Case for Change and recommended future operating model: Secondary Care Orthodontics

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Executive Summary

Background and context

Secondary care orthodontics is a highly specialised clinical specialty. Concerned with the alignment of the jaws and bite as well as the straightening and movement of the teeth, the indication for secondary care is the need for a multi-disciplinary approach, with approximately 75% of patients on a secondary care pathway having the input and intervention of restorative dentistry, orthognathic or oral surgery in their pathway. Within the Lancashire and South Cumbria population of 1.8m, an estimated 1,400 patients require the service each year; most of these patients are under the age of 18. At the current time, all four acute Providers in LSC are commissioned to provide the service.

Secondary care orthodontics in LSC is fragile; there are gaps in the consultant workforce, the BTH service has been closed to new referrals since March 2023, there are long waiting times for treatment in all but one of the acute Trusts, and, in places, challenges in reviewing patients for their follow up care in the optimum timescale. The level of fragility within the service is recognised with orthodontics one of the priority specialties in LSC for improvement and transformation.

Future operating model to achieve sustainability

The work done to review the current service model and consider and quantify opportunities to improve and transform the service has confirmed both high impact improvement opportunities and changes required to the service. These can be summarised under three distinct heading:

1. Pathway and operational delivery improvements

- **Optimising the skill mix** – There is opportunity to increase the therapist workforce to reduce the number of additional consultants required in LSC and increase the efficiency of how the service is delivered.
- **Standardising and optimising the delivery model** – There is currently variation in how the service is delivered across all Trusts. Standardising the acceptance criteria, clinic templates and the running of multi-disciplinary clinics will increase capacity and better manage demand into the service.

- **Optimising primary care capacity** – The introduction of an advice and guidance pathway with specialist paediatric dentists and early discharge pathway to primary care will support optimising the use of secondary care capacity.

2. Concentration of service delivery to ensure scale and efficiency

The work done has highlighted a fundamental issue with the current operating model, which sees clinics delivered out of eight locations by a substantive consultant workforce of only six. This aligns with the findings of the clinical blue-print document; essentially three suboptimal scale services operating over too many sites.

Moving to an operating model where there is a greater concentration of clinic delivery in a smaller number of sites will create efficiencies, build resilience and, most importantly, will enable the optimum skill mix workforce model to be implemented; without a change in service model, this won't be possible to fully operationalise.

3. Commissioning model

Lastly, it is recommended that a single leadership model for orthodontics is considered, taking into account the benefits and disbenefits of doing so and being clear on the interdependencies and gateways required for this to happen.

The service at ELHT is high performing and sustainable and therefore the perhaps predictable outcome of the recommended solutions to the fragilities in the other three services almost entirely based on replicating the ELHT service. A single leadership model could accelerate the need to standardise the service model, strengthen the professional supporting infrastructure for clinicians and, through having single accountability for deploying resources across the whole of LSC, strengthen the need to reduce the current inequalities and inequity of access to the service.

Resource requirements and financial implications

Workforce

The detailed modelling work undertaken to forecast the future capacity requirements when all improvement interventions are embedded indicates the requirement for one additional WTE consultant from that currently in post in September 2024 and 2.6 WTE therapists. This is summarised below:

	Orthodontic workforce - as at September 2024					Future resource required (inclusive of admin DCC, SPA etc)	Increase / decrease
	LSC	BTH	ELHT	LTH	UHMB	LSC	LSC
Consultants - total	5.67	0.2	3.3	1.17	1	5.87 WTE	+ 1 WTE
Consultants - substantive	*4.87*	*0*	*3.3*	*0.57*	*1*	*5.87 WTE*	*+ 1 WTE*
Consultants - locum	*0.8*	*0.2*	*0*	*0.6*	*0*	*0*	*-0.8 WTE*
Middle grades (excl. supernumerary)	1.8	0	0.8	0	1	1.2WTE	- 0.4 WTE
Therapists	2.81	0.2	1.81	0.4	0.4	5.41 WTE	+ 2.6 WTE

It should be noted that the recommended workforce is less than that currently within budgets – details are provided in the case.

Physical estate

Detailed work is now required to both confirm the optimum future locations for clinics to achieve the concentration of delivery described and, with this, an appraisal of the estate options available now and with investment. This work is within the project plan. However, it is

important to note at this point that the current physical estate available in the acute sector does not have space to accommodate the recommended future operating model change and, indeed, is a constraint to training additional therapists.

Finances

The recommended future model for orthodontics is expected to improve the service's system financial position by approximately £673k, representing a 62% increase in profitability from 2023/24 SLR reported positions.

The proposed future budget also sees a reduction of £180k to the existing budget.

It is not yet known whether there are any capital requirements for the future operating model.

Next Steps

To proceed in addressing the fragility of Secondary Care Orthodontic services, several key steps have been identified to be completed within Q4 2024/25, these include:

- Pathway and operational delivery improvements mobilised across LSC.
- System-wide capacity transition plan to be developed that will maintain service delivery whilst awaiting opportunities to fill the consultant vacancy and the training of additional therapists is progressed.
- Options appraisal for future commissioning model completed and agreement on future model.
- Options appraisal for physical estate opportunities completed and proposed LSC timetable completed, including satellite clinics to maximise efficiencies identified.

