Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government Committee

Dydd Mercher, 6 Hydref 2010
Wednesday, 6 October 2010

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Irene James	Llafur Labour
Ann Jones	Llafur Labour
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Dr Hugh Bennett	Ymgynghorydd Meddygol mewn Iechyd Cyhoeddus Deintyddol, Iechyd Cyhoeddus Cymru Consultant in Dental Public Health, Public Health Wales
Dr Alastair Clarke-Walker	Seiciatrydd Ymgynghorol Consultant Psychiatrist
Nicolas Cowan	Defnyddiwr Gwasanaethau Service User
Professor Jeremy Knox	Orthodontydd Ymgynghorol, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Consultant Orthodontist, Abertawe Bro Morgannwg University Local Health Board
Neil Loughborough	Defnyddiwr Gwasanaethau Service User
Robert Paxman	Prif Swyddog Gweithredol a Sylfaenydd Talking2Minds Chief Executive Officer and Founder of Talking2Minds
Ian Pitchford	Hyfforddwr a Darparwr Therapi, Talking2Minds Trainer and Therapy Provider, Talking2Minds
Emma Procter	Pennaeth Bwrdd Iechyd Lleol Aneurin Bevan Head of Primary Care, Aneurin Bevan Local Health Board
Carol Richards	Apêl Plasty'r Gelli Aur (Healing the Wounds) Golden Grove Mansion Appeal (Healing the Wounds)
Kevin Richards	Rheolwr Gyfarwyddwr, Apêl Plasty'r Gelli Aur (Healing the Wounds) Managing Director, Golden Grove Mansion Appeal (Healing the Wounds)
Dr David Thomas	Ymgynghorydd Meddygol mewn Iechyd Cyhoeddus Deintyddol, Iechyd Cyhoeddus Cymru Consultant in Dental Public Health, Public Health Wales

Simon Weston OBE	Noddwr, Talking2Minds Patron, Talking2Minds

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.01 a.m.
The meeting began at 9.01 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everybody. Welcome to today's meeting of the Health, Wellbeing and Local Government Committee. I welcome all Members, members of the public and witnesses to the meeting. I remind you that headsets for simultaneous translation and sound amplification are available in the public gallery and, of course, in this room. If anybody has any problem with using these, the ushers will be able to help. Committee members and members of the public may wish to note that the simultaneous translation feed is available on channel 1, while channel 0 is the language being spoken. I would be grateful if everybody could turn their BlackBerrys, mobile phones and pagers off because they can interfere with the broadcasting and other equipment.

[2] If it is necessary to evacuate the room or the public gallery in the event of an emergency, everyone should follow the instructions of the ushers, who will be able to guide people to the appropriate exit. Finally, I remind everyone that the microphones are operated remotely. No-one has to push any buttons; they will just magically turn on as you begin to speak—hopefully. You do not have to press any buttons to deactivate them either.

[3] We have received apologies this morning from Andrew R.T. Davies and from Irene James. There are no further apologies. Dai will be joining us shortly. So, without further ado, I invite Members to make any declarations of interest under Standing Order No. 31.6. I see that there are none.

9.02 a.m.

Ymchwiliad i Driniaeth ar gyfer Anhwylder Straen wedi Trawma i Gyn-filwyr y Lluoedd Arfog: Casglu Tystiolaeth
Inquiry into Post-traumatic Stress Disorder Treatment for Veterans: Evidence Gathering

[4] **Darren Millar:** We will move straight into item 2 on our agenda, continuing with our inquiry into post-traumatic stress disorder treatment for veterans in Wales. I am delighted to welcome this morning Kevin Richards, the managing director of the Golden Grove Mansion Appeal (Healing the Wounds); Carol Richards, who is also a director of the appeal; and Dr Alastair Clarke-Walker, who is a consultant psychiatrist. Welcome to you all this morning. Thank you for the papers that have been circulated to all Members in advance of this meeting. As those papers have already been circulated, we will go straight into questions.

[5] Dr Clarke-Walker, you highlight in your evidence some of the issues and difficulties

with diagnosing PTSD. How do you think that diagnosis can be improved, and what changes are required to NHS services to help that process?

