



NHS England – Midlands & East (East)

NHS England
West Wing
Victoria House
Capital Park
Fulbourn
Cambs
CB21 5XA

Email address: england.dentaleast@nhs.net

30th October 2017

Dear Patient or Parent/Carer,

Please share your views with us on orthodontic services

We are writing to you as a patient, parent or carer of someone who is receiving orthodontic treatment, as we would like to hear your views about your experience of these services.

Orthodontic treatment (usually with braces) is most often used to improve the appearance and alignment of crooked, protruding or crowded teeth and, to correct problems with the bite of the teeth.

NHS England Midlands and East (East) is responsible for buying orthodontic services to make sure they meet the needs of local people. The current contracts to provide these services will be coming to an end in March 2019. We will shortly be commissioning (buying and managing) new contracts to provide orthodontic services after this date so would like your views on what the services should look like.

Please help us by completing the attached short questionnaire. For patients who are under the age of 18, the questionnaire can be completed by a parent, guardian or responsible adult, if appropriate. All replies will be anonymous.

We would be very grateful if you would either complete the questionnaire and hand it back to the person who has asked you to complete it or you can post it, marked for the attention of the Primary Care Dental Team – Orthodontics, to the address provided above by Wednesday 3rd January 2018.

If you would like to provide your feedback in more detail please email us at england.dentaleast@nhs.net, marked for the attention of the Primary Care Dental Team – Orthodontics.

Alternatively, should you have any general questions about NHS dental care or charges please go to www.nhs.uk or contact our Customer Services Team by telephone on 0300 3112233, or by email at england.contactus@nhs.net

Thank you very much for your help in completing this survey.

Yours faithfully,

A handwritten signature in black ink, appearing to read 'Debbie Walters', is positioned above the typed name.

Debbie Walters
Interim Contracts Manager – Dental Lead
NHS England – Midlands and East (East)

Patient Survey - Orthodontic services

Number	Question	Response				
Section 1: About you						
1	What village/town/city do you live in?					
2	Which county do you live in?					
3	Are you the patient or are you answering this on behalf of your child or someone that you look after?	Patient		Parent/Carer		
4	At what stage of orthodontic treatment are you/the person you are representing?	Awaiting an appointment for initial assessment	Had the assessment and now waiting for the treatment to start	In treatment	Treatment has been completed and now wearing a retainer	
5	Where do you/the person you are representing currently have orthodontic treatment?	Please provide the name of your orthodontic practice:				
Section 2: Waiting times						
6	How long after you/the person you are representing was referred for orthodontic treatment did you/they have to wait for the first appointment with an orthodontist?	0 – 3 months	4 – 6 months	7 – 12 months	1 year to 18 months	Over 18 months
7	Do you/the person you are representing think this was an acceptable length of time to wait?	Yes If Yes, skip to Question 10			No If No, please answer questions 8 and 9	

8	Were you/the person you are representing given an explanation as to why you had to wait that length of time for the first appointment with an orthodontist?	Yes If yes, please state the reason provided:				No	
9	What length of time would you/the person you are representing consider to be acceptable?	0 – 3 months	4 – 6 months	7 – 12 months	1 year to 18 months		
10	How long after the assessment with the orthodontist did you/the person you are representing have to wait for orthodontic treatment to start?	N/A – assessed and treatment not required	0 – 3 months	4 – 6 months	7 – 12 months	1 year to 18 months	Over 18 months
11	Do you/the person you are representing think this was an acceptable length of time to wait?	Yes If Yes, skip to Question 14		No If No, please answer questions 12 and 13			
12	Were you/the person you are representing given an explanation as to why you had to wait that length of time for orthodontic treatment to start?	Yes If yes, please state the reason provided:				No	
13	What length of time would you/the person you are representing consider to be acceptable?	0 – 3 months	4 – 6 months	7 – 12 months	1 year to 18 months		

Section 3: Choice of orthodontist

14	Were you/the person you are representing offered a choice of orthodontist?	Yes	No	Don't know
15	If treatment has ended, were you/the person you are representing treated by the same person during the entire treatment?	Yes	No	Not applicable as treatment ongoing

