Service Specification No.	QVV/311
Service	Secondary Care – Level 3b Orthodontic Services v.3.3
Commissioner Lead	NHS Dorset ICB
Provider Lead	Dorset County Hospital, Dorchester
Period	April 2024
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Contents

1. Background

1.1 Description of Speciality

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

Orthodontic treatment should only be undertaken in situations where it is believed to be in the patient's best interests in terms of their oral health, function and/ or psychosocial wellbeing. In all situations, the clinical advantages and long-term benefits of Orthodontic treatment should justify such treatment and outweigh any detrimental effects.

Orthodontic care includes the provision of advice and education for patients, parents and other health-care professionals. It includes monitoring the development of teeth and providing interceptive measures, with appliances, where appropriate. The majority of Orthodontic work is carried out with removable and fixed appliances when all the primary teeth have been lost.

The Index of Orthodontic Treatment Need (IOTN)[1] is a clinical assessment of malocclusion severity utilised within the NHS to select those individuals who would benefit most from Orthodontic treatment. NHS treatment is mainly provided in primary care (except in exceptional cases) for patients with:

- Grade 4 or 5 Dental Health Component of the Index of Orthodontic Treatment Need[1];
- Grade 3 of the Dental Health Component of that Index with an Aesthetic Component of 6 or above.

A Consultant led hospital service will mainly care for cases that require multidisciplinary input and which are outside the scope of a Specialist Orthodontist. Such patients may be those with a facial deformity that requires corrective treatment, often involving surgery, or complex restorative cases with multiple missing teeth. Further details are set out in Section 1.4.

1.2 Aims of the Orthodontic Service

i. The overall aim is to provide equitable, accessible, high quality and cost-effective Consultant Orthodontic Services in line with the NHS England National Guide for Commissioning Orthodontics, 2015[2] ('the Commissioning Guide').

ii. The service is aimed at those patients who require orthodontic procedures, defined in Section 1.4, that are not expected to be within the remit of General Dental Practitioners or primary care Specialist Orthodontic services.

iii. Care for adults (aged 18 years and over) should only be carried out for patients who would normally meet the criteria for hospital referral (e.g. orthognathic and/or complex MDT cases) or where there are exceptional circumstances. In such cases the exceptional circumstances must be documented in the patient record.

iv. The provider must treat all eligible patients and not discriminate in any manner contrary to the relevant regulations. There are no geographical boundaries. The patient must be under regular continuing care of a General Dental Practitioner.

[1] The Development of an Index for Orthodontic Treatment Priority: European Journal of Orthodontics 11, p309-332, 1989 Brooke, PH and Shaw WC

v. Dental service provision must be in accordance with best practice as set out in the following guidance or subsequent legislation changes:

- High Quality Care for All – Next Stage Review, 2008
- NHS Constitution, 2009
- Implementing care closer to home, 2007
- Modernising Medical Careers
- Ionising Radiation Regulations
- British Orthodontic Society, Orthodontic Radiographs Guidelines (2015)
- British Orthodontic Society, Guidelines on Supervision of Qualified Orthodontic Therapists (2012, updated 2016)
- British Orthodontic Society, Professional Standards for Orthodontic Practice (2014)
- AIDS/HIC Infected Healthcare worker Guidelines
- Equality Act, 2010
- Human Rights Act 1998
- Dental Practitioners' Formulary
- GDC Fitness to Practice
- GDC Standards
- Caldicott principles
- The Hazardous Waste Regulations
- The Health and Safety at Work Act (1974) statement of policy with respect to the health and safety at work of all employees
- Decontamination of Dental Instruments – Health & Technical Memorandum (HTM) 01-05, Parts 1 and 2" (DoH 2013)
- Health Protection Agency Guidance on Infection Control, Communicable Diseases for Primary and Community Care within the local area
- Securing excellence in dental commissioning NHS Commissioning Board 2013
- Guide for Commissioning Dental Specialties - Orthodontics, 2015.
- British Orthodontic Society, Clinical Guidelines on retention, (revised 2013)
- Royal College of Surgeons of England, National Clinical Guideline for the extraction of first permanent molars in children (2014)
- Five Year Forward View, NHS England 2014 and Next Steps (2017)
- Working Together to Safeguard Children (2018)
- Making Every Contact Count
- Delivering Better Oral Health (2017)
- UK Government's Sustainable Development Strategy
- NHS England Long Term Plan 2019

1.3 Assessment of Orthodontic Treatment Need

There are a number of methods for assessing need. It is estimated that around one third (33%) of children, in any given population, will require orthodontic treatment.

An assessment of the need for Orthodontic services has been carried out in each of the local offices within the NHS England and Improvement South West Region to inform the procurement of primary care orthodontic services, with new contracts mobilised from 1st April 2019.

1.4 Level of Orthodontic provision

i. There are several factors which need to be considered when describing the complexity level of an orthodontic case. These include the type of malocclusion, the technical difficulty in improving function and aesthetics, together with any patient modifying factors. (See **Appendix A** for complexity of Orthodontic Treatment)

ii. The clinical service will comprise provision at Level 3b as defined in the NHS England Commissioning Guide for Orthodontics, 2015[2] ('the Commissioning Guide') and includes:

- Patients with clefts of the lip and/or palate or craniofacial syndromes;
- Patients with significant skeletal discrepancies requiring combined Orthodontics and Orthognathic surgery;
- Patients who require Orthodontics and complex Oral Surgery input (e.g., multiple impacted teeth);
- Patient with complex restorative/paediatric dentistry problems requiring secondary care input in a multidisciplinary environment;
- Patients with complex medical issues, including psychological concerns, which require close liaison with medical personnel locally;
- Patients with medical, developmental or social problems who would not be considered suitable for treatment in specialist practice;
- Complex Orthodontic cases not considered suitable for management in specialist practice
- Referrals where advice or a second opinion is required from a secondary care Consultant (i.e. to those providing Level 1, 2, 3a care).

iii. Level 3b Consultant Orthodontic care is mostly multidisciplinary in nature and the service will need to work closely with other dental specialties to ensure an integrated approach to both planning and treatment.