[6] **Dr Clarke-Walker:** I will be speaking from experience—and this is not found in the books but is what happens in practice. I specialise in substance misuse and general psychiatry. Treating substance misuse is really a peculiar thing and you cannot learn it from books. You can learn certain stuff from books, but the real thing is very challenging. The success rate of treatment for addictions is pitifully poor, which is rather demoralising.

[7] Anyway, when I was involved in treating substance misuse, I would be assessing someone and I would do a full assessment and realise that they had PTSD or depression. The fact is that you have a whole human being to consider. It is not just half their brain or half their body that comes through the door and the other half can be ignored. I was informed that I could not treat mental illness as we were not funded for it, and so I would have to treat just the substance misuse, which is a real waste, because guess who can do the lot? *Moi*. So, that was frustrating.

[8] People would say that it was not a problem, because we could talk to our consultant colleagues, we would know exactly what was happening and we could liaise with them. With the best will in the world, the three biggest problems that I found with substance misuse as a separate sub-speciality and general adult and other divisions of psychiatry were communication, communication, communication—just as with estate agents, it is location, location, location. Although psychiatrists feel as though they understand substance misuse and those people understand what each other are doing, they do not really understand. If you have separate entities, you will always have the left hand doing something different from the right hand.

[9] I think that it should be one person responsible for the whole person. I think that a trauma service should be set up, so that the clinicians and the team do not address just the PTSD or any associated trauma phenomena such as depression, but also the substance misuse. Then you would not have to ask which was the chicken or the egg, and that sort of thing. You can look at the whole human being and tailor treatment to the individual's needs. Sorry, I am going on, am I not?

[10] **Darren Millar:** Not at all. Just for the record, should this be a veteran-specific service or are you talking about a wider service available to others as well?

[11] **Dr Clarke-Walker:** I personally feel that trauma is trauma, and, let us be quite frank, it is horrific. I think that the soldiers must be treated, but I also feel that paramedics, ambulance people, people in the forces, and doctors have to see truly gruesome things, and so it should be open to all people who experience trauma. At the end of the day, we are all human beings.

[12] **Darren Millar:** Okay, thank you. Mr Richards or Carol Richards, do you have anything to add to that?

[13] **Mr Richards:** We are looking to have all the agencies and all the support at the Golden Grove, so that we can offer post-traumatic stress treatment for the armed forces and, as the doctor has said, for civilians in uniform. We want to be able to treat anyone who is suffering post-traumatic stress at the mansion at Gelli Aur.

[14] If I give you a breakdown of what we aim to do at Gelli Aur, it might give you more understanding of what we can achieve. We have held meetings with Talking2Minds, Hafal, and Professor Jonathan Bisson, and they are very happy with what we want to achieve at the mansion. Is that okay?

[15] **Darren Millar:** Yes, give us a brief overview.

[16] **Mr Richards:** Okay. I served with the 1st Battalion, the Royal Regiment of Wales as a combat medic. I completed tours in Northern Ireland, and I treated my friends who had been blown up on the streets by bomb blasts. They were blinded and had their legs shattered, so this is very personal to me, because it is my friends who are suffering and who are in extreme agony. I also served in Desert Storm, where I treated quite a few casualties, mainly Iraqis, but they were still casualties and they were still people in suffering.

[17] We established Golden Grove, because we saw a need for a post-traumatic stress disorder facility based in Wales. At the moment, there is no fixed facility to send these guys to from the armed forces.

[18] **Darren Millar:** So, is the focus of your service more veteran specific? Although you do get other individuals, does it primarily serve veterans?

[19] **Mr Richards:** Yes, we treat serving soldiers, veterans, families, and the children of the veterans. We have also cleared it with the Charity Commission for England and Wales that we can treat civilians in uniform. Anyone suffering post-traumatic stress can use the facilities at the mansion, because we are open to anyone who is suffering. As the doctor said, our aim is to help the broad spectrum of people suffering post-traumatic stress.

[20] We give care and support to service personnel, veterans and their families who are suffering as a result of military conflicts. Some have come from Afghanistan, Iraq, the Falklands, Aden and Malaya, to name but a few, and we were approached recently by a Korean veteran asking for help. He has been suffering from post-traumatic stress for almost 60 years and he came to ask if we could help him. Obviously, we will try our best.

