National Assembly for Wales
Health and Social Care Committee

Orthodontic Services in Wales

July 2014

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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The Committee was established on 22 June 2011 with a remit to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters encompassing: the physical, mental and public health of the people of Wales, including the social care system.

Current Committee membership

David Rees (Chair)
Welsh Labour
Aberavon

Leighton Andrews
Welsh Labour
Rhondda

Rebecca Evans
Welsh Labour
Mid and West Wales

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Plaid Cymru
South Wales East

Kirsty Williams
Welsh Liberal Democrats
Brecon and Radnorshire

After the Committee's agreement of this report, Rebecca Evans was appointed as Deputy Minister for Agriculture and Fisheries.

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Chair's foreword

Orthodontic treatment aims to improve the appearance, position and function of crooked or abnormally arranged teeth. As a Committee we recognise the potential psychological and oral health benefits of such treatment, and believe that it is right that the NHS continues to fund orthodontic treatment for young people where there is clinical need. However, we also recognise that orthodontic services represent just one element of the Welsh Government's *Together for Health: A National Oral Health Framework 2013-18*, and are clear that resources must be used wisely.

Our report builds on the work done by the Third Assembly's Health, Wellbeing and Local Government Committee in 2011, and we welcome the progress that has been made. The establishment of three regional managed clinical networks has improved relationships, and facilitated more robust data collection and the sharing of best practice. Orthodontic services are being delivered through more innovative models, and the number of assessments that do not lead to treatment is reducing. There are more dentists with special interests and orthodontic therapists, which will release capacity for specialist orthodontists to deliver more specialised services.

Although progress has been made, there is still further to go. Waiting lists vary between local health boards, inappropriate referrals are still being made by some practitioners, and the payment and contractual arrangements require reform if they are to support robust performance and quality monitoring.

Our recommendations are intended to help maintain the current positive direction of travel. We hope that the Minister for Health and Social Services will respond positively, so that we can be sure that should we, or our successor Committee, revisit this subject in future, we would hear that everybody across Wales had equitable access to effective, efficient, high quality orthodontic services.

David Rees
Chair of the Health and Social Care Committee
July 2014

The Committee's recommendations

The Committee's recommendations to the Welsh Government are listed below, in the order that they appear in this report. Please refer to the relevant pages of the report to see the supporting evidence and conclusions:

Recommendation 1. The Committee recommends that the Minister for Health and Social Services works with local health boards and managed clinical networks to develop robust monitoring arrangements to ensure consistent compliance with treatment outcome requirements. (Page 12)

Recommendation 2. The Committee recommends that the Minister for Health and Social Services confirms when the electronic referral system will be introduced, and sets out the actions local health boards and managed clinical networks can take to identify patterns of inappropriate referrals, and plan and deliver suitable targeted interventions. (Page 16)

Recommendation 3. The Committee recommends that the Minister for Health and Social Services sets out the actions local health boards and managed clinical networks can take, with associated timescales, to improve waiting times in each local health board area, and identifies the monitoring arrangements he will put in place. (Page 20)

Recommendation 4. The Committee recommends that, to ensure that the service received by patients is of a sufficient standard, the guidance issued to local health boards by the Chief Dental Officer in relation to commissioning orthodontic services includes best practice for the establishment and monitoring of such services. (Page 24)

Recommendation 5. The Committee recommends that the Minister for Health and Social Services takes steps to reform payment arrangements for orthodontic services to address the concerns raised by the Committee. (Page 35)

Recommendation 6. The Committee recommends that the Minister for Health and Social Services reviews the guidance available to support local health boards in entering into contracts for the provision of orthodontic services which take local needs into account. Such

guidance should cover, as a minimum, determination of contract length, robust performance and quality monitoring arrangements, protections against the selling on of contracts, and contract exit arrangements. (Page 36)

1. Introduction

Background

1. Orthodontic treatment aims to improve the appearance, position and function of crooked or abnormally arranged teeth. NHS funded orthodontic treatment is usually only available for people under the age of 18 who have a clear clinical need for treatment, although in some instances orthodontic treatment may be provided to adults on a case by case basis.

2. The need and eligibility of young people for NHS orthodontic treatment on dental health grounds is assessed using the Index of Orthodontic Treatment Need ("IOTN"). The IOTN dental health component consists of five grades, ranging from Grade 1 (almost perfect teeth) to Grade 5 (severe dental health problems). There is also an aesthetic component, which assesses the level of dental attractiveness. Patients are assessed in the first instance by their own general dental practitioner, and should only be referred to a practitioner providing NHS orthodontic treatment if they meet certain criteria.

3. The orthodontic workforce includes a range of professionals who provide treatment in a range of primary and secondary care settings, including general dental practitioners, dentists with special interests, specialist orthodontic practitioners, hospital consultants and orthodontic therapists.

The Committee's inquiry

4. Following a general scrutiny session with the Chief Dental Officer ("CDO") for Wales on 21 November 2013,[1] at which orthodontic services were highlighted as an area of particular interest, the Health and Social Care Committee ("the Committee") agreed in January 2014 to undertake an inquiry into orthodontic services in Wales.[2]

5. The terms of reference of the inquiry were to examine the provision of appropriate orthodontic care in Wales, including:

[1] National Assembly for Wales, Health and Social Care Committee, *RoP [para 2-186]*, 21 November 2013
[2] Ibid, *HSC(4)-03-14: Minutes*, 30 January 2014

- access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales;
- the effectiveness of working relationships between orthodontic practices and local health boards ("LHBs") in the management of local orthodontic provision, and the role of managed clinical networks ("MCNs") in helping to deliver more effective orthodontic services in Wales (e.g. effective planning and management, improvement in the appropriateness of referrals and performance management, workforce arrangements);
- whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money;
- whether orthodontic services are given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector; and
- the impact of the dental contract on the provision of orthodontic care.

6. The Committee is grateful to all those who took the time to contribute to its inquiry. A list of those who gave oral evidence is provided at Annex A to this report, and a list of the consultation responses is provided at Annex B.

2. Provision of orthodontic services

Framework for service provision

7. The framework through which orthodontic services in Wales are planned, commissioned and delivered in Wales has evolved in recent years, in response both to the recommendations of an independent expert group chaired by Professor Richmond (which reported in 2010 and is due to update its report in 2014), and to the report of the Third Assembly's Health, Wellbeing and Local Government ("HWLG") Committee in 2011.