Section 4: Travel to appointments

16	How far do/did you/the person you are representing have to travel for your appointments?	0 – 5 miles	6 – 10 miles	10 – 15 miles	15 – 20 miles	Over 20 miles
17	Do you think this is an acceptable distance to travel?	Yes		No If No, what distance would you consider to be acceptable?		
18	Would you/the person you are representing be prepared to wait longer to get an appointment closer to home?	Yes			No	
19	What would be the furthest distance you/the person you are representing be prepared to travel (single journey in miles)? Bear in mind that once treatment has started, appointments will usually be every two months for up to two years. Please state in miles or kilometres.					Please enter the maximum distance:
20	How do you/the person you are representing get to orthodontic appointments?	Car	Public transport	Walk/cycle		
21	Do you or the person that you are representing have any other comments about travel to your/their appointments?					

Section 5: Appointment times			
22	Were you/the person you are representing happy with the day and time of the appointments offered to you/them?	Yes	No
23	Do you have a preferred day and time that you/the person you are representing would like to be able to have appointments?		
24	Would you/the person you are representing like to have appointment times outside of school hours and if so, what times would you/they prefer?		
Section 6: Further information			
25	Do you/the person you are representing feel you/they were provided with enough information about the treatment you/they were/are going to receive?		
26	Do you or the person that you are representing have any other comments about the orthodontic services that are available?		
27	NHS England may wish to contact some patients/carers for further information about your experience of the service. If you would be happy to be included in the possible selection for a follow up call, please provide a contact telephone number and email address. Please note that not all patients/carers providing contact details will be contacted.	Contact Telephone Number: Contact Email Address:	

Thank you very much for completing this survey and sharing your views with us.

EQUALITIES MONITORING

To ensure that our services are designed for the population we serve, we would like you to complete the short monitoring section below. The information provided will only be used for the purpose it has been collected for and will not be passed on to any third parties. If answering this question on behalf of your child please answer these questions on their behalf.

What is your age?	
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What is your gender?		
Male	Female	Prefer not to say
X	X	X

Do you or have you ever considered yourself as transgender?					
Yes	X	No	X	Prefer not to say	X

What is your ethnic group? (Tick one box only)	
White British	X
White Irish	X
Gypsy or Irish Traveller	X
Any Other White background	X
Pakistani	X
Bangladeshi	X
Indian	X
Any Other Asian Background	X
Caribbean	X
African	X
Any Other Black Background	X
White and Asian	X
White and Black Caribbean	X
Any Other Mixed Background	X
Chinese	X
Arab	X
Any Other Ethnic Group	X
Prefer not to say	X

Do you consider yourself to be disabled? (Tick one box only)					
The Equality Act 2010 states that a person has a disability if: 'a person has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on that their ability to carry out normal day-to-day activities'					
Yes	<input checked="" type="checkbox"/>	No	<input checked="" type="checkbox"/>	Prefer not to say	<input checked="" type="checkbox"/>

If yes above, what type of disability do you have? (Tick all that apply)					
Learning disability/difficulty	<input checked="" type="checkbox"/>	Long-standing illness or health condition	<input checked="" type="checkbox"/>	Mental Health condition	<input checked="" type="checkbox"/>
Physical or mobility	<input checked="" type="checkbox"/>	Hearing	<input checked="" type="checkbox"/>	Visual	<input checked="" type="checkbox"/>
Prefer not to say	<input checked="" type="checkbox"/>	Other:	Please specify here		

Which of the following best describes your sexual orientation?					
Heterosexual / straight (opposite sex)	<input checked="" type="checkbox"/>	Bisexual (both sexes)	<input checked="" type="checkbox"/>	Gay or Lesbian (same sex)	<input checked="" type="checkbox"/>
Other	<input checked="" type="checkbox"/>	Prefer not to say	<input checked="" type="checkbox"/>		

What is your religion or belief?					
No religion or belief	<input checked="" type="checkbox"/>	Buddhist	<input checked="" type="checkbox"/>	Christian	<input checked="" type="checkbox"/>
Hindu	<input checked="" type="checkbox"/>	Jewish	<input checked="" type="checkbox"/>	Muslim	<input checked="" type="checkbox"/>
Sikh	<input checked="" type="checkbox"/>	Other	<input checked="" type="checkbox"/>	Prefer not to say	<input checked="" type="checkbox"/>