NHS England – South (South East)

Orthodontic Needs Assessment – December 2017

An amendment to the **Revised Orthodontic Needs Assessment for Kent, Surrey and Sussex – December 2016** comprising:

- Corrections to Table 17: Draft Commissioning Intentions for NHS England (KSS) on Page 43 and Page 44.

- Feedback to the Revised Orthodontic Needs Assessment for Kent, Surrey and Sussex – December 2016 has been appended (Appendix 8).

Revised Orthodontic Needs Assessment for Kent, Surrey and Sussex December 2016

A review of an original document written in 2015 by Brett Duane and Christopher Allen

Edited by Jackie Sowerbutts and Na Yeoun Kim

Executive summary

Orthodontics services are currently commissioned by NHS England from a range of primary and secondary care providers. Activity data for primary care is transmitted to a central body, the NHS Business Services Authority (BSA) who provide data to facilitate local monitoring of contracts. Most orthodontic contracts in Kent, Surrey and Sussex (KSS) expire in March 2018. NHS England is planning to tender for orthodontic services in the next 12 months for a minimum 5-year-period across the whole of the South of England.

The key population data set used to assess orthodontic need is 12 year olds which is when many children requiring treatment would begin to be assessed and treated if appropriate. Using population projections, there appears to be a 7-9% predicted growth in the population within KSS until 2022. The population of 12 year olds then reduces back down again to almost current levels by 2027. This population change does not take into account the large scale developments that are proposed for this area with more than 15,000 houses planned for this period across KSS during the next 5 years.

The location of services is usually focused around population hubs. However, there is a need to ensure equity of access in more rural areas such the south of Surrey, the north of Sussex and some coastal areas and southern parts of Kent where patients can travel much greater distances to access care. Location of services also needs to take into account actual populations of 12 year olds to ensure viable and sustainable local service provision.

Within Kent and Medway there are 29 General Dental Service (GDS) contracts and Personal Dental Service (PDS) agreements which support orthodontic provision; within Surrey and Sussex there are 47 agreements. Treatment locations were selected for the year 2013-14 for contracts located in the analysed area to reflect best to where patients actually receive orthodontic care. The maps below show all treatment locations in the area and within a 10km buffer around the border.

Figure 1: Treatment locations in Surrey and Sussex

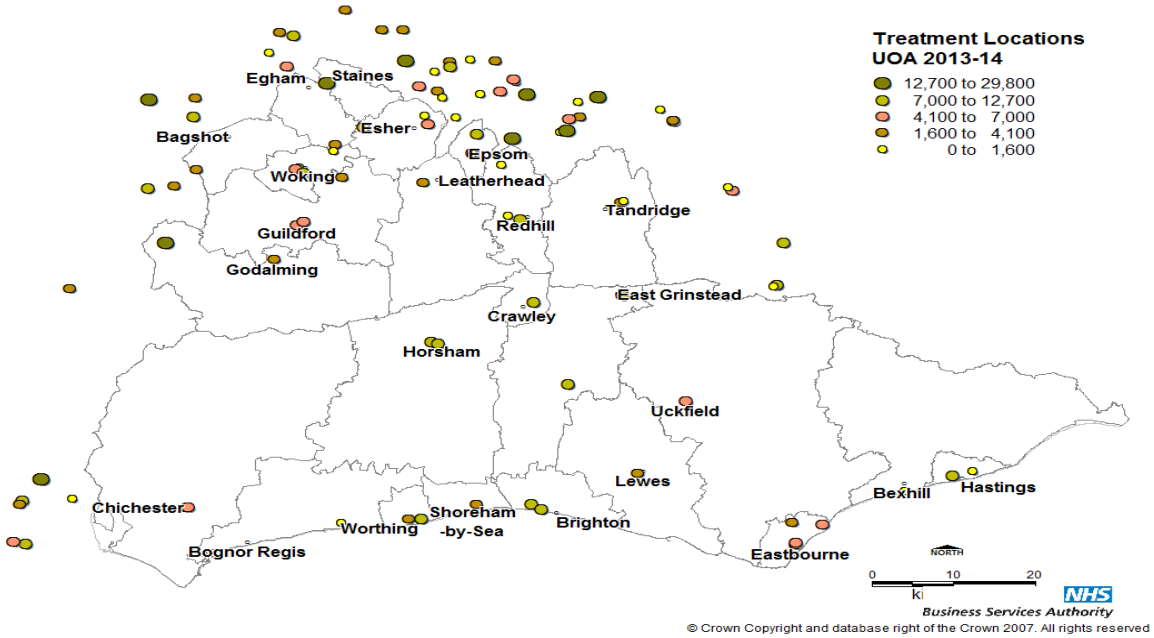
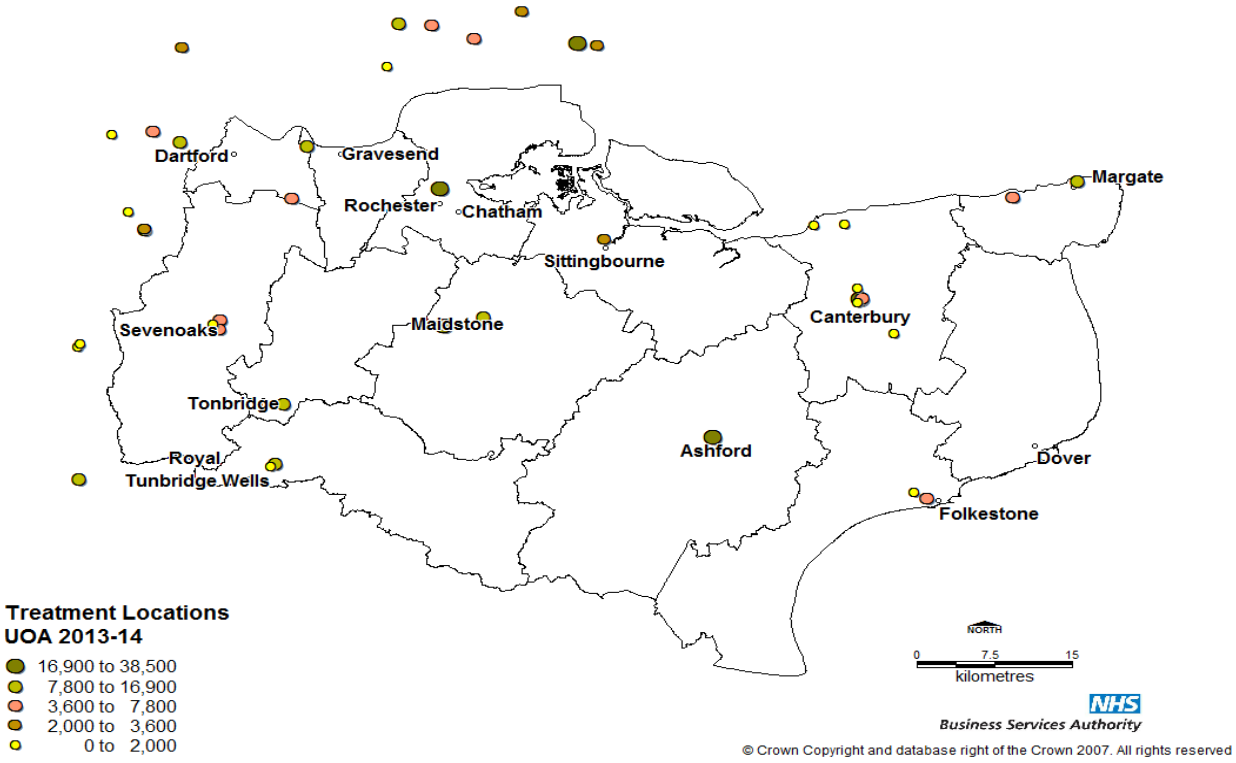


Figure 2: Treatment locations in Kent



Orthodontists are contracted in “units of orthodontic activity” (UOA), with an annual contract value (ACV) based on a specific number of UOAs. Payment is monthly in arrears based on an annual contract value monitored by the unit of orthodontic activity.

Following the contract reforms of 2006 there has been a significant shift in how orthodontic services are delivered; with many GDS contracts no longer offering orthodontics and there has been a large increase in the number of PDS agreements with specialist orthodontists, exclusively offering orthodontic care. In addition, there has been a shift from secondary care to primary care (PDS) for less severe orthodontic cases.

Contractors are expected to treat children under the NHS if they score an IOTN of 3.6 or greater. However, the NHS Regulations 2005 states that this can vary if the contractor is of the opinion, and ‘has reasonable grounds for this opinion that orthodontic treatment should be provided to a person who does not have such a treatment need by virtue of the exceptional circumstances of the dental and oral condition of the person concerned.’

Work is in progress to improve the efficiency of existing primary care contracts by a number of different approaches. Examples of this include:

- maximising the proportion of initial assessments leading to treatments and reducing inappropriate referrals or those that are made too early for the child to be suitable to enter into care.
- reduction of the relatively high level of “concluded” cases where treatment has been “abandoned” or “discontinued”
- minimising the number of transfer cases resulting from the breakdown of patient/orthodontist relationships. These can occur for example when relationships break down, or when patients move areas. However in either example NHS England must pay twice to treat the same child.

There is a significant amount of secondary care provision in hospitals across KSS. A hospital orthodontic unit provides a comprehensive diagnosis, second opinion and treatment service to manage complex malocclusions for children and adults. Referrals are primarily from specialist practitioners either for second opinions or because they are very complex cases and unsuitable for primary care e.g. those cases that would also benefit from multi-disciplinary approach such as orthognathic cases requiring surgical correction of the jaws or cleft lip and palate cases where bone grafts and replacement of multiple congenitally missing teeth may be required. Teaching and supervision of specialist trainees is also another important function of hospital units and requires a certain number of simpler cases to be treated in the hospital setting.

The previous needs assessment was developed by a working group and consulted on widely. There has been engagement with the profession continuously since then, leading up to the start of the procurement process. Comments are invited on this revised document to Jackie.sowerbutts@phe.gov.uk.

A number of recommendations were made as part of this needs assessment when it was first completed in 2014, some of which have already been partially or fully implemented. The updated list of recommendations is as follows:

Recommendation 1: Commissioners should investigate the reasons behind the variable travelling times across KSS, taking secondary orthodontic service provision into account, and consider whether to commission services to reduce this travel.

Recommendation 2: The Local Office needs to consider the higher than average levels of access to orthodontic care within the South East region, when commissioning orthodontic services.

Recommendation 3: Commissioners need to consider the comparatively lower proportion of children accessing care in Adur, Arun, Brighton and Hove, Chichester, Dartford, Dover, Gravesham, Hastings, Rother, Tunbridge Wells and Waverley. This consideration also needs to take into account the access patients may have to secondary care.

Recommendation 4: Commissioners should ensure the recording of waiting lists is standardised to allow patients to easily compare their options. This standardisation could include using a more intuitive set of waiting list measures such as the availability of the next three available new patient assessments.

Recommendation 5: When commissioning orthodontic services consideration should be given to the placement of services closer to patient's schools. This may also reduce patient travel, and the time taken away from school to obtain orthodontic care.

Recommendation 6: Keeping in mind proximity to school, commissioners should consider along with other factors such as equity, locating services close to the "proposed facilities" as highlighted by Geographic Information Systems (GIS) analysis. Particular attention should be made to the highlighted areas of yellow in Figure 12.

Recommendation 7: Within secondary care there is a need for Local Offices to work with hospitals' orthodontic departments to help influence and support the measurement of activity and costs to fully understand the provision of care and the complexity of the patients' needs. Details of care should include category of care, IOTN scores, and patient age. Commissioners should work with their national colleagues to support better collection of local data.

Recommendation 8: NHS England needs to consider the appropriate management of requests for a new course of treatment on patients presenting mid-treatment from another practice. This should include appropriate encouragement of orthodontists to request approval from the Local Office.

Recommendation 9: The Local Education and Training Board (LETB), Health Education England (HEE) needs to work with commissioners to support the appropriate professional measurement of IOTN, and in turn to support GDPs to explain the principles of orthodontic treatment at the point of referral in order to manage patients' and carers' expectations.

Recommendation 10: The Local Office should consider the introduction of a revised UOA in line with the transition guidance of approximately £56.50 without compromising the quality of care provision.

Recommendation 11: The Local Office should work with orthodontists, and referring GDPs to ensure that patients are referred at an appropriate time (with motivation for treatment and good oral health) and that IOTN is understood. This should ensure that rejected cases are returned (with reasons) to primary care referrers.

Recommendation 12: There needs to be a consultation with future patients and their carers to better understand their expectations of services and how this may influence future commissioning.

Recommendation 13: NHS England needs to ensure whilst working with national guidance that it works with providers to improve the reporting of Peer Assessment Review (PAR) scoring as a quality indicator. NHS England needs to ensure support is given to the Managed Clinical Networks (MCN) to facilitate appropriate levels of PAR assessment. This should follow national guidance on calibration, photography and selection of patients.

Recommendation 14: Commissioners need to support providers in accurate reporting and work with their national colleagues in order to facilitate better notification mechanisms from the BSA including reporting of concluded courses of treatment and PAR scores.

Part A The updated Orthodontic Needs Assessment 2016

1. Aims and objectives

- To determine if sufficient NHS orthodontic care is currently commissioned for the local population and if population changes will alter this need over the coming 5 years
- To describe available resources
- To assess and calculate orthodontic need (Normative, Comparative, Felt and Expressed need)
- To analyse demand for orthodontics
- To analyse performance of current service provision focussing on Normative need.

2. Data sources

Data was collected from the NHS Business Services Authority (BSA):

Using a template developed for the Public Health England (PHE) South region, information was gathered for the financial year (12 schedule months up to March 2014) to show the most current activity profile. For access and distances the 24 month period up to March 2014 was included to provide a greater picture of patients in the area those who have received orthodontic assessments or treatment. Current data (e.g. for the time period 2015-16) has not been requested as there has been little alteration in contract activity over this period to make a significant difference to the findings of the report.

Patient postcodes for all orthodontic patients were placed into Public Health England (PHE) Geographic Information Systems (GIS) software, and optimised; to provide an optimal picture, based on home postcode of where orthodontic services should be commissioned, to reduce patient travel. Information was sought on waiting lists directly from orthodontic contractors. Comparative information was downloaded from the Health Information Services site[1], and the Scottish equivalent Information Services Division.[2] Secondary Uses Services (SUS) data[3] were also requested from all hospitals with orthodontic units.

3. Current provision in the primary care setting

Orthodontists are contracted in “units of orthodontic activity” (UOA), with an annual contract value (ACV) based on a specific number of UOAs. Payment is monthly in arrears based on an annual contract value monitored by the unit of orthodontic activity (UOA).

Within Kent and Medway there are 29 General Dental Service (GDS) contracts and Personal Dental Service (PDS) agreements which support orthodontic provision; within Surrey and Sussex there are 47 agreements.

Figure 1: Treatment locations in Surrey and Sussex

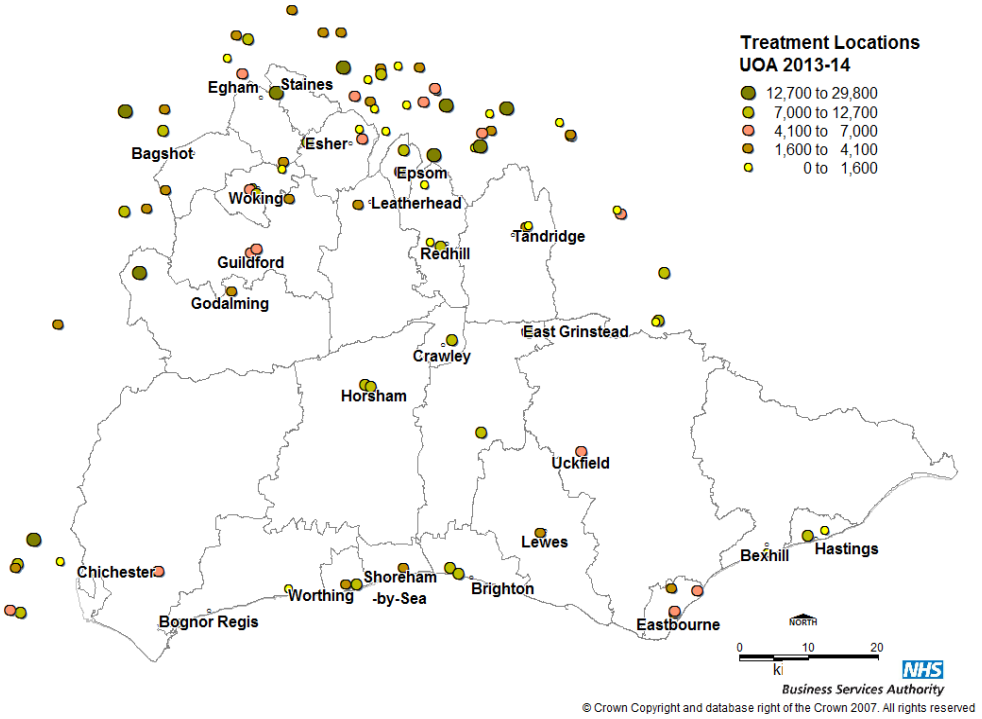
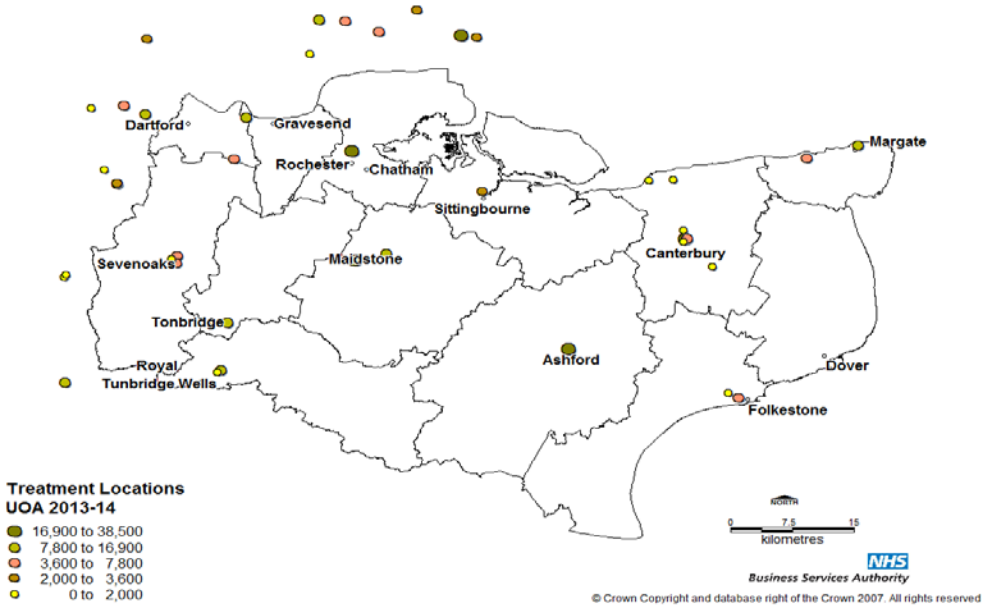


Figure 2: Treatment locations in Kent



Following the contract reforms of 2006 there has been a significant shift in how orthodontic services are delivered, with many GDS contracts no longer offering orthodontics and a large increase in the number of PDS agreements with specialist orthodontists, exclusively offering orthodontic care. In addition there has been a shift from secondary care to primary care (PDS) for less severe orthodontic cases.

NHS England is now responsible for commissioning a variety of NHS services including primary and secondary care dental services. Primary care services were funded from the primary care dental budget whereas hospital based orthodontics were/are often commissioned as part of a secondary care block contract. Historically there was a distinction in the funding stream but now both are funded from NHS England dental budgets. This creates an opportunity for commissioners to commission across the services to create a seamless service.

In November 2013, further advice (Transitional Commissioning of Primary Care Orthodontic Services[4]) was issued by the Department of Health advising that before any new procurement process can be considered, Local Offices (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.

The purpose of assessing orthodontic treatment need is to determine if sufficient effective and efficient orthodontic care is currently commissioned for the local population and if population projections will alter this needs assessment over the coming years. A needs assessment can also provide a fair and equitable process for all contract holders and provide an element of proportionality when dealing with contractors at the procurement process. Within England NHS orthodontic treatment is available to anyone who scores at least 3.6 on the Index of Orthodontic Treatment Need (IOTN). Age based eligibility restrictions have been adopted in some areas. Patients over the age of 18 can only be seen under the NHS within the primary care setting if their PDS Agreement particularly specifies this. Patients who are assessed before their 18th birthday may still have orthodontic care funded if eligible for care under the NHS.

4. Orthodontic provision in the secondary care setting

A hospital orthodontic unit provides a comprehensive diagnosis, second opinion and treatment service to manage complex malocclusions for children and adults. Primary care based specialist orthodontic practitioners and General Dental Practitioners (GDP) account for the majority of referrals. There is established multi-disciplinary working with Oral and Maxillo-facial Surgery/Restorative/Paediatric Dentistry and ENT colleagues with complex cases assessed in designated multidisciplinary clinics. Supervision and teaching of trainees are an important aspect of the treatment provided in hospital

orthodontic units. A number of designated orthodontic units in KSS are linked to the South Thames cleft service and provide local treatment for cleft lip and palate patients as part of the regional cleft services.

Secondary care is different from primary care for a number of reasons. Both services are funded by NHS England. However, secondary care services must follow 18 week referral to treatment protocols as well as their waiting time performance targets. For new patients and follow up patients they are bound by a number of different rules including:

- secondary care commissioning rules (e.g. new : follow up ratios)
- data capture on outcome/activity
- the requirement to code using Payment By Results (PBR)
- individual trust rules e.g. specific Key Performance Indicators
- waiting time initiative and performance targets e.g. 18 week referral to treatment rules.

Orthodontic treatment, in certain situations, may require a multidisciplinary team approach and this is often better offered by team led by a consultant. Currently this service takes place in a secondary or tertiary care setting in a dental hospital or a District General Hospital. Such patients may be orthognatic patients who require surgical correction of the jaws or cleft lip and palate patients where bone grafts and replacement of multiple congenitally missing teeth may be required. Such treatment is usually consultant led and also forms the basis for specialty training as well as requiring a simpler case mix for the trainees. Specialists who wish to become consultants in orthodontics require a further two years training following completion of their orthodontic specialty training. During this period trainees are required to achieve competencies in specific areas such as 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 with the Examination (ISFE) awarded by Royal College of Surgeons (RCS) and satisfactory completion of all Annual Review of Competence Progression (ARCP).

5. Assessing orthodontic need and demand

There are a number of ways to define health need including[5],

Normative Need: Defined by professionals and based on assessment against an agreed set of criteria.

Comparative Need: A comparison of individuals or groups of similar individuals is undertaken with regards to services or resources.

Felt Need: This includes what people perceive as being important i.e. subjective feelings of what people really want.

Expressed Need: These are the needs which arise from felt needs when expressed in words or action to become demand.

5.1 Normative need

The IOTN is one means of assessing the normative need for orthodontic treatment and this consists of two parts, an Aesthetic component (AC) and a Dental Health Component (DHC). The AC consists of a scale of different levels of "dental attractiveness" grade 1 being the most attractive, and grade 10 the least. The DHC has been grouped into grades 1 and 2 being malocclusions requiring slight or no need for treatment, grade 3 being borderline cases and grades 4 and 5 representing those in 'great need of orthodontic treatment'[6]. Contractors are expected to treat children under the NHS if they score an IOTN of 3.6 or greater.

Published data of the need in 11-12 year olds in the UK population identifies that, based on IOTN of 3.6, approximately one third of this age cohort will need and want orthodontic treatment. Unlike many other health needs this is consistent across population and ethnic groups.

There are many formulae that have been developed to try to quantify the amount of orthodontic treatment that would be required for a population. The following means of estimating potential normative need were taken from the Orthodontic Needs Assessment conducted in South East Wales in 2009[7].

- Brook and Shaw (1989) reported that 39% of the 11-12 year population had a DHC of 4 or 5 or DHC of 3 with AC> 6[8,9].
- Holmes (1992)[10] reported that 36.3% of children had a DHC 3 and an AC of 6 or higher. A further 4% were wearing orthodontic appliances (Holmes' calculation is therefore 36.3 % plus the 4% wearing appliances.).
- Stephens (1992)[11] used a prediction method based on twelve year old population to calculate orthodontic treatment need. According to his method, one third of 11-12 year-old children will fall under IOTN 4 and 5. Stephens has also factored in the interceptive orthodontic treatment and adult orthodontics into his formula. Stephen's formula is calculated as follows[11]:

(12 year old population / 3) x (100 + Interceptive Factor + Adult Factor) / 100
(12 year old population / 3) x (100 + 9 + 4) / 100
= (12 year old population / 3) x 113 / 100

- Burden and Holmes[12] (1994) reported that, based on IOTN, approximately one third of 11-12 year old children in the UK would greatly benefit from orthodontic treatment. A further 5% were wearing orthodontic appliances.
- The National Child Dental Health Survey (2003) found that 35% of 12 year old children in the UK had a DHC of 4 or 5 and an AC of 8-10. A further, 8% were wearing orthodontic appliances.

The population estimates for Local Authorities can be seen in Table 1 and 2.

Table 1: Population estimates for Local Authorities 2015

Local Authority	Population estimate 2015
Brighton and Hove	285,276
Medway	276,492
East Sussex	544,064
Kent	1,524,719
Surrey	1,168,890
West Sussex	836,256
KSS (total)	4,635,697

Table 2: 12 year old population with estimated normative need

KSS Area	Estimated 12 year olds in total (2012-based Subnational Population Projections- 2015 projection)	Stephens formula	Burden and Holmes	National Child Dental Health Survey (estimated need)	Estimated based on highest prevalence in English region of 33%
Brighton and Hove	2,380	896	959	833	785
East Sussex	5,640	2,124	2,273	1,974	1,861
West Sussex	8,940	3,367	3,603	3,129	2,950
Surrey	13,380	5,039	5,393	4,683	4,415
Kent	16,940	6,380	6,827	5,929	5,590
Medway	3,060	1,152	1,233	1,071	1,010
Total	**51,968**	**19,575**	**20,943**	**18,189**	**17,149**

The normative need for orthodontic care as assessed by GDPs will be different from the "true" normative need assessed by orthodontists. This difference will inevitably result in a higher number of patients who actually seek care at an orthodontist, because of the number of children who are referred for consultation purposes. This is a service orthodontists provide, regardless of normative need of the patient, and this also requires the payment of UOAs. However, it is anticipated that the more aware GDPs are of the criteria for NHS care, the better the quality of referrals to specialists and hence the more efficient the use of the contract becomes.