Orthodontic Treatment in collaboration with Restorative Dentistry
Children and adults with absent or mal-positioned teeth may require orthodontic treatment to change tooth positioning prior to restorative management.

Orthodontic Treatment in collaboration with Paediatric Dentistry
These specialties work closely together in the management of the developing dentition, developmental defects e.g. amelogenesis imperfecta and trauma. Moderate to severe Hypodontia (developmentally absence of many teeth) requires multi-disciplinary planning and treatment by the Orthodontic, Paediatric and Restorative Dentistry specialty.

Orthodontic Treatment in collaboration with Oral Surgery
Joint assessment and planning is required in the management, in particular, of unerupted and ectopic teeth, infraoccluding primary teeth, supernumerary teeth and other dental pathology.

Orthodontic Treatment in collaboration with Oral and Maxillofacial Surgery
Severe discrepancies in jaw, and therefore tooth, relationships may only be treated with elective orthognathic surgery. This requires integrated case assessment and treatment planning for a phased treatment delivery involving both specialties. Surgical intervention is generally only considered in the adult patient although treatment planning and orthodontic intervention may commence prior to this. Treatment should only be undertaken in line with the relevant NHS England guidance[3]. If a clinician wishes to treat a patient that does not

[2] https://www.england.nhs.uk/primary-care/dentistry/dental-commissioning/dental-specialities/
[3] NHS England guidance re Orthognathic Treatment

meet these criteria, then they should liaise with Commissioners to discuss whether or not the patient can be treated on an exception basis.

Orthodontic Treatment in collaboration with Cleft Services
An additional paragraph needs to be included to recognise the hub and spoke nature of this service and collaboration. This commissioning specification provides the funding for the 'spoke' part of the service.

Orthodontic Treatment in collaboration with Craniofacial Surgery
There are a small number of regional craniofacial referral centres in England. The orthodontic departments at the specified hospitals are involved as required in the management of patients with severe craniofacial deformity.

The service may also undertake cases which meet the criteria for Level 2 or Level 3a but where there are additional modifying patient factors that make it appropriate for the patient to receive Consultant led care.

1.5 Expected Outcomes

i. The provider will ensure the following:

a) The delivery of safe and appropriate care;
b) Successful completion of planned treatment with a reduction in the Peer Assessment Rating (PAR) score as anticipated within the original treatment plan[4];
c) Patients receive a written treatment plan outlining the proposed care (copy of letter to referring GDP is acceptable);
d) Patients are offered a choice of routine appointment times, dependent on availability;
e) Patients are contacted within 10 working days following clinical triage of the referral form to determine eligibility to agree an appointment date;
f) The initial assessment appointment to be offered within 12 weeks of receipt of a fully completed referral;
g) Patients not eligible for management in secondary care are identified within 12 weeks and then referred back to the referrer with any appropriate information relating to future treatment within 10 working days of the need being identified;
h) Patients are assessed and scheduled for treatment in a timely manner based on clinical need/age. As a general rule, the expectation is that patients who meet the NHS eligibility criteria will commence treatment within 18 weeks of referral.
i)

ii. Additionally, providers will be required to:

a) Participate in and support the approved dental training programmes, in conjunction with the Managed Clinical Network (MCN) for Orthodontics, Health Education England (HEE), and NHS England and Improvement;
b) Ensure the service is represented at and actively engages with the MCN for Orthodontics, this includes attending meetings and participation in the MCN's programme of work as agreed locally;
c) Comply with information requests from the Orthodontic MCN/NHS England and Improvement as required under Schedule 6 of the NHS Standard Contract.

[4] A reduction in PAR score may not be anticipated or appropriate particularly in cases with limited objectives

2. Scope

2.1 General Principles

i. The service will deliver orthodontic treatment to those patients who meet the criteria in Section 1.4. The service is aimed at those patients who require orthodontic procedures outside the remit of General Dental Practitioners or primary care specialist orthodontic services.

ii. The provider must treat all eligible patients as defined within this service specification and not discriminate in any manner contrary to the relevant regulations.

iii. Eligibility for treatment is as defined in the relevant NHS regulations and the Commissioning Guide.

iv. The Provider must ensure that patients are only be offered one course of NHS-funded routine Orthodontic treatment, in line with the Commissioning Guide, unless there are exceptional circumstances. Such cases would include where interceptive or growth dependent treatment has been undertaken and IOTN remains greater than 3.6. Any patient seeking a second course of treatment who has not previously undergone interceptive treatment would need to apply via the Commissioner who will seek clinical advice, where necessary, on whether a second course of treatment should be approved. A second course of treatment for an adult or child who has previously abandoned treatment or failed to comply with guidance on retention would not normally be agreed unless there are other exceptional circumstances.

v. There may be occasions where an appliance has to be removed during a course of treatment to allow a patient to undergo other procedures such as diagnostic services. Recommencing treatment would not constitute a new course of treatment.

