FEATURE

# What does the future hold for orthodontics?

There are mounting challenges for the UK's largest dental specialty, says **Caroline Holland**.

Orthodontics is the largest dental specialty in the UK; with the British Orthodontic Society (BOS) owning a head office in London and running an annual conference, a journal and newsletter, and with close ties to European and international organisations, orthodontics is a contented specialty.

But today there are mounting challenges undermining the sanguine outlook of the BOS membership of nearly 2,000. These range from the lack of opportunities for newly qualified specialists to uncertainty around the procurement of NHS contracts and the issue of system-based orthodontics, controversial the world over.

If British teeth today are better than American teeth as has recently been claimed, then we have orthodontists and the NHS to thank. More than 200,000 under-18s start NHS orthodontic treatment annually in England and Wales with more than one third of the young population qualifying for treatment. High street specialists can be credited with ensuring that *The Big Book of British Smiles* given to Lisa Simpson – daughter of Homer – by her orthodontist to persuade her of the horrors that awaited her if she didn't proceed with treatment is now a comic irony.

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And financial factors have had a positive impact over the last decade too: the orthodontists' journey through the 2006 contract was relatively painless compared to that of GDP colleagues. The move to a caseload contract resulted in standardised monthly payments (without the burden of collecting patients' charges as all NHS treatment for under-18s is free) and then there was further icing on the cake as orthodontic practices became highly sought after.

But, in 2016, for a multitude of different reasons, the world of orthodontics and its future appear less rosy. Orthodontic claims are rising according to Dental Protection and 20% of claims in 2010 were linked to aligner systems. Both Dental Protection and the Dental Defence Union have published advice to members warning them about the treatment of adults who may have unrealistic expectations of treatment while the BOS itself has published *The BOS Guide: Orthodontics for Adults*, with advice on choosing treatment, supported by a video.

For Richard George, BOS Director of External Relations, the manufacturers of orthodontic systems have much to answer for. Manufacturers market systems to dentists with the assurance that treatment can be delivered after a few days of training and they market directly to patients, promising their system delivers a new smile in less time. Yet there is no evidence, says Richard, that any particular system can provide faster and better treatment than any other.

The academic and former Chair of the General Dental Council Kevin O'Brien has been examining the claims of various suppliers in his internationally followed blog. In a recent post he questioned whether two days' training was enough time for a dentist to be competent. But he went on to say it was time that specialist societies worked more closely with GDP education and training so that they could work as teams, not competitors.

Richard says BOS wants to grasp this nettle – but simultaneously he would like to see the marketing claims of the manufacturers given less credibility. The phrase 'short-term orthodontics' should be banished, he said, and replaced by 'limited objective orthodontics' (LOO). 'By using different terminology, the patient understands that their treatment is not comprehensive and is based around a compromise. If everyone buys into this then LOO is a fantastic opportunity for GDPs.'

Some orthodontists think the issue will play itself out. Among them is Steve Chadwick, Vice-Dean of the Faculty of Dental Surgery of the Royal College of Surgeons of England. For him, the key concern of the moment is the treatment of newly qualified specialists who can't find work. 'You have a situation where young specialists are struggling. They are coming off their MOrth and what are they supposed to do next? They struggle to earn money through the NHS. UOAs [units of ort] are not directly allocated to young specialists.'

Unfortunately, he says, practice-owners are starting to choose between taking on a young specialist and an orthodontic therapist. 'I think there is a kind of wrong-headedness. A young orthodontist will look after their own cohort of patients and provide treatment plans of their own. The development of OT is an opportunity to improve the quality of care by allowing orthodontists to safely look after more patients.

'As a nation we have invested a lot of money in training individuals to be specialists and if they don't end up providing care in the community that is a colossal waste of our resources. They have also made sacrifices of their own to get the qualifications they need and I think we should be doing more to support them.'

Orthodontists have always cared for the wider specialty – the BOS incorporates a Training Grades Group and supports orthodontic nurse and technician groups. But can this nurturing environment continue to flourish when faced by the new business drivers at work

in the NHS? Steve says he would like to see practices with long-term contracts being obliged to take on a young specialist to join that practice. 'That could be a form of key performance indicator to ensure newly qualified specialists have a route into the market.'

Meanwhile, Guy Deeming, Chairman of the BOS Orthodontic Specialists Group, is worried about the potential impact of the procurement exercises on the horizon. And, he points out, that while the 2006 contract seemed relatively painless at the time, it had a sting in its tail. Orthodontists were unwittingly signing up to Personal Dental Services (PDS) contracts which were time-limited, unlike General Dental Services contracts. Over the last few years, most PDS contracts have been rolled over. But this can't last. Where they weren't rolled over, there has been a lingering sense of injustice among those who had committed to the NHS and lost out in a bidding battle.

Guy said: 'The cold hard truth is that it's very difficult to find any flexibility within the legislation to allow contracts to roll on.' Procurement is an expensive business – he estimates it costs a local authority between £25-65,000 to run the exercise and also factor in the expense of continuity of care and legal challenges if one contract is terminated and another provider commissioned.

Commercial procurement processes are governed by European and UK legislation as well as NHS regulations. According to Elaine McLean, a solicitor specialising in EU commercial and procurement law, there is no cause for concern following the EU referendum. She was speaking at a commissioning symposium organised by the BOS on the day following the referendum and predicted that any changes are years off.

Nevertheless, procurement is a legal minefield and Guy worries that it doesn't necessarily allow for the interests of the patient to be readily served. If it becomes a dispassionate fee-based tendering exercise and the UOA is set too low, the new business is set to fail with disastrous consequences. Track record and capability to deliver must be taken account of, he says.

In order to achieve the best results, Guy says, much hangs on the service specification. These should be created at local level and led by the Managed Clinical Networks working with Local Professional Networks to structure service provision in their areas.

This was the driver for the symposium, he said. It brought together key people from Public Health England, the BDA, NHS England and Area Team dental and MCN and LPN leads. 'We want to present a unified voice speaking to this diverse audience from all regions of the country with one end in mind – getting the best outcome for patients.'

According to the NHS Business Services Authority, there is high – over 90% – patient satisfaction with existing providers. Roughly £250 million is spent annually on primary care orthodontics in England and Wales.

One obvious way for commissioners to cut costs – surely the agenda in all aspects of healthcare – would be to limit the patients who qualify for treatment by raising the bar to IOTN score 4 and 5.

Brian Kelly, Senior Orthodontic Adviser with the NHSBSA, commented: 'It would be a very sad day if children with an IOTN score of 3 with an aesthetic component of 6 or above were to be deprived of NHS-funded orthodontic treatment. Many of them are being teased and bullied at school, and you can tell – the aesthetic component of IOTN is very valuable.

'And the benefits are not just cosmetic. Once a patient is accepted into treatment, orthodontists have a huge role to play in educating patients and influencing their diet. Orthodontics can really make a difference to the future dental health and general well-being of these patients.'

No-one is quite sure what the future holds, hence the sense of unease throughout the orthodontic community. Guy concludes: 'What seems important right now is that the orthodontic budget is not eroded by the high costs of procurement and that the needs of patients and the success story that is British orthodontics are kept in perspective.' ■

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