8. The Welsh Government issued *Together for Health: A National Oral Health Plan for Wales 2013-18* in March 2013, which provides a national framework for oral health in Wales.[3] Stemming from this, each LHB has its own oral health plan, setting out its local priorities and actions. In addition, the Minister for Health and Social Services ("the Minister") is advised by the Strategic Advisory Group on Orthodontics ("SAGO"), and three MCNs have been established in North, South East and South West Wales.

9. Witnesses were positive about the impact of the MCNs on orthodontic services in Wales, especially the roles they had played in improving relationships between LHBs and orthodontic practitioners,[4] providing mechanisms for the sharing of good practice and a sense of shared direction,[5] and supporting LHBs in the development of referral management and orthodontic service capacity.[6]

Data collection

10. Public Health Wales ("PHW") raised concerns about whether the current treatment outcome reporting requirements are fit for purpose, and about the subsequent impact on the availability of comprehensive data to inform the commissioning, monitoring and planning of services.[7] Professor Richmond of Cardiff and Vale University Health Board ("CVUHB") referred to inconsistencies in the completion of forms by practitioners, which made it difficult to identify completed,

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[3] Welsh Government, *Together for Health: A National Oral Health Plan for Wales 2013-18*, March 2013
[4] National Assembly for Wales, Health and Social Care Committee, *Consultation response OS08 British Medical Association Cymru Wales*
[5] Ibid *RoP [para 217]*, 8 May 2014
[6] Ibid *RoP [para 374]*, 8 May 2014
[7] Ibid, *Consultation response OS04 Public Health Wales*

discontinued or abandoned treatments. He suggested that while the situation was improving, there would be a benefit in LHBs being a bit more "bullish" about requiring the accurate completion of forms.[8]

11. The British Orthodontic Society ("BOS") challenged this characterisation, saying that administrative errors in the completion of the forms could result in them being "erroneously interpreted [...] as failure to complete treatment".[9]

12. LHBs told the Committee that data collection was improving. Hwyel Dda University Health Board ("HDUHB") said that it was operating a pilot single point of referral scheme, which was assisting in the collection of referral data.[10] The Committee also heard that MCNs were working with LHBs to carry out independent treatment outcome audits to provide additional information about quality, outcomes and outputs, with a view to assisting LHBs and the Welsh Government assess whether orthodontic services provide value for money.[11]

13. The Minister told the Committee that the structure now in place encouraged LHBs to focus on issues of monitoring and evaluation, which in turn improved the availability and reliability of statistical information.[12] He praised the MCNs, saying that they had made "notable achievements" within a short period of time, including:

> "the development of cogent referral protocols and processes, the refinement of the clinical quality monitoring system and the development of an accreditation process used to identify dentists with enhanced skills and capable of delivering high quality NHS orthodontic care."[13]

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[8] National Assembly for Wales, Health and Social Care Committee, *RoP [para 470, 472 and 474]*, 8 May 2014
[9] Ibid, *HSC(4)-17-14(ptn1) - Additional information provided by witnesses who attended the Committee's meeting on 8 May 2014 in relation to the inquiry into orthodontic services in Wales*, 26 June 2014
[10] Ibid, *RoP [para 388]*, 8 May 2014
[11] Ibid, *Consultation response OS14 South East Wales Local Orthodontic Committee and Managed Clinical Network*
[12] Ibid, *RoP [para 7]*, 4 June 2014
[13] Ibid, *HSC(4)-14-14: Paper 1 – Evidence from the Minister for Health and Social Services*, 4 June 2014

The Committee's view

14. The Committee welcomed the MCNs' role in improving relationships between LHBs and orthodontic providers, and increasing the focus on performance monitoring and sharing best practice. It acknowledged the evidence given by LHBs and the Minister that data collection was improving, and that more robust statistical information was now available, but was concerned that PHW still considers the reporting on treatment outcomes to be insufficient.

Recommendation 1: The Committee recommends that the Minister for Health and Social Services works with local health boards and managed clinical networks to develop robust monitoring arrangements to ensure consistent compliance with treatment outcome requirements.

3. Referrals

15. A general dental practitioner may refer a patient for NHS orthodontic treatment if they present with good oral hygiene, have good dental status, and have an IOTN grade 4 or 5, or a grade 3 with a high aesthetic component rating. The Committee heard from a number of witnesses, including PHW, that more progress needs to be made to ensure that all referrals made are appropriate.[14]

Multiple referrals

16. In its 2011 report, the HWLG Committee raised concerns about the impact on waiting times of patients being referred onto more than one orthodontic waiting list.[15] Both the BOS[16] and the British Dental Association ("BDA")[17] told the Committee that they were anecdotally aware of multiple referrals, in part as a consequence of long waiting lists, as dentists referred patients onto multiple lists to maximise the chances of getting to the top of a list more quickly.

17. The Minister told the Committee that progress had been made to reduce this practice since 2011.[18] Dr Sandham, Chair of the SAGO, was hopeful that the introduction of new electronic referral systems would help to identify and deal with multiple referrals.[19]

Early referrals

18. The Committee received evidence from the BOS that 15% of hospital patients and 23% of specialist new patients were referred at least a year earlier than might be clinically required,[20] and that this was partly a consequence of long waiting lists.[21]

19. The Minister told the Committee that PHW had identified that there were patterns of specific practitioners referring patients too

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[14] National Assembly for Wales, Health and Social Care Committee, *Consultation response OS04 Public Health Wales*
[15] Ibid, Health, Well-being and Local Government Committee, *Orthodontic services in Wales*, February 2011
[16] Ibid, Health and Social Care Committee, *RoP [para 196]*, 8 May 2014
[17] Ibid, *RoP [para 197]*, 8 May 2014
[18] Ibid, *RoP [para 98]*, 4 June 2014
[19] Ibid, *RoP [para 25]*, 4 June 2014
[20] Ibid, *HSC(4)-17-14(ptn1) - Additional information provided by witnesses who attended the Committee's meeting on 8 May 2014 in relation to the inquiry into orthodontic services in Wales*, 26 June 2014
[21] Ibid, *RoP [para 222]*, 8 May 2014

early, and that such patients remained on waiting lists for long periods until they reached a suitable age for treatment.[22] When asked about the feasibility of prohibiting early referrals, the CDO advised that this would be problematic, as in a small proportion of cases it could be appropriate for younger children to receive early interventions.[23] The Minister acknowledged the Committee's concerns about inappropriately early referrals of younger children for orthodontic treatment, and said that he would commission Professor Richmond to consider whether it would be beneficial for Welsh Ministers to issue guidance on this matter.[24]