2.2 Service Description

i. The Provider will provide services in line with Level 3b provision (and other patients with modifying factors) as described in the Commissioning Guide (see Section 1.4).

ii. There are several factors which need to be considered when describing the complexity level of an orthodontic case. These include the type of malocclusion, the technical difficulty in improving function and aesthetics, together with any patient modifying factors. (See **Appendix A** for complexity of Orthodontic Treatment).

iii. The service will include:

a) Assessment for eligibility to NHS treatment; including checking of status for patients not normally resident in the United Kingdom;

b) Treatment services, including interceptive treatment, in-hours urgent care treatment (available to all patients who are being provided with the service under this contract as well as, in exceptional circumstances, patients who are accessing Consultant orthodontic care elsewhere in the country and are unable to access urgent care under their regular orthodontist) delivered according to their clinical condition;

c) Treatment may include examination, taking of radiographs, photographs, and study models, diagnosis, preventative care, advice, planning of orthodontic treatment and supply and repair of orthodontic appliances including retainers for a period of 12 months following the completion of active orthodontic treatment;

d) The appropriate referral to other healthcare providers for associated dental treatment and / or any other appropriate and necessary healthcare.

2.3 Whole System Relationships

i. All service providers are required to ensure clinical representation and participation in the core Orthodontic Managed Clinical Network (MCN) / LDN agreed work programme.

ii. Service providers will work closely with the local Orthodontic MCN to implement and improve the patient pathways and ensure that the patient receives a high-quality service.

iii. Service providers will also work with local health and wellbeing services by referring or sign-posting patients (and/or their family members) to lifestyle services e.g. smoking cessation, healthy eating, physical activity.

2.4 Interdependencies

There is interdependency with primary dental care and other Dental Specialties (see Section 1.4), particularly where additional treatment is needed as part of the treatment plan. The Provider will need to demonstrate effective working relationships with primary care colleagues (both Specialist and General Dental Practitioners) to ensure appropriate management of the patient in accordance with the agreed pathways. This would include liaison where necessary with the GDP to ensure compliance with oral hygiene or completion of extractions or with a Specialist where a treatment plan has been provided so that care can be undertaken in a primary care setting.

2.5 Relevant networks

These include but are not limited to the following:

- NHS England and Improvement
- Managed Clinical Network (MCN) for Orthodontics
- Local Dental Network (LDN)
- Integrated Care Board (ICB)
- Integrated Care Systems
- Primary Care Providers
- Local Dental Committees (LDC)
- Other relevant clinical networks
- Local Authority Health and Wellbeing Boards and Scrutiny Committees.
- Public Health England (PHE)
- Health Education England (HEE) and Postgraduate Deanery
- Healthwatch

3. Service Delivery

3.1 Service Requirements

i. The Provider will:

a) Ensure that service provision conforms to relevant guidance and standards;
b) Provide a Consultant-led clinical service in line with that set out in the Guide for Commissioning Specialist Services - Orthodontics, 2015;

c) Receive and acknowledge appropriate referrals via the designated Referral Management Service (RMS) (where available);
d) If dental treatment is required before orthodontic treatment can commence, communicate the requirements to the referring GDP who is responsible for undertaking or arranging referral for treatment (for example extraction or exposure to undertake themselves or refer where this is complex[5]);
e) For referrals that are deemed inappropriate following clinical triage of the referral form or face to face clinical assessment, respond to the referring dentist within 10 working days to request clarification, confirm reason for rejection or arrange onward referral to Specialist providers where clinically appropriate;
f) Work with primary care colleagues to improve their orthodontic referrals with the aim of ensuring that referrals are appropriate;
g) Liaise with the referring practitioner and provide a written report containing the clinical decision and treatment/referral provided. Reports to be sent within 10 working days of the completion of the assessment, the end of active treatment at the point retainers are fitted and ultimately discharged following the period of retention;
h) Provide high-quality, timely and appropriate care;
i) Maintain good working relationships with colleagues in and outside the NHS who contribute to the overall care of any patients to ensure that this is conducted in the most appropriate, efficient and effective manner;
j) Monitor and seek to improve service satisfaction rates to include NHS Friends and Family, Patient Recorded Outcome Measures (PROMs), treatment outcomes using the Peer Assessment Rating (PAR) and Patient Reported Experience Measures (PREMs);
k) Implement a programme to ensure that feedback from service users is sought and acted upon;
l) Follow the Commissioners' referral pathways as agreed with the local MCN;
m) Schedule patients assessed as eligible for treatment/advice from a trained member of the team in a timely manner based on clinical need/age;
n) Ensure robust procedures are in place to address issues arising from the patient pathway (see **Appendix B**);
o) Ensure that patients with orthodontic emergencies such as debonded brackets and bands, lost modules and fractured removable appliances are offered an urgent appointment within two working days.

ii. The clinician providing the service will:

a) Discuss the requirement of co-operation, motivation and general health with the patient, which is consistent with the provision of Orthodontic treatment, highlighting the importance of their ability to maintain good oral hygiene to ensure no harm is done;
b) Discuss the requirement that the patient and carer are willing and able to commit to frequent attendance, which may be during school hours, over the course of Orthodontic treatment and ensure they are aware of the need to wear appliances. The exception to this is patients requiring assessment for interceptive extractions or advice only;
c) Provide the patient with a written agreement setting out expectations both from the patient and provider and including comprehensive information about their treatment as set out in Section 6 (standardised template as agreed by the provider and MCN);
d) Ensure that the patient and/or carer is given a written orthodontic treatment plan. This outlines details of the braces and retainers that they will be given, in addition to other important facts about their proposed treatment;

[5] The service should not routinely undertake extractions under General Anaesthetic unless this is clinically necessary.

e) Ensure that following the agreed retention period[6], the patient's NHS Treatment will be officially completed, and the patient will be discharged back to their General Dental Practitioner;
f) Ensure that where a patient's need is outside the scope of the service they are referred to a more appropriate provider of care.