Normative need - a projected population

The projected populations of Kent, Surrey and West Sussex are increasing until 2020, with less projected population increase in East Sussex, Brighton and Hove, and Medway. There is an anticipated increase of approximately 7 -10% of 12 year old population within these areas.

Table 3: Projected population of 12 year olds in KSS

Area	2015	2016	2017	2018	2019	Percentage increase
Brighton and Hove	2,380	2,440	2,500	2,560	2,600	9.2%
East Sussex	5,640	5,700	5,840	5,940	6,040	7.1%
Kent	16,940	17,360	17,800	18,280	18,680	10.3%
Surrey	13,380	13,600	14,040	14,460	14,760	9.5%
West Sussex	8,940	9,060	9,280	9,500	9,680	8.1%
Medway	3,060	3,120	3,200	3,280	3,320	8.5%

Using the population for 12 year olds in this area and 2 year data from 2012-14, the normative need was calculated. Each local authority had a different estimated population increase. This increase was used for each locality depending on its relevant local authority. For localities below this was based on calculating 33% of the child population at 2019 for each locality.

5.2 Felt need

This is the need that people perceive as being important i.e. subjective feelings of what people really want. It is measured within orthodontic care as the percentage of children who think their teeth need straightening and are prepared to wear a brace. The felt need can be shown in Table 4. It should be noted that the actual numbers for each Local Authority (LA) (e.g. Brighton and Hove) are quite low, and therefore the confidence intervals surrounding these numbers are probably high.

Table 4: Subjective feelings of what people really want - percentage of children who think their teeth need straightening and are prepared to wear a brace

LA	12-year-old Population (Mid-2008)	Number examined and questioned	% of Children who think their teeth need straightening and are prepared to wear a brace
Brighton and Hove City	2,437	91	38.9%
East Sussex Downs and Weald	3,916	118	29.4%
Eastern and Coastal Kent	9,290	504	35.9%
Hastings and Rother	2,151	155	30.8%
Medway	3,279	96	39.8%
Surrey	13,395	593	33.1%
West Kent	8,700	457	41.4%
West Sussex	9,784	287	35.3%
England	608,460	31,681	35.4%

Within KSS, the demand for orthodontic care is high with between 29.4% and 41.4% of children “feeling” their teeth need straightening. The national average is 35.4%.

5.3 Expressed need

Expressed need is the need which arises, when felt need becomes expressed in words or action to become demand i.e. the number of children who present for treatment, as shown in the table below.

Table 5: Expressed need for orthodontic care for 12 year old children, 2012

Region	Assess and accept (number of children, then % of children)	Assess and Review	Assess and Refuse	Abandoned (patient decision)	Discontinued (clinical decision)
Surrey	5,435	8,237	2,116	170	84
	41%	62%	16%	1%	1%
Brighton and Hove	846	889	229	3	4
	32%	34%	9%	0%	0%
West Sussex	3,022	4,043	603	58	35
	34%	45%	7%	1%	0%
East Sussex	1,599	2,170	439	47	40
	27%	37%	7%	1%	1%
Kent	6,297	7,885	1,848	185	63
	35%	44%	10%	1%	0%
Medway	1,741	1,287	553	210	60
	53%	39%	17%	6%	2%

Please note that the numbers of assess and accept, assess and review, and assess and refuse cannot be added together as they can relate to the case i.e. a child can be assessed and reviewed, and then assessed and accepted within the same time period.

5.4 Comparative need

The orthodontic need of KSS patients can be compared with groups of similar individuals e.g. by comparing to England counterparts.

Within England 4.4 million UOAs are performed, which calculates as care for approximately 34% of the population. Within KSS, there is a higher amount of UOAs performed, working out as between 38% and 43% of the population. The average amount of money spent within primary care on providing orthodontic treatment for a 12

year old ranges from £532.00 in Surrey and Sussex to £597.00 in Kent and Medway based on 2014 data.

It is unknown why KSS has greater activity than national levels. From a deprivation perspective, the region is less deprived than the whole of England and this may explain the increased uptake of orthodontic care. It may be that orthodontic care is more available based on increased availability at the time of the contract change in 2006. It may be that KSS has less secondary care; however as discussed later in the document, secondary care costs for this region are already potentially higher than proposed national expenditure.

Based on 22 UOAs per child, which is the number allocated per course of treatment, the following Table 6 can be constructed.

Table 6: Average UOA costs per 12 year old child for England and KSS regions, 2013/14

Area	UOAs performed 2013-14	Population 12 year olds (2013 for England, and projected 2015 for KSS)	Equivalent UOA performed per 12 year old	Number of children seen as percentage of 12 year old population	Average total cost based on £60 per UOA	Cost per 12 year old child
England	4,400,000	593,200	7.4	34%	£93,200,000	£466
Kent and Medway	187,760	20,000	9.7	43%	£11,941,569	£597
Surrey and Sussex	236,532	27,960	8.5	38%	£14,864,040	£532

Table 7: Breakdown of cost of UOA by area, 2013/14

Area	Assess and accept	Assess and review (which might also be included in accept)	Assess and refuse	Cost
Surrey and Sussex	£13,790,408.76	£888,541.71	£185,089.28	£14,864,039.75
Kent and Medway	£11,235,243.47	£556,523.89	£149,801.55	£11,941,569.00

Within Surrey and Sussex, around £15 million worth of UOAs were provided in 2013/14 in primary care. Of these approximately 7% (£888,542) were classified as “assess and review”. In this instance, a patient is referred to and assessed by an orthodontist, but is perhaps not ready for care at that time. Within Kent and Medway, approximately £12 million worth of UOAs are provided, with less than 6% being assessed and reviewed (£556,524) and, similar to Surrey and Sussex £149,802 of UOAs being actively refused.

A further 1.3% of patients (£185,089) are assessed by a Surrey and Sussex orthodontist but are not accepted for care (because the child does not meet the criteria for acceptance for care under the NHS; they are categorised as “assess and refuse”. The position is very similar in Kent and Medway. It is also possible that some people classed as “assess and refuse” decide they don’t want NHS orthodontics and elect to seek private treatment.

Table 8: Summary information on assess and accept/review/refuse in 2013/14

Assessment Outcome	Number of UOAs		Total UOAs
	Surrey and Sussex	Kent and Medway	
Assess and accept	219,348	176,627	395,975
Assess and review	14,133	8,749	22,882
Assess and refuse	2,944	2,355	5,299
Repairs	107	29	136
Total	236,532	187,760	424,292

Under the terms of their contract orthodontists are allowed to discuss private options with patients and their carers e.g. the use of ceramic brackets which some people may feel are more aesthetically acceptable. Private care is also sometimes chosen as a way of avoiding an NHS waiting list until there is capacity for the child to be treated.

Potential capacity was calculated by dividing total UOAs by 22. The number of UOAs "spent" on assessing and reviewing, or assessing and rejecting patients is the subject of debate between commissioners and providers. Commissioners would argue that looking at Table 8 there is capacity in the system to provide additional orthodontic care for children, if we could reduce the amount of time orthodontists spent on assessing and reviewing patients, and increase the time spent actively treating patients. This capacity would equate to 28,181 UOAs spent (Assess and review, assess and refuse) equalling 1280 children within KSS which would contribute significantly to the extra activity required to treat the rising 12 year old population within KSS.

6. Current service provision gap analysis

An important aspect of the effectiveness of dental commissioning is the ability of patients who meet criteria, to obtain needed dental treatment when they request it. This can apply to orthodontics as well as general dentistry.

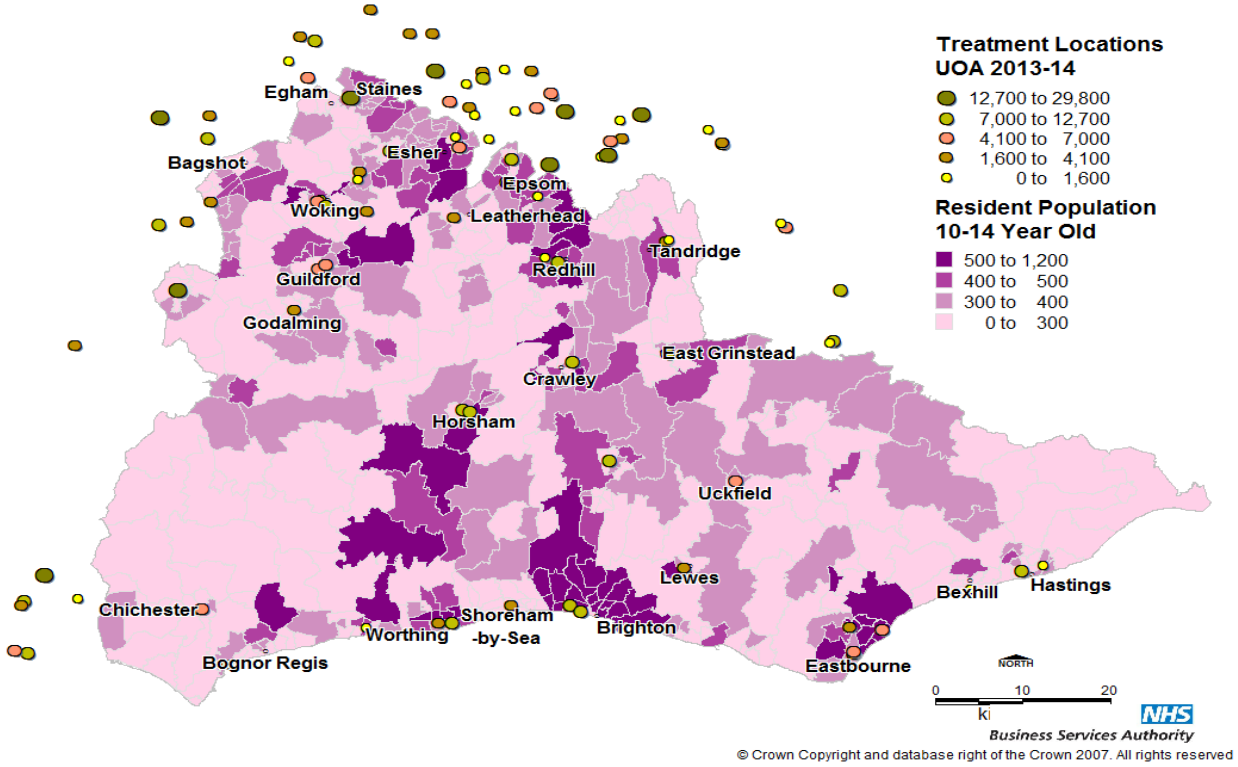
The following measures can give an indication of the effectiveness of commissioning including treatment location, population, average distance travelled, population density, waiting list, secondary schools, historic patient location, patient inflow/outflow, deprivation and ethnicity. Commissioning primary orthodontic care also needs to take into account the current provision of secondary care.

6.1 Treatment location and population

Location of service provision can help assess the effectiveness of dental commissioning, especially when combined with other data such as deprivation and access rates. Activity data is based on patient residence postcode as entered onto the patient form FP17 which is completed whilst at the dental surgery.

The map below shows treatment locations overlaid onto ward level population for 10-14 year olds (source: Mid-Year 2012: population and household estimates for wards in England and Wales, ONS).

Figure 3: Treatment locations and ward level population densities for 10-14 year olds in Surrey and Sussex

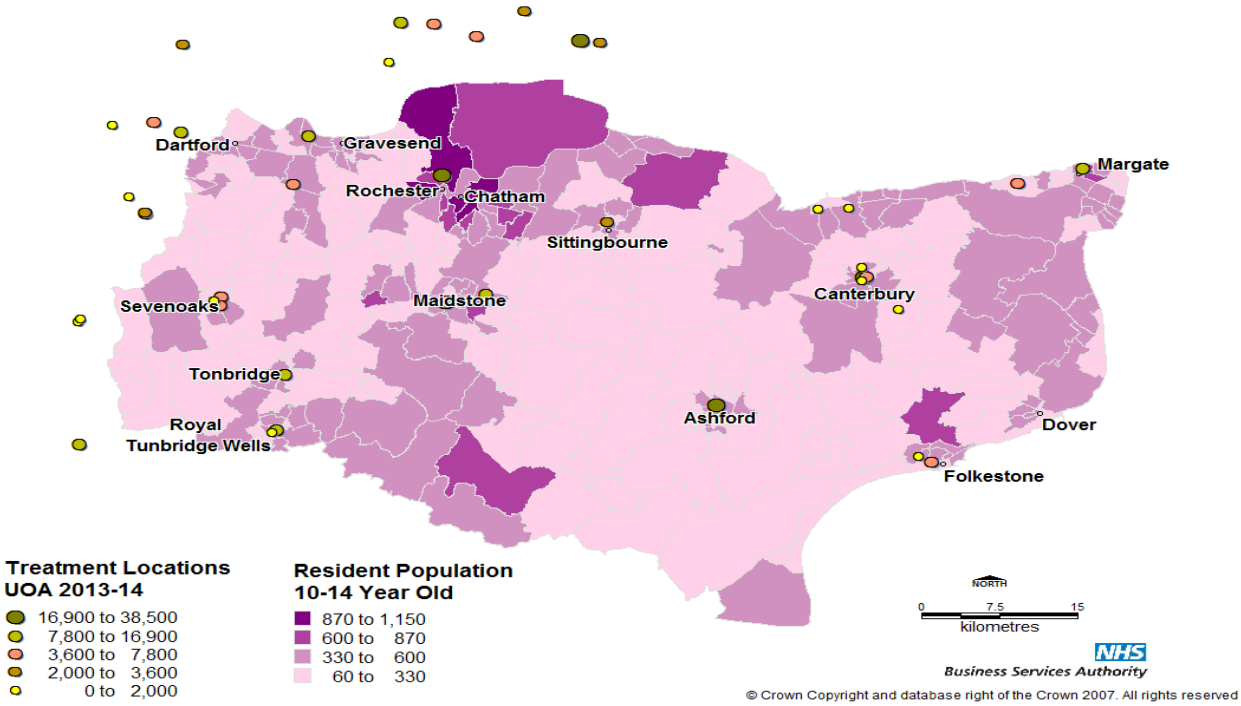


Within Surrey and Sussex, there are a number of large orthodontic practices in Staines, Epsom, Horsham, Brighton, Hastings. There are highly concentrated populations south of Horsham, and north of Brighton, and to the east of Guildford.

Within Kent, there are generally much bigger orthodontic practices with similar density populations as shown in the Figure below.

Further information on population densities can be found at Appendix 1.

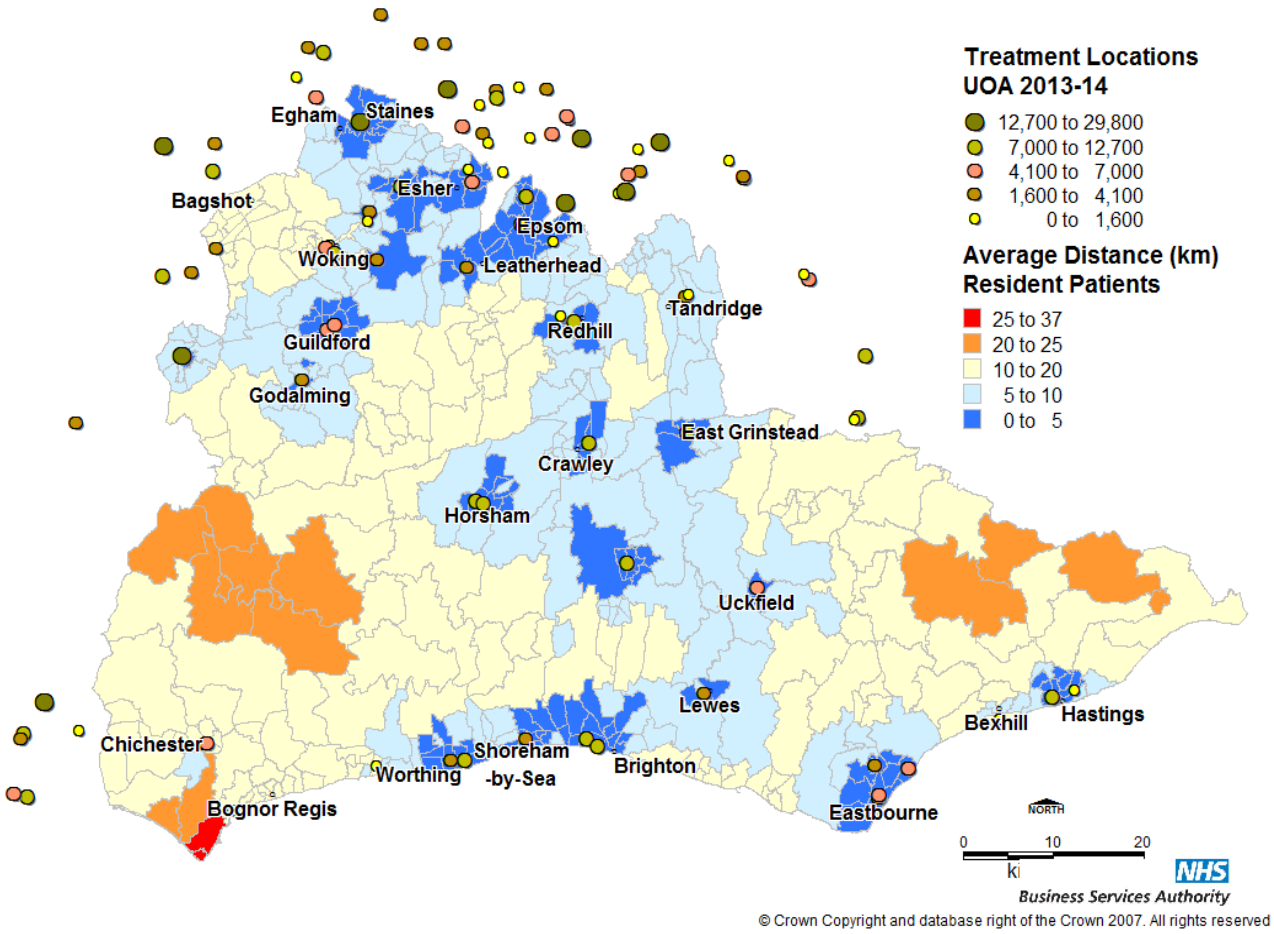
Figure 4: Treatment locations and ward level population densities for 10-14 year olds in Kent and Medway



6.2 Treatment location and average distance travelled

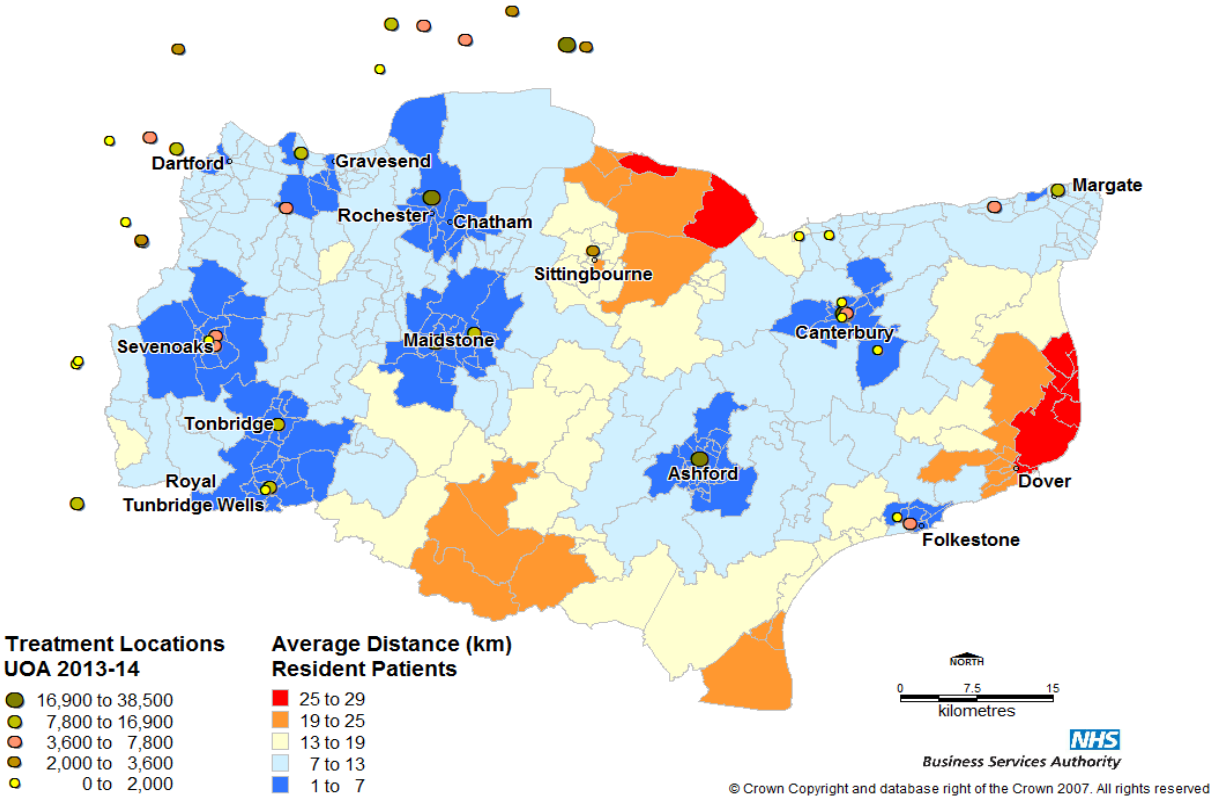
Within Figure 5 the average distance travelled by patients can be seen. The highest distance is 37 km. Some patients would choose to travel longer distances to access a particular provider or one that is close to the child's school. Small populations of children in a particular area would not indicate the need for commissioning more local services as there needs to be a minimum level of need within a locality to make a service sustainable. The map does not include the provision of secondary care orthodontics.

Figure 5: Delivered UOA treatment locations (12 months to March 2014) & average distance travelled by of resident patients attending an NHS orthodontist (24 months to March 2014) in Surrey and Sussex



There are areas south of Bognor Regis where patients have to drive higher than average distances to access an orthodontist. This may be because of the low child population in this region, which would make it difficult to sustain a specialist orthodontic practice there.

Figure 6: Delivered UOA treatment locations (12 months to March 2014) & average distance travelled by of resident patients attending an NHS orthodontist (24 months to March 2014) in Kent and Medway



There are areas of Kent (such as north of Dover) and east of Sittingbourne where there are higher than average distances to be driven to access an orthodontist.

When analysing these maps secondary care provision needs to be considered. Chichester for example has secondary orthodontic providers close by which may provide some primary care type orthodontics. This means that relying on driving distances for this region to access primary care type orthodontic care as an indicator for making commissioning decisions may be potentially flawed.

Recommendation 10: Commissioners should investigate the reasons behind the variable travelling times across KSS, taking secondary orthodontic service provision into account, and consider whether to commission services to reduce this travel.

6.3 Population density for resident child population

Population density measures the number of people resident in an area (kilometre squared, km^2) and therefore the potential need for services in an area. The map shows wards population density (resident population per km^2). Those areas with darker shading have the highest density. See also Appendix 1.

Figure 7: Total resident patients attending NHS orthodontist (24 months to March 2014) in Surrey and Sussex

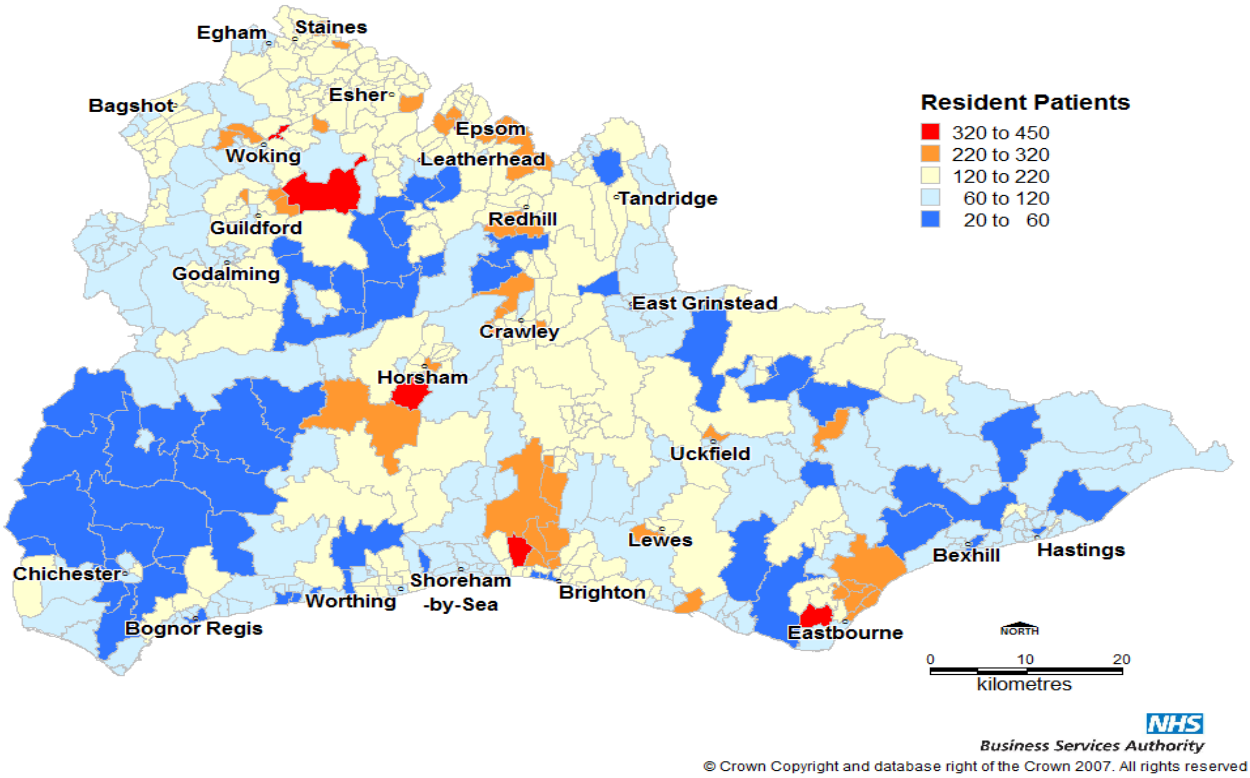
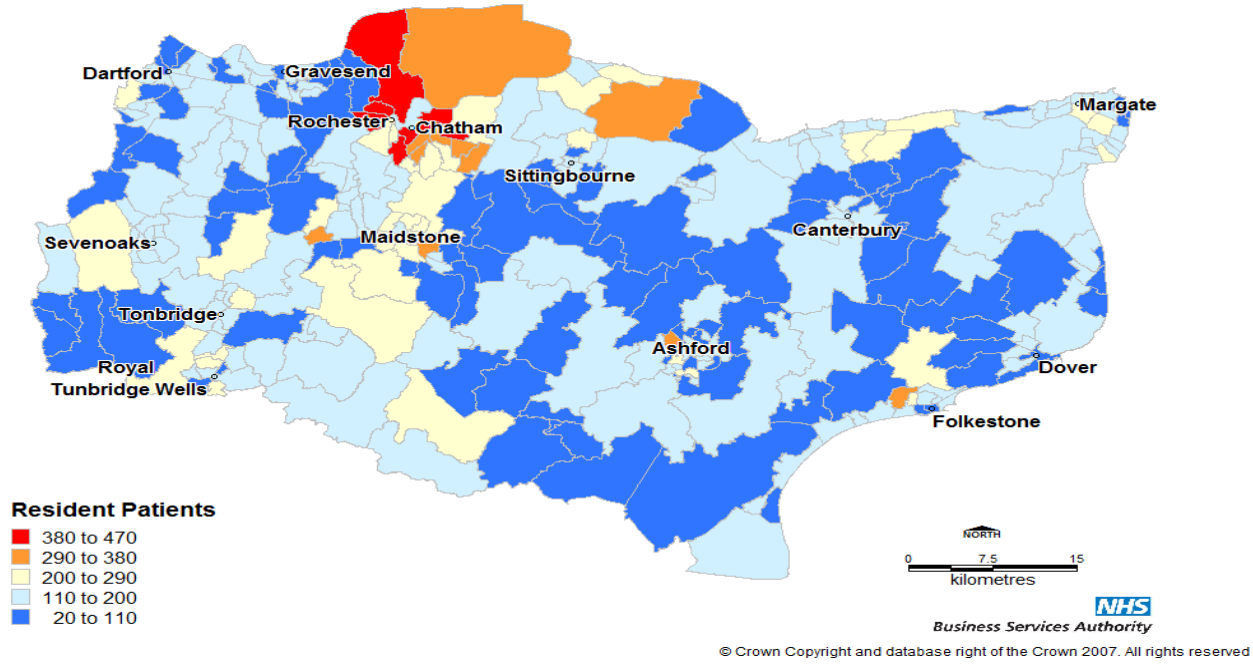


Figure 8: Total resident patients attending NHS orthodontist (24 months to March 2014 in Kent and Medway



6.4 Percentage of residents attending an NHS orthodontist

Table 9 below shows the percentage of residents by age group who attended an orthodontist.