The approval timeline for the case for change and recommended future operating model is also set out below:

- Orthodontic fragile service project group – 7th January 2025
- Clinical Advisory Group – 16th January 2025
- Clinical Portfolio Board – 22nd January 2025
- ICB CRG – 30th January 2025
- Primary Care Commissioning Committee – 15th February 2025
- Provider Collaborative Executive Committee – early February 2025
- All four acute Trust Executive Teams – early February 2025
- Provider Collaborative Board – 13th March 2025

1. Introduction and purpose

Orthodontics is a dental specialty focused on aligning your bite and straightening your teeth through the use of braces. Orthodontic services are provided in both Primary Care (circa 90% of activity) and Secondary Care (circa 10% of activity). It should be noted that Primary Care Orthodontics is carried out by specialists who have completed a three-year training programme and have a 'Membership in Orthodontics' (MOrth) qualification. Whereas Secondary Care Orthodontics is led solely by Consultant Orthodontists who have undergone an additional two-year training and completed an additional examination to gain the qualification of 'Fellowship in Orthodontics' (FDS Orth). Clinical indications for Secondary Care treatment include complex care and/or interdependency to other specialty care and where there is an indicative need for a multi-disciplinary approach to patient care.

The purpose of this paper is to outline:

- The case for change, setting out the current service model and reasons for Secondary Care Orthodontic services being recognised as a Fragile Service. The impact this is having on patient access and quality is described, before setting out the barriers to delivering the most cost-effective model.
- The recommended future target operating model, which has been informed by a review of improvement opportunities, analysis of the different service models across the four Trusts and the output of the demand and capacity modelling for Secondary Care Orthodontic services. The paper provides a summary of the analysis and conclusions reached.
- The considerations and initial pathway and timeline for transforming to the recommended future operating model and ultimately how the fragility of the service can be resolved in the future.
- The next steps and key actions both in the short and longer term to ensuring the sustainability of Secondary Care Orthodontics within Lancashire and South Cumbria.

2.1 Background

Lancashire and South Cumbria's Provider Collaborative Board and Integrated Commissioning Board in November 2023 identified Orthodontics as one of three 'Fragile' services within the system. As part of the review, all services within Lancashire and South Cumbria were assessed across key functions including Workforce, Finance, Clinical Standards and Performance. A fragile services programme was established with Orthodontics one of the three projects within this programme.

The purpose of the Orthodontics Fragile Services Programme is to create a robust and sustainable service for the Lancashire and South Cumbria population, ensuring timely access and reducing unwarranted variation in access and clinical outcomes irrespective of a patient's place of residence. Orthodontics is considered as a priority area of focus for the establishment of an optimised future operating model due to its current fragility in the provision of services, significant gaps in existing provision and the difficulties in recruitment and retention of consultants into parts of the system.

Secondary care Orthodontic services are currently commissioned from all four acute Trusts in LSC, and delivered out of eight sites, as shown in the Figure 1 below.