3.2 Workforce

The Orthodontic service will be led by dentists who are Consultants in orthodontics. The orthodontist will have undergone a minimum of 2 years post-CCST training (over and above primary care orthodontic specialist training) in order to manage these complex malocclusions. The service may also include specialists and training grades.

This service is being commissioned to provide Level 3b care and therefore, in line with the Commissioning Guide, must be Consultant led:

- Care may be delivered using skill mix (for example orthodontic therapist, orthodontic trainees or dentists with the appropriate enhanced skills), but all care must be overseen by an Orthodontic Consultant;
- The provider must maintain effective communication with Commissioners and the Local Dental Network (LDN) through the Orthodontic MCN to ensure high quality patient care.

3.3 Clinical Competencies

Providers will be expected to provide evidence that clinical support staff (i.e. nurses / therapists) hold valid registration with the General Dental Council. A qualified dental nurse, Registered General Nurse (RGN), or one on an approved training programme, must support the treating clinician at all times. Additionally, all clinical staff must have the appropriate clinical indemnity.

All clinical staff should work within their scope of practice and be able to demonstrate evidence of appropriate CPD for on-going registration as well as participation in a robust clinical governance programme including peer review, appraisal and personal development planning, clinical audit and the management of serious incidents. All staff should undertake an annual programme of mandatory training, as required by the employing provider, including the management of medical emergencies and resuscitation and child CPR.

Where required, clinical supervision will be applied in order to quality assure care. All new staff should undergo the relevant employment checks and a programme of induction.

All members of staff who provide clinical care to patients should have received appropriate training to provide lifestyle advice using the principles of Making Every Contact Count.

Mandatory child and adolescent safeguarding training must be undertaken.

3.4 Location(s) of Service Delivery

The services will be delivered from the following locations:

Dorset County Hospital, Dorchester

[6] This would normally be one year unless otherwise agreed as part of the treatment plan.

3.5 Premises Requirements

The Provider will be responsible for the funding of all premises and service delivery costs, including but not limited to consumables, equipment, laboratory services and appliances and IT operational infrastructure as included in reference costs for determination of the relevant PBR tariff.

The Provider will ensure that the premises used for the provision of the Orthodontic service are:

- Suitable for the delivery of an orthodontic services, i.e. meet the current legal and professional standards for the provision of dental services and will be subject to approval by NHS England and Improvement;
- Equipped to meet the reasonable needs of all patients. To offer both consultation and treatment facilities in a confidential and private setting, enable a parent/carer to accompany the patient as required, with reasonable adjustments for people with additional needs or learning disabilities;
- Compliant with HTM01-05 best practice standards;
- Equipped to deal with emergency situations and provide equipment including oxygen, drugs and resuscitation facilities, decontamination (and other equipment as appropriate);
- Registered with the Care Quality Commission (CQC);
- Compliant with the requirements of the Equality Act 2010;
- Provide appropriate waiting-room accommodation for patients and parents/carers;
- nsure that equipment and facilities conform to relevant standards / regulations and are maintained regularly in line with guidelines and manufacturers protocols;
- Ensure any laboratory services are registered with the Medical Devices Agency and work within the relevant legislation;
- Have in-house access to Dental Panoramic Tomography. In addition, the Provider should have access to other appropriate radiographic facilities as part of their contractual provision i.e. Lateral Cephalometric radiography and Cone Beam CT;
- Ensure that robust governance and quality assurance programmes to ensure a safe environment is in place for all service users; and
- Ensure all legal requirements relating to the use of radiographic equipment are met.

The Provider must ensure that the telephone number to be used by patients and or professionals in connection with the delivery of the Orthodontic service must not start with the digits 087, 090 091 or consist of a local personal number, unless the service is provided free to the caller;

3.6 Accessibility and Opening Hours

The service will be flexible and responsive to individual patient need in accordance with the Equality Act 2010 and the NHS and Social Care Act 2008.

The Provider will monitor patient/carer satisfaction to include accessibility and implement change where reasonable and appropriate following discussion and agreement with the Commissioner.

The Provider will ensure equity of access to patients with special needs, including learning and sensory difficulties, vulnerable and hard to reach groups and patients with protected characteristics.

3.7 Patient Pathway(s)

See **Appendix B** for the commissioned orthodontic patient pathway.

Providers must adhere to the referral management protocol (as developed by the MCN and agreed with NHS England and NHS Improvement) in line with the principles of this specification.

The Provider will demonstrate, on request, that robust procedures are in place to address issues arising from the patient pathway (for example validation of patient data, management of patient/carer complaints and incidents, management of clinical information/data security etc). The Provider is also expected to demonstrate a shared care approach and will support the GDP in ensuring good oral hygiene throughout treatment.

3.8 Training

The Provider may be required to provide ad hoc advice and training to referrers (where necessary) to ensure appropriate referrals, and to participate in and contribute to, an agreed programme of continuing professional development for all relevant clinicians.

By agreement with the Commissioners/Health Education England, the Provider should offer a suitable number of training places.

Teaching Hospitals require access to an appropriate number of patients at all levels of complexity (to support teaching and training). The same is true, in terms of workforce development, of District General Hospitals and other secondary care settings, which will also require sufficient numbers of patients of suitable complexity to develop appropriately skilled clinicians.

If appropriate, the Provider should ensure that dental undergraduates receive an appropriate number of Level 1 Orthodontic cases for training. In addition, the Provider should ensure that dental post-graduates receive an appropriate number of Level 1 and/ or more complex Level 2 and/or 3 Orthodontic cases for training. These cases can be sourced specifically through the referral management system. Separate training waiting lists should not be maintained in such a way as to delay patients from receiving the care they need.