Table 9: Percentage of resident population aged between 6and 24 years attending an orthodontist in Surrey and Sussex, Kent and Medway and England.

Area	% of resident population attending an orthodontist		
	6-12 year olds	13-17 years	18-24 years
Surrey and Sussex	13.4%	21.1%	0.5%
Kent and Medway	13.8%	23.3%	0.7%
England	9.9%	20.3%	0.7%

As would be expected children have the highest levels of orthodontic access. Attendances are total attendances (and include any patient who is accepted for treatment, review, or refused.) The South East area has a higher percentage of resident child population attending an orthodontist than nationally.

Recommendation 11: The Local Office needs to consider the higher than average levels of access to orthodontic care within the South East region, when commissioning orthodontic services.

These figures are broken down further by Local Authority area which shows a wide variation in access. For most of the residents who live in KSS there is higher than national average access to orthodontic care. The reverse is true for Dartford, Tandridge, Brighton and Hove, Chichester, Sevenoaks, Hastings, Rother, Arun, Surrey Heath, and mid Sussex. These variances could be accounted for by children in some of these areas receiving care both within the local Acute Trusts and outside of the KSS area as they are close to the border e.g. Surrey Heath.

Figure 9: Percentage of resident population aged between 13 and 17 in Surrey and Sussex

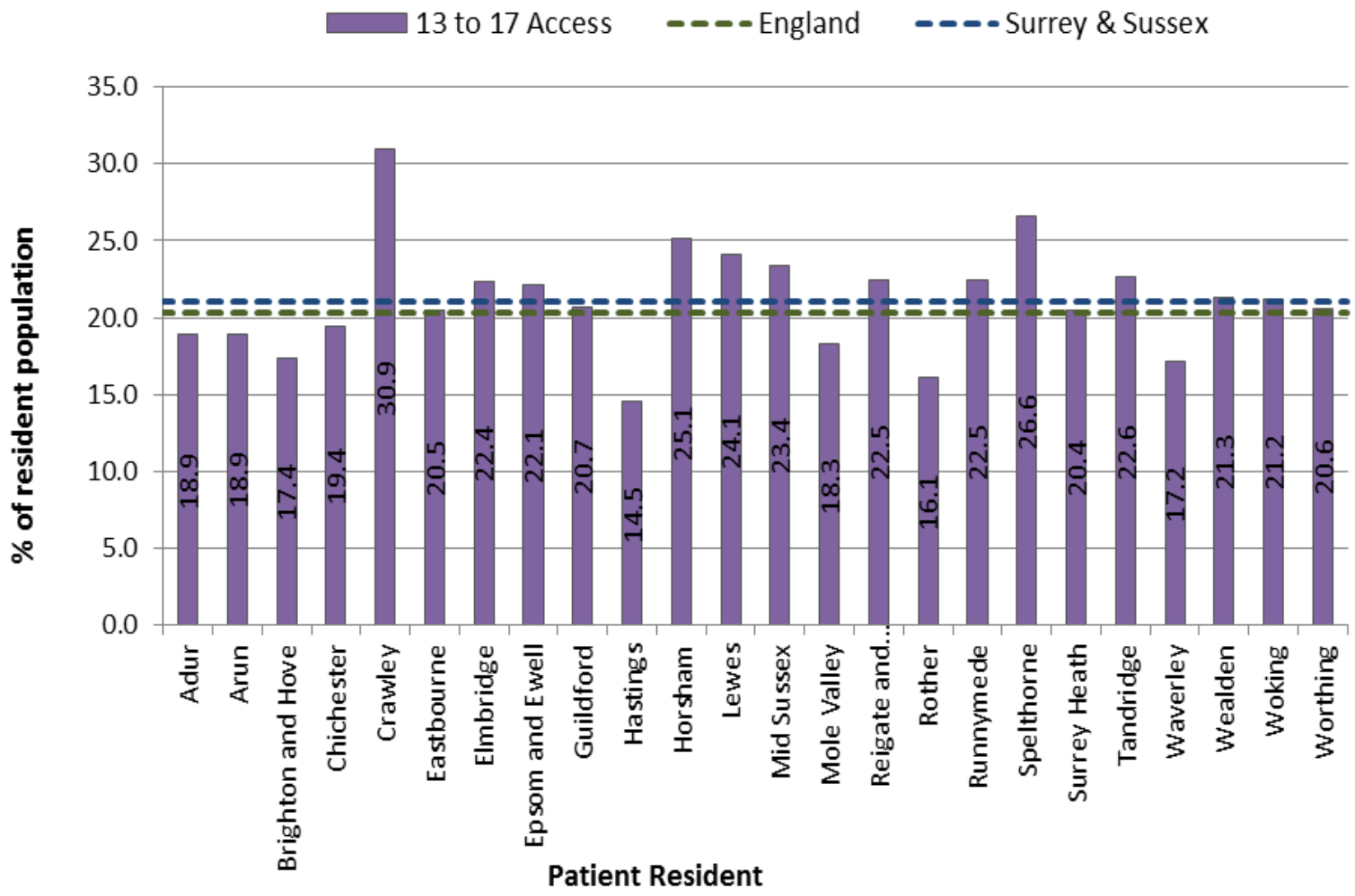
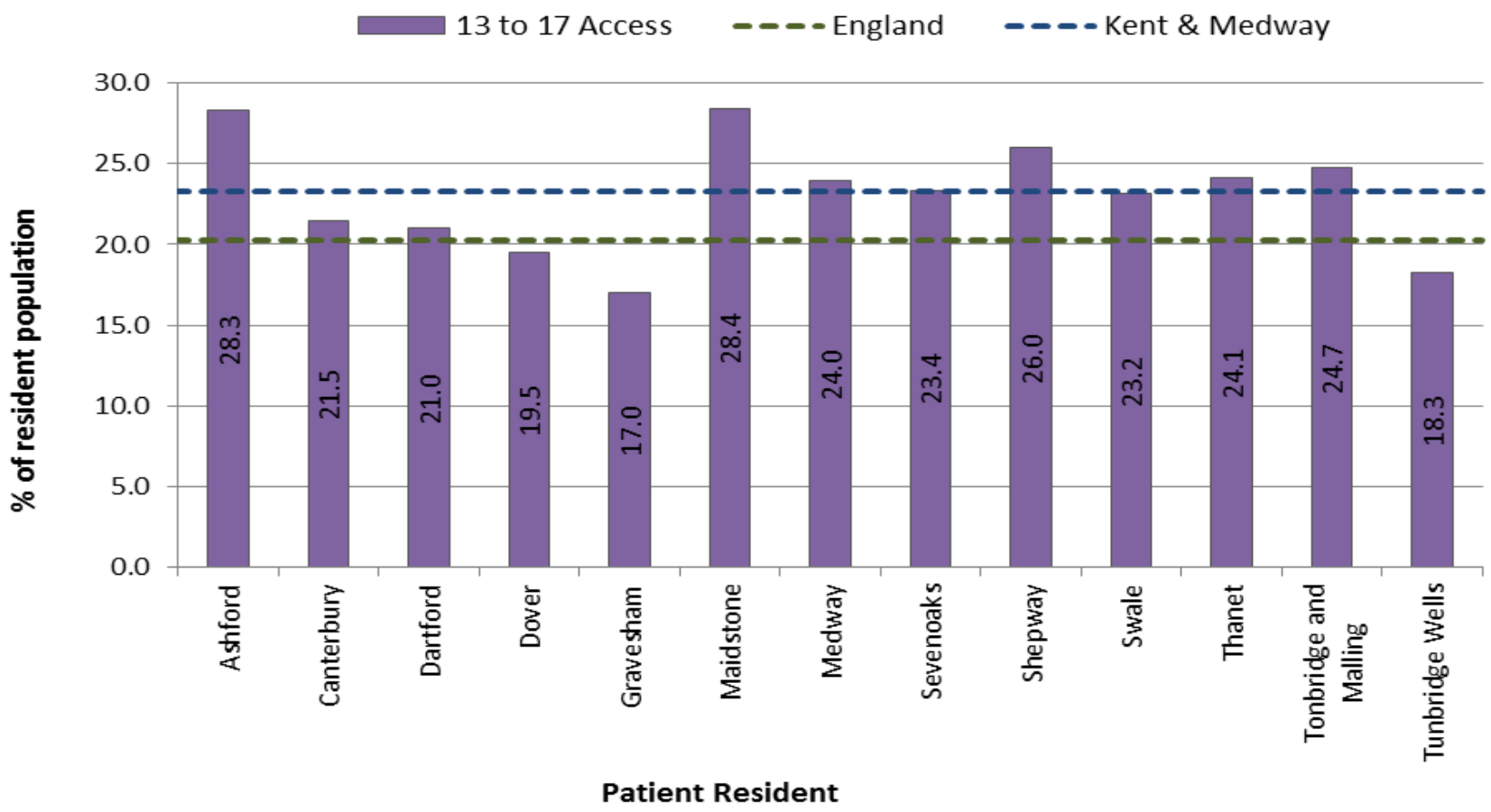


Figure 10: Percentage of resident population aged between 13 and 17 in Kent and Medway

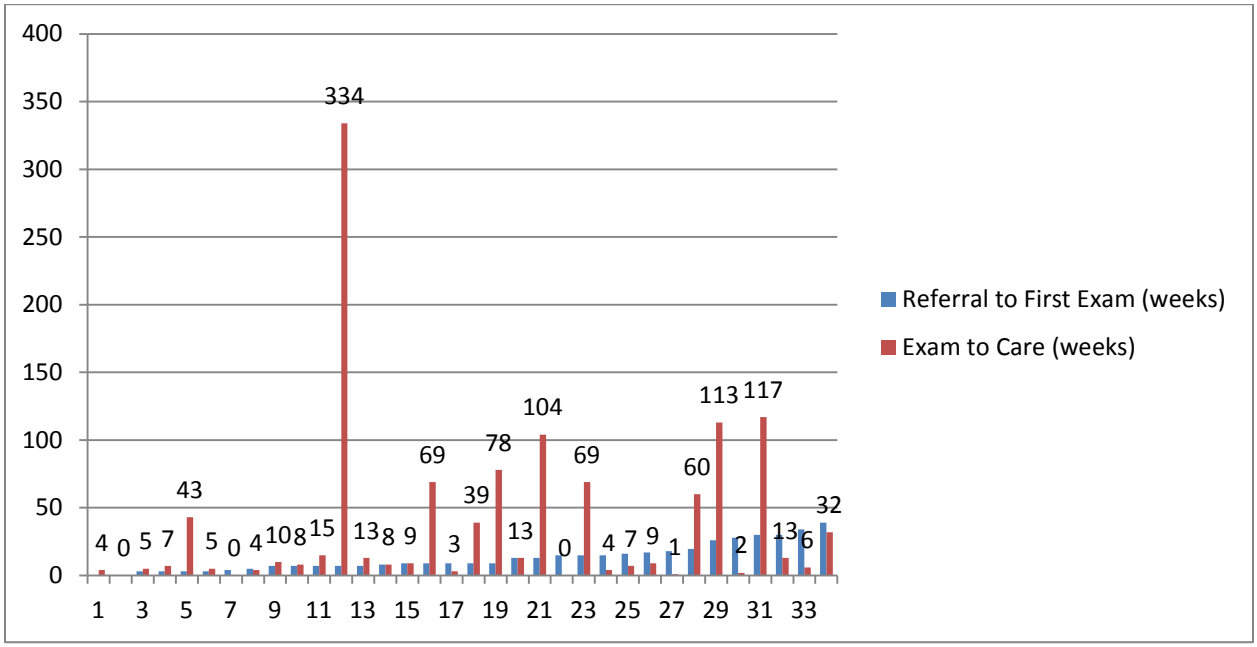


Recommendation 12: Commissioners need to consider the comparatively lower proportion of children accessing care in Adur, Arun, Brighton and Hove, Chichester, Dartford, Dover, Gravesham, Hastings, Rother, Tunbridge Wells and Waverley. This consideration also needs to take into account current secondary care.

6.5 Waiting list

There is no consistency in the way waiting lists are created by practices across KSS. There are considerable differences (see Figure11) in waiting lists- with most practices able to see patients for an exam (assessment) within about 9 weeks (median), and after another 8 weeks (median) for treatment. There are however a number of outliers, with some practices expecting the patient to wait over 6 months, and with 10 practices requiring patients to wait between 43 and 334 weeks. No figures were available for the practices in Kent. Since this was originally written the waiting times for patients to be seen has reduced, primarily due to the work done to increase the efficient use of the contracts. There is no current data on the waiting list position available.

Figure 11: Time taken from referral to first exam, (assessment) and from first exam to treatment start in Surrey and Sussex (weeks1) N.B. Data are not available for Kent.



The two key factors influencing the score in this indicator are the ability of the Local Office to manage contracts and also the ability of GDPs to make appropriate referrals.

[1] Kent and Medway waiting lists were not available

There is currently no national guidance for waiting list management or prioritisation by providers.

It is possible that the single biggest factor in determining the differing waiting list between providers is the relative popularity of providers in a certain area with referring dentists and patients/parents. Some practices will be more popular than others for good reason but therefore will compare less favourably when measured using assessment/treatment ratios and waiting lists. This needs to be reflected and take in consideration when looking at overall providers' performance.

Commissioners suggest that the current variable emphasis placed on waiting time to assessment and waiting time to treatment is confusing to patients and generates many queries to the Local Office and can result in patients moving elsewhere after an assessment when they find they have another 2 years to wait for treatment. If people were placed onto orthodontic waiting lists when they were ready to be treated rather than when they were first assessed waiting lists would be much less of an issue.

Recommendation 13: Commissioners should ensure the recording of waiting lists is standardised to allow patients to easily compare their options. This standardisation could include using a more intuitive set of waiting list measures – such as availability of the next three available examinations.

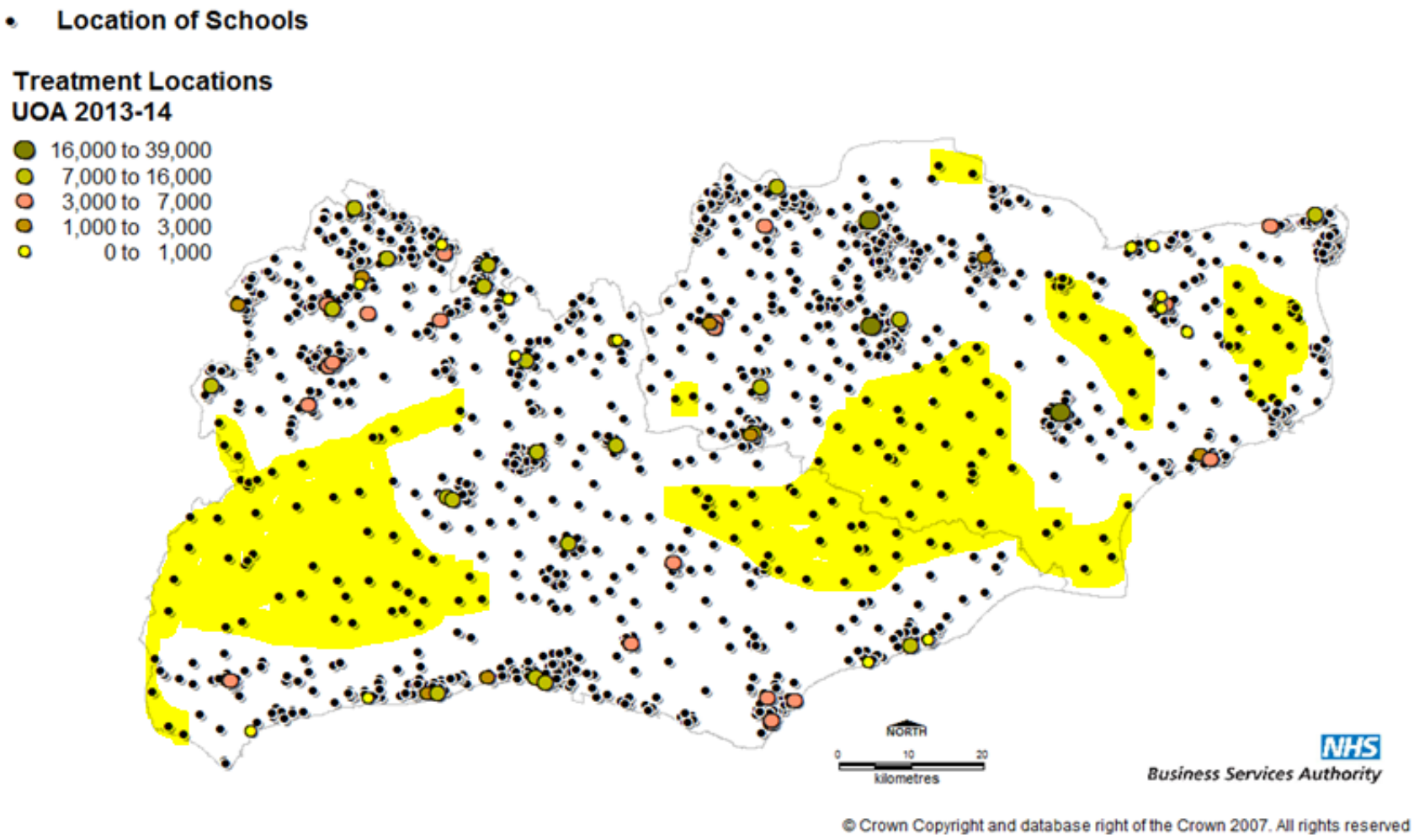
6.6 Orthodontic provider location and secondary schools

It has been suggested by orthodontists that most children attend orthodontic appointments travelling directly from their secondary school. There is no data on how many children travel from secondary school, or how many would travel from secondary school if there were services in close proximity. However in order for NHS England to commission services which reduce the travel and time taken from Education to attend an orthodontist from school, it should consider the following graph with priority given to commissioning orthodontic services within the areas highlighted in yellow, where current orthodontic provision is low.

Recommendation 14: When commissioning orthodontic services consideration should be given to placement of services closer to patient's schools. This may also reduce patient's travel times and the time taken away from school to obtain orthodontic care.

Recommendation 15: Keeping in mind proximity to school, commissioners should consider along with other factors such as equity, locating services close to the "proposed facilities" as highlighted by GIS analysis. Particular attention should be made to the highlighted areas of yellow in Figure 12.

Figure 12: Schools and location of orthodontic care



6.7 Patient in flow and outflow

Patent in flow occurs when patients are resident outside of the Local Office and receive orthodontic treatment from KSS Local Office contracts. Significant numbers of patients from outside an area may limit access to services for residents.

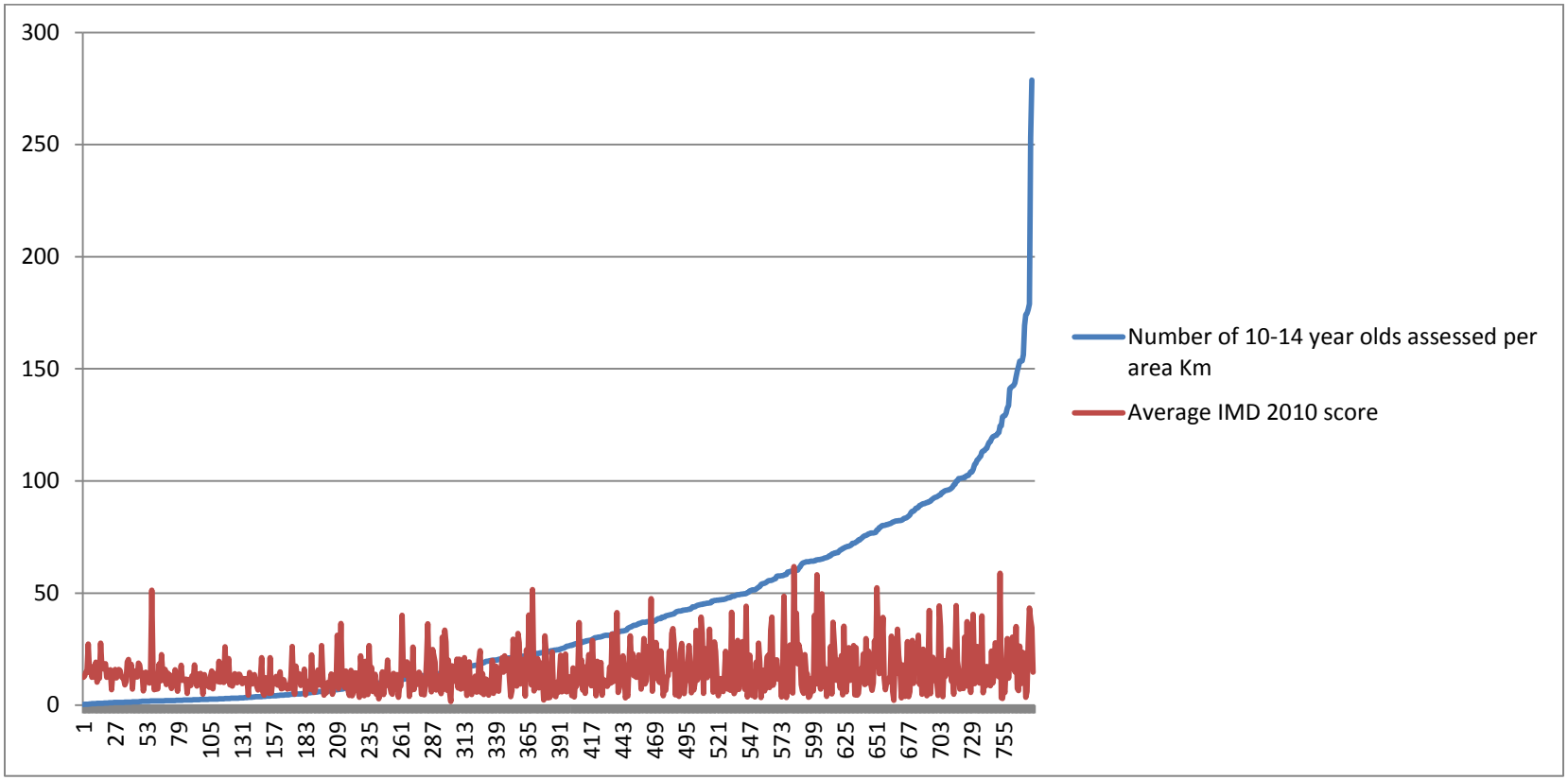
Patient outflow occurs when patients living within KSS have received their dental treatment out with the area. Significant numbers of patients travelling outside may be an indication of poor quality or a lack of services in an area. There is little difference between patient in flow and outflow (see Appendix 2). As the flow ins and outs are fairly similar then financially this should raise little concern for the Local Office but should be closely monitored for any changes. However, this may affect some of the population uptake rates quoted within the tables.

7. Demography

7.1 Deprivation

In a recent Scottish study uptake of orthodontic services was shown to be highest in areas of low deprivation.[13] In KSS there seems to be no relationship between access and deprivation. When the number of children assessed per km^2 was plotted against deprivation score (IMD), there appears to be no relationship between the two variables. It is possible that the rural geography is masking the underlying relationship between deprivation and access, as shown in Figure 13. For more information on deprivation please see Appendix 3.

Figure 13: Deprivation relationship - number of 10-14 year olds assessed per km^2 and average IMD 2010 score



7.2 Ethnicity

Equity of access to health services is a key marker of quality healthcare services. In April 2010, a change was made requiring mandatory completion of the ethnicity marker on the FP17. The chart in Appendix 4 shows the proportion of courses of treatment (FP17s) where ethnicity is recorded (i.e. the ethnicity group has been filled in or the patient declined) and the percentage where an ethnicity is included (i.e. the ethnicity group has been filled in; this excludes those where the patient declined). Within KSS, the proportion of people who complete the form is around 60%, and therefore no definitive conclusion can be drawn from ethnicity data.