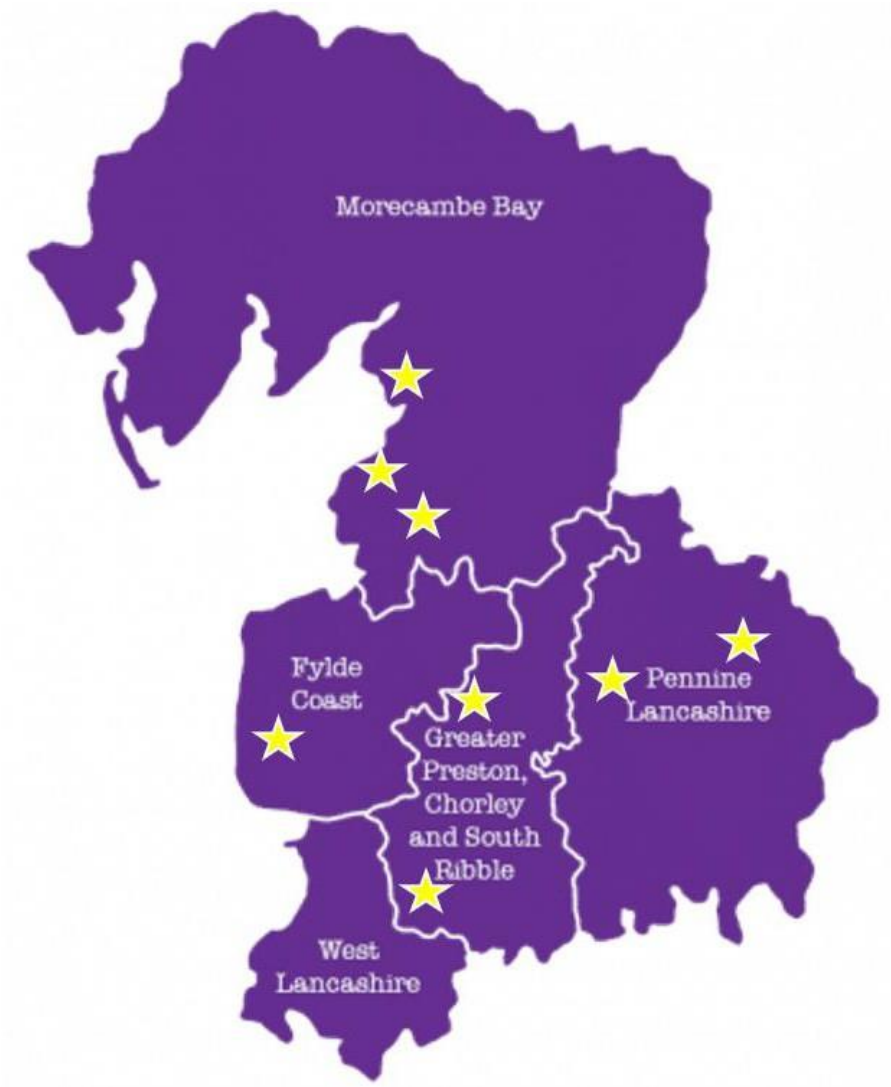

Figure 1 - Secondary Care Orthodontic Services - Geographical Location

During the financial year of 2023/24, Secondary Care Orthodontic services across Lancashire and South Cumbria saw a total of 1,297 OPFA, 2,888 OPFUP and 9,407 OPROCs. It is estimated following an audit that c.25% of patients are discharged after a OPFA and hence it can be assumed that of the 1,297 patients attending a OPFA during 2023/24, that approximately 950 patients would have gone on to require Orthodontic treatment. It should be noted that due to the challenges at Blackpool Teaching Hospitals during this period (loss of their substantive Consultant) activity figures are artificially reduced and not representative of the true demand for the service.

2.2 Drivers for change

Secondary Care Orthodontics can be considered fragile due to several reasons which predominantly fall into three categories – workforce, clinical standards and performance.

2.2.1 Workforce

Figure 2 illustrates the clinical workforce within Orthodontics across Lancashire and South Cumbria which varies across each provider. The primary cause of the fragility of the service is gaps in the consultant workforce, with 2.77 WTE vacancies within the substantive budgeted Consultant workforce, though this is mitigated to a degree by 0.80 WTE of bank Consultants. At the time of writing this report, insourcing support was also in place within the system. It is recognised nationally that there is a shortage of Orthodontic Consultants, and following several months of advertisement, the system has been unable to recruit to the substantive vacancies and this has had a knock-on effect across the system, as well as causing significant inconvenience to patients and their families.

There is a varying workforce model across the four providers which has previously and continues to impact on delivery. UHMB has a single-handed Consultant service; BTH has had no substantive Consultant in post since March 2023 and is currently reliant on a locum working 1 day a week. LTH and ELHT have a consultant working across the two organisations via a service level agreement, with LTH employing a further consultant and ELHT three. The shortage of substantive Consultant posts is particularly challenging in the current operating model which is predominantly Consultant-delivered care.

Workforce (WTE) by Trust	ELHT	LTH	BTH	UHMB
Substantive Consultant Workforce (Budget)	3.30 (3.30)	0.58 (1.35)	0 (1.00)	1.00 (2.00)
Bank Consultant Workforce	0	0.60	0.20	0
Total Consultant Workforce	**3.30**	**1.18**	**0.20**	**1.00**
Substantive Middle Grade Workforce (Budget)	0 (0)	0 (0)	0 (0)	0.4 (0.6)
Trainee Workforce (Budget)	0.8 (0.8)	0 (0)	0 (0)	2 (2)
Total Middle Grade/Trainee Workforce	**0.80**	**0**	**0**	**2.40**
Therapist Workforce (Budget)	1.81 (1.81)	0.40 (0.40)	0.20 (1.00)	0.40 (0.40)
Total Therapist Workforce	**1.81**	**0.40**	**0.20**	**0.40**

Figure 2 - Workforce WTE for Orthodontic Services across LSC

As shown in figure 2, across the system there is a total of 2.81 WTE therapists, with varying levels of experience; from newly trained to those with several years' experience. It should be noted that most of a therapist's clinical workload requires supervision from a consultant (c. 85%), which creates an interdependency with consultants being present on site. Therapists work only at their host organisation and therefore for providers with a single-handed Consultant, the therapist clinics are not able to run as frequently as they need to be cancelled or significantly reduced when the Consultant is on leave or absent. This is not an issue for ELHT, where there are four consultants and therefore the ability for consultants to cross-cover to supervise therapists, resulting in minimum impact on therapist clinics running when a consultant is on leave.

Orthodontic services within Lancashire and South Cumbria are also supported by a total of 3.2WTE of middle grade/trainees. However, it should be noted that several of these trainees are supernumerary, in that they do not see patients in clinic independently or enable consultant clinics to be increased when they are working alongside them. Additionally, as trainees are on rotation, it cannot be guaranteed that posts will be filled when trainees changeover. The capacity provided by trainees therefore cannot be depended on to provide reliable, sustainable capacity.

Finally, it should be noted that there are varying levels of multi-disciplinary support within each provider from aligned services including Restorative, Orthognathic and Oral Surgery. Not all providers within the system have the necessary multi-disciplinary clinical support and therefore are reliant on other providers or honorary contract Consultants attending on an ad-hoc basis. The lack of multi-disciplinary support in some providers may unduly prolong what is already a long orthodontic treatment process and in addition limits the attraction, recruitment and retention of Orthodontic Consultants to Lancashire and South Cumbria.

2.2.2 Clinical Standards

There is variability across Lancashire and South Cumbria in the way in which Secondary Care Orthodontics is delivered, this spans across the whole pathway.