9.10 a.m.

[21] Golden Grove is a 156-bedroomed mansion with a 100-acre country park, which is run mostly by Carmarthenshire County Council. We need a facility where the boys and girls feel relaxed in a large area of space. You will find that anybody who stresses out in the forces normally disappears into the woods. That is where they feel safe. They will make a tent and camp out. They will get a caravan and live in the woods. That is where they feel safe. That is why 100 acres would make them feel safe. At the mansion, they are being treated by veterans, so it is veterans treating veterans. They can understand the psyche.

[22] What we notice as well is that the service personnel conversion to a military mindset consists of three phases: like a lesson plan, there is a beginning, a middle and an end. Obviously, the beginning is the introduction and conversion to the military mindset and military training to change the civilian mind into the military psyche. This happens over a period of time, so it is a gradual sort of line-up until they are fully trained. The middle is the career of the service personnel who are now fully conditioned into the military way of life. That is all they are: military. The civilian side of things has gone.

[23] The end is abrupt, and this is the part where post-traumatic stress happens. There is no transition on leaving the armed forces to become a civilian. It is at this stage that problems start to occur because you learn to become a soldier, you serve as a soldier, and then you just turn 180 degrees and you are a civvy, and that does not work. That is why former members of the armed forces make up 11 per cent of the prison population, because they cannot handle it. They have been removed from the military environment where almost everything is taken care of for them, including employment, training, housing, clothing and medical requirements. All these everyday needs are dealt with within the cocoon of the military

family. If there are any problems, they will sort it out. When these are removed and the service career is over, they are left to make provision for themselves, and some of them just do not know what to do. They cannot cope with it.

[24] I will offer an example of an incident involving a warrant officer class 1, which is more or less like a regimental sergeant major. I did a job for this guy many years ago. He had just left the forces and he had some builders to the house. He was shouting at these builders, trying to make them stand to attention and so on, and these builders just looked at him daft because he had lost authority. He had no respect anymore and he did not understand that it is not going to work in civvy street. You cannot go to a builder and say, 'Right, get that done now. Stand to attention when you are talking'; it just did not work. So, he literally lost it and obviously he suffered big time.

[25] **Darren Millar:** Before we go into some of the questions, which will drill down into some of the information you have already given to us, in your experience are the people more likely to suffer with PTSD longer serving individuals who find it difficult to remember what it was like on civvy street or are they the younger individuals who have been there for two or three years?

[26] **Mr Richards:** As you know, post-traumatic stress takes up to 16 years to come out. It takes a long time. One of the other directors who could not be here today, Arfon Williams—he sent his evidence to you—is a sufferer of post-traumatic stress and has been treated by Sir Jonathan Bisson. We are noticing now that the timescale for starting to suffer post-traumatic stress is not 16 years or even five years, but one tour of Afghanistan. It is happening to the youngsters. These young lads are seeing things that they should never see in their lives. They are on patrol, a bomb goes off and their friend, who they just had breakfast with, is killed by an improvised explosive device.

[27] The point is that the news portrays it as, 'Soldier killed by bomb blast'. What they do not convey on the news is what that soldier looked like. It is not a human being anymore; it is just a mess on the floor. One of the young lads broke down because bits of his friend were being picked up by dogs and being taken away for food. Then they have to get plastic bags and pick up their friend and put him in the plastic bags. It does not just stop there. Once it has been removed, they carry on for the next three, four or five days of the patrol knowing that every step that they take from then on could be their last.

[28] **Darren Millar:** Thank you for that.

[29] **Dr Clarke-Walker:** May I add another point?

[30] **Darren Millar:** Yes, please do, then we are going to go into some more detail, but, as I said, we have limited time available.

[31] **Dr Clarke-Walker:** It relates specifically to your question. There is a fairly recent research paper on this particular issue, and the data shows that younger men and those from the more junior ranks are two to three times more likely to have the PTSD phenomena and to commit suicide.

[32] **Darren Millar:** That is very helpful evidence. If you can send details of that paper to the committee clerk, that would be very helpful.

[33] **Helen Mary Jones:** I know that we need to move on, but I think that that is very interesting and it does not surprise me, because that is certainly what is reflected in my constituency work.