Identifying inappropriate referrals

20. Professor Richmond told the Committee that the majority of referrals made by general dental practitioners were appropriate, although there was significant variation between practitioners. He cited examples of individual practitioners with 40% rates of refusal of their referrals, and suggested that any intervention to address inappropriate referrals should be targeted towards such individuals or practices.[25] Abertawe Bro Morgannwg University Health Board ("ABMUHB") said that it was at an early stage in collating accurate data about referrals and validating waiting lists, but that such information would eventually assist in identifying patterns of inappropriate referrals by particular practitioners, and in targeting interventions and training resources as required.[26]

21. The BDA said that the majority of general dental practitioners were "very capable" of determining cases where it was clear whether or not a patient should be referred. It could however be more challenging for them to make decisions about borderline cases, particularly when there was parental pressure for a specialist referral.[27] The BDA suggested that putting resources into the provision of training for general dental practitioners about appropriate referrals and the use of the IOTN would be effective in reducing inappropriate referrals and, therefore, waiting lists.[28] The BOS told the Committee

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[22] National Assembly for Wales, Health and Social Care Committee, *RoP [para 35]*, 4 June 2014
[23] Ibid, *RoP [para 43]*, 4 June 2014
[24] Ibid, *RoP [para 93]*, 4 June 2014
[25] Ibid, *RoP [para 351]*, 8 May 2014
[26] Ibid, *RoP [para 358-60]*, 8 May 2014
[27] Ibid, *RoP [para 207]*, 8 May 2014
[28] Ibid, *RoP [para 181]*, 8 May 2014

that the inclusion of the IOTN as part of the core continuing professional development for general dental practitioners would be beneficial,[29] and could reduce the number of referrals by 5-10%,[30] but said that the demand for training sessions that had been provided in 2011 following the report of the HWLG Committee had tailed off.[31]

22. To address concerns about inappropriate referrals and guide general dental practitioners to the most appropriate providers, MCNs in South East and South West Wales have introduced referral management systems, which include referral guidelines, protocols and forms. The South East Wales Local Orthodontic Committee and MCN said that the effectiveness of its system was yet to be fully evaluated, but that anecdotal evidence from orthodontic providers suggested the appropriateness and quality of referrals was improving, and practices were able to undertake some triage of referrals.[32] The North Wales MCN advised that it was in the process of producing a common referral form for use across the network.[33] However, other evidence received by the Committee questioned whether, given the similarity of issues faced across Wales, it was appropriate for each region to customise its own approach or whether an all Wales approach would be more advantageous.[34]

23. The Minister told the Committee that money from the 2014-15 telehealth technologies fund was being invested in new electronic referral systems to be delivered by NHS Wales Informatics and the CDO,[35] with a view to providing:

> "an all Wales, national electronic based referral system, that will allow us to drill down [...] below the figures in a way that we are not completely able to do now."[36]

24. He said that this would enable MCNs to identify which practitioners might require interventions, and to work with them to understand and improve their referral practices.[37]

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[29] National Assembly for Wales, Health and Social Care Committee, *RoP [para 208]*, 8 May 2014
[30] Ibid, *RoP [para 192]*, 8 May 2014
[31] Ibid, *RoP [para 189]*, 8 May 2014
[32] Ibid, *Consultation response OS14 South East Wales Local Orthodontic Committee and Managed Clinical Network*
[33] Ibid, *Consultation response OS15 North Wales Managed Clinical Network*
[34] Ibid, *Consultation response OS06 Q Dental Care Ltd*
[35] Ibid, *RoP [para 104]*, 4 June 2014
[36] Ibid, *RoP [para 108]*, 4 June 2014

The Committee's view

25. The Committee was concerned by the evidence it received about the number of inappropriate, early and duplicate referrals that were still being made by some general dental practitioners. It noted that progress had been made since the HWLG Committee reported in 2011, but was of the view that further progress needed to be made to ensure that patients were referred appropriately.

26. The Committee welcomed the evidence from the Minister that new electronic referral systems were being introduced, which would help identify patterns of inappropriate referrals and enable training or other interventions to be targeted as required.

Recommendation 2: The Committee recommends that the Minister for Health and Social Services confirms when the electronic referral system will be introduced, and sets out the actions local health boards and managed clinical networks can take to identify patterns of inappropriate referrals, and plan and deliver suitable targeted interventions.

27. The Committee was also concerned to note that significant numbers of patients were being referred earlier than clinically necessary. While the Committee accepted that there might be patients for whom an early referral was appropriate because of particular orthodontic need, it welcomed the Minister's commitment to commission Professor Richmond, as part of his report on orthodontics this year, to consider whether it would be useful for additional guidance to be issued to general dental practitioners in relation to referring young children for orthodontic treatment.

28. If Professor Richmond concludes that such guidance would be beneficial, the Committee expects that the Minister would issue guidance as soon as possible, and monitor its impact on the number of inappropriately early referrals.

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[37] National Assembly for Wales, Health and Social Care Committee, *RoP [para 45]*, 4 June 2014

4. Waiting lists

Length of waiting lists

29. The HWLG Committee expressed concern about the length of waiting lists for orthodontic treatment in Wales in its 2011 report. Evidence received by the Health and Social Care Committee during the course of its inquiry showed that the long waiting lists persist, although there is some variation in waiting times between LHBs, and between primary and secondary orthodontic care. Table 1 shows referral to treatment and assessment times for each LHB as at March 2014.

Table 1 Waiting lists for primary and secondary orthodontic provision as at March 2014[38]

Local health board	Primary care waiting times (latest available data)	Secondary care waiting lists (latest available data)
Abertawe Bro Morgannwg University Health Board	R to T: average 24 months	26 weeks
Aneurin Bevan Local Health Board	R to A: 3-36 months A to T: 2-36 months	R to A: 2-3 months A to T: 18-36 months
Betsi Cadwaladr University Health Board	R to A: 6-24 months (average 16 months) A to T: 0-2 months (average 6 weeks)	Data not provided
Cardiff and Vale University Health Board	R to A: 12-24 months A to T: 0-2 months	R to A: 2-5 months R to T: 18-20 months
Cwm Taf Local Health Board	Most patients are referred to practices in Cardiff (included in CVUHB figures)	R to A: 2-8 months R to T: 18-24 months
Hywel Dda University Health Board	R to A: average 9.6 months Referral to treatment: 2.4 years	R to A: 4 months R to T: 7-8 months
Powys Teaching Health Board	Referral to treatment: 6-18 months	Up to 42 months

[38] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-14-14: Paper 1 – Evidence from the Minister for Health and Social Services*, 4 June 2014. NB Data for Abertawe Bro Morgannwg University Health Board relates to December 2013.

