that might include consideration of equity and access, which should be conducted as a minimum prior to any procurement or negotiations with existing providers. As an example where the UOA value does not fall within the ‘excellent’ range a provider could opt to increase the number of case starts (within the existing contract value) and/or reduce the number of repeat assessments to offer better value.

Annex 3

Quality and Value Audit Framework

Orthodontic Contracts

September 2013

Introduction

The aim of this tool is to support commissioner's review existing orthodontic providers and their service delivery against a quality outcomes and value framework. Where relevant, this will therefore enable the status of services (GDS and PDS) to be understood and/or reported in a needs assessment in preparation for procurement. It can be also be used for the purpose of negotiation to extend a PDS agreement in this transition period and/or to take single tender action for time limited PDS contracts.

There are a total of 5 indicators, each contributing to a maximum of 20% of the total score. Excellence would be considered a score of between 90 – 100%. However, this assessment should be completed annually as part of on-going quality improvement and monitoring.

To extend a PDS agreement with assurance, practices need to score 90% or above to extend the existing contract for a further 3 years. If the score is above 70% the contract may be extended for a further 2 years year, however, the provider would need to agree to make necessary changes to achieve 90%. Those contracts achieving below 70% but above 50% are given one year and those below 50% a 6-month period in order to improve the quality and value of service provided and reach at least 70% score for a further year extension and 90% for a further 2 years. If these scores are not achieved within the 6-month period, commissioners should consider further procurement dependent on the local needs assessment.

The 5 indicators set in this tool are as follows:

Indicator Number	Area	Indicator detail
Indicator 1	Value for Money	Current Unit of Orthodontic Activity (UOA) value
Indicator 2	Efficiency	Case assessments versus case starts
Indicator 3	Outcome	Peer Assessment Rating
Indicator 4	Outcome	Completion of cases started

Indicator 5	Patient Experience	Referral to treatment within 18 weeks

Much of the Information associated with these indicators can be found in the orthodontic vital signs schedule for individual contracts, others will require a specific data gathering exercise by commissioners.

Indicator 1 – Value for money (Current unit of orthodontic activity value)

Rationale

£55 was commonly used as the devisor to convert a GDS practitioner's gross earnings during the reference year (the "CACV") into units of orthodontic activity as part of the introduction of the new orthodontic contract on April 1, 2006.

Uplifts have impacted on this and the current average value UOA value is approximately £59. Recent procurements have sought in many cases to achieve better value.

In order to secure excellence it is essential that quality is funded appropriately and that no NHS body seeks to drive the cost to below what could support desired quality. The price for UOAs would be expected to fall within 10% below or above the 55 devisor used in 2006 to represent value for money.

Current UOAs at a cost higher than £65 or lower than £45 should be challenged.

Practices will need to negotiate the numbers of UOA commissioned to ensure they achieve this indicator.

Information to bench mark

Commissioners need to collate this information from POL and all current contracts in place.

Indicator	Weighting	Benchmark	Measures	Excellent	Good	Acceptable	Unacceptable
1 - Total contract value	**20%**	**All contracts**	**UOA cost**	£51 - £59	£47- £63	£45- £65	< £45
							> £65
Score:				20	15	10	0

Indicator 2 – Efficiency (case assessments versus case starts)

Rationale

Some UOAs are currently being used within contracts for reviews of patients who have been referred to specialist orthodontic practice too soon. Some patients are seen and are unable to proceed to a case start due to incorrect IOTN assessment by referring practitioner and/or because the oral health and/or compliance is poor. Other patients are assessed and listed for further review if referred too early. This is a wasteful use of specialist resource i.e. UOAs.

This type of assessment is essentially a validation of the IOTN and referral. UOAs should not usually be directed to this activity. Every orthodontic treatment case start requires that a detailed orthodontic assessment is completed and that attracts a UOA as part of the case start claim. This is appropriate use of specialist resource and time.

Some PCTs implemented a central capture/demand management of referrals system. This supported higher quality of onward referral to specialist orthodontic practices i.e. IOTNs are always 3.6 or higher; good compliance and oral health can be validated so that onward referral for orthodontic assessment and case start achieves closer to a 1:1 ratio.