[34] Is there any research to suggest that some of the reasons why lower ranks and younger people suffer worst might be related to experiences that they had before going into the military? I know that care leavers will often choose a military life because they do not have family support, so they go into that structure, and they are safe while they are in there, but when they come out, not only do they have the awful experiences that Kevin was talking about to deal with, but they also have the vulnerabilities and difficulties with coping that they brought into the service. That is purely anecdotal from my point of view and I wonder whether the evidence supports that at all.

[35] **Dr Clarke-Walker:** I cannot recall a specific paper from the top of my head. I can answer the question fully, but I know that people are pushed for time. I will briefly make a point in relation to that. If you look at the personal histories of these younger men who are going in to the more junior ranks, you will find that they have come from maybe not the most fortunate backgrounds. That impairs their functional cognitive coping mechanisms adversely. You understand what I have said, do you not?

[36] **Helen Mary Jones:** I do.

[37] **Dr Clarke-Walker:** That is a very real possibility. These people are psychologically more vulnerable. They might have the muscle, but muscle is no protection against horror.

[38] **Darren Millar:** Thank you; it was important to get that on the record.

[39] **Veronica German:** We have heard evidence that symptoms of PTSD can take some years to appear, and you talked about that just now. Is that your experience? If that is the case, what needs to be done to ensure that veterans who are suffering after a long period of time are diagnosed and then helped, because they are way out of the system by then?

[40] **Mr Richards:** The problem with post-traumatic stress is that it needs to be addressed as soon as they come back from conflict, before they become veterans. Once the MOD has diagnosed them as having post-traumatic stress, the normal pattern would be to give them tablets and then assess them. Obviously, the tablets do not work; they need proper treatment. After six months, if they are still the same, the MOD more or less discharges them from the army as being unfit for service. The MOD then sends them back to Wales as broken Welsh men and women and says to Wales, 'Give us some new blood; we need replacements for these broken boys'. We need to make sure that we can sort it out with the regiments, especially the Welsh regiments, so that if they have any problems at all, they can be sent to a facility in Wales, because they are Welsh soldiers. Obviously, that is what we are going to do with Golden Grove. We can assess them and send them to organisations like Talking2Minds, which you are going to speak to later on. It is a fantastic organisation. We have sent guys there for treatment and counselling and, as Bob Paxman will explain later, they are fixed. There was one young lad, about 19 years of age at the time, and his friend was in the lead vehicle that overturned in Iraq a few years ago—I do not know if you remember it—and he drowned in that vehicle. This young lad dived into the river three or four times to save his friend and all he could hear was his friend screaming until he drowned. This young lad suffered. He had experienced nightmares and so on. We paid for a course for him at Talking2Minds and, as Bob would say, he is fixed. His nightmares have stopped, so it works. We have to catch them early enough.

[41] **Darren Millar:** In terms of the specific question, what we are trying to nail is that, in some people, it would appear that it takes many years for them to manifest any symptoms of PTSD—

[42] **Dr Clarke-Walker:** May I comment?

[43] **Darren Millar:** Yes, of course.

[44] **Dr Clarke-Walker:** I am trying to say this in lay persons' terminology. It is a fact of society, whether we like it or not and however politically incorrect it may be, that women can talk about their problems more than men. This is the bottom line: men tend to bottle it up. The problem is that these are supposed to be big strong men who do not have all these feelings. I think that we could agree that bottling things up is not the best way to approach things.

[45] What can happen is that they may be in denial. There was a fairly recent paper that said that, basically, the PTSD sequelae are very low. I could really criticise that paper, but that is outside the remit of your question; suffice to say that it is an incredibly biased paper. What happens is that these guys are suffering and they are in denial—they do not accept that they are in so much pain. It can take many years before they can admit it. Let us look at what happens in that process: they are probably beating their wives, possibly divorced, and the children see dysfunctional behaviour and get into crime and drugs.

9.20 a.m.