8. Secondary dental care providers (orthodontic)

We know from conversations with some secondary care providers, for example with (but not limited to) Brighton and Hove, and East Sussex each attendance is coded as a new or a follow up patient and code for procedures done e.g. fit appliance, adjust fixed appliance, de-bond etc. It is possible that these codes are collected as “in patient” attendances rather than outpatient attendances. Within Brighton and Hove all patients also have IOTN codes but this is not able to be captured in CIU coding system.

SUS information was requested on the detail of the type of orthodontic care delivered at each of the hospitals. There is limited SUS data available for Kent and Medway. There were 247,930 episodes of care recorded within secondary care 2008-14 as can be seen within Table 10.

Table 10: Episodes of hospital care recorded 2008-14

Area	Episodes of Care
Kent and Medway	13,815
Surrey and Sussex	234,115
Total	247,930

The SUS data shows that although the activity within hospital is increasing, there is insufficient data, based on the information received to date to form a comprehensive and reliable picture of what is happening within secondary care.

Within the 244,491 episodes recorded, the PBR speciality codes 143 (orthodontics) was used to identify dental procedures. Within the 244,491 episodes there were 232,233 procedures that were not coded making any conclusions challenging.

In addition, other data was requested individually from all hospitals which provide secondary care data. To date information was only received from two hospitals;

In a recent audit of referrals into four large secondary care providers (Kingston, Western Sussex, Royal Surrey and Ashford and St Peter's) the following information was collected as can be seen in Table 11.

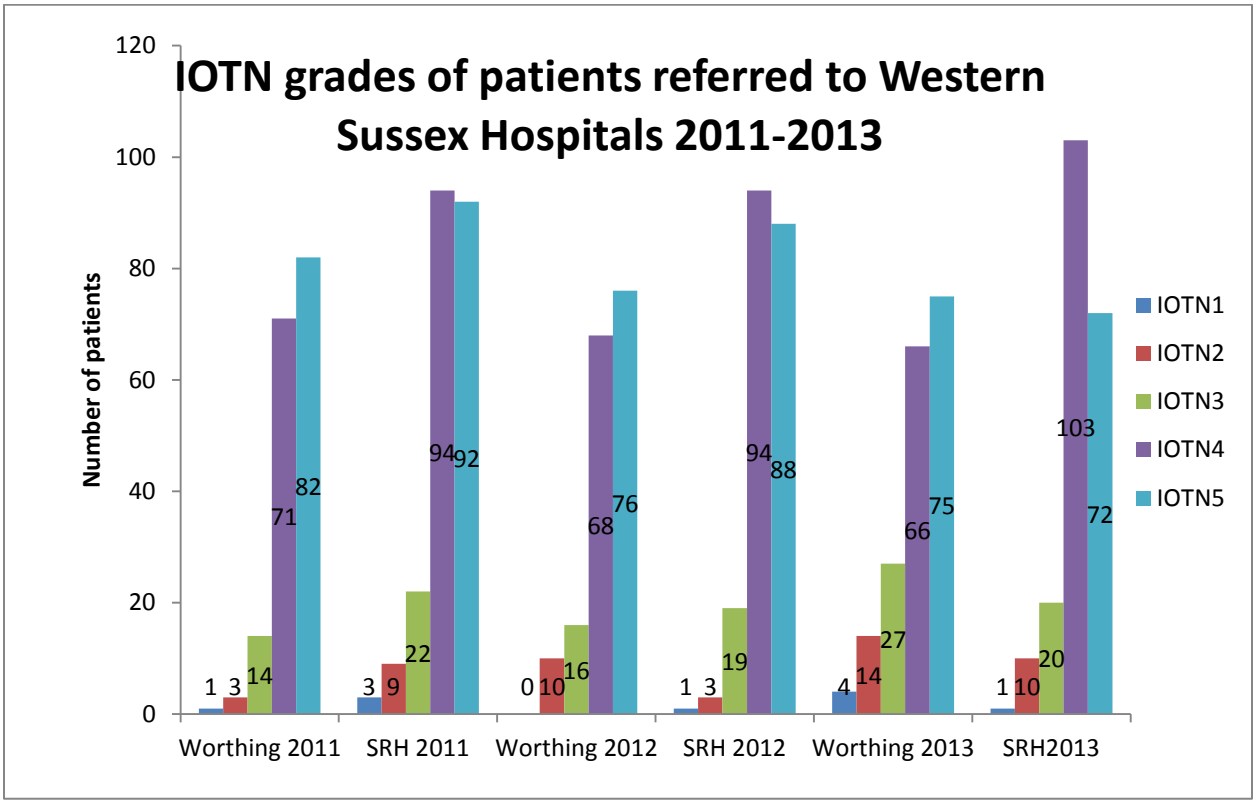
Referrals within KSS are now made electronically and it is hoped that this will enable a much improved understanding of referral patterns once reports are available next year, 2017/18.

Table 11: Audit on referrals into secondary care

Referral source					
GDP	Specialist	Community	Maxillofacial	GMP	Other
33%	52%	12%	1%	0.25%	1.75%
Referral for type of orthodontic care					
Orthodontic	Ortho/Oral Surg	Ortho/Restorative	Orthognathic	Other	
43%	23%	6%	20%	8%	
IOTN Score					
1	2	3	4	5	
0%	3%	11%	39%	47%	

It should be noted that an IOTN score of 2 does not necessarily equal inappropriate referral e.g. this score would include the appropriate advice to patients and the referring practitioner regarding e.g. re extraction of hypoplastic first molars.

Figure 14: IOTN grades referred to Western Sussex Hospitals, 2011-13



Approximately half (45%) of referrals into secondary care originate from GDPs and the CDS, 52% come from Specialists. 3% of patients referred into the service are banded as IOTN 2, with half of the referrals being categorised as IOTN 5.

Recommendation 16: Within secondary care there is a need for Local Offices to work with secondary trusts to help influence and support the measurement of activity and costs to complete this section of the needs assessment. Details of care should include category of care, IOTN scores, and patient age. Commissioners should work with their national colleagues to support better collection of local data.

9. Referrals

Until recently in all areas of KSS (except West Sussex) patients could be referred directly to secondary care or to an orthodontist of their choice in primary care. The Local Office has introduced an electronic referral system for all referrals including orthodontics from all sources which will cover the whole of KSS by the end of 2016. Anecdotally some clinicians have concerns about the benefits to patients of a wider introduction of an orthodontic referral management system. There are also concerns from a minority of practitioners that there is a risk that they might not classify patients correctly at the point of referral. This comes from a lack of familiarity with the electronic system as GDP referrers do not have to make the classification themselves but provide key information to allow for a suitable trained specialist to make that final decision. The electronic system is new and constantly being reviewed and developed.

Orthodontists are currently expected to ask for authority to treat patients who change orthodontist care, mid treatment. This is not a contractual obligation, but is Local Office protocol. According to the Local Office, orthodontists do not consistently request such authority. Changing provider part way through orthodontic care does have a significant effect on the costs of care for NHS England as effectively it doubles the cost of treatment. There are often perfectly legitimate reasons why people change care midway through treatment e.g. a move from Dover to Guildford.

Recommendation 17: NHS England needs to consider the appropriate management of requests for a new course of treatment on patients presenting mid-treatment from another practice. This should include appropriate encouragement of orthodontists to request approval from the Local Office.

The key to efficient use of the contract is to ensure the quality of the initial referral from GDPs. This includes explaining the eligibility of the child for NHS treatment, the length of time needed to treat case, the need for full compliance throughout including excellent oral hygiene and the role of retainers post active treatment. It is important that carers and patients understand this before the referral is made rather than raise expectations that cannot be delivered by the treating orthodontist.

Some training has been provided already in conjunction with Health Education England (HEE) and continues to be provided through the regular Deanery programme and other sources. In addition a short referral guide has been produced which can be found at Appendix 5 to assist GDP’s in making the decision at what point should a referral be made if clinically indicated.

The Dental Electronic Referral System (DERS) orthodontic referral pathway has inbuilt prompts within it to indicate what information should be captured by the GDP once a decision to refer has been made. The GDP is not being asked to determine the IOTN score of the child being referred but to be able to have a working knowledge of the need for orthodontic treatment and whether the child is at the optimum point for a referral both in terms of age and readiness for treatment which includes good oral hygiene and any caries present to be treated prior to referral.

Recommendation 18; The Local Education Training Boards (LETB) needs to continue to work with commissioners to support the appropriate professional measurement of IOTN, and in turn to support GDPs to explain the principles of orthodontic treatment at the point of referral in order to manage patients' and carers' expectations.

10. Cost of orthodontic care based on 2013/2014 figures

Costs within primary care and secondary are different. This difference can be for a number of reasons. In primary care the costs relate to the number of UOAs needed to complete a case (including abandoned, discontinued cases etc.), and the UOA cost. In secondary care, the costs relate to tariff costs set by the NHS nationally for first and follow-up appointments. The care provided in secondary care is further complicated by the capping of follow up appointments by the Trust for all specialities. Some trusts allow their orthodontic providers to see patients for 7 follow-up appointments, whilst others are allow 14. It is understood that the average number of follow up appointments allowed for orthodontics across secondary care is 12. However, the position of the Local Office is that all orthodontic patients should have as many appointments as required to complete treatment based on individual clinical need.

10.1 Primary care

Table 12 shows the orthodontic activity and value for Surrey and Sussex and Kent and Medway.

Table 12: Contracted amounts of UOAs

Area	Value of UOA element	Contracted UOAs 2013/14	Average value of UOA (based on contracted)	Minimum value in region (2013/14)	Maximum value in region (2013/14)
Kent and Medway	£11,941,569.00	187,760	£63.60	£55.40	£66.99
Surrey and Sussex	£14,864,039.75	236,532	£62.84	£61.81	£68.34

It can be seen that the average price of a contracted UOA is £63.60 in Kent and Medway and slightly less (£62.84) within Surrey and Sussex. There is a UOA price range from £55.40 to £68.34 across contacts in KSS. As previously discussed, the cost of providing primary care orthodontics to a 12 year old per capita amounts to £597.00 in Kent. The average UOA activity for Kent per 12 year old population is 9.7. For Surrey and Sussex, the total expenditure per 12 year old population is £532.00 with a total UOA activity per 12 year old population of 8.5 based on 2012 figures, although recent work to improve the efficiency of the contract will have changed these average values slightly.

10.2 Secondary care

A recent orthodontic needs assessment carried out in Greater Manchester estimated an annual spend in secondary care for orthodontic services of £3.6 million (based on available 6-month data). The Pan-London Group suggested an annual cost across the London region of £12.6 million for secondary care orthodontic services during 2011/12.

According to the commissioning orthodontic guide, assuming a similar picture across NHS England Local Offices/regions (owing to largely similar needs of approximately 30% of the population), this would suggest there is an annual spend of somewhere in the region of £40-50 million for secondary care orthodontic care in England.

In 2013-14 the following costs were charged to Kent and Medway and Surrey and Sussex across England for secondary care. It is interesting that within KSS region there is £11 million spent on secondary care; it is possible therefore that the £40-£50 million that has been suggested as a national spend, based on KSS figures is not accurate. These figures can be seen in Table 13.

Table 13: Secondary costs within KSS

Area	Cost
Kent and Medway	£3,585,328
Surrey and Sussex	£7,647,984
Total	£11,233,312

Table 14: Secondary care costs categorised by trust

For ease of viewing any cost less than 1% has been removed.

Trust	Cost	Percentage
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	£183,357	1.6%
KINGSTON HOSPITAL NHS FOUNDATION TRUST	£236,111	2.1%
SURREY AND SUSSEX HEALTHCARE NHS TRUST	£275,782	2.5%
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	£404,810	3.6%
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	£460,717	4.1%
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	£674,374	6.0%
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	£824,715	7.3%
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	£1,122,028	10.0%
MEDWAY NHS FOUNDATION TRUST	£1,193,433	10.6%
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	£1,370,893	12.2%
EAST SUSSEX HEALTHCARE NHS TRUST	£1,735,416	15.5%
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	£2,402,496	21.4%
Total	£11,157,134	96.9%

10.3 Primary and Secondary care

Total (primary and secondary) orthodontic costs can now be expressed as £38 million pounds as below, with 29% of the cost associated with secondary care. See Table 15.

Table 15: Cost of primary and secondary care in KSS

Area	Cost	Percentage total cost
Kent and Medway primary care	£11,941,569	31%
Surrey and Sussex primary care	£14,864,040	39%
KSS secondary care	£11,157,134	29%
Total	£37,962,743	100%

As can be seen from earlier discussions on population growth there would have to be further investment of approximately £2,500,000 with the majority of this going into primary care for the commissioner to meet this growing need if no further action was taken to improve the efficiency of the current contracts. As in line with the cost pressures on the rest of the NHS current work has identified that this funding needs to be identified from savings within the current orthodontic budget by further improving the efficiency and value for money of the contracts both current and future.

Recommendation 10: The Local Office should consider the introduction of a revised UOA value in line with the transition guidance of approximately £56.50.

11. Summary of the orthodontic health needs assessment

There is a future need for the commissioning of additional courses of treatment of about 8% above the current levels of care provided. Most of this additional activity could be obtained through better use of the current commissioned levels of UOA across KSS, as it has already started to happen over the last 2 years. There is also a need to improve the quality of referral from GDPs to ensure that cases are not referred too early (under 9 years) unless there is a clinical indication which justifies such early referral.

There needs to be a redistribution of some of this activity to help improve travelling times for patients. There also needs to be a public consultation exercise to ensure that any new procurement meets the needs of the population over the next 10 years.

The profession now needs to become fully engaged in the process of procurement and take the opportunity to express their concerns, and help shape services for the future through the Orthodontic Managed Clinical Networks (MCN) and the KSS Local Dental Network (LDN). All comments should be addressed to: Jackie.sowerbutts@phe.gov.uk or on 07826 891397 PHE lead for oral health KSS.

Part B. Future plans for the commissioning of orthodontic provision in Kent, Surrey and Sussex

12. Recommendations review

Since the orthodontic needs assessment was written in 2014 there has been much work done by the NHS England contracting leads within the Local Office to significantly improve the efficiency of the existing orthodontic contracts.

The recommendations from the original report that have been worked on are as follows.

Recommendation 11: Area Teams should consider changing referral criteria so that orthodontists would only accept patients with IOTN scores of 4 or 5.

Response: The Local Office has committed to commission lOTN scores of 3.6 and above in line with the current national policy.

Recommendation 12: Commissioners need to consider how to reduce the number of assessments per patient.

The Orthodontic assessment framework provides the team with good data and identifies outliers. The team has visited all providers within the last 2 years to better understand this position, and this has resulted in significant changes in rates as below.

Table 16: Change over time in use of contract UOA

Area	% Assess and review		% Assess and refuse	
	2012/13	2015/16	2012/13	2015/16
Kent and Medway	45.6%	21.2%	12.7%	11.5%
Surrey and Sussex	52.1%	19.3%	11.0%	8.5%
England	45.6%	33.4%	12.7%	12.3%

This extra capacity would only exist however, in a perfect system where children were only referred at an appropriate age, where no waiting list existed and where the child was seen immediately for care. Conversely, orthodontists may argue that the current system, with only a relatively small percentage of the contract being used on assessments that do not then progress to episodes of treatment, benefits patients and dentists by providing advice only and can also be optimal care.

Recommendation 14: Education programmes for referring dental practice including IOTN and appropriate referrals should take place. This should also include advice for the dental teams on how to educate patients.

Response: There are a number of courses that dentists could attend to better understand the purpose of orthodontic assessments and the use of the IOTN score. In addition the DERS system which is now used when making orthodontic referrals has been designed in such a way that dentists are prompted for certain pieces of information such as simple measurements and photographs to ensure appropriate referrals are made. This does put the onus onto referring dentists for explaining the eligibility criteria for NHS orthodontic treatments to patients and carers, as well as the patients' responsibilities during care and the importance of patient compliance throughout any proposed course of treatment.

Recommendation 17: There is a need for commissioners to influence and reduce the proportion of failed to complete orthodontic treatments. This may involve increasing patient commitment through an appropriate Provider/Patient contract.

Response: A patient contract has been agreed and is in use for all new courses of treatment across KSS. See Appendix 6.

Recommendation 18: The IOTN score of 3.6 should be reinforced. Commissioners need to consider how they can encourage better recording of IOTN scores, particularly in the areas highlighted.

Response: Refer to the response for **Recommendation 14** above.

13. Improving the quality of the initial referral

Training has been provided to GDPs to raise awareness of the IOTN scoring and the eligibility of children for a course of NHS orthodontic treatment. Dentists were advised to attend and may have taken up this opportunity. However, there is always a turnover of staff and dentists and hence, a short referral guide has been developed in order to support GDPs. This can be found at Appendix 5. It is hoped that dentists will use this guide when discussing potential referrals with families and carers as a tool to explain why children may or may not be eligible for NHS care and also when would be the best time for children to be referred.

Recommendation 11: The Local Office should work with orthodontists, and referring GDPs to ensure that patients are referred at an appropriate time (with compliance and good oral health) and that IOTN is understood. This should ensure that rejected cases are returned (with reasons) to primary care referrers.

14. Public consultation

In order to help with future planning of services it would be useful to understand the patients' and the public's view on accessing care and waiting times for appointments.

There has already been some work done through the “Family and Friends” survey but more should be done to better understand the views of service users when planning for the future.

The opportunity for circulating a further survey to patients who have been recently referred through DERS has arisen and should be considered as a way to get useful information to help with the planning of future services. A draft proposed questionnaire can be found at Appendix 7. In addition the work Healthwatch does on behalf of services should be explored and any lessons identified that could be transferable to the future provision of orthodontic care considered. Early discussions in the South network have identified the following proposed standards for waiting times for entry into care: a maximum 3 month waiting time for first assessment and then another 9 months for start of treatment. This is yet to be agreed as part of the future procurement process.

Recommendation 12: There needs to be a consultation with future patients and their carers to better understand their expectations of services and how this may influence future commissioning.

15. Quality of treatment provision

The current contracting arrangements have provision for examining the care that orthodontists provide. However, there is limited constituency in the way that this is done. There is good information on the use of the contract and how this has changed to improve the overall efficiency of the contact as previously discussed but limited information on treatment outcomes which is usually done through Peer Assessment Review (PAR) scores at the end of treatment by the orthodontist themselves.

Recommendation 13: NHS England needs to ensure whilst working with national guidance that it works with providers to improve the reporting of PAR scoring as an indicator. NHS England needs to ensure support is given to the MCNs to facilitate appropriate levels of PAR assessment. This should follow national guidance on calibration, photography and selection of patients.

Work has already started on obtaining more information on completed courses of treatment and understanding the reasons why some courses are terminated early.

Recommendation 14: Commissioners need to support providers in accurate reporting and work with their national colleagues in order to facilitate better notification mechanisms from the BSA including reporting of concluded courses of treatment and PAR scores.

16. Procurement

The majority of orthodontic contracts in KSS expire at the end of March 2018. A decision has been made that this process will be carried out to the same protocols across the South of England which is yet to be agreed. Until this has been agreed across the South, there seems to be little added value to make definitive statements in this needs assessment about future contracts in KSS. However there are some emerging themes which are set out below. An important principle about procurement is that once the process begins all queries about future contracts and procurement issues must be directed to the procurement team and not the NHS England Local Office. The Local Office team will continue to communicate with current providers about current contracts and performance through this period which is anticipated to start at the beginning of 2017.

An initial discussion was held to identify the areas where activity was required across KSS. In order to create improved experiences for patients with reduced travelling and the possibility of a wider spread of appointment times, including the possibility of appointments outside of the core hours of 8.30 to 6.00pm, it was decided that packages of UOA would need to be at least 15,000 with additional activity of a minimum of 3,000 UOA in those areas where a need for a satellite practice has been identified. Very few of the existing contracts in KSS would meet these criteria.

Currently, there are a significant number of very small contracts (under 1,000 UOAs) which only allow for small numbers of patients to be treated each year. There is evidence that this may have a detrimental effect on patient care when practitioners do not provide orthodontic treatment on a daily basis. It also restricts choice for patients. Nevertheless, this needs to be balanced by the fact that these patients would prefer to be treated locally by the specific provider. The aim would be to absorb these small contracts into larger ones offering patients more choice of appointment times and peer support for the treating orthodontists.

The needs assessment has identified a need for more UOAs to be commissioned overall across KSS. This commissioning will not be universal with more provision in some areas and less in others but the challenge will be how the funding for this is identified. Three separate approaches are under consideration:

1. A national requirement to reduce the UOA rate. Figures around the £56.50 per UOA are currently seen as offering value for money while still being able to sustain the quality of service provision
2. Working with GDPs to improve referrals with the aim of ensuring that as many assessments as possible result in a course of treatment provided rather than using activity for patients who are not eligible for NHS care, are not yet dentally

ready for a course of treatment or who may not fully understand the need for a very high level of compliance to ensure a good outcome.

3. Currently 15-16% of all children referred for orthodontics in KSS are under 9 (England 12.3%). Whilst some of these children may be ready to start, the full adult dentition is not usually erupted until approximately 12 years of age. Early treatment starts may not only prolong the treatment length and delay the achievement of good orthodontic treatment but can also result in children becoming demotivated and less than optimal outcomes achieved.

The KSS Local Office discussed making the following commissioning intentions, but more work is required before final decisions on bidding lots can be made. It should be stressed that these are initial thoughts and may not be the final position. The concept of commissioning by lower tier local authority does then allow for individual variations across the South.

Table 17: Draft Commissioning Intentions for NHS England (KSS)

Area	Current commissioned UOA	Comment
Medway (Unitary Authority)	38,257	1 contract
Ashford (Kent)	26,639	1 existing contract is not being re-procured. GDS contract with UOAs could be re-negotiated to convert into UDAs
Canterbury (Kent)	20,293	1 contract only
Dartford (Kent)	6,659	1 contract with base in Gravesham
Dover (Kent)	0	1 contract based in Shepway with satellite in Dover
Gravesham (Kent)	13,600	1 contract with satellite in Dartford
Maidstone (Kent)	25,129	1contract with a potential UOAs reduction
Sevenoaks (Kent)	11,440	1 contract
Shepway (Kent)	7,289	1 contract with a satellite in Dover
Swale (Kent)	1,560	1 GDS contract with UOAs has now converted all activity to UDAs. Possible satellite required from Canterbury or Maidstone
Thanet (Kent)	13,608	1 contract
Tonbridge and Malling (Kent)	8,503	1 contract to be based in Tunbridge Wells with satellite in Tonbridge
Tunbridge Wells (Kent)	10,479	1 contract to be based in Tunbridge Wells with satellite in Tonbridge
Elmbridge (Surrey)	14,627	1 contract covering parts of Runnymede as well
Epsom and Ewell (Surrey)	19,592	1 contract

Guildford (Surrey)	14,295	1 contract with possible satellites in Godalming and Ripley
Mole Valley (Surrey)	3,806	1 contract to include Reigate, Redhill and Tandridge areas
Reigate and Banstead (Surrey)	8,089	1 contract as above. Banstead area to be covered by Epsom and Ewell
Runnymede (Surrey)	0	See Woking and Elmbridge. No satellite required.
Spelthorne (Surrey)	13,141	Not a time limited contract - no new procurement required
Surrey Heath (Surrey)	6,254	Satellite of Farnham based contract
Tandridge (Surrey)	2,589	Covered by Reigate and Banstead
Waverley (Surrey)	22,500	Godalming covered as a satellite of Guildford contract Farnham based contract to cover Surrey Heath
Woking (Surrey)	13,631	1 contract with satellite in West Byfleet Covering parts of Runnymede as well
Adur (Sussex)	2,500	No practice – to be covered by Worthing
Arun (Sussex)	0	Covered by Chichester with a possible satellite in Bognor Regis
Brighton and Hove Unitary Authority	18,457	Current provision approx. 18,500 UOAs – 24,000 UOAs required Practice to be based in Mouslecomb with satellites at Portslade and Lewes.
Chichester (Sussex)	6,730	1 contract 10,000 UOAs including a possible satellite in Bognor
Crawley (Sussex)	9,343	1 contract
Eastbourne (Sussex)	17,847	1 contract
Hastings (Sussex)	8,139	1 contract in Hastings with satellite in Rye
Horsham (Sussex)	15,634	1 contract
Lewes (Sussex)	3,356	Satellite of Brighton and Hove
Mid-Sussex (Sussex)	17,917	1 contract
Rother (Sussex)	0	See Hastings (satellite at Rye main practice at Hastings)
Wealden (Sussex)	5,040	1 contract
Worthing (Sussex)	11,122	1 contract to include Adur population

The challenge now is for the South Commissioning leads and the procurement team to meet and agree all the principles for procurement growing forward. In reality, there will need to be a longer than usual mobilisation phase to the new contracts to individually deal with the issues of cases currently in treatment with unsuccessful providers plus other general issues. This will take up to 9 months so agreement on the process for the

procurement of the new contracts needs to be completed within the first three months of 2017.

17. Conclusions

In general, there is good orthodontic provision across KSS. Much work has been done by the Local Office especially over the last 2 years to improve the efficiency and effectiveness of the existing orthodontic contracts and several of the recommendations from the original report have already been implemented. This work needs to be continued to ensure efficient use of the current contracted levels of activity at a time of constrained resources.

Predicted population growth of an average of approximately 8-9% means that there needs to be an increase in overall resources available. This needs to be done by dis-investment in certain areas, an increase in other areas and the consideration of the establishment of further orthodontic practices as satellites of larger practices in others to ease the burden of travelling for patients. There also needs to be a careful evaluation of the current UOA rate, which varies significantly across KSS, to ensure that any reduced UOA rate still maintains and improves the quality of service provision.

Part C: Appendices

Appendix 1: Treatment locations

The map below shows treatment locations overlaid onto ward level population for 10-14 year olds (source: Mid-Year 2012: population and household estimates for wards in England and Wales, ONS). The aim is to show the effectiveness of dental commissioning in relation to the key population group for orthodontic activity.