30. The consequences of such waiting lists can include delaying the transfer of appropriate primary care patients to secondary care, a reduction in enthusiasm for treatment, or children passing the optimum age for treatment.[39]

31. Professor Richmond told the Committee that there were capacity and consistency issues across Wales which contributed to lengthy waiting lists, evidenced by a high number of assessments being carried out when compared with treatments, variation in the ratio of treatment starts to completions across LHBs, levels of retreatments, and the number of starts in terms of the total Units of Orthodontic Activity value ranging from zero to 89%.[40]

32. The Minister outlined areas in which improvements had been made since the HWLG Committee reported, including:

- a 59% reduction in the four years since 2010 in the proportion of orthodontic assessments which did not lead to treatment; and
- the commissioning by LHBs of 2,000 additional units of orthodontic activity in the last year for which there are figures, which equated to 500 more children receiving orthodontic treatment.[41]

33. In his written evidence, the Minister said that the retreatment of patients who had previously received orthodontic treatment during 2009 accounted for about 13% of all orthodontic treatments provided during 2012-13. In addition, in 2012-13, approximately 630 patients either abandoned or discontinued their treatment.[42] He told the Committee that achieving efficiencies in relation to retreatments and the discontinuation or abandonment of treatment could help to reduce waiting times.[43]

Waiting list initiative

34. The HWLG Committee recommended that the Welsh Government fund a one-off waiting list initiative to clear the backlog of patients

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[39] National Assembly for Wales, Health and Social Care Committee, *Consultation response OS03 British Dental Association*
[40] Ibid, *RoP [para 428]*, 8 May 2014
[41] Ibid, *RoP [para 21]*, 4 June 2014
[42] Ibid, *HSC(4)-14-14: Paper 1 – Evidence from the Minister for Health and Social Services*, 4 June 2014
[43] Ibid, *RoP [para 22-3]*, 4 June 2014

waiting for orthodontic treatment.[44] The then Minister for Health and Social Services rejected the recommendation, saying that her priority was to address inefficiencies in the system and free up resources and capacity.[45]

35. The Committee heard mixed views on whether it would be appropriate to pursue this recommendation. A one-off initiative was supported by the Orthodontic National Group, which favoured face-to-face triage to validate the waiting list, and ensure that the patients on the list meet the required threshold for NHS orthodontic treatment.[46] However, the BOS was cautious about whether a one-off funding initiative was appropriate or feasible.[47] Peter Nicholson of the BOS told the Committee that while validating the list could eliminate inappropriate or borderline referrals,[48] and enable patients requiring urgent hospital treatment to be seen more quickly,[49] simply transferring patients to treatment waiting lists would expose a lack of treatment capacity in specialist practices, hospital orthodontic services, hospital oral surgery and maxillofacial services and tertiary referrals and would not therefore reduce the backlog.[50]

36. Professor Richmond was of the view that more work needed to be done to understand and manage the profiles of the waiting lists, for example in relation to the patients' ages,[51] and that a one-off funded waiting list initiative would be of assistance only if it were targeted towards particular groups, such as patients from 14 to 17 years of age.[52]

37. ABMUHB agreed with this view, saying that the validation of waiting lists would assist in targeting money appropriately.[53] However, other LHBs[54], PHW[55] and Q Dental Care Ltd[56] were concerned that any

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[44] National Assembly for Wales, Health, Well-being and Local Government Committee, *Orthodontic services in Wales*, February 2011
[45] Welsh Government, *Written Response by the Welsh Assembly Government to the report of the National Assembly for Wales Health, Wellbeing and Local Government Committee: Orthodontic services in Wales*, March 2011
[46] National Assembly for Wales, Health and Social Care Committee, *Consultation response OS05 Orthodontic National Group*
[47] Ibid, *RoP [para 178]*, 8 May 2014
[48] Ibid, *RoP [para 189]*, 8 May 2014
[49] Ibid, *RoP [para 194]*, 8 May 2014
[50] Ibid, *RoP [para 179]*, 8 May 2014
[51] Ibid, *RoP [para 364-5]*, 8 May 2014
[52] Ibid, *RoP [para 336]*, 8 May 2014
[53] Ibid, *RoP [para 337]*, 8 May 2014
[54] Ibid, *RoP [para 338-9]*, 8 May 2014

one-off action without additional recurrent funding would only be a short term solution which would not address the underlying issues.

38. The Minister told the Committee that he did not consider a one-off orthodontic waiting list initiative to be a priority for the level of investment that would be required (approximately £1million), and that he had no plans to provide funding for such an initiative. He believed instead, like the former Minister, that the reduction or elimination of inefficient, inappropriate and early referral processes, and of assessments which do not lead to treatment, would make the system more efficient and reduce waiting times.[57]

The Committee's view

39. The Committee noted that there was divided opinion about whether a one-off waiting list validation initiative would represent value for money, and that alternative approaches to improve the appropriateness of referrals and increase efficiencies within the system could serve to reduce waiting lists in a more sustainable way.

Recommendation 3: The Committee recommends that the Minister for Health and Social Services sets out the actions local health boards and managed clinical networks can take, with associated timescales, to improve waiting times in each local health board area, and identifies the monitoring arrangements he will put in place.

[55] National Assembly for Wales, Health and Social Care Committee, *Consultation response OS04 Public Health Wales*
[56] Ibid, *Consultation response OS06 Q Dental Care Ltd*
[57] Ibid, *RoP [para 10-1]*, 4 June 2014

5. Access to orthodontic services

Regional variations in access to orthodontic services

40. Witnesses were concerned about variable geographical access to primary and secondary care orthodontic services, particularly in sparsely-populated rural areas where the number of patients in need of treatment is not sufficient to support the provision of standalone specialist practices.[58]

41. The BOS explained that orthodontists and dentists are private businesses, which could impact on the spread of service provision across Wales, particularly as a result of the costs of establishing practices, and the impact of time limited contracts for the provision of orthodontic services on the desirability of setting up practices in particular locations.[59]

42. The Minister told the Committee that he was aware that more needed to be done to ensure more equitable access to orthodontic services across Wales. He acknowledged the challenges of establishing expensive facilities in more remote or rural areas, but was of the view that options such as teledentistry and treatment in primary care settings could minimise the extent to which individuals were required to travel.[60]