- There is variable application of the acceptance criteria across providers, and this is evidenced to result in a higher demand for outpatient first attendances within some Trusts than others.
- Secondary Care Orthodontics is one of few Secondary Care specialties without an established advice and guidance process in place. This results in an increased demand for outpatient first attendances. At the present time, around 26% of patients are discharged after their first outpatient attendance. Evidence supports the presence of an advice and guidance service reducing this, creating additional first outpatient capacity.
- The waiting time for Secondary Care Orthodontic treatment is beyond the 18-week standard and there is variation across providers within Lancashire and South Cumbria. This is described in detail within section 2.2.3.
- Finally, it should also be noted that treatment pathways within Orthodontics can last between 2.5 years to 3 years for most patients, with the requirement to attend follow up appointments at 6-8-week intervals. Due to the current fragility across Lancashire and South Cumbria, several providers report waiting times beyond the 6-8 weeks for follow up reviews to be undertaken. Not only does this bring a risk of patient harm but it can also result in longer treatment plans for patients, as well as exacerbating the considerable commitments on patients, families and carers.

2.2.3 Performance

Secondary Care Orthodontic performance against the national RTT standards has been challenged for several years, compounded by the Covid-19 pandemic. At the present time, all four acute providers across the system are reporting a waiting time for treatment of beyond 18 weeks, with some reporting waits of beyond 65-weeks to commence treatment.

Figure 3 documents the number of patients per wait band across Lancashire and South Cumbria, as of the 15th November 2024. The target to eliminate 78-week waits was 31st March 2023 and 65 weeks by 30th September 2024, so as is illustrated below, Orthodontics is a performance risk for the system.

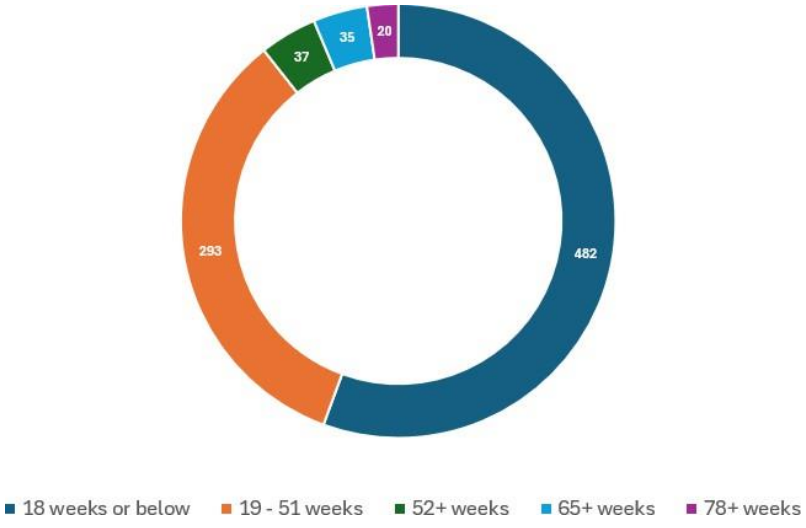

Figure 3 - Number of patients across waiting time bands for Secondary Care Orthodontics across four LSC providers (as of 15th Nov 24).

There is current variation in access to Secondary Care Orthodontics across Lancashire and South Cumbria. At the present time, only three of the four acute providers are accepting new patient referrals, thus patients referred within the Fylde Coast catchment area, are being referred to an alternative provider, instead of Blackpool Teaching Hospitals.

Providing a comprehensive service that is available to all, is one of the guiding principles of the NHS, yet there are current inequalities in access and thus quality within Secondary Care Orthodontic services. The three acute providers accepting new patient referrals have reported waiting times for a first outpatient appointment of between 16 to 40 weeks and waits of between 21 to 65 weeks for commencement of treatment.

3. Opportunities to improve and future Target Operating Model

To address the fragility of Secondary Care Orthodontic services as described, there will need to be several considerations. A variety of improvement opportunities have been identified which will support the optimisation of secondary care capacity. However, in addition to this, other factors need to be considered as the improvement opportunities alone will not satisfactorily mitigate the fragility of the service.

The recommended future target operating model can be summarised in three district themes:

High impact pathway and operational delivery improvement opportunities

- Skill mix changes in the service - An optimised skill mix within the service, employing additional Therapists, will ensure consultant capacity is used to best effect. Employing additional therapists would result in the need for one additional consultant to be recruited from the current number of substantive consultants in post. This is a net reduction in the consultant capacity currently in post when locums are factored in.
- Optimising primary care capacity **–** Through several changes to the pathway, primary care capacity can be better utilised to ensure only patients requiring secondary care services access it.
- Standardised and effective operational delivery – the future model will see standardised acceptance criteria, standardised delivery of clinics and pathways into multidisciplinary services.

Concentration of service delivery to ensure scale and efficiency

- Increased concentration of service delivery to realise the benefits of scale and efficiency, whilst ensuring access continues to be provided to patients.

Commissioning model

- Appraising the benefits and disbenefits of a single leadership model for the service is recommended. This based on the recommendations put forward in this paper to create a sustainable model primarily based on the system-wide replication of the service model in place at ELHT.

3.1 - High impact pathway and operational delivery improvement opportunities

There is current variability in the way in which Secondary Care Orthodontics is delivered across Lancashire and South Cumbria and opportunity to make improvements to the pathway. Standardising delivery and implementing these improvements, whether partly or fully implemented, will support the effectiveness and efficiency of the service in the future.

Improvement Opportunity One – Standardising the acceptance criteria
There is existing variability across acute providers in rejection rates at the point of referral. The acceptance criteria should provide a single view of the Index of Orthodontic Treatment Need, underpinned by peer rated assessment of cases. An acceptance rate of 55% should be in place across the system. The impact of this improvement would be an additional 47 additional OPFA slots per year.