3.9 Safeguarding and Information Governance

The provider will comply with the requirements set out in the NHS Standard Contract[7] in respect of safeguarding, and information governance.

4. Referral, Access and Acceptance Criteria

4.1 Acceptance criteria

The Provider must ensure that the service will accept any patient who is eligible for NHS care (see below) and who requires Consultant led care in line with the recommendations set out for Level 3b care within the Commissioning Guide, unless the Provider is of the opinion, and has reasonable grounds for its 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

[7] The NHS Standard Contract as available from https://www.england.nhs.uk/nhs-standard-contract/22-23/

dental and oral condition of the person concerned. The exceptional circumstances must be documented in the patient record.

Any referrals received that fall outside of the guidance will not be funded under the contract, unless prior approval has been received from the Commissioner.

All patients who fulfil the criteria for treatment must also have good oral hygiene and be actively supported in the prevention of dental diseases throughout orthodontic treatment.

4.2 Management and recording of failed appointments

The Provider is expected to demonstrate effective methods of monitoring and reducing failures to attend to improve service utilisation and improve treatment outcomes. As a minimum this should include the use of a written agreement setting out expectations both for the patient and Provider (standardised template to be agreed by the MCN).

When a child misses an appointment, the Provider should ensure that this is recorded as 'Was Not Brought' rather than 'Did Not Attend' as the future consequences to the patient of the missed appointment are important, particularly if treatment is not completed. Safeguarding process to be followed, as per Provider policy, for missed appointments.

4.3 Referral Route

The NHS England commissioned referral management systems will be the only route for all referrals from primary dental care providers.
Each referral data set will be compliant with the service standard and include necessary x-rays and patient history.

4.4 Referral source

Source of referrals will usually be via an Orthodontic Specialist or General Dental Practitioner (GDP). Other tertiary referrals may be received in the following circumstances:

- General Medical Practitioner;
- Patient requests a second opinion;
- Transfers from other hospitals;
- Internal referrals where these meet the guidance.
- Armed Forces
- Prisons

Referrals will be forwarded to the service provider via the referral management process (where available) unless otherwise directed by the Commissioner.

Patients seeking to transfer into the area will only be accepted according to the NHS England agreed local protocol (see also Appendix C).

4.5 Procedure on referral

- All referrals will include digital copies of relevant radiographs where available;
- The Provider will ensure that all referral forms will be subject to clinical triage to determine eligibility for assessment;

- The Provider will return incomplete or inappropriate referrals to the referrer;
- The Provider will ensure that any referrals that require additional clinical information to explain the need for advice or where there is no indicator that the patient meets the criteria for NHS treatment such as to warrant an assessment are returned to the referring GDP with an explanation as to why the patient has not been offered an assessment;
- The Provider will ensure that all patients are contacted within 10 working days of receipt of fully completed referral to be offered an appointment date;
- The Provider will ensure that all patients are offered an initial assessment within 6 weeks of receipt of fully completed referral;
- Once booked, the Provider will make information available to the patient giving details of the provider and 'what to expect';
- The clinician should ensure that an oral health assessment/review has been carried out and that the information collected, and the risks identified are reviewed and shared with the patient before entering treatment. It is never in the patient's best interests to plan and deliver orthodontic treatment in the absence of a stable oral environment when the risk of dental disease is high. The clinician should also ensure that prevention of dental disease is a focus throughout the treatment pathway;
- The Provider must detail clinical aspects of the proposed orthodontic treatment should be considered to ensure that it will be beneficial to the patient;
- Once the clinical face-to-face assessment has been undertaken, the Provider will correspond with the referrer indicating the findings and outcome within 10 working days;
- If dental treatment is required before orthodontic treatment can commence the Provider must communicate this to the patient's GDP. The Orthodontist will be responsible for advising on the dental treatment required before orthodontic treatment can commence. Dependant on the complexity this could involve a referral to secondary care, a tier 2 oral surgery provider or back to the GDP in line with the NHS England National Commissioning Guide for Oral Surgery and Oral Medicine, using the locally agreed referral management system/process;
- The orthodontist will liaise with the GDP to ensure a shared care approach to oral hygiene throughout treatment. The GDP remains responsible for interventions such as fluoride varnish and routine assessments;
- The Provider must provide patients accepted for treatment with a written agreement setting out expectations both for the patient and provider (standardised template to be agreed with the MCN).

Waiting times for treatment should be based on clinical need. As a general rule the expectation is that patients who meet the NHS eligibility criteria will commence treatment within 18 weeks of referral.

4.6 Exclusion criteria

The referral management service or Provider should identify excluded or non-eligible patients before being assessed. The Provider must not accept for assessment:

- Patients for whom the referral management service (where available) protocol has not been adhered to;
- Patients who have been referred / currently awaiting assessment by an alternative provider;
- Patients who do not fulfil the clinical criteria for secondary care orthodontics;
- Adult patients already rejected by a specialist or GDP practice;

- Patients seeking a second course of treatment without explicit agreement from the commissioner except as described in [Section 2.1];
- Transfer patients where prior approval has not yet been provided by the Commissioner particularly where there is a lack of clarity about eligibility for NHS care;
- Patients with Cleft Lip or Palate abnormalities (services for these patients are provided under a hub and spoke arrangement of care. The 'hub' part of this service is commissioned and paid for separately by NHS England Specialised Services and the spoke element is funded from the dental budget);
- Level 2 and 3a treatment except where there are modifying factors and teaching need.