Achieve an assessment to case start ratio as close to 1:1 as possible. A reasonable benchmark may be a ratio of 1.5 - 2.0: 1 case assessments to each case start. To calculate this, use the most recent vital signs report.

How practices can achieve the requirements

Some excellent orthodontic practices already run new referral rapid validation clinics to assess appropriateness of referral and compliance, etc. and will only claim a UOA if a full orthodontic assessment is completed as part of a case start. Occasional rejections can occur after a full orthodontic assessment is completed but this approach reduces the number of `assessments` to take the ratio as close as possible

to 1:1. Patients not meeting the IOTN criteria for NHS service can be offered choice and those who require orthodontic case starts soon can be seen more quickly.

Work with referrers and others to ensure that patients are referred at an appropriate time (with compliance and good oral health) and that IOTN is understood will ensure that rejected cases are returned to primary care referrers with detailed reasons why; to educate referring GDPs and patients. Excellent specialist practices reduce waiting lists and develop triage systems to ensure that patients are not reviewed repeatedly. Area teams could assist providers by establishing validation clinics in localities.

Indicator	Weighting	Benchmark	Measures	Excellent	Good	Acceptable	Unacceptable
2 - Ratio of case assessments to case starts Rapid access validation of referrals clinics in place if no central capture system Informative letters to referring dentists if IOTN persistently incorrectly reported	**20%**	**Note trend at March 2010, March 2011 & March 2012. Note at the end of each subsequent financial year.**	**Ratio**	1:1 to 1.4:1	1.5 to 1.9: 1	2 to 3.9 : 1	> 4 : 1
		Score:		20	15	10	0

Indicator 3 – Outcome (peer assessment rating)

With an increasing focus on outcome of health care it is important to ensure that PAR scoring is not only completed to expected standards but that the results form part of performance management.

Monitoring the outcome of the orthodontic treatment provided following the case assessment and treatment provided as per clause 157 of the PDS contract in accordance with 'Methods to determine outcome of orthodontic treatment in terms of improvement and standards'

In accordance with clauses 156 to 160 – the outcome of orthodontic treatment, practices will be required to submit the PAR scoring matrix.

PAR scoring will in future be undertaken within a managed orthodontic clinical network (accountable to an LPN and NHS England area team under a peer review mechanism.

Rationale

It is a statutory requirement of the NHS orthodontic contract for all orthodontists to monitor treatment outcomes for 20 cases plus 10% of the remainder of their caseload every year using PAR (Peer Assessment Rating). In orthodontics it is important to objectively assess whether a worthwhile improvement has been achieved in terms of overall alignment and occlusion for an individual patient or the greater proportion of a practitioner's caseload.

Unless an individual is calibrated on the use of the index, the results they produce will not be valid or reproducible and should not be used to assess the standard of someone else's treatment. It is the responsibility of the "user" (e.g. provider) to ensure that the person scoring the models has been properly calibrated. Good practice would be the PAR scoring of consecutive finished cases to reduce any bias in selection.

Peer Assessment Rating (PAR) means an index of treatment standards in which individual scores of the components of alignment and occlusion are summed to calculate an overall score comparing pre and post treatment with the expectation that there will be an overall improvement of at least 30% reduction in PAR score.

Using the weighted PAR Index it was revealed that at least a 30 per cent reduction in PAR score is required for a case to be considered as 'improved' and a change of 22 PAR points to bring about 'great improvement'. For a practitioner to demonstrate high standards the proportion of an individual's caseload falling in the 'worse or no different' category should be negligible and the mean reduction should be as high as possible (e.g. greater than 70 per cent). If the mean percentage reduction in PAR score is high and the proportion of cases that have been 'greatly improved' is also high, this indicates that the practitioner is treating a great proportion of cases with a clear need for treatment to a high standard [3].

How Practices can achieve the requirements

As part of the monitoring process of the outcome – the Contractor should calculate a Peer Assessment (PAR) of the patients study cast taken at or after the case assessment but prior to the commencement of orthodontic treatment. Subsequently, a PAR score should be calculated for the patient at the completion of the orthodontic course of treatment using clinical outcome monitoring software. This could be completed for every patient rather than just a sample and excellent practices will move towards this.