Improvement Opportunity Two – Reducing Variation in the operational delivery of the service There is existing variability across acute providers in both the number of appointment slots per clinics, did not attend (DNA) rates and the delivery of multidisciplinary clinics within Orthodontics. Outpatient templates should be standardised and increased in applicable providers to ensure at least 7 patients per clinic (on average) and providers should strive to reduce DNA rates to 6% or below. The impact of implementing both changes would create an additional 1,042 OP slots per year.

In addition to this, there should be consideration around the way in which multi-disciplinary clinics run (either joint or independent)[1] across the system and whether there is opportunity to refine and standardise pathways.

[1] A joint clinic is a multidisciplinary clinic where an Orthodontic Consultant and a Consultant from another dental specialty (e.g. Restorative or Oral Surgery) review a patient jointly and collectively proceed to treatment planning. An independent clinic is where a Consultant Orthodontist refers a patient onto another dental specialty, but the patient is seen separately to their Orthodontic
attendance.

Improvement Opportunity Three – Optimising the Skill Mix The skill mix delivering Secondary Care Orthodontic Services across Lancashire and South Cumbria differs across the four providers, with some being predominantly Consultant-led and others having an increased Therapist input. Based on the demand and capacity modelling for Secondary Care Orthodontics, the optimised skill mix is 1:1.5 Consultant v non-consultant clinic ratio. Figure 4 details the current clinic ratios across the system. It is pertinent to note that the ratio for BTH is not representative of the service delivered prior to its closure in March 2023, but reflective of the temporary resourcing model to only support patients already referred into the service prior to this time.

Trust	Consultant v Non-Consultant Clinic Ratio
ELHT	1:1.5
LTH	1:0.6
BTH	1:1
UHMB	1:2

Figure 4 - Consultant v Non-Consultant Clinic Ratio for Secondary Care Orthodontics

Improvement Opportunity Four – Paediatric Advice and Guidance
East Lancashire Hospitals has been piloting a paediatric advice and guidance service since early 2023. On average, East Lancashire Hospitals have reviewed email requests for 8 patients per month and have been able to respond with advice, therefore preventing the referral of the patient into the service. Data from a clinic audit undertaken at East Lancashire Hospitals indicates that 6% of referrals accepted and attending clinic could have gone through the Advice and Guidance service and avoided the first outpatient attendance. The impact of this improvement would create capacity for an additional 91 OP slots per year.

Improvement Opportunity Five – Primary Care Early Discharge Scheme
A new initiative has been piloted (no data collected) in East Lancashire Hospitals to discharge patients who are clinically appropriate to conclude their treatment in primary care. The early discharge scheme is now live for a pilot period across Lancashire and South Cumbria until March 2025. It is assumed that 10% of patients will be clinically appropriate for early discharge into primary care and on average patients will be discharged with two thirds of their treatment still left to complete. It can therefore be assumed that for this cohort of patients on average of 12 appointments will be diverted from secondary care; this will primarily reduce demand into therapist clinics as opposed to consultants. Broadly, this initiative when fully embedded could reduce outpatient follow-up demand by 5% each year, or 954 OPFU.

The aggregated impact of these five improvements is as follows:

Improvement opportunity	Capacity created in secondary care	Capacity create in WTE / clinics
Standardising the acceptance criteria	128 additional OPFA slots	18 Consultant clinics a year
Reducing variation and standardising operational model	1,564 additional slots a year	223 clinics a year
Standardising clinic templates	741 additional slots a year	106 clinics a year
DNA rates	301 additional slots a year	43 clinics a year
Optimising skill mix	Increasing therapist workforce (3 WTE), reduces consultant clinics to 5 a week. Net reduction from current capacity including locums.	
Paed. advice and guidance pathway	100 OPFA	14.2 consultant clinics a year
Early discharge to primary care pathway	Diversion of 1,046 OPFU a year	149 clinics or c. 0.5 WTE therapists

Figure 5 - Aggregated Improvement Opportunities for Secondary Care Orthodontics

It should be noted that although these five improvements will make a material improvement to Secondary Care capacity, they will not ultimately alone address the fragility of Secondary Care Orthodontics due to the single-handed nature of several services a critical driver to the issues historically and currently being experienced. Therefore, other considerations need to be made to address the longer-term fragility of the service.

3.2 Concentration of service delivery to ensure scale and efficiency

Although the identified improvements (section 3.1) will provide significant additional capacity within the system, to fully address the fragility of the service moving forward a review of the number and location of sites where clinics are held is critical.

Location

Secondary Care Orthodontic Services across Lancashire and South Cumbria are currently delivered across eight physical locations, these are as follows:

- **Morecambe Bay:** Royal Lancaster Infirmary, Furness General Hospital and Queen Victoria Hospital
- **Fylde Coast:** Blackpool Teaching Hospitals
- **Pennine Lancashire:** Royal Blackburn Hospital and Burnley General Hospital
- **Greater Preston, Chorley and South Ribble:** Royal Preston Hospital and Chorley District Hospital

Given this geographical footprint is currently delivered by a substantive workforce of 5.68 WTE Consultants (2 x WTE of which are single-handed Consultants at their respective Trusts), consideration must be given around whether this delivery model is sustainable moving forward. Without considering the geographical space in which the service operates, ultimately the fragility of the service will not be resolved as there will still be two Orthodontic providers within Lancashire and South Cumbria operating a single-handed Consultant model (UHMB and BTH). The inherent fragilities of single-handed consultant services have materialised at both Trusts during the last 18 months, with long periods of time where residents have not had access to a local service.