4.7 Response time & detail and prioritisation

The Provider must ensure that the Initial assessment appointment with the service is offered on a date within 6 weeks of receipt of a fully completed referral providing this is compatible with the provider's contracted activity levels to ensure compliance with the 18 weeks requirement. The Provider must liaise with the Commissioner where this is not possible for a sustained period of time so that the patient pathway can be managed.

4.8 Data collection / submission

The Provider must comply with the data requirements listed below:

- Submission of waiting list and waiting times' data in line with locally agreed reporting requirements.

5. Discharge Criteria

5.1 Procedures on Discharge

The Provider is expected to follow the British Orthodontic Society guidance *'Liability of Practitioners for continuing care after completion of active treatment'.*

Taking into account local safeguarding protocols:

- **Patients whose treatment is complete.**
  On completion of treatment, the Provider must ensure the referring GDP and the patient receive a discharge summary (including the Unique Reference, where available) within 10 working days. If appropriate, other agencies will also be informed.

- **Patients whose treatment is not complete.**
  The Provider will discharge patients who were not brought for appointments (WNB) according to the DNA protocol (agreed by NHS England and NHS Improvement). Where appropriate, other agencies may be informed. The Provider should be able to demonstrate that they have made reasonable efforts to contact the patient and/or carer and inform them what will happen if they don't attend.

  Where patients are discharged due to non-compliance with the treatment requirements, the Provider will need to be able to demonstrate that they have liaised with the GDP and explained the consequences of the non-compliance to the patient and/or carer and are satisfied that all reasonable efforts have been made to ensure the patient is in a position to continue with their care.

- **Patients who do not commence treatment**.
  If a patient fails to attend for their initial assessment, the Provider will discharge the patient back to the referring GDP.

5.2 Information Standards

The Provider will ensure that discharge information will:

- Include the URN (where available) and the NHS Number (where known);
- Contain clear instructions for the patient's GDP for any on-going care;
- Clear instructions to the patient and/or carer regarding the use of any retainers and the consequences of non-compliance;
- Contain a summary of the treatment provided;
- Contain details of continued treatment to be given by the service;
- Be sent to the referring GDP within 10 working days of treatment completion date.

6. Prevention, Self-Care and Patient and Carer Information

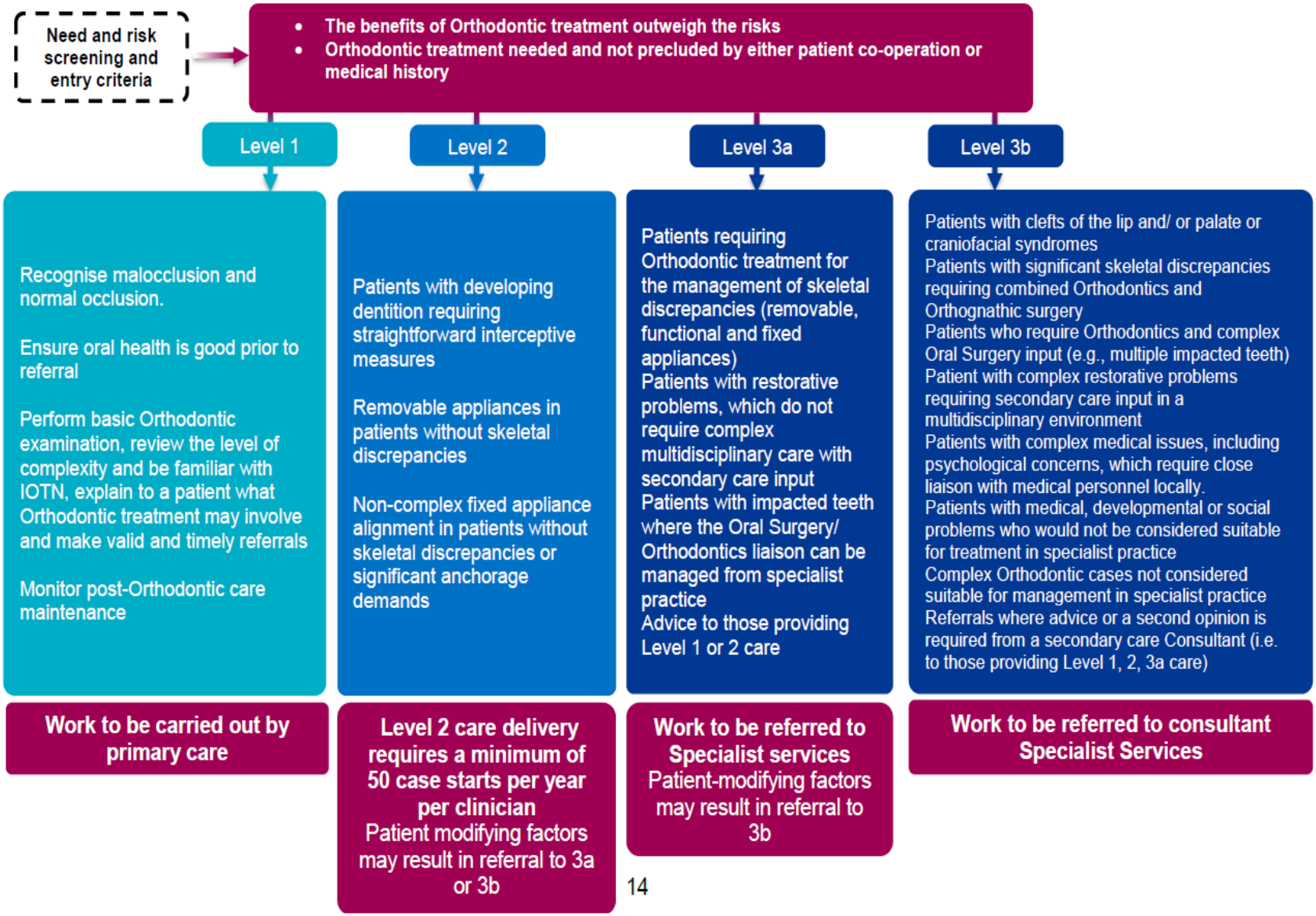
Providers will ensure that patients and/or carers are provided with relevant verbal and written information in a variety of formats, and where necessary utilising an interpretation or translation service. They will also be required to provide information concerning the outcome of the assessment, such that the patient and/or carer are clear why a specific treatment opinion has been selected.