[46] These people probably use loads of alcohol, because it is part of the lifestyle, and then people say that they are druggies—missing the whole point—and these people are not coming to the fore with it. So, unfortunately, the true realities, the temporal nature, is that it takes a lot longer than it should to come out, because they are trained to kill but they are not trained to feel and identify their problems. Also, unfortunately men do not tend to cry. They get angry and irritable. I am not being sexist; I am just talking of human beings medically. I apologise, I am not trying to offend anybody with what I am saying, but this is life. Life and death is not politically correct and these people tend to have anger. So what do they do? They turn to the fist, and beat people up, and the next thing is that you have vets making up 11 per cent of the prison population, and we really are behind. I do not think that it is ethical that these people are banged up in prison and not being treated. Forgive me, I am not a US-ophile but, unfortunately, the United States is ahead of us on this game. Was that succinct enough?

[47] **Darren Millar:** Yes, that was very helpful.

[48] **Veronica German:** May I push a bit further? We had discussions at the last meeting about whether it would be helpful, moral and right to make a note on somebody's health record that they have been in the armed forces, so that, when they present to their general practitioner or whoever, it might jog them. Some people say that people might not want it there, so it would be interesting to know what you think about that.

[49] **Dr Clarke-Walker:** I am sorry, I do not see the shame of serving the forces of our country. I think that it is something to be held with pride. Is it okay to say that?

[50] **Darren Millar:** We have had mixed responses. Essentially, there are some people who would rather it not be disclosed, which is fine on an individual basis, but we accept that the majority of people would be very happy to share that.

[51] **Mr Richards:** The problem is that it takes a long time before post-traumatic stress comes out for these veterans. They have left the forces. A lot of youngsters are just Queen's assassins: that is what they are trained as—they are killers. They go to war to fight and to kill, and obviously to survive. When they come out they have no skills, they cannot easily get back into civilian life, because their friends have gone, the military has gone; there is nobody to talk to on the same level, with the same psyche and the same sense of humour. It is totally gone. That is why it sometimes takes a long time for post-traumatic stress to come on board. We need to help them as soon as possible. Again, as I said, it turns 180 degrees. We need to give them a skill, give them a job, train them to become plumbers, plasterers and electricians.

We have the facilities, we are capable of having facilities at the mansion in the future. We need to give them a job, to help them overcome what they are going through, so that they have something with which to support their families; give them something to hold on to so that they are respected, that they have a job to go to, so that they can support and feed their families. A lot of them with post-traumatic stress are, to be honest, a burden on the NHS and others because they have not got a skill—they do not know what to do. We want to give them a skill, want to get them off benefits, get them into a workplace to make them feel better for themselves and give them self-respect.

[52] **Darren Millar:** You are covering some of the things that we were going to move on to later; thank you, it is helpful.

[53] **Val Lloyd:** I was going to ask about the treatment but you talked about the holistic approach, so I will move on. What is needed to improve the evidence base for the effectiveness of treatments and therapies?

[54] **Dr Clarke-Walker:** I am going to be as succinct as I can on that, because that is a big question. That could be a paper in response. I am quite upfront about this—I want to set up a trauma centre myself. You need to be really focused on the true realities. You are talking about people committing suicide. What you want is to have people coming in and people coming out, so you want to know the numbers going in, you want to know those that are successfully treated, those that are still in treatment, the duration of successful treatment and those that are still untreated. I have instructed a colleague of mine to ask questions to the NHS and various organisations. Only one organisation—it was not Combat Stress—was forthright in giving an answer and there is no data on this. I put it to you, it is like if you go to buy a car—I am sorry; I am a lad—and you say, 'Here is £30,000' and then you turn round to the salesman and say, 'What model is it?' 'I do not know.' 'What make is it?' 'I do not know.' 'What colour is it? Oh, when am I going to get the car?' 'Well, I cannot tell you.' That is what is happening with the NHS.

[55] I want to set up a service where you will see who comes in, it will be all public forum, it will be all data, and it will be there for everybody to see and to be researched independently by a university so that they can see that these people are successfully treated, and the duration to successful treatment. So, basically, they will see that money goes in and how much is successful for people being treated. How do you do that? You do that by valid and reliable assessment scales. That is how you do it and there are agreed PTSD, depression rating scales for the various disorders, and that is what I will be setting up. I came into medicine to save lives—that is my passion, that is my narcissism, so to speak—but also to improve the quality of people's health, wherever I can. They will be the two points that I will be looking at. Did that answer your question?

[56] **Val Lloyd:** It did answer it, basically. I think that you were telling me there is no recognised published evidence base.