In addition to this, the current location of services hinders the ability to maximise therapist capacity due to the supervision requirements – hence Trusts with only one Consultant will naturally have lower activity levels more frequently throughout the financial year, ultimately leading to patients not being reviewed within the necessary safe timescales. It is also not possible to operationalise the optimum skill mix ratio of consultant to non-consultant clinics with only one consultant working from one Trust / site.

The current geographical footprint of Secondary Care Orthodontic services is leading to some patients receiving what could be described as sub-optimal care in a highly specialised service. Providers with only one Consultant are reporting difficulty in ensuring patients are followed up within the necessary timescales which provides an evidence-base for a greater concentration of clinics within Lancashire and South Cumbria. An initial review of referrals over the last 12 months across the region has been completed and it is noted that the highest volume of referrals come from the Blackburn and Central Lancashire region, leading to an emerging model of greater concentration of delivery in these locations. As part of this review, remote areas such as Barrow and areas of higher deprivation, such as Central Blackpool, are being specifically reviewed. It is acknowledged that a greater concentration of clinics within Lancashire and South Cumbria cannot be at the expense of residents living in the peripheral areas of Lancashire or health inequalities being exacerbated.

It is therefore recommended that the number and location of sites where Orthodontic services are offered from in the future is changed to see a greater concentration of clinics in a smaller number of locations to achieve a more equitable, safe and sustainable model of delivery. As part of this model, satellite clinics could continue to be offered in remote areas such as Barrow and within areas of higher deprivation such as Blackpool. This model would allow Orthodontic services to deliver the scale and efficiencies required and protect appropriate levels of access across the region. It is important that we remain mindful of the equitability of dentistry services. The Orthodontic pathway requires patients to attend a series of appointments at 6 to 8-week intervals for a period of 2.5 to 3 years. The reduction in the number of hospitals where this service is offered could potentially have significant travel implications for patients and their families, if appropriate satellite sites are not considered.

3.3 Commissioning model

The benefits of having a single leadership model for orthodontic services going forward should be considered. A high-level options appraisal has been undertaken, noting the benefits and disbenefits of a number of different commissioning models available; from remaining with the status quo to moving to a single provider, which would see the full centralisation of the service across LSC.

Whilst done at the high level, this suggests that many of the options available are unviable or will not either address the drivers for the fragilities in the service or support the transformation of the service to the recommended future model.

A number of benefits are indicated against a Lead Provider model and therefore it is recommended that this is given further consideration for the future. There are a number of risks however identified with this model, particularly for the Trust who would become the Lead Provider, and therefore it is key to recognise at this point the gateways / conditions that would need to be in place for this to progress. This includes a review of the financial implications to mitigate any passing or exacerbation of any financial risks, and a need for some existing providers to reduce waiting times and backlogs to ensure performance risks are mitigated before a model like this could be operationalised.

4. Future capacity required for the service - Demand and Capacity Output

The Demand and Capacity modelling has been completed to consider the incoming demand to all four acute providers and then the aggregated impact of the improvement opportunities across the system when implemented. The output of this is shown in appendix 1.

A review of the staffing requirements across the system to support the output of the Demand and Capacity modelling has been completed. In summary, when comparing our current substantive workforce in post to that of the proposed future state, an additional 5 Consultant clinics and 16 Therapist clinics per week are required to deliver the service as shown in figure 6 below.

	Current weekly capacity					Weekly clinic capacity required - Consultant and therapists clinics at 40% consultants and 60% therapist / trainee capacity when consultant on leave	
	Consultant and speciality doctor clinics - substantive	Consultant and speciality doctor clinics - locum	Total consultant clinics	Therapist / trainee clinics	Consultant v non-consultant clinic ratio	Number of consultant clinics (42 weeks)	Number of therapist / trainee clinics (42 for 15% / 30 week 85% split)
BTH	0.0	2.0	2.0	2	1:1	6	10
ELHT	17.5	0.0	17.5	26	1:1.5	15	26
LTH	6.5	5.0	11.5	4	1:0.4	7	12
UHMB	6.0	0.0	6.0	12	1:2	7	12
Total	30.0	7.0	37.0	44		**35**	**60**
Increase / decrease from current substantive capacity						**5**	**16**

Figure 6 - Demand and Capacity Output - Workforce

It would be prudent therefore to recruit an additional 1 WTE Consultant Orthodontist. At the present time, there are 2.77 WTE budgeted Consultant vacancies within the system (1 at BTH, 1 at UHMB, 0.77 at LTH). In addition, due to the instability around trainees and the possibility that these are not guaranteed moving forward, an additional 3 WTE Orthodontic Therapists should be recruited to stabilise future non-consultant capacity across the system.

5. Constraints

Physical Space

Dental chair space within acute providers at the present time is a constraint to delivering additional Orthodontic activity. The constraints on current clinical space

capacity must be resolved in both the short-term for Trusts to clear the backlogs and longer-term to be able to deliver the future recommended model of having additional therapists and appropriate concentration of service delivery.

Secondary Care Orthodontic Services share chair space alongside other hospital Dentistry sub-specialities and hence estate space within acute providers is limited. One of the four providers has previously received a quote of over £250k to convert a disused room into an Orthodontic clinic room with a chair that has already been purchased and remains not in use. The significant cost is due to the requirement for dental treatment rooms to have a minimum of 10 air changes per hour as well as the generator to service this requirement.