Service delivery models

43. The Committee heard that innovative service delivery models could be used to address the variation in service provision across Wales, particularly in rural areas where it might be impractical to establish a specialist practice. Models advocated by the BOS included dentists with special interests, community dental services and peripatetic use of community clinics by orthodontic specialists.[61] In addition, the BDA suggested that specialists could hold sessions in established dental practices.[62]

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[58] National Assembly for Wales, Health and Social Care Committee, *Consultation response OS08 British Medical Association Wales*
[59] Ibid, *RoP [para 243]*, 8 May 2014
[60] Ibid, *RoP [para 21-3]*, 4 June 2014
[61] Ibid, *RoP [para 245-6]*, 8 May 2014
[62] Ibid, *RoP [para 247]*, 8 May 2014

44. LHBs were aware of the need for flexible commissioning of innovative service models, and outlined the arrangements in their areas. ABMUHB indicated that it used dentists with enhanced skills or special interests to address the gap between provision by general dental practitioners and by specialist orthodontists. It said that this could be a successful model as long as sufficient support was available to practitioners from the LHB and MCN.[63] Powys Teaching Health Board ("PtHB") said that it used a range of models to take account of local circumstances in different parts of its area. Both PtHB[64] and HDUHB[65] said that their arrangements were under review, with a view to improving access for patients.

45. The Chair of the SAGO was pleased with the work done to date to establish service delivery models based on dentists with special interests, although progress varied across Wales.[66] However, the Minister said that LHBs must develop more effective commissioning models if they were to ensure that orthodontic treatment remains affordable and good value for money.[67] The CDO told the Committee that he intended to issue further guidance for LHBs in relation to commissioning services later in 2014.[68]

46. The Minister said that in orthodontics, as across the NHS more widely, services were too frequently provided by someone of higher professional competence than necessary, because "the system acts as a sort of escalator",[69] and outlined the need to:

> "grow a new cadre of orthodontic therapists and dental therapists – people who can do the more routine, straightforward side of the job, so that much more highly trained people are not spending their time doing things that someone else could do."[70]

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[63] National Assembly for Wales, Health and Social Care Committee, *RoP [para 399]*, 8 May 2014
[64] Ibid, *RoP [para 391]*, 8 May 2014
[65] Ibid, *RoP [para 397]*, 8 May 2014
[66] Ibid, *RoP [para 113]*, 4 June 2014
[67] Ibid, *HSC(4)-14-14: Paper 1 – Evidence from the Minister for Health and Social Services*, 4 June 2014
[68] Ibid, *RoP [para 114]*, 4 June 2014
[69] Ibid, *RoP [para 51]*, 4 June 2014
[70] Ibid, *RoP [para 50]*, 4 June 2014

Training

47. ABMUHB told the Committee that the CDO was working to ensure that training and development were available to dentists seeking to develop special interests in orthodontics, and agreed that it was a way in which LHBs could reduce the pressure on specialised services in rural areas. The representative from ABMUHB said that the LHB had worked in partnership with the University of South Wales to develop a model in relation to its endodontic services which could be transferrable to training community dentists in orthodontics, provided that resources and relevant individuals could be identified.[71] PtHB and CVUHB confirmed that they were undertaking similar work, but HDUHB said that at present it was not.[72]

Recruitment

48. The Committee heard evidence from the British Medical Association Wales ("BMA Wales")[73] and LHBs[74] that recruitment issues, such as the attractiveness of posts and restrictions in local recruitment were making it difficult to reduce secondary care treatment times in some areas of Wales. PtHB said it had found it difficult to recruit to its previous model of senior dental officers in salaried orthodontic posts, which had been of benefit in providing flexibility in rural areas,[75] partly because the health board was unable to compete with the practice-based model on salaries.[76]

49. The evidence suggested that there are no difficulties in recruiting for training posts across the UK, and that the national recruitment campaign was oversubscribed with candidates of a high standard. However, the BOS noted that "whether, subsequent to getting their specialist training, they want to come to work in Wales is another issue".[77]

50. The CDO echoed this, saying that the nine training posts in Wales for orthodontists are filled annually.[78] He sought to reassure the

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[71] National Assembly for Wales, Health and Social Care Committee, *RoP [para 399-401]*, 8 May 2014
[72] Ibid, *RoP [para 403-5]*, 8 May 2014
[73] Ibid, *Consultation response OS08 British Medical Association Wales*
[74] Ibid, *RoP [para 409]*, 8 May 2014
[75] Ibid, *RoP [para 391]*, 8 May 2014
[76] Ibid, *RoP [para 395]*, 8 May 2014
[77] Ibid, *RoP [para 253]*, 8 May 2014
[78] Ibid, *RoP [para 58]*, 4 June 2014

Committee that sufficient orthodontists are being trained, but acknowledged that there are difficulties in recruiting trained orthodontists in some parts of Wales. He said however that recruitment difficulties are not limited to orthodontics, as he was aware that similar difficulties were experienced in West and North West Wales across other medical and dental specialisms.[79] The Minister acknowledged this difficulty, but told the Committee that he did not plan to offer incentives, rather to ensure that the available skills were used effectively, and that use was made of technologies such as teledentistry, to improve equity of access to services.[80]

The Committee's view

51. The Committee noted that there was regional variation in the provision of orthodontic services across Wales, particularly in rural areas, and that innovative models of service delivery were being explored, including the use of dentists with special interests, teledentistry and orthodontic therapists. The Committee welcomed the use of such models to improve patient access, but emphasised that the quality of services must be maintained.

Recommendation 4: The Committee recommends that, to ensure that the service received by patients is of a sufficient standard, the guidance issued to local health boards by the Chief Dental Officer in relation to commissioning orthodontic services includes best practice for the establishment and monitoring of such services.

52. The Committee was concerned about the difficulties in recruitment of trained orthodontists to some areas in Wales, and the contrast with the oversubscription of national recruitment to training positions, but recognised that this is an issue which recurs across medical and dental specialisms. While the Committee does not intend to make a specific recommendation in relation to the recruitment of orthodontic specialists, it expects that the Minister will monitor the scale and impact of recruitment difficulties in medical and dental specialisms in rural areas, and may return to this issue in the future.

[79] National Assembly for Wales, Health and Social Care Committee, *RoP [para 58]*, 4 June 2014
[80] Ibid, *RoP [para 60]*, 4 June 2014

Patients who reach the age of 18 following referral

53. The Committee heard conflicting evidence about access to orthodontic services by patients who are referred on to a waiting list before, but not treated until after, they are 18. LHBs told the Committee that they take a "pragmatic view", and that such patients' treatment will generally be funded.[81] However, the BOS said that it had experience of the NHS Business Services Authority deciding that patients were ineligible on the basis of their age, despite having been on waiting lists since before they were 18.[82]

54. The Minister said that the regulations were clear that those on a waiting list before the age of 18 would have their treatment funded, even if they were over the age of 18 by the time that they were treated.[83]

The Committee's view

55. The Committee welcomed the clarification given by the Minister about access to NHS orthodontic treatment for patients who are referred before they are 18, but not treated until after they are 18.