Reasonable adjustments should be made where necessary for people with disabilities. This may include additional communications with patients and carers, priority appointments or easy read materials. The need for reasonable adjustment should be recorded on a patient record.

Orthodontic care is a partnership therefore, prior to initiation of treatment, the patient and/or carer should be provided with the information listed in Appendix D verbally and in writing on what can be expected of the clinician and what is expected of them:

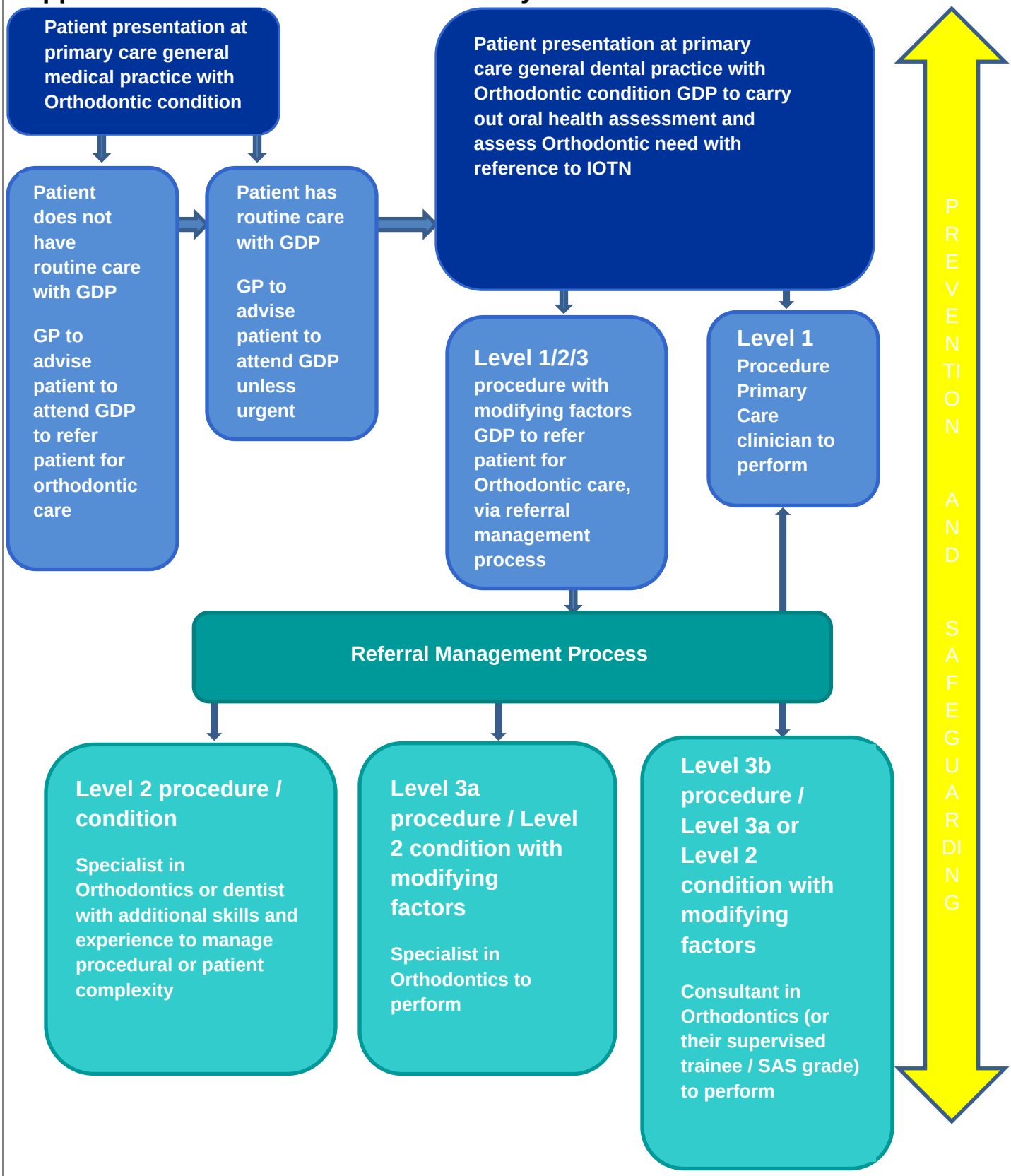
Providers should be able to demonstrate that the information is provided in such a way that supports the patient and/or carer's ability to give valid consent to initiate treatment.

Appendix A - Complexity of orthodontic treatment[8]



[8] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-orthodontics.pdf

Appendix B - Illustrative Patient Pathway[9]



[9] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-orthodontics.pdf

Appendix C – Transferring between providers during treatment protocol

(see also Section 11.1 of the NHS England Dental Policy Book refers for transfers from outside of the UK)

It is a provider's decision whether to accept transfer cases in both circumstances below. It is also a provider's decision whether any transfer cases continue with their original treatment plan or, following discussion with the patient and parent/carer, whether the treatment plan will change.