Although Secondary Care Orthodontics is regarded as specialist, it does not necessarily need to be completed within an acute setting. Therefore, consideration must be given around alternative settings, including dental space at the University of Central Lancashire (UCLAN) and Primary Care providers. However, 76% of patients within Secondary Care Orthodontic services require multi-disciplinary care and therefore the movement of Secondary Care Orthodontics outside of a hospital setting may lead to fragmentation and fragility of the multi-disciplinary pathway, ultimately leading to longer waiting times and multiple outpatient attendances for patients to receive the appropriate input to their care. Therefore, the maintenance of multi-disciplinary working will be a key consideration, alongside whether other dental specialties could move into an alternative space to free up estate within acute providers for Orthodontic services to expand.

Therapist Banding

Lancashire and South Cumbria currently has 2.81 WTE Therapists operating across the whole geographical footprint, all of these have been up skilled and trained from existing nursing workforce within Lancashire and South Cumbria. The training can take up to 12 months and hence requires an investment from the host organisation and Consultant workforce.

Within Lancashire and South Cumbria, this role is currently AFC Band 6, however, there is variation within the North West region, and neighbouring ICS's, notably Cheshire and Merseyside, who offer these roles at a Band 7 AFC. The lower banding of these roles in LSC is presenting an immediate retention risk – and therefore a risk to further destabilise the service
- and a barrier to future recruitment. It would be prudent therefore to consider the re-banding of this role to ensure recruitment and retention within the region as well as ensure the resource that is placed into the Therapist training is worthwhile.

It should be emphasised that the Secondary Care Orthodontic future operating model relies heavily on the Therapist workforce. If re-banding was not considered, it is felt that this would be critical to the sustainability of the service moving forward and may lead to further difficulties in recruitment.

Multi-disciplinary specialties

With c. 50% of secondary care orthodontic patients requiring the input and intervention of restorative dentistry, orthognathic and oral surgery, the capacity requirements in these specialities will need confirmed and assured.

6. Finances

Budget comparison

The proposed future model sees a £180k reduction to the existing budget. This is driven by the proposed change in the skill mix and increase in the therapist workforce to optimise the use of Consultant capacity.

Due to the current levels of vacancies in the service, the proposed budget is an increase on current spending levels in 2024/25. However, the current level of spend incorporates locum and insourcing costs, which are at a premium. These costs would cease once the new workforce model was in place and, in addition to this, the overall capacity and level of activity generated through the proposed budget greater than the current runrate on income into the specialty. It is pertinent to highlight that orthodontics is funded from dental budgets and not ERF.

Service Line Reporting 2023/24

The orthodontic SLR position for Lancashire and South Cumbria shows a deficit of approximately £1m for 2023/24. After excluding Trust overheads, this results in a favourable contribution of £667k across the system. It is pertinent to note several nuances when reviewing the SLR positions for orthodontics in 2023/24. After closing to referrals in March 2023, BTH had limited service provision throughout 2023/24 due to vacancies, leading to significantly lower income and costs compared with other Trusts. Additionally, an analysis of LTH's SLR report reveals that their apportionment methodology seems to include costs for other specialties without the corresponding income. Nevertheless, the table reflects the Trust-report values, offering a good indication of the service's financial performance during 2023/24.

The recommended future model for orthodontics is expected to improve the system's financial position by approximately £673k, representing a 62% increase in profitability. This projection has been costed by modelling the increase in activity to be delivered when all changes are in place at the 2024/25 tariff, deducting the additional staffing resource, and a percentage of non-pay costs based on Trust SLRs.

7. Next Steps and proposed transition timeline

In order to progress, several actions have been agreed, to be completed before the end of Q4 2025/25. These actions will then shape the work to be completed within 2025/26.

In addition to this, a high-level transition timeline has been developed to illustrate the expected transition period, including the expected recruitment timeline for additional workforce.

7.1 Next Steps

As agreed within the December 2024 Orthodontic Collaboration Workshop, the below actions will support the delivery of the long-term delivery plan for Secondary Care Orthodontics within LSC:

7.2 Proposed Transition Timeline

Figure 7 documents a high-level transition timeline for Secondary Care Orthodontics within Lancashire and South Cumbria. To note, the identified improvement opportunities have already begun to be implemented across the region. It should be noted that there are anticipated challenges with the recruitment of Orthodontic Consultants which is a national challenge. In addition, the recruitment of additional Orthodontic Therapists must be in line with the national Orthodontic Therapist training timeline, of which, the next course begins in Summer 2026. It should therefore be assumed that in the short term there will be a reliance on both locums and insourcing to maintain service provision.

Action	Timeline	Lead
Temporary resource plan to be developed – namely for BTH and UHMB	End of Jan 25	Jessica Kelly
Location		
Continued granular work on referral demand – with focus around Barrow and Central Blackpool cohorts.	End of Dec 24	Jessica Kelly
Refine location demand and complete a working weekly template of activity with proposed satellite sessions included.	End of Jan 25	Jessica Kelly/Providers
Physical Space		
Review of options outside of an acute setting, including UCLAN and Primary Care Providers	End of Jan 25	Jessica Kelly/ICB
Completion of a site visit to LTH (RPH/CDH) to review estate and opportunities available to increase Orthodontic activity	End of Jan 25	Jessica Kelly/LTH
Completion of a site visit to ELHT (RBH/BGH) to review estate and opportunities available to increase Orthodontic activity	End of Jan 25	Jessica Kelly/ELHT
Workforce		
A review of the Orthodontic Therapist job description and work for reconsideration of banding	End of Jan 25	Jessica Kelly/Alison Marsh
Delivery Model		
Options appraisal to be developed around Lead Provider options and benefits	End of Dec 24	Karlyn Forrest
Identified Improvement Opportunities		
Task and Finish group to be developed to review DNA rates across LSC and opportunities to improve.	Q4 2024/25	Jessica Kelly/Providers
Task and Finish group to be developed to review joint clinics across LSC and opportunities to improve both in the short and long term.	Q4 2024/25	Jessica Kelly/Providers