Patients who relocate following referral

56. The Committee questioned the witnesses on access to orthodontic services for individuals who relocate between LHB areas after they have been referred onto a waiting list. LHB representatives confirmed that such access to NHS orthodontic treatment is based on the original date of referral.[84]

57. The Minister outlined the role of MCNs in preventing individuals being disadvantaged as a result of relocation.[85] He agreed that relocation within Wales, or between England and Wales, should not impact on patients' ability to access orthodontic services in a timely manner, but noted that the current arrangements for payment could result in double payments if patients relocated.[86]

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[81] National Assembly for Wales, Health and Social Care Committee, *RoP [para 506]*, 8 May 2014
[82] Ibid, *RoP [para 238]*, 8 May 2014
[83] Ibid, *RoP [para 86]*, 4 June 2014
[84] Ibid, *RoP [para 508-19]*, 8 May 2014
[85] Ibid, *RoP [para 83]*, 4 June 2014
[86] Ibid, *RoP [para 74]*, 4 June 2014

The Committee's view

58. The Committee welcomed the reassurance provided by LHBs and the Minister that individuals would not be disadvantaged as a result of legitimate relocation between different areas in Wales, or between England and Wales. However, it was concerned by the Minister's evidence that the current payment arrangements could result in treatment being funded twice as the result of relocation. This issue is explored further in Chapter 7.

6. Prioritisation of orthodontic services provision

Prioritisation of orthodontic services provision

59. *Together for Health: A National Oral Health Plan for Wales 2013-18* notes that approximately £13 million per annum is spent on primary care orthodontics, which accounts for approximately 10% of the primary care dental budget and 40% of the total spend on children's dentistry in primary care dental services.[87] The Minister told the Committee that he agreed with the conclusions of Professor Richmond's review of orthodontic services and the HWLG Committee that enough resource was allocated to orthodontic services, but that changes were needed to ensure that the money was used more efficiently.[88]

60. The BDA supported the provision of NHS orthodontic services, as long as they were based on identified need not demand, but said that if any additional resource was available for dental services in Wales, investment in preventative practice and basic dental disease should be prioritised.[89] PHW agreed, saying that while it recognised that orthodontic treatment could have preventative benefits, the cost of achieving such outcomes would be higher, and the positive health impacts at a population level lower, than addressing caries, gum disease and oral cancer.[90]

61. Some of the evidence received by the Committee suggested that under the current financial pressures, available resources should be diverted to those with the greatest dental health needs by raising the threshold for NHS orthodontic treatment to IOTN grades 4 and 5, thereby excluding grade 3 with a high aesthetic component.[91] Concerns were raised however about the desirability of introducing different access to care in Wales compared with the rest of the UK,[92] and whether the number of referrals would be significantly reduced.[93]

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[87] Welsh Government, *Together for Health: A National Oral Health Plan for Wales 2013-18*, March 2013
[88] National Assembly for Wales, Health and Social Care Committee, *RoP [para 11]*, 4 June 2014
[89] Ibid, *RoP [para 325]*, 8 May 2014
[90] Ibid, *Consultation response OS04 Public Health Wales*
[91] Ibid, *Consultation response OS08 British Medical Association Wales*
[92] Ibid, *Consultation response OS14 South East Wales Local Orthodontic Committee and Managed Clinical Network*
[93] Ibid, *Consultation response OS10 Dr David Howells*

62. Mr Nicholson of the BOS suggested that if the threshold for NHS treatment was raised to grade 4 and 5, access would be reduced for about 5% of patients. In his view this would result in inequality, as "the better-off parent will fund it privately; the people who lose out will be the less privileged in society".[94] Mr Nicholson questioned the extent to which it is possible to identify the effectiveness and long term benefits of preventative schemes,[95] and queried whether resources should be diverted away from orthodontics, which he said was "working effectively, is treating need, is cost effective and has measurable outcomes".[96]

63. LHBs spoke in favour of preventative schemes such as Designed to Smile,[97] and, while recognising the psychological and oral hygiene benefits of orthodontics,[98] were clear that resources had to be used appropriately and in line with the Welsh Government's prudent healthcare approach.[99] PtHB suggested that in order to meet need while using resources appropriately and managing increasing waiting lists, LHBs and the Welsh Government needed to consider making changes to the contractual arrangements and models through which services were delivered.[100]

64. *Together for Health: A National Oral Health Plan for Wales 2013-18* states that the Welsh Government believes that NHS orthodontic services must be provided strictly in terms of need, not demand.[101] The Minister recognised that patients are moving from wanting to ensure they have healthy teeth, to wanting cosmetically pleasing teeth,[102] but told the Committee that he considered investment in addressing dental inequality across Wales, through preventative

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[94] National Assembly for Wales, Health and Social Care Committee, *RoP [para 328]*, 8 May 2014
[95] Ibid, *HSC(4)-17-14(ptn1) - Additional information provided by witnesses who attended the Committee's meeting on 8 May 2014 in relation to the inquiry into orthodontic services in Wales*, 26 June 2014
[96] Ibid, *RoP [para 330]*, 8 May 2014
[97] Ibid, *RoP [para 419]*, 8 May 2014
[98] Ibid, *RoP [para 414]*, 8 May 2014
[99] Ibid, *RoP [para 420]*, 8 May 2014
[100] Ibid, *RoP [para 420-1]*, 8 May 2014
[101] Welsh Government, *Together for Health: A National Oral Health Plan for Wales 2013-18*, March 2013
[102] National Assembly for Wales,Health and Social Care Committee, *HSC(4)-14-14: Paper 1 – Evidence from the Minister for Health and Social Services*, 4 June 2014

dentistry in communities in which there is currently poor oral health, to be a priority over further investment in orthodontic services.[103]

The Committee's view

65. The Committee agreed that access to NHS orthodontic services should be based on need, not on demand, and that investment in oral health should be prioritised according to the impact at a population level to ensure that value for public money is achieved. The Committee expects, however, that the Minister will keep his priorities under *Together for Health: A National Oral Health Plan for Wales 2013-18* under review, to ensure that the actions delivered under the strategy continue to achieve the intended outcomes, and represent value for money.