Transfers from outside of the UK

A dentist must establish that the patient is entitled to receive NHS care. If they are, the onus is on the patient (and not GDP or orthodontist) to obtain the relevant information from their original orthodontist so that the GDP can make a referral. The new orthodontist must establish from the information supplied by the original orthodontist whether the patient met the NHS eligibility criteria before their original treatment began, i.e. that they were under 18, an IOTN or at least 3.6 and have good oral health). If they did not (due to age or insufficient IOTN) and their current status does not meet NHS eligibility criteria the NHS will not fund continuation of treatment and this must be completed privately. If the patient cannot provide their original assessment and treatment information, it is their IOTN status at the time of referral that determines whether the NHS will complete their treatment (ie they must have an IOTN of at least 3.6). If the information supplied by the original orthodontist demonstrates that the patient met NHS criteria at the start of treatment, or their IOTN at the time they are referred in the UK, as the patient has not received NHS treatment to that point, they are entitled to a course of NHS treatment.

The transfer of patients already in an orthodontic course of treatment to and/or from other areas requirements

A patient is only entitled to one NHS funded course of treatment (this excludes where a patient still meets NHS criteria following interceptive treatment) apart from exceptional circumstances.

Transfers are to be initiated by the patient's GDP; when a patient moves they should source a new GDP to ensure ongoing continuing care. Following discussion whether referral to a more local orthodontist to complete care is appropriate (i.e. the treatment is not almost complete or the distance is not considered great when considering this is for specialist treatment and changing orthodontist during a course of treatment can extend the duration of treatment) once the patient has chosen their preferred new orthodontist the GDS practice should make the patient aware that the previous orthodontist will need to be contacted to provide details of the treatment previously undertaken (see below) to include with the referral to the new orthodontist.

If the transfer request is made by the original orthodontist, the new orthodontist must establish that the patient has a GDP for their ongoing continuing care before considering whether to accept the transfer and also that the transfer has been approved by the Commissioner.

The referral must be made using the Local Office's usual referral pathway. All providers should co-operate in providing information to the orthodontist taking over the care of the patient. This should include the original assessment, IOTN score, x-rays, models and photographs as a minimum and ideally the full patient record. Such information must be transferred securely and shared directly with the receiving clinician.

Appendix D – Information to be given to patients prior to initiation of treatment

- Information in accordance with contemporary standards for valid consent;
- Treatment plan including an estimation of length of treatment and visit frequency;
- Ensure the patient and/or carer has a clear understanding in advance of what will happen to them during the treatment, who will be responsible for delivering each element of care and why, for example, the patient may be returned to their GDP for extractions;

All appropriate British Orthodontic Society leaflets;

- What is expected of them in terms of commitment including self-care, compliance, and under what circumstances treatment will be terminated e.g. poor attendance, poor oral hygiene, abusive behaviour;
- That once braces have been fitted they will need to attend on a regular basis for adjustments, normally every 6 to 8 weeks and they have been informed by the orthodontist how long the active treatment is likely to take;
- Maintenance information including that they need to keep their teeth and braces clean and follow the advice of the orthodontist and their team. If the patient's cleaning does not reach the acceptable standard they understand that their teeth might be permanently marked and that the orthodontist may suggest that the braces are removed early and the patient's treatment 'discontinued'. Members of the orthodontic team should be able to provide appropriate advice on lifestyles taking a whole family holistic approach;
- Patients and their carers should be advised regarding the importance of attending their general dental practitioner for regular check-ups, preventive care and treatment throughout their course of orthodontics. It is important that they understand the distinct roles of the orthodontist versus the general dentist;
- If the patient's fixed braces are broken repeatedly, the patient and /or carer has been advised that the orthodontist may be forced to terminate treatment and that the patient will not be able to access this treatment elsewhere on the NHS;
- The patient and/or carer has been advised that the patient will need to attend the appointments on time and on the correct day. If the patient is late, the orthodontist may be unable to see the patient If the patient misses their appointment or cancels without giving 24 hours' notice, the patient will be offered the next available appointment (usually six to eight weeks after the date of the failed/late cancelled appointment). Should this happen on two occasions without genuine reason or advance notification, the patient's treatment may be terminated prematurely, and they will not be able to access further treatment elsewhere on the NHS; additional consideration should be given when dealing with patients from vulnerable or hard to reach groups to ensure they are not inadvertently disadvantaged;
- The patient and/or carer has been advised that, if retainers are removable, they need to be worn in accordance with the instructions given to the patient and/or carer;
- Once the braces are removed, the responsibility for the future position of the patient's teeth depends on the patient wearing the retainers long term;
- The patient and/or carer has been advised that the hospital will supervise retention for an agreed period (normally one year) and that the patient will be discharged back to their general dental practitioner (GDP) after this period.
- Following this year period, replacement retainers from the hospital will be charged for on a cost basis regardless of age or exemption status;
- If removable or fixed retainers are broken or lost during this initial one-year period, there will be a charge unless the breakage is as a result of fair wear and tear;
- That teeth may try to move throughout life due to continued growth/development or other biological changes and that the patient is strongly recommended to continue with part-time

wear of the retainers on a permanent basis (i.e. for life). The orthodontist cannot be responsible for any movement of the patient's teeth if they stop wearing their retainers;

- If the patient or carer contacts the practice, or any other orthodontist, subsequent to ceasing the wear of their retainers with a problem that their teeth are moving out of alignment, the patient realises that any further treatment to realign teeth may involve the use of fixed appliances. Subsequent treatment required is very unlikely to be available on the NHS, including replacement retainers, unless there are very exceptional circumstances that can be evidenced.