[3] Clinical Standards Committee GUIDELINES FOR PRIMARY CARE TRUSTS AND LOCAL HEALTH BOARDS TO ASSESS THE TREATMENT OUTCOME OF PATIENTS TREATED BY SPECIALIST ORTHODONTISTS OR DENTISTS USING THE PEER ASSESSMENT RATING (PAR) INDEX. British Orthodontic Society 2009.

Indicator	Weighting	Benchmark	Measures	Excellent	Good	Acceptable	Unacceptable
3 - Peer assessment rating **At least first 20 cases plus 10% of the remainder of the annual completed caseload will be PAR scored as per contract.** **Of the cases scored, mean (average) PAR score improvement of at least 65%** **(British Orthodontic Society – Clinical Standards committee July 2009)**	**20%**	**Practices will be asked to submit information re: PAR scoring of completed cases**	**Percentage improvement in mean average PAR score in a random sample of 10% of cases per year (min 20 cases)**	> 70%	At least 65%	At least 60%	**Less than 60 %**
Score:				20	15	10	0

Indicator 4 - Outcome (cases that are started are completed)

Rationale

Despite detailed assessment of need and compliance occasionally orthodontic treatment that is commenced for a patient cannot be completed. A patient's circumstances can change, a patient may move away from an area, or compliance promised at the start is withdrawn. Monitoring orthodontic cases that are started but not completed should be part of performance management and evidence of why a case has started but was not completed should be held by a practice and reported on an annual basis. Practitioners need to ensure completed courses are recorded.

Orthodontic providers need to report case completions, for the purposes of this tool; this is at the end active treatment and before the retention phase.

Information to bench mark

Commissioners need to collate this information from DSD and compare with information submitted by the practice.

Indicator	Weighting	Benchmark	Measures	Excellent	Good	Acceptable	Unacceptable
4 - Cases that are started are completed **Reporting of case starts not completed and reasons why**	**20%**	**Percentage of case starts in a year**	**Percentage of case starts completed**	> 75%	Above 70%	More than 60%	< 60 %
		Score		20	15	10	0

Indicator 5 - Patient experience (referral to treatment within 18 weeks)

Rationale

Once a case has been referred there should be a timely validation of the referral (as outlined in indicator i.e. patient has IOTN 3.6 or above, good OH, stable mouth and is willing to comply). Following validation of referral appropriateness the priority of the full orthodontic assessment and case start timing can be estimated and planned. The optimum timing for a case start is not exact but it is reasonable to assume that each case can be prioritised and will fall into categories, 0- 6 months, within a year and/or within 18 months. A patient can then be listed for an orthodontic assessment and case start date following this decision. (>18 months would be deemed as having been referred too soon). The 18-week measure starts for each category after 6 months, one year or 18 months so that all pre-treatment planning and extractions required by the patient have been completed:

6 months + 18 weeks
one year +18 weeks or
18 months + 18 weeks.

Whilst there is no formal time measure in primary care, as with secondary care orthodontic services, it is desirable that this should be within 18 weeks. Patients who have been referred too early should be returned to primary care with an explanation and will need to be re referred for future validation.

Information to benchmark

Commissioners need to collate the waiting list times from referral to case start for each contractor and this information can be published to offer patient choice. As mentioned in indicator 2, Area Teams may have a validation clinic in each locality to report on waiting times and facilitate a central list if required.

Indicator	Weighting	Benchmark	Measures	Excellent	Good	Acceptable	Unacceptable
5 – Assessment to case start within the optimum time range + 18 weeks	**20%**	**100% of assessment to case starts commenced within optimum time + 18 weeks i.e. 6 months + 18 weeks 1 year + 18 weeks 18 months + 18 weeks**	**Percentage of case starts within 18 weeks of orthodontic assessment optimum time range**	75% +	60%+	50% +	< 50%
		Score:		20	15	10	0

References:

1. Securing Excellence in Commissioning NHS Dental Services NHS Commissioning Board Feb 2013

2. Clinical Standards Committee. Guidelines for primary care trusts and local health boards to assess the treatment outcome of patients treated by specialist orthodontists or dentists using the peer assessment rating (PAR) index. British Orthodontist Society 2009

First published November 2013
Published in electronic format only