Figure 15: Child population density resident in Surrey and Sussex

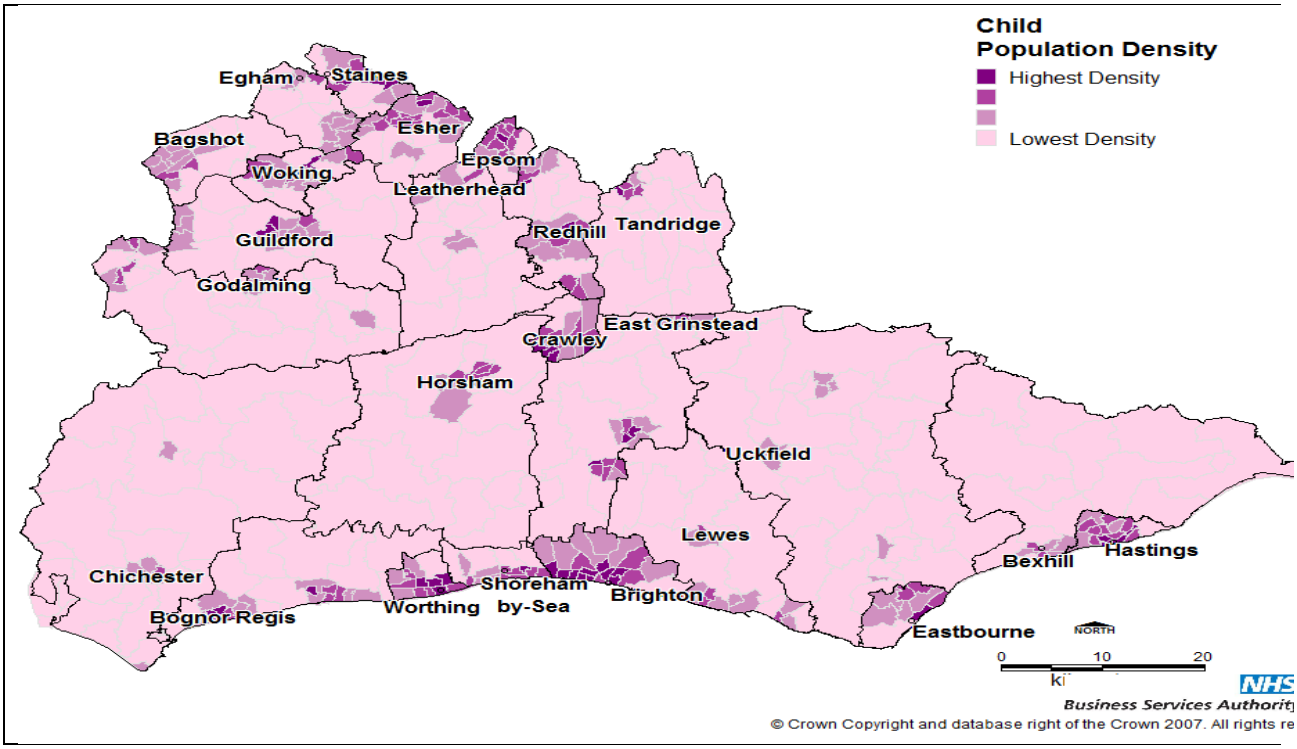
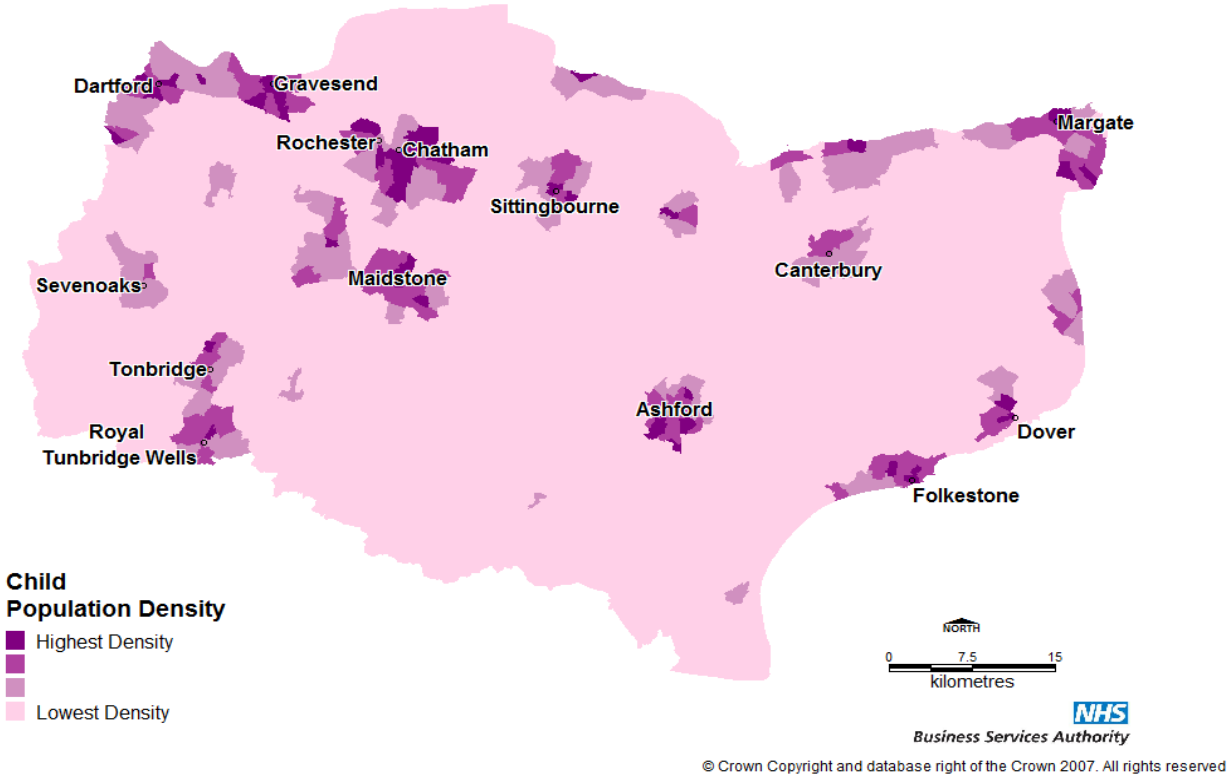


Figure 16: Child population density resident in Kent and Medway



Appendix 2: Patient in flow and outflow from Kent and Medway, and from Surrey and Sussex

Patient Flow In is where patients are resident outside of the Local Office area and receive orthodontic treatment from NHS England Local Office contracts. Significant numbers of patients from outside an area can limit access to services for residents.

Patient Flow Out highlights where the patients living within an area have received their dental treatment. Significant numbers of patients travelling outside may be an indication of poor quality or a lack of services in an area out with NHS England KSS.

Patient flow in: Resident health body area for patients treated at a contract in the Local Office, determined by the postcode recorded in the personal details section of each FP17. If a patient postcode is not included on the FP17 then the patients' residency is classed as "unknown" and has been excluded from the tables below.

Patient flow out: Contract health body area for patients living in the Local Office determined by the postcode recorded in the personal details section of each FP17. A patient may be counted more than once where more than one FP17 is received with a different postcode and/or surname for the same person.

Table 18 and Table 19 shows both "flow in" and "flow out". "Flow In" signified by the proportion of child patients that Attended a dentist in the area and were resident either in that same area, a neighbouring area, a non-neighbouring area (other) or where the postcode information contained in the FP17 was insufficient to assign a resident area (unknown). "Flow Out" shows the proportion of child patients resident in an area that attended a dentist either in the same area, a neighbouring area, or a non-neighbouring area (other). The numbers for patients resident in the area are the same for flow in and out but the totals from which a percentage is calculated can differ.

Table 18: Flow In and Out Percentage of Orthodontic Patients 2013/14 Surrey and Sussex

Flow In	
Local Office of residency	% of patients treated in Surrey & Sussex
Same	89.2%
Neighbour	10.6%
Other	0.1%

Flow Out	
Local Office of treatment	% of patients resident in Surrey & Sussex
Same	92.1%
Neighbour	7.8%
Other	0.1%

The table below shows the highest proportion of total patients outside Surrey & Sussex In terms of “flow in” this relates to the areas where patients live who received treatment at a contract in Surrey & Sussex; for flow out this is the areas where patients living in Surrey & Sussex received treatment.

There is similar inflow and outflow of patients within Kent and Medway, and Surrey and Sussex.

Table 19: Flow in and out percentage of orthodontic patients in Kent and Medway, 2013/14

Flow In	
Local Office of Residency	% of Patients Treated in Kent & Medway
Same	95.1
Neighbour	4.7
Other	0.1

Flow Out	
Local Office of Treatment	% of Patients Resident in Kent & Medway
Same	94.6
Neighbour	5.2
Other	0.1

The table below shows the highest proportion of total patients outside Kent & Medway In terms of “flow in” this relates to the areas where patients live who received treatment at a contract in Kent & Medway; for flow out this is the areas where patients living in Kent & Medway received treatment.

Table 20: Flow in and out of orthodontic patients in most common areas of Kent and Medway, 2013/14

Flow In	
Local Office of residency	% of patients treated in Kent & Medway
Kent and Medway	95.1%
Surrey and Sussex	3.1%
South London	1.6%
North East London	0.0%
Essex	0.0%

Flow Out	
Local Office of treatment	% of patients resident in Kent & Medway
Kent and Medway	94.6%
South London	4.7%
Surrey and Sussex	0.5%
North East London	0.1%
Essex	0.0%

Table 21: Flow in and out of orthodontic patients in most common areas of Surrey and Sussex, 2013/14

AT of residency	% of patients treated in Surrey & Sussex		Net flow of patients in/out
	Flow In	Flow Out	
Surrey and Sussex	89.2	92.1	-
South London	4.2	3.9	Net flow into Surrey and Sussex from South London
Kent and Medway	-	2.4	Net flow out to Kent and Medway
Wessex	4.0	0.8	Net flow into Surrey and Sussex from Wessex
Thames Valley	1.3	-	Net flow into Surrey and Sussex from Thames Valley
North West London	0.8	0.4	Net flow into Surrey and Sussex from North West London

As the flow ins and outs are fairly similar then financially this should raise little concern for the Local Office. This will need to be monitored over the years to continue to assess any possible impact that this may have in the longer term.

Appendix 3: Deprivation

The map below shows level of deprivation by lower super output area. Those areas shaded purple have the highest overall Index of Multiple Deprivation (IMD) score, relative to the area as a whole, and therefore can be classed as the most deprived. It must be stressed that this level of deprivation is relative to the particular area analysed. Main towns are included for geographical reference. Areas around the South Coast are shown in greater detail below the main map.

Figure 17: Map to show IMD score 2010 by LSOA Kent and Medway

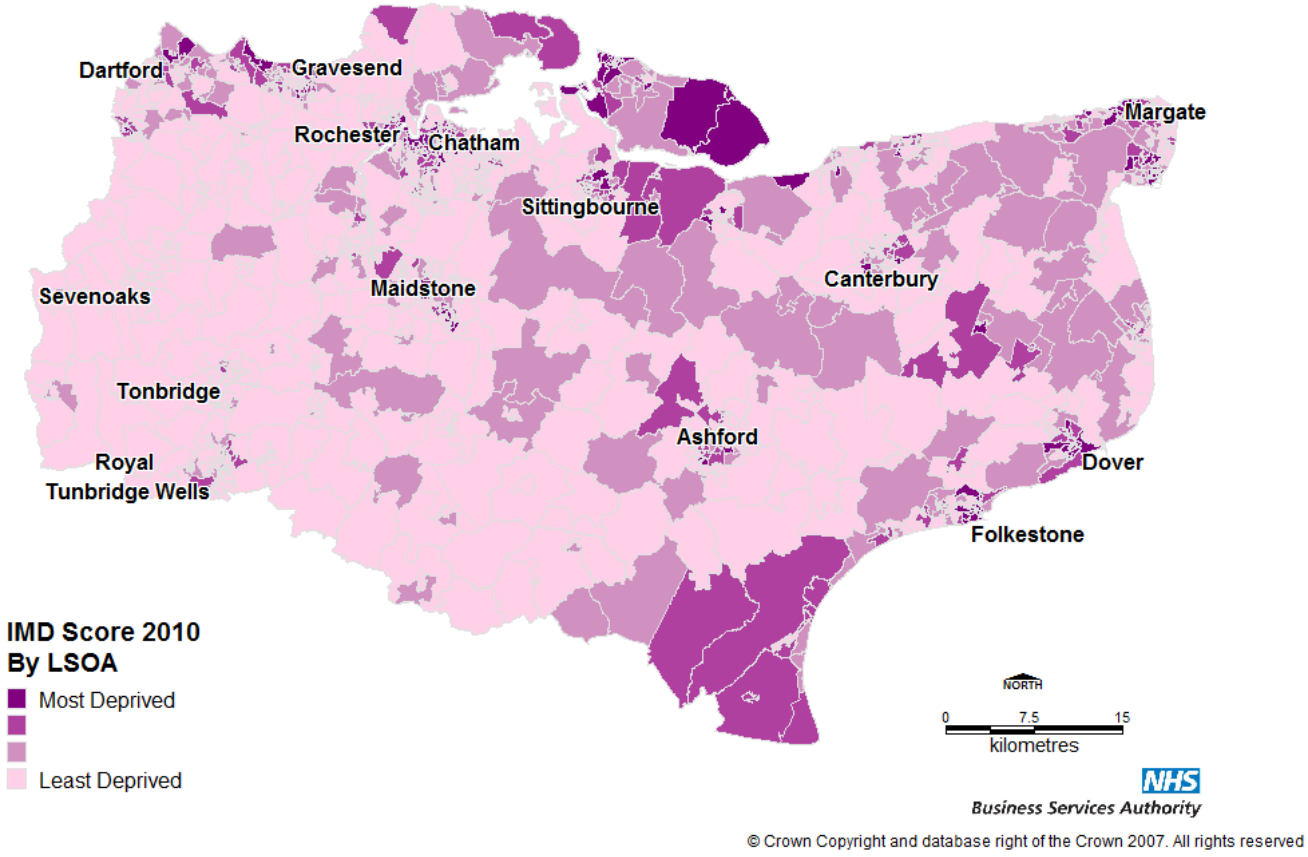
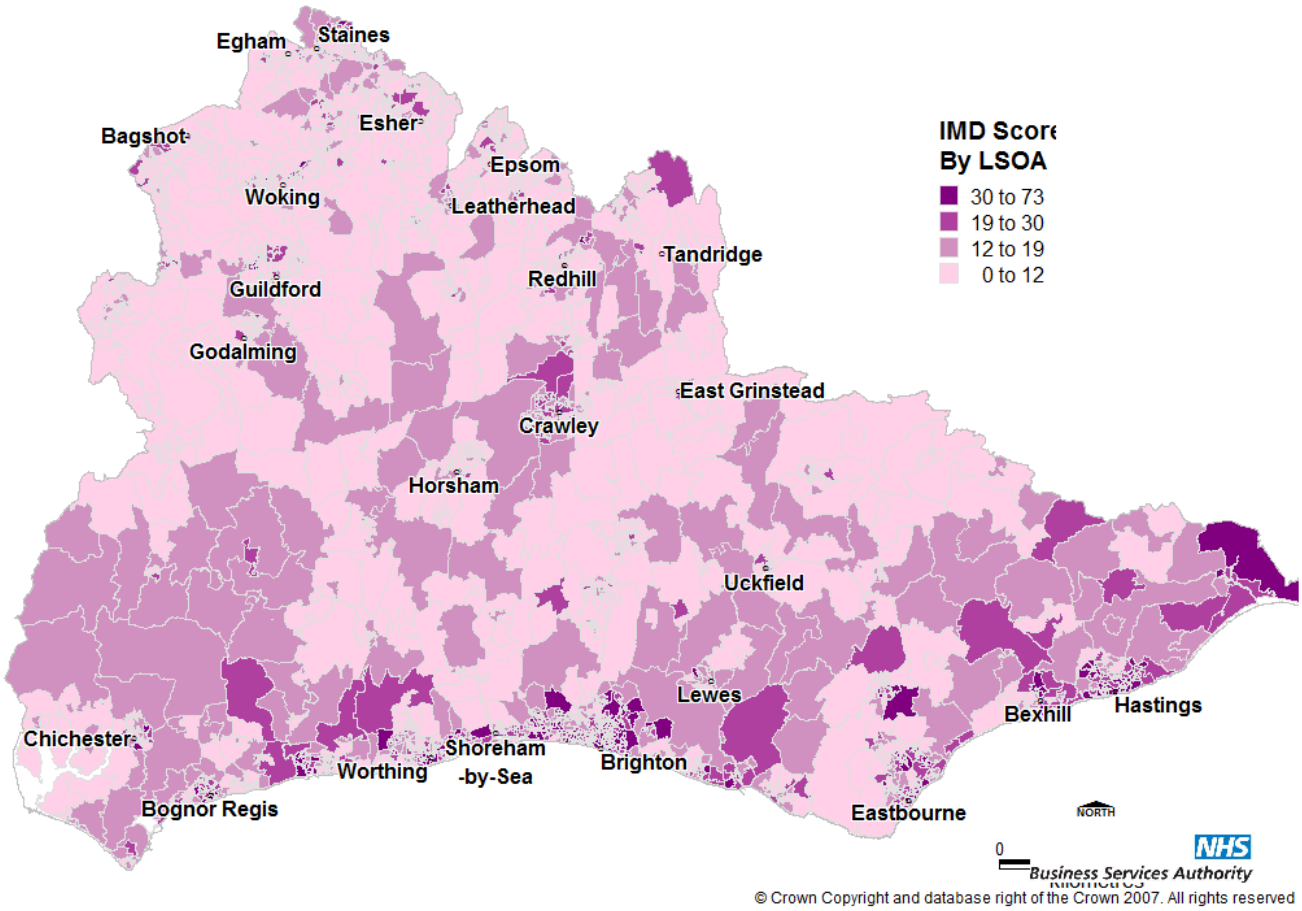


Figure 18: Map to show IMD score 2010 by LSOA Surrey and Sussex



Appendix 4: Ethnicity

Table 22: Breakdown of ethnicity recorded on orthodontic FP17s in Surrey and Sussex, 2013/14

Ethnicity	Total FP17s	% recorded
White British	22,136	59.4%
Patient declined	6,295	16.9%
Unspecified	6,247	16.8%
Other White Background	480	1.3%
Indian	348	0.9%
Other mixed background	279	0.7%
Pakistani	263	0.7%
White and Asian	234	0.6%
Other Asian Background	205	0.6%
Any other ethnic group	155	0.4%
Black African	110	0.3%
White & Black Caribbean	100	0.3%
Chinese	99	0.3%
White and Black African	88	0.2%
White Irish	88	0.2%
Bangladeshi	77	0.2%
Black Caribbean	37	0.1%
Other Black background	28.	0.1%

Appendix 5: Short referral guide currently out for comments. The draft guide can be found on the next page

References for the short guide

1. British Orthodontic Society, 2010. Managing the Developing Occlusion - A guide for dental practitioners. London: British Orthodontic Society
2. British Orthodontic Society, 2014. Information for dentists: making an orthodontic referral. *British Orthodontic Society Website,* [online]. Available AT http://www.bos.org.uk/Information-for-Dentists/Making-an-Orthodontic-Referral [Accessed 15 November 2016].
3. NHS England, 2015. Guides for commissioning dental specialties - Orthodontics. London: NHS England
4. Dowsing, P., Sandler, J., 2007. A guide to making appropriate orthodontic referrals. *Dental Update*, 34(8), p.487-491.
5. Flett, A.M.C., Sandler, J., 2016. The role of the GDP in assessment and management of the early orthodontic referral. *Dental Update*, 43(8), p.706-720.

Stage of Dental Development	Age	Monitor	Consider	Refer
Early mixed dentition	7-9	Normal eruption of permanent incisors and first permanent molars Presence of malocclusion Severe crowding of incisors Significant displacement of incisors Increased overjet/reverse overjet Anterior/posterior crossbites Non-coincidence of upper and lower centre lines Severe skeletal discrepancies Long term prognosis of permanent incisors and first molars (caries or trauma related) Persistent thumb or finger sucking habits leading to marked increase in overjet and/or anterior open bite	Investigation to identify the cause of delay in eruption when a tooth fails to erupt within six months of its contra-lateral tooth Abnormal developmental position or missing teeth Supernumerary teeth or odontomes Trauma to deciduous teeth causing ankyloses or dilacerations Retained deciduous teeth Impaction Extraction of deciduous teeth displacing their permanent successors Prevention of centre line shift through balancing extraction (extraction of the contra-lateral deciduous canine) AT early loss of a deciduous canine early loss of first deciduous molars leads to centre line shift Support and advice on habit cessation	Presence of abnormal developmental position, supernumerary teeth or odontomes, missing teeth, ankyloses or dilacerations, impaction Poor long term prognosis of permanent tooth which may require extractions Indication for early interceptive treatment due to severe skeletal discrepancies, personal habits, and teasing or bullying from the appearance of the teeth Failure to comply with habit cessation advice
Late mixed dentition	10-11	Normal eruption of permanent teeth Submerging deciduous teeth Presence of malocclusion Severe crowding Severe contact point displacement Increased overjet/reverse overjet Anterior/posterior crossbites Anterior/lateral open bites Deep overbites Non-coincidence of upper and lower centre lines Severe skeletal discrepancies Space loss for permanent premolar teeth from early loss of deciduous teeth	Investigation to identify the cause of delay in eruption (*as above*) Extraction of deciduous teeth to relieve significant crowding or if the permanent successor is being displaced Prevention of centre line shift through balancing extraction (*as above*) Management of space loss Unlikely to require intervention if there is no crowding Avoid extraction of deciduous second molars before the age to 10, if possible, to allow minimal space loss Balancing extraction of deciduous second molars is not justified May require space maintainers Radiographic investigation using the Parallex technique to	Congenitally missing permanent teeth Indication for early interceptive treatment due to severe skeletal discrepancies (especially in patients with class III skeletal relationship), and teasing or bullying from the appearance of the teeth Unfavourably positioned canines (or other teeth) Radiographs indicate ectopic position or damage to adjacent teeth

		N.B There is a tendency for deciduous molars or permanent first molar to drift mesially and the anterior teeth to drift distally Position of the unerupted permanent canine from age 10 *N.B The favourable canine is usually palpable buccal to the resorbing deciduous tooth by the age 10-11* Poor long term prognosis of one or more first permanent molars	locate ectopic permanent canine Extraction of deciduous canine if root resorption not progressing or for spontaneous improvement in the position of palatally displaced permanent successor Extraction of all permanent first molars if one or more are of poor long term prognosis Optimal space closure if extracted when calcification of the bifurcation of the roots of the second permanent molars should have just commenced The presence of permanent teeth must be confirmed prior to any extractions	Canine crown overlaps the most distal incisor root Enlargement of canine follicle Poor long term prognosis of one or more first permanent molars requiring extractions – to confirm the number of teeth or timing of extraction
Early permanent dentition ***(Best time to carry out treatment for the majority of patients)***	12-14	Full orthodontic assessment Alignment and crowding of lower labial segment Presence and position of all anterior teeth and the inclination of the incisors on the upper labial segment Incisor relationship: overjet, overbite, centrelines Presence, position and quality of all posterior teeth and crowding in buccal segments Buccal occlusion: molar relationship, crossbites, open bites, mandibular displacement Skeletal pattern Soft tissue profile	Index of Orthodontic Treatment Need (IOTN) Discussion with patient/parents regarding: reason for orthodontic treatment required possible treatment options and duration importance of meticulous oral hygiene and dietary control whether patient qualifies for NHS treatment location of orthodontic practice and waiting time any need for any preventative/restorative treatment prior to making a referral Assessment of patient/parents motivation for orthodontic treatment	Suitable for NHS treatment: a minimum score of 3 in the Dental Health Component AND 6 or above in the Aesthetic Component of IOTN

Appendix 6: NHS Patient/Orthodontist Partnership Contract

This is a Kent, Surrey/Sussex standard Patient/Orthodontist Partnership Contract given to all patients undertaking orthodontic treatment at (*enter practice name*). Patient compliance is vital to enable us to achieve the best possible orthodontic treatment outcome. This document provides useful information to ensure that treatment progresses smoothly and that our patients obtain the best possible results.

The Patient's Commitment:

I…… wish to undertake orthodontic treatment at the (*enter practice name*). My treatment has been discussed with me by my Orthodontist and/or Treatment Co-ordinator. I have read and understood the enclosed British Orthodontic Society leaflet entitled 'What Are The Risks Of Orthodontic Treatment?' I understand that I will be given a separate written NHS orthodontic treatment plan. This outlines details of the braces and retainers that I will be given, in addition to other important facts about my proposed treatment.

Active Orthodontic Treatment

Once the braces have been fitted I understand that I will need to attend on a regular basis for adjustments - normally every 6 – 8 weeks. I have been informed by my Orthodontist and/or Treatment Co-ordinator how long my active treatment is likely to take.

I will need to maintain a good standard of oral hygiene, keeping my teeth and braces clean and follow the advice of the Orthodontists and their staff. If my cleaning does not reach the acceptable standard I understand that my teeth might be permanently marked and that the Orthodontist may suggest that my braces are removed early and my treatment 'discontinued'. I am aware that I have to avoid sticky/hard food and fizzy drinks. If my fixed braces are broken repeatedly, I understand that the Orthodontist may be forced to terminate my treatment and that I will not be able to access this treatment elsewhere on the NHS.

I understand that I will need to attend the appointments on time and on the correct day. If I am late, the Orthodontist may be unable to see me since his/her treatment session might subsequently run late and thus inconvenience all other patients scheduled to Attend after my appointment. If I miss my appointment or cancel without giving 24 hours' notice, I will be offered the next available appointment (usually six – eight weeks after the date of my failed / late cancelled appointment). Should this happen on two occasions, – in conjunction with the Local Office of NHS England - my treatment may be

terminated prematurely and I will not be able to access this treatment elsewhere on the NHS.

The Retention Period and Retainers

At the end of active treatment the Orthodontist will remove my braces and fit retainers. The Orthodontist and/or Treatment Co-ordinator will explain what retainers are and why they must be worn. The 'retention period' commences the day that braces are removed.

Removable & fixed retainers:

I understand that, if retainers are removable, they need to be worn in accordance with the instructions given to me.

I understand that, once the braces are removed, the responsibility for the future position of my teeth depends on my wearing the retainers long term.

I understand that the Practice will *supervise* retention for a period of one year ONLY (the cost of this supervision is included in the NHS contract) and that I will be discharged back to my General Dental Practitioner after this period. Following this year period, replacement retainers will be charged for on a private basis regardless of age or exemption status. This condition also applies to the provision of retainers by the General Dental Practitioner

I understand that, if removable or fixed retainers are broken or lost during this initial one year period, there will be a charge. If a fixed retainer is used, it usually remains in position for at least 5 years. If I return after being discharged to have this (or any other type of retainer) repaired or removed, there will be a charge.

I understand that, at the end of this initial year of retention, my treatment at the (*enter practice name*) will be officially complete. There will be a charge for any further appointments, the repair or replacement of removable retainers and the repair or replacement of bonded retainers.