[103] National Assembly for Wales, Health and Social Care Committee, *RoP [para 31]*, 4 June 2014

7. Orthodontic services contracts

2006 general dental services contract

66. Before the introduction of the 2006 general dental services contract, simple orthodontic cases could be undertaken by general dental practitioners, who would receive payment on the successful completion of treatment. The 2006 contract changed this, making it very difficult for a dentist who has not undertaken postgraduate training in orthodontics or orthognathics to take on and treat simple cases.

67. The 2006 general dental services contract introduced Units of Orthodontic Activity ("UOAs"), which are allocated according to the weight of treatment required. Dentists are paid a monthly sum according to a contract with the LHB, and in return have an obligation to deliver a specified number of UOAs in the course of a year. They are credited with UOAs at the start of each course of orthodontic treatment, although the treatment may be carried out over a number of years.

68. The BOS outlined the impact of the 2006 contract on the distribution of orthodontic and dental services across Wales, and on referrals to specialist services, saying that the introduction of the 2006 contract:

> "effectively capped orthodontics at the levels that were there at the time. It also fixed it largely by locality. If you were in far West Wales and there was no orthodontics there at the time, there would be no orthodontics there afterwards."[104]

69. Mr Nicholson told the Committee that following the introduction of the contract, services and resources were concentrated in the CVUHB area. He said that this had been one of the drivers for the establishment of an MCN in South East Wales, as orthodontists from other health board areas within the region had wanted to ensure that patients from their areas had equitable access to services.[105]

70. Overall, the evidence received by the Committee suggested that the 2006 dental contract is seen as an improvement on the previous

[104] National Assembly for Wales, Health and Social Care Committee, *RoP [para 259]*, 8 May 2014
[105] Ibid, *RoP [para 259]*, 8 May 2014

contract, but that there were aspects of the contract which could be changed to increase its efficiency and effectiveness. PHW was concerned about variation in the interpretation of the requirements of the contract across Wales. Its written evidence said that within the bounds of the current contract, it believed that the work the MCNs are undertaking in relation to quality and safety, recognition of dentists with enhanced skills and referral and pathway guidance were driving improvements, but that much greater reform would be required if there was to be a real impact.[106]

Payment for provision of orthodontic services

71. The BOS explained that under current payment arrangements orthodontic service providers are contracted to provide a certain number of UOAs annually, and receive payment for the annual number of UOAs in monthly instalments. At the start of an individual course of treatment, the number of UOAs required for the full course of the treatment are allocated to that case.[107]

72. Evidence received demonstrated that there are concerns about these arrangements, including the increased potential for treatments to be abandoned before completion,[108] and the potential for double payments to be required should a provider's contract expire before a patient's treatment is completed, meaning that another provider has to be identified.[109] A representative of PtHB told the Committee that he would prefer for an element of payment to be made upfront, with some of the payment to be reserved until treatment was satisfactorily completed, with independent peer assessment carried out on a random sample basis.[110]

73. The Committee also heard concerns from LHBs about their ability to commission services through flexible and innovative models under the 2006 contract, as the contract requires that practices are paid the same amount for each UOA, regardless of whether the service is provided by an orthodontic specialist or an orthodontic therapist.[111]

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[106] National Assembly for Wales, Health and Social Care Committee, *Consultation response OS04 Public Health Wales*
[107] Ibid, *RoP [para 279]*, 8 May 2014
[108] Ibid, *Consultation response OS04 Public Health Wales*
[109] Ibid, *Consultation OS11 Hywel Dda University Health Board*
[110] Ibid, *RoP [para 395]*, 8 May 2014
[111] Ibid, *Consultation response OS17 Cardiff and Vale University Health Board*

74. *Together for Health: A National Oral Health Plan for Wales 2013-18* states that the Welsh Government intends that all primary care orthodontics should be provided by orthodontic specialists and/or dentists with special interests, and that as the skill mix and services change, there will be a need to review the funding of such services. The Plan commits the Welsh Government to work with its counterpart in England to review the general dental services orthodontic contact by 2016.

75. The Minister told the Committee that the review was at an early stage, and was not due to report until 2016-17, but that he intended to make some interim changes to the regulations, including those governing payment arrangements for orthodontic treatment. He explained that under the current arrangements, 37.5% of the dental budget for children was spent on the 6% of children in Wales who receive orthodontic treatment, but that the current system of payment prior to treatment risked double payments as a result of abandoned treatments and re-presentation of patients to other orthodontist providers[112] or the relocation of patients from one LHB area to another.[113] To address this, he said that he was minded to alter the payment structure so that while it would still recognise the investment made by orthodontists and include an element of upfront payment, some proportion of the payment would be tied to the completion of the course of treatment.[114]

76. The Committee asked about the timing for the changes that the Minister had outlined, and the CDO indicated that following Professor Richmond's follow up report, due to be published in summer 2014, he would be providing advice to the Minister about any changes required to the regulations. Following this advice, time would be required for consultation and implementation.[115]

Length of orthodontic service contracts

77. The current contract is underpinned by the NHS Personal Dental Services Agreement Regulations 2005, which provide for the establishment of time limited contracts. Witnesses raised concerns

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[112] National Assembly for Wales, Health and Social Care Committee, *RoP [para 66-7]*, 4 June 2014
[113] Ibid, *RoP [para 74]*, 4 June 2014
[114] Ibid, *RoP [para 67]*, 4 June 2014
[115] Ibid, *RoP [para 70]*, 4 June 2014

with the Committee about the appropriateness of fixed term contracts, including:

- the impact of the uncertainty which can arise towards the end of fixed term contract periods on investment and development[116] and on whether practices are willing to take on particular cases;[117]
- the ability of practitioners to recoup the investment costs associated with establishing or taking over a practice within the lifetime of a short fixed term contract;[118]
- the costs of retendering for contracts,[119] although one health board did refer to the benefits of the retendering process to encourage innovation in service delivery models.[120]

78. There was some discussion of the impact of the length of contracts on diversity of providers within the sector. The BOS was concerned that fixed term contracts "paved the way for the big corporates to come in",[121] and expressed concerns about the model through which such enterprises delivered orthodontic services, in particular the level of supervision provided to orthodontic therapists.[122] In addition, the Committee heard evidence from other witnesses that longer term contracts could be more attractive to corporate organisations,[123] and that retendering processes favoured corporate providers, which could lead to the risk of a monopoly of orthodontic provision in an area if multiple contracts were awarded to the same provider within one, or neighbouring, LHB areas.[124]