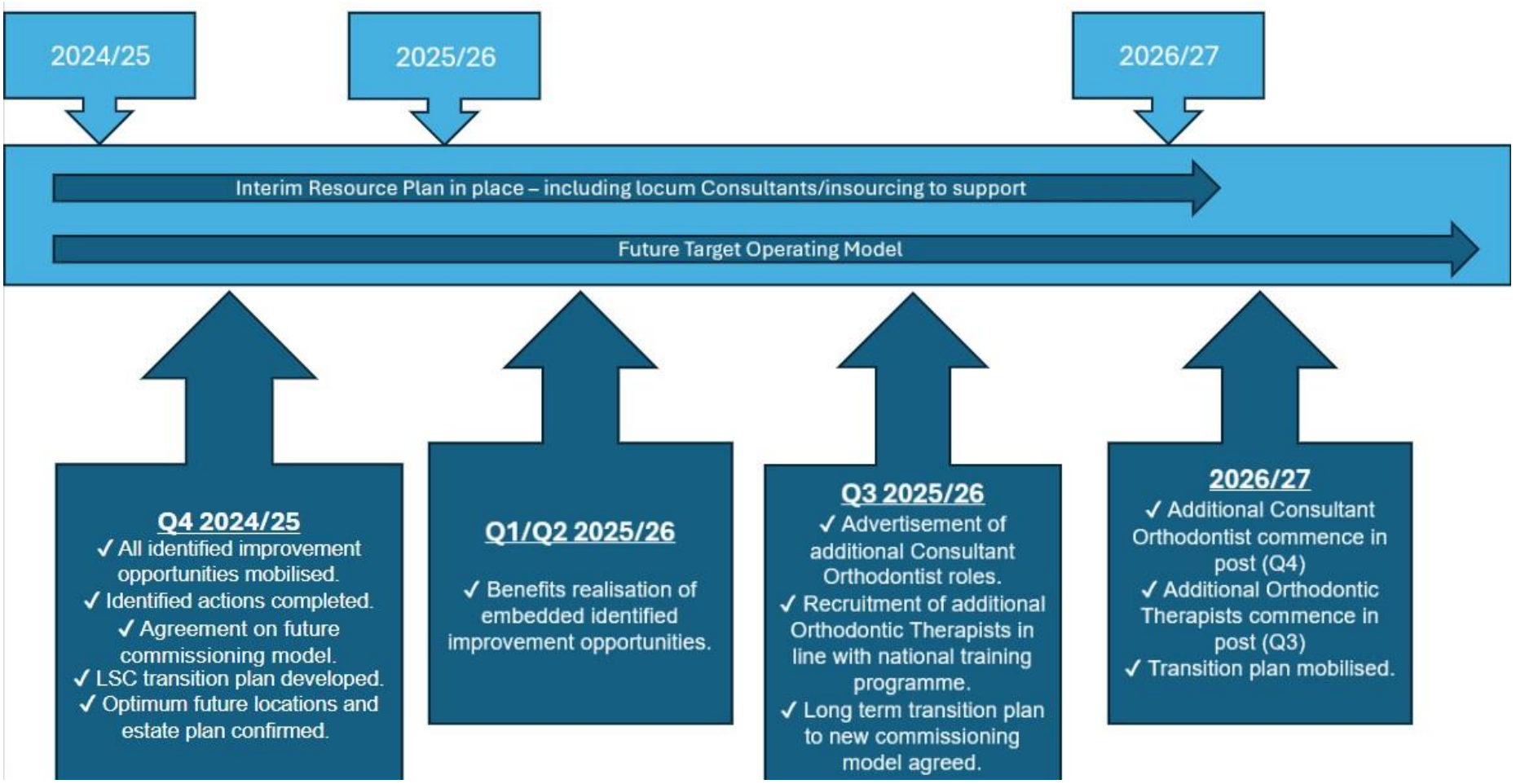

Figure 7 - Proposed Transition Timeline for LSC Secondary Care Orthodontic Services

Appendix 1- Secondary Care Orthodontics – Demand and Capacity Output

	LSC	BTH	ELHT	LTH	UHMB
Annual demand					
No. of referrals into the service	3039	517	1297	640	585
No. of new patients to be seen in OPFA (55% acceptance rate)	1671	284	713	352	322
Total number of OPFA clinics (Factoring in capacity for 6% DNAs, 6% reduction from A&G service and standardisation of OPFA clinic templates)	**238**	**40**	**102**	**50**	**46**
No. of patients progressing to treatment after OPFA (74%)	1163	198	496	245	224
No. of joint clinics required	**91**	**8**	**48**	**10**	**25**
Total no. of OPFU clinics required (once early discharge factored in)	**3020**	**514**	**1289**	**636**	**581**
Capacity requirements					
No. of consultant clinics a week (44% of all activity and 42 week year)	35	6	15	7	7
Therapists / trainee clinics a week (56% of all activity, 85% supervised and 30 week year and 15% unsupervised at 42 weeks)	60	10	26	12	12