I understand that teeth may try to move throughout life due to continued growth/development or other biological changes and that I am strongly recommended to continue with part-time wear of the retainers on a *permanent basis (i.e. for life).* My Orthodontist cannot be responsible for any movement of my teeth if I choose to stop wearing the retainers.

If I contact the Practice, or any other Orthodontist, subsequent to ceasing the wear of my retainers with a problem that my teeth are moving out of alignment, I realise that any further treatment may involve the use of fixed appliances. There will be a charge for a review appointment (to assess the problem), and for any subsequent treatment. *Such*

subsequent treatment is very unlikely to be available on the NHS unless there are very exceptional circumstances that can be evidenced.

The Orthodontist's Commitment:

The Orthodontist will explain the treatment as fully as possible and make sure you understand the treatment options. You will also be given a printed treatment plan. This outlines details of the braces and retainers that will be used, in addition to other important facts about the proposed treatment.

The Orthodontist will endeavour to see you on time for each appointment. If a clinic is running late, this is probably due to circumstances beyond the control of the Orthodontist. If your Orthodontist is unavailable you may be seen by another Orthodontist. For an emergency appointment, the Orthodontist may remove any discomfort only and a full repair may have to wait until your normal booked appointment.

During a course of active treatment and your retention period:

It may not always be possible for the same orthodontist to provide all care during a course of treatment. In exceptional circumstances the course treatment may need to be completed at another practice but this will be discussed with you prior to any change of practice.

We are only able to provide a maximum of 2 repairs to a fixed appliance.

If you break/ lose a removable appliance or retainer, a charge will be incurred.

Excessive numbers of breakages means that treatment will be ineffective and prolonged, and the Orthodontist may be forced to terminate it prematurely.

Please be informed that you might be able to claim a refund for payments made for lost/broken appliances if the charge causes 'undue financial hardship'. Form FP17R11 can be downloaded from the Business Services Authority website (www.nhsbsa.nhs.uk/DentalServices.aspx). Your receipt should be sent with the completed form to the Dental Services Division of the BSA.

Out Of Hours Emergencies

If you have any discomfort in relation to your brace outside normal surgery hours, the information leaflet given to you on the day the brace was fitted contains advice on how

to deal with common problems. If the problem cannot be resolved by following the advice, please contact the responsible out of hours providers (details of which are available at the Orthodontic and your general dental practice) Please note that this is reserved for severe discomfort related to your brace which you cannot rectify yourself by ceasing the wear of the brace or removing the offending part yourself as a temporary measure.

I, ……,the patient/parent/guardian of ……, hereby consent to the above named patient undergoing the proposed orthodontic treatment.

Signed:……. Patient/Parent/Guardian. Date: ……

If you have any further queries, please contact the surgery (enter practice telephone number) during working hours.

Appendix 7: Patient questionnaire

Your dentist has agreed with you to make a referral for your child to receive orthodontic treatment. In order to help NHS England plan orthodontic services over the next ten years we are asking for your help. All replies will be anonymous.

	Yes	No	Not sure
Were you informed by your family dentist that your child might child need braces?			
Did your family dentist explain why your child may need braces?			
Did your family dentist explain about Index of Orthodontic Treatment Need (IOTN) and suggest that that your child may qualify for NHS orthodontic treatment?			
Did your child have a full dental check-up and have all necessary dental treatments completed before being referred for an orthodontic consultation?			
Did your family dentist comment on your child's tooth brushing before making a referral for braces?			
Were you advised that sugary snacks and drinks must be avoided for the duration of wearing braces?			
Was it explained what would happen after the initial referral in terms of initial consultation, possible treatment options and expected treatment length?			
Were you offered a choice of locations where you could take your child for treatment?			
Were you told about how long you might need to wait for an assessment appointment AT the different location options given to you?			
Was this wait acceptable for you and your child’s needs?			
Were you given any information leaflets on orthodontic treatments and the associated risks and benefits by your family dentist?			
Did you receive a copy of the referral letter sent to an orthodontist by your family dentist?			
Was your choice of Orthodontic practice influenced by the location of your home or the child’s school or any other factors?			
What would be the furthest distance you would be prepared to travel? (Single journey in miles) bearing in mind that once treatment has started appointments will usually be every two months for up to two years.			

What other information do you feel that you need to know about a course of orthodontic treatment for your child?	

Appendix 8: Responses to the Orthodontic Needs Assessment by Jackie Sowerbutts Locum Consultant Oral Health Lead NHS England – South (South East).

Introduction

The purpose of the document is to inform NHS England and current orthodontic providers in Kent, Surrey and Sussex about the responses made to the recently circulated Revised Orthodontic Needs Assessment. The Revised Orthodontic Needs Assessment built on the work completed in 2015 by Christopher Allen and Brett Duane, Consultants in Dental Public Health. The revised version updated some of the data and the recommendations that had been made some of which were already implemented. In addition early thoughts about the future procurement of orthodontic services in 2018 were added as well as a patient questionnaire and a referral guide for GDPs. There have been detailed comments made from the profession about this document identifying a number of emerging themes for consideration. Some of these responses have been from individual current providers, often about the particular circumstances of their contract. Other responses have been sent as the result of discussions between recognised group members e.g. the Orthodontic MCNs and the Channel group of LDCs. There have also been some direct conversations with providers but who have then not followed through their concerns in writing.

Feedback

The orthodontic MCNs have worked together and summarised their concerns in a lengthy response which is reproduced in full in **Annex 1.** In addition to this comprehensive response from the MCNs there have been a significant number of individual responses from current providers some of whom have produced very long documents with detail about their own contract. Rather than respond to the individual comments the key points have been extracted from the responses given and grouped according to the identified themes. All the responses have been included either in part or full in the table in **Annex 2**. An attempt has been made to anonymise these responses but this has been constrained by the particular point an individual is trying to make e.g. the proximity to specific schools.

Some individuals have been responded to directly but I would like to take this opportunity to thank all responders for the significant time and effort that has been put into putting their views forward. The document also identifies what further actions will be taken to address the views put forward.

A patient questionnaire has also been circulated seeking parent and carers' views especially on the reasons given for the referral and what patients may expect through the delivery of a course of treatment. In addition questions have been asked

about distances parents and carers are prepared to travel and the ease of proximity of services to schools but as yet no results have been analysed

This document will be passed to NHS England – South (South East) for their consideration and a copy will be sent to all those who have taken the trouble to submit their views.

Identified Themes

1. Contract size
2. The UOA rate of £56.50
3. Proximity of services to schools
4. Transfer cases from unsuccessful bidders
5. Benefits of smaller local practices
6. Waiting lists
7. Quality of service provision and KPIs
8. Hospitals and training future workforce
9. Professional engagement during the production of both versions of this document.
10. Calculating future need and Stephens' formula
11. Travelling times, ease of travel and extended hours
12. Length of contract
13. Referral guide and early referral
14. Access to NHS dentistry
15. DERS
16. Specific geographical issues
17. Factual inaccuracies

Response to the individual themes

1 Contract size of 15,000 UOAs

This has attracted the most comments almost all of which are critical of NHS England – South (South East) expressed intention to commission a minimum size contract of 15,000 UOAs with a satellite proviso of 3,000 UOAs minimum in some areas. The main issues are:

a) What evidence is this view based on other than a desire to have fewer contracts for NHS England to manage?

b) This would favour larger providers and corporate bodies.
c) Contradicting the principles of procurement to increase competition and to have better travelling times for patients
d) The value of a local smaller provider who has a better understanding and relationship with their local community
e) Shorter travelling times to local practices
f) The unknown legal and financial challenges of working in a “federation” style arrangement
g) Ensuring the quality of provision of services and the power of an on-site owner with a vested interest

a) What evidence is this view based on other than a desire to have fewer contracts for NHS England to manage?

The orthodontic MCN said “*There are great concerns surrounding some of the suggestions in this section, especially surrounding the consolidation of contracts in some areas to single, much larger contracts. This would seem to be at odds with the concept of increasing patient choice, reducing travelling times as well as creating opportunities for new market entrants.*

The document suggests that initial discussions led to the belief that in order to deliver enhanced patient experiences such as extended hours and reduced travelling times, contracts would need to be at least 15,000. We would dispute this assertion and there is absolutely no reason why services cannot be improved by way of more convenient surgery hours and improved value for money with smaller contracts as most are nowadays.”

No final decision has yet been made on the size of the bidding lots.

This figure was based on the assumption that this would be the work of 2 WTE specialist orthodontists working together. This would bring peer support and cross cover during holidays and other absences and make best use of the space and resources invested. NHS England also has a policy of moving away from the traditional single-handed practitioner as changes in the overall legal requirements and compliance has substantially increased over the last ten years. There are potential efficiencies and economies of scale to be had by groups of providers working together to address these wider management issues. It could also offer patients more choices of appointment times and extended hours. It has also been the consistent model of future provision that the team has been discussing with current providers across the South East for more than a year. Very few practices are as large as this across the South East but there are several successful models of practices of around this size and some much bigger practices within the South East.

It may be helpful for providers to consider working together as a “federation” and how this could work on a legal footing. An example was given, of the challenge of using geography as a basis, of a town where there are two practices where one is owned by an individual and the other by a corporate body. The two practice contracts amount to approximately 15,000 UOAs and it could make commissioning sense to make this one bidding lot. However the natural affinity is with the corporate body in this town working with another practice owned by the same corporate body in this area to make the necessary 15,000 UOAs leaving the smaller (but viable and popular privately owned practice) potentially isolated. Providers are encouraged to approach their advisers (BDA/BOS) for support in forming such a working arrangement and any relevant contract documentation

There is a view among the profession that a 15,000 UDAs contract would be likely to need 3 WTE specialist orthodontists working with therapists to assist with service delivery which may pose some recruitment issues especially in more rural areas. Recent discussions with the procurement team across the South has also raised concerns that this may not be a model that would suit all areas especially those in more rural parts with poor communication links. There may need to be more flexibility when making the final determination of the bidding lots that will be on offer. Suggestions have been made, especially by smaller contract holders, that a contract of 3,000 UOAs which is the current proposed size of a satellite in the South East would make a viable locally based contract in its own right. There are currently multiple examples of this type of practice in the South East that operate successfully.

Proposed action: NHS England to undertake further work to identify the areas to be covered by each procurement lot and to consider if there should be some flexibility of size to better accommodate the needs of the local population. This should include the development of criteria that contracts should meet in order to be viable and sustainable in the future.

b) This would favour larger providers and corporate bodies.

The Orthodontic MCN said “*A significant restriction of options for patients in some areas is also likely to be a concern to the Competition and Markets Authority (CMA) who would need to be involved in any such proposals. The CMA will be particularly concerned about the creation of monopolies in some areas where monopolies do not currently exist. They will also be concerned about patients not having a certain number of options within a specified radius. A significant reduction in the number of contracts also potentially reduces further the opportunity for new market entrants, which is one of the underlying driving forces of transparent procurement. The timeframe for a CMA investigation and potential clearance (typically a minimum of 6 months) would need to be factored into the procurement timeline. At the end of this process there would be a realistic possibility that the CMA would not sanction the proposals.”*

There has been a change in the profile of practices in recent years with now several dominant providers in the area. There is a belief among clinicians that corporate bodies have considerable administrative support in their organisations for putting forward strong bids at volume across the area and would be motivated to do so as the contract size on offer is large. This apparent advantage is often balanced out by the benefits of localism and personal responsibility that a smaller individual provider can bring to a bid. This could create a strong bid that have the same chance of success as a bid made by a corporate entity especially when evidenced based by current contract performance.

Proposed action - A number of events and initiatives have already been taken by LDCs and MCNs to help support future providers understand the procurement process. NHS England as the commissioner is not in a position to support any such event but would urge all future providers to take advantage of these opportunities in the next few months. The procurement team will also answer queries and post these on the procurement website so that it is open and transparent to all and will act as a good source of further information for all potential future providers.

c) **Contradicting the principles of procurement to increase competition and to have better travelling times for patients**

The Orthodontic MCN said *"In some areas, creation of single larger contracts is likely to considerably reduce patient and GDP choice and even increase travelling times."*

Channel LDC said *"Travelling times across the LAT vary enormously. It may take less time to travel 20 miles in one area than it does 4 in another but this doesn't seem to have been considered. Government statistics show that Surrey has the slowest roads in the country at these times and I am sure it's not much better over the whole area. Can you demonstrate if and how these variations have been recognised?"*

The issue of increasing competition in the market has been covered in the response above as NHS England. At this stage it will be difficult to predict what the final outcome of the procurement process will be. NHS England has taken advice previously from the Competition and Market Authority when going out to tender and is aware of the overarching principles to create a wide and competitive market.

Travelling times are a very important issue as is the proximity of future services to good transport links. A patient survey is in progress to better understand the travelling times that are thought to be acceptable. It is important that the new service criteria should clearly state travelling distance standards but be flexible enough to encourage all providers including smaller new providers to maintain a competitive market.

Proposed action – Travelling times to be considered when making final decisions about lot size

d) The value of a local smaller provider who has a better understanding and relationship with their local community

A provider said "*We are concerned this (contracts of 15,000 UOA) will exclude smaller practices and individual practitioners leaving everything in the hands of a few large operators who are more than likely to be corporates. Is that the way we or indeed our patients want to go?*

This has also been put forward as a concern by Healthwatch who said how much people value local services. Evidence shows that patients favour orthodontic practices that are directly known to the referring dentists who have knowledge of the outcomes of the treatment provided to their patients. Some comments have been sought from local schools which are very much in favour of minimising the time children are away from lessons. Small providers are often the owner of the business and strong arguments have been put forward that this helps to safeguard the quality of the service provided. These are all factors that bidders have the opportunity to put forward as positive attributes that their proposal may bring.

Proposed action – NHS England to consider flexibility in lot sizes to ensure that there are still opportunities for local services to be developed that better suit the needs of the local population. Healthwatch may need to be involved in the final decision making process for the lots.

e) Shorter travelling times to local practices

A provider identified the following criteria in relation to travelling –

- *A site that is close to the areas of highest deprivation*
- *A site that is close to the areas from which patients have to travel the furthest to see an orthodontist (Figure 6).*
- *Excellent transport links for rail, bus and road*
- *Proximity to the main local secondary schools"*

This has always been the ambition as travelling times in the South East can be protracted even over short journeys with poor connectivity across rural areas in particular. Ease of travelling should also be considered as not all families have easy access to cars and new services should be sited close to public transport. Another aspect of travelling time is the amount of time parents and carers have to take off work to take children to appointments. However there is also evidence to show that travelling to quality services especially when these can be combined with trips to school extend the acceptable range of travel.

Proposed action: Travelling times to be considered when making final decisions about lot size

f) The unknown legal and financial challenges of working in a "federation" style arrangement

There is significant concern from the profession about the potential need to work together in groups to jointly bid for the large lots that will be on offer. The legal responsibilities within such groups and the future practice values are the subject of much debate with no easy solutions as this is a relatively untried arrangement in orthodontics which is still dominated by the single provider model working with associates and, increasingly, corporate body arrangements.

Currently there are examples where there are multiple names on the contract. The commissioner's relationship is with the named contract holders. In the future the commissioner would not necessarily be interested in the legal relationship that binds these people to the contract as the relationship is created through the contract for services and no other. It may be helpful for potential providers to consider working together as a "federation" and how this could work on a legal footing. During the tendering process it is for the potential providers to demonstrate the strength and validity of the working relationship which can be created in a number of ways as determined by the potential providers. NHS England would advise individuals to take further legal advice on this as they are not in a position to advise on any particular model. For many providers this agreement will have far reaching consequences for practice owners.

Proposed action - Future providers should take their own legal and professional advice when considering working with others should they be successful in this procurement round. NHS England is not in a position to offer and views and advice on what these future arrangements between providers might be.

g) Ensuring the quality of provision of services and the power of an on-site owner with a vested interest

A provider said *"Big service contracts do not guarantee quality and nor do they foster competition to drive up standards; also they do not necessarily provide local care for local people. Ongoing assessment of quality of outcomes and identifying where this falls short and what to do about it, needs to be part of a robust process and should be a key part of any new contract"*

The new service specification will include quality markers such as KPIs (which have not yet been agreed) and the need to PAR score cases. References will also be required for any future providers and bidders will have the ability to include testimonials within the bid. Those bidders who have current contracts will be able to evidence the quality of their existing performance through their OAF reports.

2. The proposed UOA rate of £56.50

The Orthodontic MCN said *"There is no doubt that there is scope to improve patients' experience and accessibility as well as introducing some economies but the recommended UOA rate of £56.50 would not be deemed acceptable without compromising quality and the viability of orthodontic providers. This recommendation is based on a 2013 document, which has little relevance in a procurement exercise for 2018."*

A final decision on any target UOA value and the whether the benefit of knowing this in advance may have to future bidders has not yet been discussed and agreed.

This rate was taken from the 2013 transitional document produced to enable commissioners to review existing contracts and consider whether the contracts should be extended. A spread of values was identified and £56.50 was the mid-point. There have been some recent procurement and incorporations both within the South East and the South and UOA values at about this rate have been achieved.

This point was discussed in detail at the recent LDC Channel meeting who strongly felt that this rate risked the quality of service provision and a high risk of contract failure especially at the beginning when set up costs are significant. Another factor to consider in this was the fact that corporate bodies are often more resilient to financial pressure than individuals which may give them an unfair advantage in the bidding process. There was also some debate whether there should be a target value for new contracts at all.

A request was made to look at current median values of contracts across the South East and individual median values for each county as shown in the table below:

Region:	Median Activity (UOA):	Mean Activity (UOA):	Median Value:	Mean Activity:	Median UOA rate	Mean UOA rate
Kent	4,164	7,203	£275,825	£473,206	66.24	65.69
Surrey	4,292	5,066	£316,822	£331,263	73.81	65.38
Sussex	4,912	5,062	£313,041	£331,637	63.72	65.51
ALL	4,395	5,836	£300,263	£382,640	68.31	65.56

There are a number of contracts that have failed recently and further information was going to be requested to identify the learning from these challenges. The one example that has been identified to date (Hampshire) showed that the small corporate that obtained this contract was declared bankrupt as their business model did not prove to be viable and they simply walked away from their professional responsibilities. There should be a requirement within the tendering documentation to demonstrate business continuity which may cover this scenario.

Proposed action - NHS England to consider whether there are any advantages to stating a preferred UOA rate and if agreed, what that rate should be based on current UOA values and the need to improve the cost effectiveness of all NHS contracts.

3. Proximity of services to schools

A provider said "*As I have a good working relationship with the local Secondary schools Head teacher's I have can versed their opinion on the impact of having a restricted service in West Byfleet and a main contract in Woking. The nine Head teachers have all responded stating that they all believe:*

- *Children having to travel further for orthodontic appointments would have a negative effect on attendance.*
- *Students will be better served by being able to access local services in West Byfleet.*
- *All have confirmed they would be willing to send questionnaires to the parents of their students to canvas their opinions."*

There has been significant evidence that this is a factor to be considered when planning future services. A public survey is in process to identify how strong a factor this in relation to patient choice when making decisions about future siting of contracts. In reality bids will be judged on the overall quality of the bid and this is only one factor. There may be overwhelming reasons for appointing a particular provider whose proposal it to set up in a particular position which may or equally may not be near a school.

There is also strong evidence to show that missing school time has a greater adverse effect on educational outcomes in children from lower socio-economic households.

Proposed action – NHS England to review the outcome of the patient survey and determine whether the proximity of secondary schools should be used as an indicator when assessing the quality of bids.

4. Transfer cases from unsuccessful bidders

A provider said *"The complexities of taking over a case load should not be underestimated. There will be some simple ones but many were treatment planning decisions have been made that may need to be changed extending the time for successful completion of the case. NHS England should postpone this procurement until this has been fully worked through as the impact on patients is high"*

This is one of the most important issues to consider when the new contract is awarded and has been the subject of many national discussions to date involving both the BDA and the BOS. Currently there are a number of options under consideration but as yet no final agreement. Unsuccessful existing providers may be offered the option to complete their cases and will be funded to do so. New providers will not get full contract values if they are not taking on transfer cases known as a stepped entry agreement. Concerns have also been expressed about the costs of transfers of records which may include plaster study models and hard copy radiographs. There has also been very limited research into what patients may think if they have to transfer to another practice mid-way through treatment.

No final decisions have yet been made on any of these issues yet but they are factors that need to be considered.

5. Benefits of smaller local practices

A provider said "*The vested interest component of the local provider should be valued for the:*

- *Time and attention to detail applied to running a small service effectively and efficiently which requires careful monitoring and management. A large hub centre sending in an associate to a remote satellite site would not be an equivalent scenario.*
- *Personal understanding and engagement of the local community that again would not be expected from a part-time associate.*
- *Ability to be better placed to respond to changing local needs more quickly and appropriately, which an associate may not be aware of or report on."*

There were many comments from individual practice owners who quoted high levels of satisfaction from their patients. They also cited other aspects such as easy parking, always seeing the same team, familiarity with families over several years as siblings were treated etc. As previously stated Healthwatch also supported localism. None of these practices cited any difficulties with offering patients choice of appointments or lack of availability on certain days and times. NHS England is actively encouraging bids from all sizes of future practices provided that the minimum standards as set out in the specification are met.

6. Waiting lists

The Orthodontic MCN said *"no attempt has been made to quantify the number of patients on current waiting lists who represent unmet historic need. Even if sufficient activity is commissioned to address normative need (despite the difficulties in calculating this figures as discussed earlier) unless unmet previous need is accounted for then it is unlikely that waiting times will be reduced for patients. For the needs assessment to be robust and a sound procurement strategy to be devised, this unmet historic need needs to be factored into the equation.*

In addition the MCN said *"inconsistent way that waiting lists are managed and recorded but it should be possible to obtain and validate this data, which would add greatly to the robustness of the needs assessment. Unless this unmet previous need is quantified and a strategy put in place to address this, any commissioning activity to meet normative need will only maintain the status quo.*

There has always been a problem quantifying unmet need as there is no consistent way of measuring how many patients are waiting for treatment and who are ready to be started at any one time. In addition although poor access to NHS dentistry has been quoted as a potential barrier for access to orthodontic treatment there is no direct evidence to show that this is the case. There is also data that shows that access to orthodontic care is better than national rates.

The needs assessment revision was carried out within a limited timescale and this did not allow an opportunity to collect waiting list data from all providers. In addition there are still no consistent parameters for waiting list so any data provided may not have been comparable. DERS is able collect data on the waiting time from referral to first assessment and then treatment but it has only been used universally for Orthodontic referrals since December 2016 so there are no reports yet. There is more up to date waiting time's information available that was not put into the updated report as follows:-

Of the practices that responded to the question time from first referral to appointment:

- Less than a month 17
- 1-3 months 26
- 3-6 months 9
- 6-12 months 3
- Over 12 months 1

- Range Immediate to 65 weeks

Of the practices that responded to the question time from assessment to treatment initiation:

- Less than a month 23
- 1-3 months 20
- 3-6 months 6
- 6-12 months 3
- Over 12 months 7
- Range Immediate to 157 weeks

A consistent way of measuring waiting times needs to be agreed to make this meaningful data. In addition patients appreciate knowing the different waiting times and make choices of referrals based on this data.

Proposed action - NHS England should consider whether those practices with consistently long waiting lists represents historic under provision and based on the need in that area increase the amount of activity commissioned within the new local contract. NHS England should monitor future waiting lists through the DERS reports.

7. Quality of service provision and KPIs

A provider said "*a Practice which has an unblemished record in terms of Compliance with the copious rules and regulations, who has consistently passed every inspection, about whom there has been negligible complaints, who has very good feedback from questionnaires and FFT tests and who has invested heavily in its infrastructure and staffing levels, stands the same chance of securing the contract as an outside professionally presented bid from someone with no history of providing high standard orthodontic care in the area"*

There was strong representation at the Channel LDC meeting about how the commissioner was going to assure the quality of service provision in the future. The application forms will have quality questions in them and references will be sought from potential providers. Existing providers will be able to demonstrate the current quality of the service through their OAF reports, CQC inspection reports etc. as evidence of the current services they provide. The Orthodontic MCNs can take a lead on improving quality across practices by agreeing quality standards, supporting practices to achieve these, encouraging audit and peer review.

Proposed action -The Orthodontic MCNs should work with the profession to develop quality standards that can be further developed by
NHS England into KPI's to help to improve the quality of service provision in the future.

8. Hospitals and training future workforce.

The Orthodontic MCN said *"It is worth noting also that eligibility criteria within secondary care units varies from unit to unit, often changing in line with demand and this factor needs consideration."*

The hospital service treats the most complex patients usually requiring multi-disciplinary care. However the commissioner recognises that there is a need for more routine cases to be available to the hospital to allow for the training of the specialist for the future. This has already been factored in the DERS referral pathway and should limit the variation in acceptance criteria between units in the future. More work needs to be done generally with the hospital service to better understand the unique benefits that this service brings to overall orthodontic care provision and access to specialist opinions across KSS.

Proposed action – NHS England is planning to work with secondary care providers to agree consistent acceptance criteria through commissioning intentions and service specifications over the next two years.

9. Professional engagement during the production of both versions of this document.

The Orthodontic MCN said *"there is widespread feeling that the level of engagement and the timeframes offered have been inadequate on this occasion for such an important exercise. There is also a feeling in many circles that the "engagement" from NHS England and its representatives is often a token exercise to allow commissioners to tick the box so to speak. It is frustrating that documents and policies are often produced citing local engagement with providers whereas in reality this has not really been the case. We hope this is an area that will improve moving forwards, starting with the formation of a core KSS orthodontic MCN as discussed on numerous occasions"*

When this document was first conceived there were a number of discussions between the Consultant in Dental PH and various groups and members of the profession. All hospitals teams were written to and requests made for data. The NHS England lead contract manager also invited all orthodontic providers to come into the offices to discuss OAF indicators and transitional scores. Almost all orthodontic providers engaged and worked with the contract manager who explained where efficiencies could be gained in the use of their contract and explain some of the early thinking of the contracting team. Recently there has been further engagement through the Kent MCN in particular and other individual key providers as well as some hospital consultants. Opportunities have been taken and also lost to widen this discussion as far as possible through the Local Dental Network meetings and this consultation period.

Proposed action - NHS England will continue to work with its providers to better understand their needs for communication and consultation and identify any learning points from this exercise for future procurements and service reviews.