79. To address these issues, witnesses suggested that contract renewals should be for a minimum of five years, or preferably on a rolling basis for well-performing practices, to ensure continuity of good care.[125]

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[116] National Assembly for Wales, Health and Social Care Committee, *RoP [para 68]*, 4 June 2014
[117] Ibid, *RoP [para 283]*, 8 May 2014
[118] Ibid, *Consultation response OS06 Q Dental Care Ltd*
[119] Ibid, *RoP [para 273 and 275]*, 8 May 2014
[120] Ibid, *RoP [para 433]*, 8 May 2014
[121] Ibid, *RoP [para 275]*, 8 May 2014
[122] Ibid, *RoP [para 290]*, 8 May 2014
[123] Ibid, *RoP [para 437]*, 8 May 2014
[124] Ibid, *Consultation response OS08 British Medical Association Wales*
[125] Ibid, *Consultation response OS05 Orthodontic National Group*

80. The idea of rolling contracts was welcomed by the BDA, which said that it would prevent orthodontic practices from refusing to take on cases which might require treatment over a period longer than the provider's contract would last,[126] and by the BOS, provided that contracts were monitored through the use of relevant key performance indicators.[127]

81. The need for performance monitoring was an issue raised by several witnesses, including the BMA Wales.[128] LHBs and the NHS Business Service Authority are responsible for monitoring standards of delivery and outcomes within the NHS, and Healthcare Inspectorate Wales is responsible for monitoring standards within the independent dental sector, although doubts were raised by some witnesses about the robustness of these arrangements.[129]

82. LHB representatives told the Committee that contracts needed to balance providing long-term security, to ensure that a provider can develop and invest in their practice, and ensuring that LHBs are able to exit from contracts should services not be delivered to a sufficient standard.[130] CVUHB said in its written evidence that the guidance issued by the Welsh Government on improving the performance management of orthodontic contracts was allowing LHBs to start to introduce tools into performance management of the contracts, but that it was still too early to ascertain the impact of the guidance on long term quality and performance.[131]

83. There was general agreement among health boards that there should be provisions within contracts to protect against contracts being sold on, but that this was not currently standard practice.[132]

84. The CDO confirmed that the regulations did give LHBs the flexibility to enter into contracts for longer periods following the initial 5-year contract, based on the needs within their areas. He said that the steps taken by different LHBs had varied, with some rolling over

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[126] National Assembly for Wales, Health and Social Care Committee, *RoP [para 283]*, 8 May 2014
[127] Ibid, *RoP [para 273 and 275]*, 8 May 2014
[128] Ibid, *Consultation response OS08 British Medical Association Wales*
[129] Ibid, *Consultation response OS06 Q Dental Care Ltd*
[130] Ibid, *RoP [para 440]*, 8 May 2014
[131] Ibid, *Consultation response OS17 Cardiff and Vale University Health Board*
[132] Ibid, *RoP [para 445-50]*, 8 May 2014

existing contracts for five years, others for three years, and others for seven years.[133]

85. The Minister said that he wanted contractual arrangements which gave orthodontists "the confidence to invest", and that to this end he was content that contracts should be issued beyond the initial 5-year standard, provided that mechanisms were in place to ensure that service quality was maintained. He said that LHBs had been issued with guidance in May 2013 as to how they could balance stability of supply with quality assurance.[134]

The Committee's view

86. The Committee was concerned to hear that elements of the 2006 general dental contract were creating barriers to the development of flexible, innovative and cost effect orthodontic services in Wales. It welcomed the work that has begun on an England and Wales basis to review the contract, but noted the Minister's evidence that this work is still at an early stage. The Committee expects that the review should include, as a minimum, ensuring that the contract provides sufficient flexibility to enable LHBs to be innovative in the way that they commission services, and to reflect new service delivery models in the way in which services are funded.

87. The Committee also welcomed the Minister's commitment to take interim steps to reform the payment arrangements for orthodontic service provision in order to address the risk of double payments for incomplete courses of treatment and drive improvements in the quality of service provision through linking an element of payment to treatment completion. The Committee noted that Professor Richmond's report, which will inform any interim changes to arrangements, will be published in summer 2014.

Recommendation 5: The Committee recommends that the Minister for Health and Social Services takes steps to reform payment arrangements for orthodontic services to address the concerns raised by the Committee.

88. The Committee noted the evidence it had received about the impact of fixed term contracts on orthodontic service providers. It

[133] National Assembly for Wales, Health and Social Care Committee, *RoP [para 90]*, 4 June 2014
[134] Ibid, *RoP [para 68]*, 4 June 2014

agreed that the quality of service provision was key, and that contracts should include robust performance and quality monitoring arrangements, as well as provisions protecting against the selling on of contracts and enabling LHBs to exit from contracts should quality standards not be met.

Recommendation 6: The Committee recommends that the Minister for Health and Social Services reviews the guidance available to support local health boards in entering into contracts for the provision of orthodontic services which take local needs into account. Such guidance should cover, as a minimum, determination of contract length, robust performance and quality monitoring arrangements, protections against the selling on of contracts, and contract exit arrangements.

Annex A - Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed on the Committee's website.

8 May 2014

Stuart Geddes	British Dental Association Wales
Peter Nicholson	British Orthodontic Society
Karl Bishop	Abertawe Bro Morgannwg University Local Health Board
Professor Stephen Richmond	Cardiff and Vale University Health Board
Bryan Beardsworth	Hywel Dda Local Health Board
Warren Tolley	Powys Teaching Health Board

4 June 2014

Mark Drakeford AM	Minister for Health and Social Services
Dr Sandra Sandham	Chair of the Strategic Advisory Group on Orthodontics
David Thomas	Chief Dental Officer

Annex B - Written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full on the Committee's website.

Organisation	Reference
Individual reponse	OS01
Kim Malpas	OS02
British Dental Association (BDA) Wales	OS03
Public Health Wales	OS04
Orthodontic National Group	OS05
Q Dental Care Ltd	OS06
British Orthodontic Society	OS07
BMA Cymru Wales	OS08
South West Wales Orthodontic Managed Clinical Network	OS09
Dr David Howells	OS10
Hywel Dda Local Health Board	OS11
Welsh Consultant Orthodontic Group	OS12
Individual response	OS13
South East Wales Local Orthodontic Committee and Managed Clinical Network	OS14
North Wales Orthodontic Managed Clinical Network	OS15
Abertawe Bro Morgannwg University Health Board	OS16
Cardiff and Vale University Health Board	OS17