10. Calculating future need – population growth and Stephen's formula.

The Orthodontic MCN said "*This work was 25 years ago and the reality is that patient/parental attitudes have changed. The number of people who decline treatment who have a health need has probably declined meaning that those in category 3 needing treatment probably outnumber those in 4/5 who do not want treatment. This problem may be even more of an issue in the southeast than other parts of the country. Thus the figure of 1/3 as proposed by Prof Stephens is probably outdated in light of increased patient desire and an updated Stephens's formula (if there was one) would probably suggest a figure between 1/3 and 50%. Let us not forget that the formula also suggested that 9% of the population would require interceptive treatment on top of this normative need figure for 12 year old and that needs to be factored in."*

In addition the following point was made *"there has been a chronic under-provision of services in most areas of the country for years leading to worsening waiting lists. This is consistent with the picture in the Southeast since the introduction of PDS."*

The MCN's conclusion was that *"Taking all the above into account, my view is that more appropriate figure for need and demand for the area is probably closer to 43% than 1/3. There is also the issue of unmet previous need arising from 10 years of chronic under-provision."*

Population growth - The predicted average growth across the South East is approximately 8% of the total 12 year old population. Population mapping including densities is also being used as are figures on uptake of current services. Estimates are that about an additional 3% of the child population will require treatment but this does vary across the South East. This does not equate to a 3% need in overall contract provision (which would be relatively easy to obtain solely through contract efficiencies) as each course of treatment that is provided is 21 UOA. Currently about 20,000 courses of treatment are provided across the South East and a further 600 courses of treatment (12,600 UOAs) may be required over and above if no efficiency savings can be made in the future. This does not include any of the current backlogs of cases or an under-provision in the system (if present on a universal basis). This means that about 5% extra UOAs will need to be commissioned in the future. The financial constraints through the whole of the NHS may mean that this increased level of future provision cannot be achieved and this may lead to a rise in waiting times in certain areas which are more susceptible to this growth e.g. Medway, parts of Kent, Mid Sussex and Surrey

Stephen's formula - There are a number of differ ways of calculating need as discussed in the Orthodontic Needs Assessment, all of which produce estimates and the rule of a third falls in the mid-range. There was also an agreement made within NHS England that this would be the basis for the needs assessments. All the other ONAs across the South area of procurement have used this as a baseline for calculating need and as such this helps to make them comparable.

11. Travelling times, ease of travel and extended hours

Channel LDC said "*Travelling times across the LAT vary enormously. It may take less time to travel 20 miles in one area than it does 4 in another but this doesn't seem to have been considered. Government statistics show that Surrey has the slowest roads in the country at these times and I am sure it's not much better over the whole area. Can you demonstrate if and how these variations have been recognised?"*

A provider said *"Most children take a session (i.e. morning or afternoon) off school for Orthodontic appointments, usually for only 10-12 visits, so extended hours are an unnecessary burden on potential Providers. There are many infrastructure issues such as staff looking after their own children, retention of staff, hours of cleaners etc. so that any anticipated service enhancement needs to be proven. The hours of 7.30 to 9.30 am and 4.30 to 6.30 pm are the times that our roads are most congested as you will know. Could you therefore explain how this disruption to working lives would benefit anyone?"*

This has always been an ambition of NHS England to help improve access to services. The constraints of the heavy traffic within the more populated parts of Kent and Surrey and the poor connectivity in the more rural south of the area are not without their challenges. Bidders will need to demonstrate that they have considered this for their preferred location for services.

There has been limited evidence to demonstrate that there is a real need for appointments later beyond 5.30 and on Saturdays although there is a buoyant market for private appointments out of hours. The main reason put forward about the reluctance to work longer hours was the disruption to staff who also had families to care for and the additional expense of employing staff for longer hours at premium time. Responses from the Public consultation have not yet been analysed as this was one of the specific questions in the survey. This would still be the preferred model for the commissioner and the position will become clearer through the bidding process.

Proposed action NHS England to review the public survey results to determine whether there are inequalities in access among different groups that may not have easy access to cars or have less ability to take time off work.

12. Length of contract

The standard issue NHS contract is for five years and NHS England does recognise the problems that this could cause some providers especially those who may need access to capital funding to establish new practices or extend existing practices to cope with any extra orthodontic activity. A business case has been put forward to NHS England to increase the length of time for orthodontic contracts. A number of options have been put forward for consideration and this should be clearer once the tendering process starts.

Proposed action: NHS England to inform potential providers of the length of contract through the procurement process. As early a decision as possible would be helpful to future providers.

13. Referral guide and early referral

A Consultant said "*Regarding the referral guidance, I think this is a good idea and we did spend quite a lot of time producing referral guidelines as requested previously".*

The principle of having a referral guide was welcomed and the one in West Sussex has been used to help develop the referral pathway with DERS. There will always be a place for the early referral of some specific conditions but there was agreement that the normal age was from 10 upwards which should help release some capacity for more cases to be treated.

Proposed action – the referral guide to be laminated and sent to practices as a usual tool when discussing the necessity of any referral with the parent of carer. NHS England should also consider informing the providers of the free BOS app that can be downloaded onto mobiles and tablets.

14. Access to NHS dentistry

A provider said ***"****We would like to point out that a particular problem existed in the Dover area for many years- patients had great difficulty and often found it impossible to access NHS general dental care. The knock on effect of this was they could not access orthodontic treatment as they needed a general dental practitioner to refer them. Thus patients were effectively disbarred from orthodontic treatment and this may be the primary reason for the lower level of patients from the Dover area being able to access orthodontic treatment."*

A GDS procurement is underway to establish new practices and increase the size of contracts in identified areas across the South East. However there remains plenty of availability of NHS practices which is sometimes not necessarily the perception of the public.

15. DERS

A provider said *"DERS is having some teething problems at present (excuse the pun) and lack of additional information that would normally be in a letter is an issue. In secondary care we do not see/use the front face of DERS but there should be some ability to input free text to support a referral and aid triage. The rads should be uploaded as high quality jpegs for them to be of diagnostic use."*

The comments about the quality of the orthodontic referrals not having as much information as a letter and the poor radiographs within DERS are noted. The DERS system is continually under review and focus groups are being established to gain user input to help to improve the system where there are identified issues.

16. Specific geographical issues

A provider said "*Table 17: There appears to be inaccuracies with the UOA totals which may be distorting the real picture of geographical spread:*

- *Thanet- 9110 appears to be an underestimation.*
- *Canterbury- 24,122 appears to be overestimated. This would bring into question the feasibility of linking it to a satellite unit in Sittingbourne.*
- *Maidstone activity is indicated to potentially be reduced which also then brings into question the feasibility of linking it to a satellite in Sittingbourne.*

There are some specific areas in Kent and along the south coast and rural areas that make travelling difficult and these have been identified as potential areas for either satellite practices or increasing the size of the contract in that area. The main issue from a geographical view point is the potential number of large planning applications either already lodged or in discussion locally that will significantly impact on existing and future local services. Planning for this unknown level of housing growth and the future population profile that may live there in the longer term is particularly challenging.

17. Factual inaccuracies

A number of specific issues have been noted and will be incorporated into the final version of the document.

Conclusion

The responses from providers have identified a number of issues that may benefit from further discussions within the NHS England and procurement teams as the final documents and decisions are developed. These responses will be considered alongside those from other areas of the South where similar exercises have been conducted. In addition the public are being surveyed who may also hold some strong views about the shape of future provision.

No final decisions on some very significant issues have been taken but proposed actions have been identified to assist in taking these views forward.

Grateful thanks must be given to all those providers who have contributed to the debate that is continuing about commissioning Orthodontics for the future across the South of England. The level of engagement in this process has been welcomed and re-enforces how useful this can be when improving the quality of any future needs assessments. It also helps commissioners when making decisions about the future shape and design of clinical services.

Disclaimer. The views expressed in this document do not necessarily reflect the views of the commissioner but are an attempt by Jackie Sowerbutts Locum Consultant in Public Health (Oral health) to NHS England, South – South East to examine the evidence and present a response to the themes raised by a significant number of current Orthodontic providers in Kent, Surrey and Sussex.

Annex 1 response from the three Orthodontic Managed Clinical Networks reproduced in full

"Feedback on "Revised Orthodontic Needs Assessment for Kent, Surrey and Sussex, Dec 2016"

Introduction and engagement

Thank you for the recent revised orthodontic Needs Assessment. Orthodontic providers and performers in the South East welcome the opportunity to comment. This document includes some of my personal views together with some of the views fed back to me via the Kent, Surrey and Sussex Orthodontic MCN's. It should be noted however that this document will not reflect all the views and I am aware that many of my colleagues will have fed back individual views directly to you concerning their own areas, units or practices. The needs assessment clearly represents a significant body of work and we thank all concerned.

Whilst we are grateful of the opportunity to offer feedback on this document it is worth noting that there is widespread feeling that the level of engagement and the timeframes offered have been inadequate on this occasion for such an important exercise. There is also a feeling in many circles that the "engagement" from NHS England and its representatives is often a token exercise to allow commissioners to tick the box so to speak. It is frustrating that documents and policies are often produced citing local engagement with providers whereas in reality this has not really been the case. We hope this is an area that will improve moving forwards, starting with the formation of a core South East orthodontic MCN as discussed on numerous occasions.

This document contains comments on some areas of the document that would benefit from correction as well as views on some of the recommendations and strategy.

5.1 Normative Need

Underpinning every Orthodontic Needs Assessment document and associated strategy is a robust assessment of normative need for a population and similarly a robust assessment of capacity. Unless these two elements can be relied upon, the validity of any needs assessment and subsequent recommendations is undermined.

Whilst the work in the needs assessment document on normative need is extensive, there are concerns surrounding both the methodology of previously utilised methods of assessing need and also the interpretation of the available data.

Many of the problems come from the fact that much of the existing research does not use the same criteria as the current NHS regulations. If I take the Child dental health survey as a simple example. This study (which did not include IOTN 3.6 and 3.7) showed that 35% of 12 year olds had an IOTN score of 4 or 5 or an aesthetic score of 8+. In addition they found another 8% already had appliances on. My interpretation of this data is that 43% of the 12 year old population requires braces not 35% as suggested in the needs assessment. In fact allowing for the fact that IOTN 3.6 and 3.7 are not included, it will be even higher. Yet in table 2 a figure of 35% is used estimating a need for 18,189 12 year olds. A figure of 43% would suggest a figure of 23,346. This is quite a difference.

My understanding on reading various citations of the Holmes work (1992) was that it was 1/3 of patients that fell into IOTN 4 and 5 not 3.6 or above. The other often-quoted tool is the Stephen's formula, which was based on work in 1992. Based on this many commissioners base normative need on 1/3. However, the work by Prof Stephens actually stated that 1/3 of the population fall into category 4 and 5 but that some patients with an IOTN of 3 (which constitutes another 1/3 of the population) also require treatment. Thus the true figure was significantly higher than 1/3 and closer to 50% but it was felt that the number of patients in IOTN DHC 3 that needed and desired treatment was probably offset by those in categories 4 and 5 who did not want treatment. Hence the figure of 1/3 was adopted as the figure that both needed and wanted treatment. This work was 25 years ago and the reality is that patient/parental attitudes have changed. The number of people who decline treatment who have a health need has probably declined meaning that those in category 3 needing treatment probably outnumber those in 4/5 who do not want treatment. This problem may be even more of an issue in the southeast than other parts of the country. Thus the figure of 1/3 as proposed by Prof Stephens is probably outdated in light of increased pt desire and an updated Stephens's formula (if there was one) would probably suggest a figure between 1/3 and 50%. Let us not forget that the formula also suggested that 9% of the population would require interceptive treatment on top of this normative need figure for 12 year old and that needs to be factored in. Within the needs assessment, this need for interceptive treatment is not being correctly assessed as such cases attract differing levels of UOA's (4) but most will then proceed to comprehensive treatment later.

Hence, there is a feeling that the figure of 1/3 probably underestimates the combination of normative need and pt desire especially in light of the IOTN threshold of the PDS contract rather than the higher threshold used in most studies. As a result of this figure being used, there has been a chronic under-provision of services in most areas of the country for years leading to worsening waiting lists. This is consistent with the picture in the Southeast since the introduction of PDS.

Of course it is appreciated that a number of patients will not want or be suitable for treatment and a number of patients who qualify for NHS care will also elect to choose private options which will further reduce the demands on NHS care. The

number of children entering private care will be very difficult to ascertain and there will be tremendous variation between areas. From personal experience, the average in our group is that around 3%-4% of NHS referrals elect to go private. However, many of these do not qualify for NHS care anyway and hence the number of patients that qualify for NHS care and elect to go private is probably very low indeed.

However, there are other factors to take into account, which will increase demands such as the small percentage of patients that receive treatment with an IOTN of less than 3.6 (this should be possible to quantify from BSA data) and also the issue of transfer cases.

Taking all the above into account, my view is that more appropriate figure for need and demand for the area is probably closer to 43% than 1/3. There is also the issue of unmet previous need arising from 10 years of chronic under-provision. Growing waiting lists since the introduction of PDS can only partly be explained by funding spent on reviews and the most likely explanation is that contract levels were not set at the appropriate levels back in 2006. Ideally a robust needs assessment should try and quantify this unmet historic need. Admittedly this is made more challenging by the inconsistent way that waiting lists are managed and recorded but it should be possible to obtain and validate this data, which would add greatly to the robustness of the needs assessment. Unless this unmet previous need is quantified and a strategy put in place to address this, any commissioning activity to meet normative need will only maintain the status quo.

5.3 Expressed need

Table 7 and 8: The data presented in these tables and the assumptions based on this data is no longer relevant as the picture has changed significantly in terms of the amount of funding spent on treatment or assess. / Revs and assess/ refuses.

As demonstrated in table 16, the amount of expenditure on assess/ rev and assess/refuse is now only 1.8% of budget in Surrey and Sussex and 2.3% in Kent. It is worth noting that this change in pattern has occurred before the DERS system was introduced. Even if all this funding were directed into treatment it would only result in 8575 extra UOA's, which equates to 408 patients across KSS not 1280 as in the document. This section therefore needs modification, as do the implications of reducing funding spent on assessments.

Once again it is worth highlighting that these assessments should still be valued by commissioners and not treated as wasted resource. In any other medical or surgical specialty, a consultation with its associated advice is seen to carry some value and is a welcome service for patients and referrers.

The principle reason for this change in ratios is likely to be a change in the claim pattern from orthodontic providers with most now not submitting or certainly submitting fewer claims for reviews on patients not ready for treatment. This change therefore probably has little to do with education of GDP's. As claims are rarely being submitted for reviews on patients not ready for treatment, it is also worth highlighting that it therefore does not affect funding and treatment activity if patients are being referred at ages too young for orthodontic treatment.

The latest data presented in table 16 also highlights that the introduction of DERS is unlikely to result in much if any more funding becoming available for treatment as almost all available funding is now attached to treatment. There are of course other benefits of a system such as DERS but it is worth highlighting that saving money is not one of them.

Paragraph 1 page 17 suggests that orthodontists can discuss private options. It is worth noting that the PDS contract and the GDC code of practice dictates that providers are obliged to discuss private options and so this paragraph should be amended accordingly.

Section 6: Current Service gap analysis

To supplement a robust needs assessment; an orthodontic strategy is dependent on an accurate picture in terms of current capacity. There are several concerns on this front surrounding this latest needs assessment document. It is worrying that there still seems to be no robust data on capacity in secondary care. The difficulties in comparing primary and secondary care are appreciated due to the different tariffs involved and the recording of episodes rather than complete cases. Some of our secondary care colleagues claim to have submitted data, which has not found its way into the Needs assessment. Without a reasonable idea of capacity within secondary care, any recommendations in terms of commissioning or decommissioning UOA's must be interpreted with caution. It is worth noting also that eligibility criteria within secondary care units varies from unit to unit, often changing in line with demand and this factor needs consideration.

Calculating capacity in primary care is an easier proposition. Dividing the available UOA's by 22 gives a reasonable idea although BSA data in recent times would suggest that dividing by 22.5 might be more appropriate. However, no allowance seems to have been made for interceptive treatment, which attracts 4 UOAs. The Stephen's formula suggests 9% of patients also require interceptive treatment. BSA data looking at patients under 10 receiving treatment may provide a more accurate picture. Funding to treat this group needs to be top-sliced from the available UOA pool, which would leave a residual figure that could be divided by 22 or 22.5 to calculate capacity. Unless this interceptive group is factored in this way, any calculations are likely to result in an over-estimation of capacity.

6.1: Treatment location and population

Fig 3 suggests that there is a large population of 12 years olds between Horsham and Worthing. This is not the case and the area is largely rural. This is supported by Fig 15, which contains more detail on population density. It would be worth reviewing the data in fig 3 and the implications of this data.

6.5 Waiting lists

Whilst some mention has been made of the variation in waiting times between providers, it is a weakness of this needs assessment that no attempt has been made to quantify the number of patients on current waiting lists who represent unmet historic need. Even if sufficient activity is commissioned to address normative need (despite the difficulties in calculating this figures as discussed earlier) unless unmet previous need is accounted for then it is unlikely that waiting times will be reduced for patients. For the needs assessment to be robust and a sound procurement strategy to be devised, this unmet historic need needs to be factored into the equation.

We would fully agree that a standardised approach to waiting lists would be a desirable goal.

Section 10: Cost of orthodontic care

Firstly, it is worth commenting that data in this section is 2 years out of date. Up to date data should easily be available. Using contemporary data, the discrepancy between current UOA values and the recommended value moving forwards as per recommendation 10 is even more startling and cannot be supported. It is also worth highlighting that the transitional guidance is over 3 years old. The figure was disputed by the BOS and the orthodontic profession at large even in 2013 but how relevant this figures is for a procurement exercise relating to contracts in 2018 is highly questionable. The concern is that with a drop in UOA value of more than 10%, standards will drop and the financial viability of some services may be precarious. It is worth noting that UOA values in recent years have already been subject to significant austerity measures with negligible rises that have not kept pace with increasing costs. Some of the proposals in terms setting up new sites would require considerable capital investment from bidders which would again bring into question the viability of such a reduction in UOA value.

Part B:

Section 16: Procurement

There are great concerns surrounding some of the suggestions in this section, especially surrounding the consolidation of contracts in some areas to single, much larger contracts. This would seem to be at odds with the concept of increasing patient choice, reducing travelling times as well as creating opportunities for new market entrants.

The document suggests that initial discussions led to the belief that in order to deliver enhanced patient experiences such as extended hours and reduced travelling times, contracts would need to be at least 15,000. We would dispute this assertion and there is absolutely no reason why services cannot be improved by way of more convenient surgery hours and improved value for money with smaller contracts as most are nowadays. In some areas, creation of single larger contracts is likely to considerably reduce patient and GDP choice and even increase travelling times.

A significant restriction of options for patients in some areas is also likely to be a concern to the Competition and Markets Authority (CMA) who would need to be involved in any such proposals. The CMA will be particularly concerned about the creation of monopolies in some areas where monopolies do not currently exist. They will also be concerned about patients not having a certain number of options within a specified radius. A significant reduction in the number of contracts also potentially reduces further the opportunity for new market entrants, which is one of the underlying driving forces of transparent procurement. The timeframe for a CMA investigation and potential clearance (typically a minimum of 6 months) would need to be factored into the procurement timeline. At the end of this process there would be a realistic possibility that the CMA would not sanction the proposals.

Consolidation of contracts will also inevitably have some consequences in terms of close down payments for completion of existing cases. There is a piece of work nearing completion on this nationally but an underlying principle of this work will be that patients will be have the option to remain with existing providers. This cost needs to be quantified by commissioners as part of the procurement process.

Summary

We hope this document has provided useful feedback. In summary, whilst we feel that this revised needs assessment document is an impressive and comprehensive piece of work, our view is that it is still a work in progress and some more data and analysis is required before robust conclusions can be drawn.

There are significant question marks about some of the methodology and interpretation of data used in the assessment of normative need. True need is probably higher than estimated and the likelihood is that there has been a slight but chronic under-provision of services for many years. This has resulted in currently unmet historic need, which ideally needs to be quantified and built into the strategy. Even if sufficient activity is commissioned to address normative need, this strategy will not address the backlog of historic need. There are also some gaps in our knowledge of current capacity, particularly in secondary care. Furthermore, there are some concerns about the way capacity in primary care has been calculated with no allowance being built in for interceptive care.

There is no doubt that there is scope to improve patients' experience and accessibility as well as introducing some economies but the recommended UOA rate of £56.50 would not be deemed acceptable without compromising quality and the viability of orthodontic providers. This recommendation is based on a 2013 document, which has little relevance in a procurement exercise for 2018.

Funding "spent" on assessments only has dropped dramatically already even prior to the introduction of DERS and this is largely due to orthodontists working with commissioners to offer greater value for money by changing the pattern of claims.

There are also significant concerns surrounding the shape of the planned procurement and contract "lots" and locations post 2018. Rather than reduce patient travel times, these suggestions would seem to have the opposite effect in some areas. There would seem to be no justification in the suggestion that in order to deliver enhanced patient service, contracts must be a minimum of 15,000 UOA's.

The proposed shape of the exercise also brings major concerns in terms of reduced patient choice and would incorporate major costs in terms of close down payments. This exercise is also likely to be a concern for the Competition and Markets Authority who would have concerns on three fronts namely: reduced options for consumers within a certain radius, the reaction of monopolies in certain areas where monopolies did not previously exist and reduced opportunities for market entrants.

We hope this has been useful and would welcome the opportunity to work more closely moving forwards with the intention of maintaining and improving orthodontic care within the KSS region.

Richard Jones, Chair, Sussex MCN
Incorporating feedback from Kent and Surrey MCN's

Annex 2 Edited Responses by themes

Theme	Comment
1. Contract size	Orthodontic Providers should have at least two Specialist Orthodontic performers within the organisation with at least 3-4 surgery capacity. Contracts of a minimum 5000 UOAs are then relatively easy to deliver in a mixed type Practice environment. I would be wary of awarding contracts which are too large or too long. Greater size does not equate to greater Efficiency or quality. Having contracts of appropriate size allows for greater flexibility for both parties. *We are concerned this (sic contracts of 15,000 UOA) will exclude smaller practices and individual practitioners leaving everything in the hands of a few large operators who are more than likely to be corporates. Is that the way we or indeed our patients want to go?* Big service contracts do not guarantee quality and nor do they foster competition to drive up standards; also they do not necessarily provide local care for local people. Ongoing assessment of quality of outcomes and identifying where this falls short and what to do about it, needs to be part of a robust process and should be a key part of any new contract. The model you show of two-centre contracts with one Provider is heavily-biased in favour of Corporate bodies given the short period of time available for other Providers to get together and align their working practices, IT systems, staffing arrangements etc. and to produce potentially successful tender documents for their services. Could you explain how this isn't the case? Also if the same Provider is in two adjacent areas that is a massive restriction on patient choice since if a

	patient is unhappy with one branch they could only transfer to the other and could possibly see the same clinician. You couldn't reasonably expect them to transfer to another Orthodontist who would receive zero payment and if the patient was dissatisfied with the pairing they would actually have much further to travel than they do at present. Has this been considered? If only one practice is proposed for Canterbury and Thanet, there is a potential monopoly issue with IDH being responsible for both areas The concept of a base practice with a satellite, or outreach clinic, would seem to be an ideal solution to a small area of population where access to orthodontic services are difficult because of distance, poor communication links and the viability of a stand-alone orthodontic practice. However, I feel that in certain areas of Kent (those I have just highlighted) show that the population would be better served with stand-alone, mid-sized orthodontic practices. The overall picture for proposed service provision seems to be favouring large isolated practices in existing locations and despite the satellites suggested, it appears that the local high quality providers are being lost. This would seem to contradict the original aim of improving access by geographically redistributing units. The above point is of particular concern to the areas of Swale, Thanet and the North Kent Coast which appear to be underserved. If procurement proceeds on hub-satellite models then effectively the small independent providers are being wiped out because to survive they would have to bid for the large hub contract against an existing large provider with resources already in place. This competition would work in the favour of the large provider. Of the large providers the corporate machine would likely have more resources than the independent large provider to accommodate a satellite site through their own chain of practices. Location would then be dictated by availability within the existing chain network rather than being an objective decision; the value of a small contract would not be sufficient to warrant investment at a new location. Also a large provider is less likely to engage another provider to lease surgery space part-time and it would no doubt be a challenge to adapt the hub's brand, policies and

	protocols to those of another business. A degree of integration is necessary for the lease model and this is easiest for a small independent provider who has just the 'satellite' to focus on. If the future picture of orthodontic provision in Kent is a handful of large providers with hub practices (+- satellites) then recent sales trends would lead us to believe that we are headed towards a corporate monopoly (IDH/ Oasis). They are the only group of potential buyers that have the financial backing to purchase such large practices. This danger is true for the proposal to eliminate the smaller contracts in Sittingbourne, North Kent Coast/ Thanet and link them to Canterbury. The latter already has a successfully performing IDH 'hub' and would have the best chance in tendering. The only avenue left to the small provider if the procurement doesn't allow for independent bids is to consider consortium bids. However, this is not a simple and straightforward option and it has legal, financial and ethical implications which may not make it an option at all. It is also potentially challenging to unite two different brands and is may not even be an option when it comes to corporates being one half of the party. Concentrating the region's provision to just a few providers also concentrates the risk. Even large suppliers can fail with the most recent example seen in 2011 in Gravesend. Self-delivery and management gives an added security by removing the risk of staff turnover which along with recruitment can be problematic for non-city locations, particularly deprived ones. A contract that can be delivered by the specialist directly avoids the need to delegate to lesser qualified staff e.g. therapist, which at the same UOA rate for the two types of delivery would give greater value for money with specialist delivery. As contract size increases and dictates a need for therapists, careful control would be needed to ensure adequate ratios of specialist: therapist: patient to ensure that sufficient levels of therapist supervision are realistically achievable to meet mandatory requirements and not jeopardise quality.

	A satellite site is likely to be open on limited days and times and have a single operator. If a patient therefore wishes to transfer provider they would have no option but to change location too to the hub site which as discussed will come at a distance with negative travel consequences. This would also be true for emergency care. The patient would face the same limitations of access at the satellite site but I would question any real benefit to the option of being seen at the hub site. This would require further travel so more tie off school which the majority of patient probably would not do as orthodontic emergencies are not usually dire and most can be self-managed at home. Besides an independent provider could have an arrangement with their base GDP for them to provide emergency care (this does not require a specialist) Whilst I can appreciate the idea that multiple small providers may not be the most efficient structure for NHS England I also do not think it is appropriate to apply a blanket rule. I feel each area and case should be considered individually. A small existing contract may simply reflect under provision and shouldn't be assumed to fairly equate to a satellite site. In areas of significant populations with successful existing providers small contracts should be viewed as valuable and potential platforms for growth if all the signs suggest that future provision planning will indicate need. However, the relevance of this point is regardless of contract size either current or future and it is that procurement should be flexible enough to facilitate bids from independent providers for such sites which should not be relegated to fixed satellite status. There is unlikely to be more than a handful of sites that this may be relevant to and hence unlikely to hinder NHS efficiency.
2. UOA rate	Minimum UOA value of around £60 should be established to maintain Practice viability and sustainability if a quality orthodontic service is to be maintained. This will also be required if extended opening hours are to be introduced i.e. 8.30 - 6.00pm as staff will quite rightly expect to be remunerated appropriately. Bearing in mind the UOA fee has been around £63 for a number of years now with Practice expenses set accordingly, it will be difficult for established Practices to accept this figure. I also

	feel that new "Startup" Practices will struggle as well! Materials are a significant expense in orthodontic practice with many Practices using American company products. The 10% drop in the value of the £ will have an impact on overheads per case treated. We are worried this will unfairly favour the larger operators particularly the corporates and would not be sustainable for the smaller operators. You speak of a pan-area UOA value of £56.50. In your report you say that the average UOA value across the area is £63 although a median value would be more accurate. A median value of £60.76 was disclosed under FOI for Hampshire in 2011, so given rises since then £63 seems to be about the median for the South and South East of England but you have arrived at a value of £56.50. Do you have any business model to support this or is it a figure plucked out of the air? If you have chosen this figure after engagement with Orthodontic Providers based in the South East with attendant high employment and high expenses, could you explain how they have helped you to arrive at this figure? Again, this is perceived to be beneficial to Providers able to withstand initial financial loss to eliminate Patient choice. Please explain how this is not so and who has helped with the model. As we all know, Practice expenses have risen considerably in the past 10 years, not to mention full Compliance with CQC regulations (we currently have just under 50 policies, many of which incur considerable sums of money for training and implementation). The suggestion £56.50 per UOA is totally inadequate. The approximately 50% reduction in non-productive assessments/reviews shown in your report translates to about £31 per treatment in Surrey and £40 in Kent/Medway. This is a sharp reduction in profits already and means an Orthodontist is already providing many more treatments per contract than at the assessment period prior to 2006. How have you factored this possible extra strain on performance into the figure of £56.50 which in effect becomes far less as the average of £63 is prior to the assessment reduction? How would you be able to demonstrate in this scenario that price is not the consideration to the detriment of the quality of provision and

	choice and that the tariff is consistent with national net averages, transparent and in the best interests of patients? Is this tender process only happening in the South East of England - what about the rest of the country? What consideration has been given to the varying costs on delivering treatment and sustaining service provision in each location? The LAT had pointed out very plainly to Orthodontic providers that it was in their best interests to achieve parity between referrals and treatments and therefore the reduction figures are not a true picture as Providers felt pressurised into the legally grey area of providing free private assessments – this is the BDA position on which they have taken advice. Your UOA figure is generally seen as unworkable except to the detriment of quality, and this by owner-Providers with personal input to fee income. Corporate bodies have no management input to income but a management tier to pay for and investors who require dividends and positive returns on capital. The inherent questions are obvious, so could you please explain how this is a level playing field for all potential bidders? The proposed UOA rate of £56.50 represents a 15% cut on the current national rate of £66.35 set in the 2004/5 test year, I wonder what evidence base there is to suggest/support this? We already have the lowest fees in Europe (a typical U/L fixed case in the EU is €3,000). A race to the bottom will just encourage the Corporates to keep bringing in cheap labour from Eastern Europe at the expense of patient safety. In my position as a Specialist in referral practice, believe me I am seeing what is going on in general dentistry in the High Streets with £5 UDA rates and most of it is truly shocking!
3. Proximity of schools	In the past six years we have registered 4,000 patients across our dental/orthodontic books of which 2,000 patients are under the age of 18 years old. The majority of our patients attend local secondary schools including: • Fullbrook (0.5 miles) – 1,588 pupils. • The Bishop David Brown School (1.2 miles) – 722 pupils • Jubilee High (3 miles) – 805 pupils In 2020 West Byfleet Secondary School will be opening excepting a further 900 pupils meaning

	that the West Byfleet area will be servicing just over 4,000 Secondary state school pupils. As I have a good working relationship with the local Secondary schools Head teacher's I have can versed their opinion on the impact of having a restricted service in West Byfleet and a main contract in Woking. The nine Head teachers have all responded stating that they all believe: • Children having to travel further for orthodontic appointments would have a negative effect on attendance. • Students will be better served by being able to access local services in West Byfleet. • All have confirmed they would be willing to send questionnaires to the parents of their students to canvas their opinions. Sheerwater (an area of need), where the second biggest secondary school is, is within walking distance to our Practice, and thus to lose the contract or its size not be increased then this will disadvantage a lower socio-economic group. We would like you to consider having a separate contract in West Byfleet, which we understand would be awarded as part of a competitive process, to meet the increasing needs of the school aged population in West Byfleet. *We are committed to providing care as close to the patient's home or school as possible and will look into the options open to us, bearing in mind the number of patients requiring secondary care in the region, their ability/willingness to travel to other sites or not, and orthodontic facilities/manpower available. Much of this planning would need to fit into the EKHUFT STP (Sustainability and Transformation Plans) model and available funding* Of the six mainstream secondary schools in Swale, five of them are concentrated in Sittingbourne with the sixth located on the Isle of Sheppey. Again this would point to the justification for and suitability of a service to be provided in Sittingbourne. The existing provider (Bespoke Orthodontics) is therefore already ideally located to serve this concentration of potential patients and the practice is within approximately one mile of the Sittingbourne schools.

TABLE B: Secondary Schools in Swale

SCHOOL	DISTANCE FROM BESPOKE ORTHO (Miles)	TOTAL PUPIL POPULATION
Borden Grammar	0.82	822
Westlands	1.03	1655
Highsted Grammar	1.09	820
Fulston Manor	1.15	1289
Sittingbourne Community College	1.55	1196
Oasis Academy Isle of	5.35	1512
TOTAL PUPIL POPULATION	-	7294

On average an NHS orthodontic patient will be at least 12 years old before they start comprehensive treatment. Most treatments last at least 18 months and require appointments to be attended approximately every 8 weeks. This means that the relevant orthodontic patient population is concentrated within secondary schools and the school is highly likely to be a base travel point for the patient at least one way regardless of the appointment time. Given that the majority of treatment is carried out during the working week it would seem logical to locate orthodontic services close to the schools to reduce travel times for regular appointments which usually only take 15 minutes. The outcome of this is less time missed from school and it is therefore an important way of reducing the impact on education which is a key consideration for ensuring all children are given the best start in life.

This suggests that ‘out-of-hours appointments’ should not be the only focus when considering orthodontic treatment impact on time lost from school. If a patient faces a significant journey for an appointment then even an out-of-hours one is likely to need time off school to allow for the travel time.

Are these intentions mapped to schools as many children seek treatment near to their school not necessarily their home postcode.

4. Transfer Cases	1) Current practice is for patients under treatment to be transferred to the new contract-holding practice on the first day of the new contract – will this continue? If not, what is being considered? 2) Who will bear the costs of transferring patient records and models? The "old" practice, the "new" practice or NHS England? 3) How will the transfer of electronic records be handled as systems may be incompatible? Dealing with the issues of cases currently in treatment with unsuccessful providers could present a problem. I do think this needs to be seriously looked at. The 2006 contract indicated that finishing such cases over a two year period would involve remuneration to the provider of 70% of the contract value in the first year and 30% in the second year. Transfer cases. As you are reducing the number of contracts it makes little sense to say that it would be a matter of swings and roundabouts to pay nothing for these cases. There would be more swings to drop patients off than roundabouts to pick them up. This would mean that Orthodontists will have a fair amount of unpaid work imposed on them along with the proposed UOA value reduction and this unpaid work may even lead to contract underperformance and breach notices. How can this not be to the detriment of provision? The question of dealing with transfer cases from unsuccessful providers needs to be quantified accurately. What is the proposed model?) Please ensure that orthodontists who fail to win their contracts back be given the opportunity to complete their cases on the 70/30% formula, assuming they can remain solvent during this period. This will give them the opportunity to lay off staff, many of whom have supported the NHS for 20-30 years, in a structured way. Area Teams should be aware that there is a very high chance of numerous bankruptcies with the attendant health problems for their practitioners. Dealing with the issues of cases currently in treatment with unsuccessful providers could present a problem. I do think this needs to be seriously looked at. The 2006 contract indicated that finishing such cases over a two year period would involve remuneration to the provider of 70% of the contract value in the first year and 30% in the second year. Will there be any additional funding to cope with extra building work and equipment required, treating patients whose appliances are incompatible with your appliances, transfer of records, etc.
5. Benefits of small local practices	Swale has a total secondary school population of over 7000 local pupils over 7 year groups. If normative need is estimated at one-third of the 12 year old population then a broad calculation would suggest a figure of 1042 in the 12 year olds year group of which one-third equals 347

	patients. The current capacity of 70 patients falls way short of fulfilling this need and would need to be increased 5 fold to almost 8000 UOAs (based on 22 UOAs per treated case) to be sufficient. Currently this excess capacity has to travel considerably further to access care. The capacity in the local area was recently halved as a nearby practice converted all UPA activity to UDAs. This extra local capacity has not been replaced and has led to a temporary increase in waiting lists. The proposals favour large existing and new practices, with the loss of all of the small, historically high-performing specialist practices in East Kent, unless additional satellite practices in the areas mentioned above are suggested ultimately. The vested interest component of the local provider should be valued for the: • Time and attention to detail applied to running a small service effectively and efficiently which requires careful monitoring and management. A large hub centre sending in an associate to a remote satellite site would not be an equivalent scenario. • Personal understanding and engagement of the local community that again would not be expected from a part-time associate. • Ability to be better placed to respond to changing local needs more quickly and appropriately, which an associate may not be aware of or report on.
7. Quality of contract provision and KPIs	Regarding primary care commissioning intentions, I would make the general comment that big service contracts do not guarantee quality and nor do they foster competition to drive up standards; also they do not necessarily provide local care for local people. Ongoing assessment of quality of outcomes and identifying where this falls short and what to do about it, needs to be part of a robust process and should be a key part of any new contract. What allowances in KPIs will be made while a practice absorbs patients under treatment? What I find most alarming (as confirmed by Cherie Young at the meeting in Redhill last October) is that once the procurement process starts the Local Office will have absolutely no clinical input into the decision to award the contract. Essentially this means that a Practice which has an unblemished record in terms of Compliance with the copious rules and regulations, who has consistently passed every inspection, about whom there has been negligible complaints, who has very good feedback from questionnaires and FFT tests and who has invested heavily in its infrastructure and staffing levels, stands the same chance of securing the contract as an outside professionally presented bid from someone with no history of providing high standard orthodontic care in the area. For an independent panel to award the contract purely on a procurement presentation is extremely disturbing. How can this be following the NHS mantra of “putting the patient first." It seems as if our

	livelihoods and that of our dedicated and loyal staff (4 of our staff have between them 90 years of experience at Mid Kent Orthodontics) are being quantified in UOAs and value for money.
8. Hospitals and training future workforce	I am astounded that 45% of referrals into secondary care come straight from GDPs. Surely the specialist practices should be the first point of referral I must agree with Lindsay about DERS. I am not sure that the data which it captures is as robust as desired. For example, we have been advised that we no longer need to submit IOTN scores or treatment complexity scores as part of our CQUIN because the data is apparently being captured by the electronic referral system but in my experience neither of these is accurately recorded by DERS so I'm afraid any data gathered by this method will be flawed. *We understand that secondary data was previously provided by the Trust and a regional audit carried out in 2015 but as far as we can see these has not been included in the report. We are committed to on-going measurement of activity. Please could you clarify what is meant by "category of care"* *Re new to FU ratios If this statistic regards" reviews" as any adjustment of the brace, then we feel this is a bit low, especially regarding complexity of the cases that we treat and that treatment last 2+ years* *As a training institution we need more lower IOTN (IOTN 3s and 4s) and routine cases referrals (Tier 3a) for our trainees-this may be problematic with DERS although has been raised recently as an issue for ongoing work. We are also worried that this will lead to deskilling of trainers in these types of cases unless they themselves treat them regularly either in a primary or secondary care setting.* I'm surprised that the regional data from South East secondary care is not included as we carried out a large audit of 6000 referrals last year and I thought this was passed on to Brett. Data was shared from hospitals as requested but has not been incorporated into the document Recommendation 10 (page 25) regarding travelling distances (esp. from Dover)-"taking secondary orthodontic service provision into account, and consider whether to commission services to reduce this travel"; *We are committed to providing care as close to the patient's home or school as possible and will look into the options open* I am astounded that 45% of referrals into secondary care come straight

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9. Professional engagement	Whilst we are grateful of the opportunity to offer feedback on this document it is worth noting that there is widespread feeling that the level of engagement and the timeframes offered have been

<table>
<tr><td>through the production of both versions of this document</td><td>inadequate on this occasion for such an important exercise. There is also a feeling in many circles that the “engagement” from NHS England and its representatives is often a token exercise to allow commissioners to tick the box so to speak. It is frustrating that documents and policies are often produced citing local engagement with providers whereas in reality this has not really been the case. We hope this is an area that will improve moving forwards, starting with the formation of a core South East orthodontic MCN as discussed on numerous occasions.</td></tr>
<tr><td>10. Future Population growth and Stephens’ formula</td><td>15,000 houses planned for this period across the South East in the next 5 years

This is a gross under estimation as our understanding it is going to be a lot more than this. For example 4,000 new houses
alone have just been approved to be built in Canterbury and a new town is planned just north of Folkestone with 40,000 houses.</td></tr>
<tr><td>11. Travelling times, ease of travel and extended hours</td><td>Distances between practices and increased working hours. Travelling times across the LAT vary enormously. It may take less time to travel 20 miles in one area than it does 4 in another but this doesn’t seem to have been considered. Government statistics show that Surrey has the slowest roads in the country at these times and I am sure it’s not much better over the whole area. Can you demonstrate if and how these variations have been recognised?

Figure 17 (Appendix 3) indicates that Swale incorporates significant areas of higher grade deprivation. When this is compared to Figure 6 it suggests that these most vulnerable groups are also the ones who have to travel the furthest distances to access orthodontic care. They could be expected to incur more travel cost and time with greater impact on time off school/ work.

Bespoke Orthodontics is the only provider within the district of Swale. Once its capacity is saturated local patients are forced to either go on a waiting list or travel further afield to Rochester, Maidstone or Canterbury at their inconvenience.

Table A: Distance from Bespoke Ortho. (ME10 2AR) of alternative providers in the 3 closest regions
<table>
<tr><th>EXISTING PROVIDER POSTCODE</th><th>DISTANCE AS CROW FLIES (MILES)</th><th>LAND TRANSPORT (MILES)</th></tr>
<tr><td>ROCHESTER-ME24JS</td><td>16.9</td><td>35.5</td></tr>
<tr><td>MAIDSTONE-ME145BT</td><td>14.6</td><td>17.7</td></tr>
<tr><td>MAIDSTONE-ME168JS</td><td>18.3</td><td>24.7</td></tr>
<tr><td>CANTERBURY-CT12LS</td><td>25.7</td><td>40.5</td></tr>
<tr><td>CANTERBURY-CT12AQ</td><td>25.4</td><td>39.3</td></tr>
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	Most children take a session (i.e. morning or afternoon) off school for Orthodontic appointments, usually for only 10-12 visits, so extended hours are an unnecessary burden on potential Providers. There are many infrastructure issues such as staff looking after their own children, retention of staff, hours of cleaners etc. so that any anticipated service enhancement needs to be proven. The hours of 7.30 to 9.30 am and 4.30 to 6.30 pm are the times that our roads are most congested as you will know. Could you therefore explain how this disruption to working lives would benefit anyone? The proposed opening times in your report for opening later than 8.30am to 6pm give me some concern. These create an extra burden on practices. Most schools finish by 3.30pm. In order to treat those patients who need after school appointments, the current late evening surgery arrangements which open until 6pm have proved sufficient for those patients needing later appointments. The ideal location offers: • A central location within the district which is convenient for the majority of the population and can easily be accessed by the areas to the East (to Faversham), to the West (Rainham/ East Medway Towns) as well as the Isle of Sheppey to the North. Bespoke Orthodontics logs data about the demographics of incoming referrals and this supports the above notion. • A position which is also central to the underserved area that lies between the closest existing providers in Rochester, Canterbury and Maidstone. This location positively impacts on the area where it is needed without negatively impacting the access to care for the local populations of the surrounding providers. • A site that is close to the areas of highest deprivation • A site that is close to the areas from which patients have to travel the furthest to see an orthodontist (Figure 6). The Sittingbourne provider is closer for these patients than any of the neighbouring existing providers and so any increase in capacity at those sites will not benefit the worst affected patient group within that area of North Kent. • Excellent transport links for rail, bus and road • Proximity to the main local secondary schools The proposed opening times in your report for opening later than 8.30am to 6pm give me some concern. These create an extra burden on practices. Most schools finish by 3.30pm. In order to treat those patients who need after school appointments, the current late evening surgery arrangements which open until 6pm have proved sufficient for those patients needing later appointments.

12. Length of contract	Five-year time limited contracts are an impossible business model for anybody who is not already a PDS or GDS provider or does not have considerable financial backing. No lender or landlord would countenance an agreement over this period. This may be seen at appeal as a restriction of patient choice and an unfair advantage to existing Providers and Corporate Groups. What is your response to this perceived restriction of opportunity and choice?
13. Referral guide and early referral	Happy to share West Sussex version which has been relied on for many years by GDPs *While some of this may be an attempt to circumvent waiting lists, there is a core of patients who do require early treatment and these still need to be seen (e.g. impacted/missing teeth, Class IIIs, crossbites with displacements), bearing in mind the American Association of Orthodontists recommends a routine orthodontic screening by a specialist for all children when they are 7 years old. In our opinion our colleagues in general dental practice currently do not have the expertise or training to correctly identify those patients who need early interceptive treatment and those that do not. If the system actively discourages referral of this type of case, these patients may well be disadvantaged.* Regarding the referral guidance, I think this is a good idea and we did spend quite a lot of time producing referral guidelines as requested previously. Jo Clark was lead for this and I'm sure would be happy to share with you again, as I think these were very comprehensive. I feel that it's important to refer ectopic canines early as its hard for GDP's to accurately identify root resorption from either a periapical or an OPG radiograph (as shown in a number of published studies). We will frequently take a reduced field of view CBCT these days.
14. Access to NHS dentistry to enable referral	We would like to point out that a particular problem existed in the Dover area for many years- patients had great difficulty and often found it impossible to access NHS general dental care. The knock on effect of this was they could not access orthodontic treatment as they needed a general dental practitioner to refer them. Thus patients were effectively disbarred from orthodontic treatment and this may be the primary reason for the lower level of patients from the Dover area being able to access orthodontic treatment. The non-colour format of your document makes it impossible for us to make sense of the demographic figures provided, but there are areas such as Maidstone and Eastbourne with only one contract each and potential increases of 7% in 12 year olds where there is possible reduction in provision and definite intended reduction in patient choice. How is this justifiable?
15. DERS	The introduction of REGO has already caused a hiatus in referrals and put additional strain on practices attempting to treat patients in an efficient manner – are any changes or modifications planned?

	DERS is having some teething problems at present (excuse the pun) and lack of additional information that would normally be in a letter is an issue. In secondary care we do not see/use the front face of DERS but there should be some ability to input free text to support a referral and aid triage. The rads should be uploaded as high quality jpegs for them to be of diagnsotic use. The DERS system appears to be working well, but have the Commissioners considered the possibility of legal challenges by patients in the future against the on-line system? Standardised waiting lists. It is impossible to standardise waiting lists as GDS Providers will always prefer to refer to those practices which they perceive to provide the best outcomes for their patients. I remember having this conversation with you at East Surrey PCT about 15 years ago, so has someone found a way to standardise waiting times whilst protecting patient choice? The new DERS system is surely able to record the waiting lists and times of initial visit to treatment. Is this so? Finally regarding DERS – it's really not working very well for us at all. GDPs are finding it hard to use, the quality of referrals are generally very poor with very little information available and that makes it impossible to triage the referral on the DERS alone, which means we have to see the patient first. Radiographs are shockingly poor quality and it is taking us such a long time to chase up the original radiograph. Either patients have to go and collect them from the referrer (often the GDP, not the specialist who has referred them and we don't often even know who that is!) or we try to get them transmitted from the referrer to us (on an NHS.net account) as a .jpg so we can upload to our PACS system. The result is that I often see patients without a readable radiograph at their consultation, but don't want to re-radiograph a young child. To be honest, in terms of quality of patient care, the old system of a well written and informative letter, with a readable radiograph attached was hugely better for the patient.
16. Specific geographical issues	There are already natural alliances in place e.g. both the Surrey Heath and nearby Woking are owned by the same company so SH as a satellite of Woking may be a more natural fit. The Farnham practice already has a satellite in Godalming and flexes patients between the two sites to aid appointment choice so this would be a better fit than Guildford Dartford has long needed specialist provision in primary care and I was pleased to see this in the commissioning intentions. However, this does not necessarily need to be linked to the practice in Gravesham, although I can see the reasons why this would be attractive for a commissioning standpoint.

My concern is over provision in the Medway / Sittingbourne area. Medway has one enormous contract which does not provide competition to drive up standards or patient choice. In addition on page 21 you've identified the long travelling times for patients East of Sittingbourne which will include the Isle of Sheppey. I would have thought expansion of the service provided at Sittingbourne would be sensible, if necessary reducing the contract at Medway to fund this.

Of the six mainstream secondary schools in Swale, five of them are concentrated in Sittingbourne with the sixth located on the Isle of Sheppey. Again this would point to the justification for and suitability of a service to be provided in Sittingbourne. The existing provider (Bespoke Orthodontics) is therefore already ideally located to serve this concentration of potential patients and the practice is within approximately one mile of the Sittingbourne schools.

TABLE B: Secondary Schools in Swale

SCHOOL	DISTANCE FROM BESPOKE	TOTAL PUPIL POPULATION
Borden Grammar	0.82	822
Westlands	1.03	1655
Highsted Grammar	1.09	820
Fulston Manor	1.15	1289
Sittingbourne Community College	1.55	1196
Oasis Academy Isle of	5.35	1512
TOTAL PUPIL POPULATION	-	7294

Thanet has a proposal for 9110 UOA only.

This would seem to be a very large reduction in the current provision in Thanet, by myself at Birchington Orthodontic Practice and Richard Flanagan's IDH in Cliftonville.

There is no provision suggested for the North Kent Coast in the Herne Bay, Whitstable, Tankerton areas, especially if my practice in Birchington is not suggested. We see a large number of children from this area. This will increase their travelling time to either Canterbury, Ashford or Thanet considerably. The Swale area seems also to be under-represented.

Swale with a population of 142,000 is a district very poorly represented. It has lost a GDP orthodontic contract and only has a very small PDS contract contracted in 2013.

	I feel an increase in UOA numbers in Sittingbourne could ensure a small hub to provide convenient orthodontic services for the towns of Faversham and Rainham on the eastern side of the Medway towns, as well as the Isle of Sheppey. Sheppey has historically been overlooked following its transfer to East Kent. If this hub were to be situated in Sittingbourne, no satellite practices would be necessary to service this region. The other regions which appear to be over looked in terms of service provision are the well-populated coastal towns of Herne Bay, Tankerton, Whitstable and Seasalter. A small hub in Whitstable or Herne Bay could service the needs of this neglected part of Kent without the need for a satellite practice Table 17: There appears to be inaccuracies with the UOA totals which may be distorting the real picture of geographical spread: • Thanet- 9110 appears to be an underestimation. • Canterbury- 24,122 appears to be overestimated. This would bring into question the feasibility of linking it to a satellite unit in Sittingbourne. • Maidstone activity is indicated to potentially be reduced which also then brings into question the feasibility of linking it to a satellite in Sittingbourne. Swale has a sizeable population of 142,417 as reported by the mid-2015 data. This is comparable to most of the nearby hub provision sites and in some cases it is more significant. As a district with affordable housing, good transport links and planned regeneration sites it would be expected to attract further population growth (see Appendix 1). However, relative to the other sites it is proportionally under-served for orthodontic activity. The diagrammatic representations of child population densities (Figures 4, 8 and 16) indicate that within this significant population there is a substantial potential patient population needing orthodontic care. If population is considered from the perspective of school populations then again it is clear (Figure 12) that there is a substantial relevant population to justify a service and an independent one in the district. It is also of significance that Swale unlike the surrounding districts of Dartford, Medway, Canterbury and Ashford does not have a secondary care centre to support provision.
17. Factual content	Repetition on page 8

Responses yet not added

Judith Edwards: Shoreham–on-Sea

I am writing to you as the existing orthodontic provider in Adur. Having read the draft Oral Needs Assessment document, and looking at your proposals for future commissioning, I was concerned to find that there may cease to be orthodontic service delivery in Adur from April 2018. Orthodontic services have been successfully delivered under the NHS in Shoreham-by- Sea for 30 years. I have a relatively small contract of 2500 UOAs and am likely to retire rather than tender, but the need for Orthodontic services will remain and the local population could easily support the delivery of 3000+ UOAs from Shoreham as a satellite unit. Adur is a deprived area with many 'looked after' and disadvantaged children. Often we are providing much more than the mechanics of orthodontic tooth movement. Many children, for most of whom private provision is not an option, will be prevented from accessing timely Orthodontic care locally, or at all, if the current provision is moved to Worthing as proposed.

The majority of my patients have traditionally been drawn from the secondary school populations of Shoreham Academy, Sir Robert Woodard Academy, Steyning Grammar School, Davison High School and Cardinal Newman School. Following the introduction of the Rego Referral System, we have been inundated with patients from much further afield; from Chichester to the east of Brighton as Shoreham has excellent transport links along the south coast. There are regular rail and bus services providing reliable public transport for patients. Some patients walk, cycle or skateboard to appointments as well as those who inevitably travel by car as it is easy to park in Shoreham at a reasonable cost.

It has been an enormous privilege and a pleasure caring for the children of Adur, and in increasing numbers, for the children of previous patients, over the past 25 years and I should be saddened if their needs were not addressed in a sympathetic manner.

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