[57] **Dr Clarke-Walker:** No. It is lamentable. The USA has lots of data on this sort of stuff.

[58] **Lorraine Barrett:** What initial health and resettlement support do people who are leaving the armed forces receive and how do you think this could be improved? We have heard evidence that they leave the forces today and they are just in civvie street tomorrow, but is there a transitional support system there?

[59] **Mr Richards:** Yes. They do a thing called a resettlement course and then they can go on a four-week course, become a plumber or plasterer or maybe apply to the fire service or prison service and so on, but it is only for a month. Things have changed since I was in. When

I was in you would go on a course and that is it, you would leave the forces, but nowadays it works on a point system. If you have not got enough points when you leave the forces, especially youngsters who are leaving now because of post-traumatic stress, they have not accumulated enough points so they have to pay towards the resettlement course, which I think is totally disgraceful of the Ministry of Defence.

[60] **Lorraine Barrett:** I am sorry to interrupt. What about the health aspect of the resettlement course? Are they assessed on a health basis?

[61] **Mr Richards:** When you leave the forces, you get documents saying home only, fit for service, downgraded and so on. These guys with post-traumatic stress are downgraded within the forces, so there is not much aftercare. The MOD discharges them and leaves it to the NHS to sort out and fund, which is totally disgraceful. The MOD broke these men and women so the MOD should have the responsibility and funding to pay the NHS for the treatment and future treatment of these veterans. It should not leave it to the NHS to pick up the tab when it is the Ministry of Defence's fault.

[62] **Lorraine Barrett:** You have talked about the people who make the armed forces their lives—they leave school or whatever and go straight into the armed forces and then straight into civvie street. What about the Territorial Army vets? It is a slightly different situation there, is it not? They will have come from their work environment and then go for a short time and then come out. Are there any specific issues that affect them?

[63] **Mr Richards:** I served nine years with the Royal Regiment of Wales. I was a medic most of my career. Then, when I left the forces I joined the TAs and I was in a hospital in Cardiff, so I was regular and TA. There is the same thing there. While you are away you get treated by the Ministry doctors and so on, but when you come home you go straight back into the NHS. So you cannot differentiate between the regulars and the TAs; it is the same sort of thing. They get looked after the same as the regulars, even though a lot of TA soldiers are a lot more dedicated in the armed forces—certain ones. They are called the weekend warriors, and they are warriors. They are so passionate about their job. This is why a lot more TAs go into conflict zones; they are determined to support their nation and protect their nation. It is the same care that they get. If they get injured, they come out, same thing again: the NHS looks after them.

[64] What is disgusting as well is that these young lads go to Afghanistan and they have to buy their own health insurance to go—it is called PAX insurance. They pay £10 per £10,000 as an extra insurance, which I think is wrong. So these youngsters, who are private soldiers, cannot afford to have 10 units of PAX for £100 a month, yet higher ranking officers, sergeants and so on, can afford it. So if the youngsters get injured they cannot be financially supported either.

9.30 a.m.

[65] **Darren Millar:** May I just clarify something? Earlier on when you were saying that it is difficult for soldiers to adapt back to civilian life and that that is one of the things that can trigger PTSD, when you do have people, as Lorraine says, who are part-time soldiers really, who are familiar with both civvy street and the life of a soldier, is there a reduced prevalence of PTSD among that population? Perhaps, doctor—

[66] **Dr Clarke-Walker:** I do not have any data on that.

[67] **Darren Millar:** There are no data available? You are not aware of any information that says they are less likely to suffer from PTSD?

[68] **Mr Richards:** It all depends on the conflict situation. If they have seen the same injuries, or have been exposed to the same injuries in defence as a regular soldier, it is exactly the same. They still can have post-traumatic stress as a result of those incidents.

[69] **Dr Clarke-Walker:** I cannot comment on the war scenario, but there is research showing that when you have a horrific event—do you want to know a gender response to it?

[70] **Darren Millar:** Yes, please.

[71] **Dr Clarke-Walker:** Okay. Research shows that in response to basically the same physical traumatic event, females have a higher incidence of PTSD, except for one big exception: rape. When men are traumatised by rape, they are more likely to get PTSD than women. That is the curveball. I will not go into the etiology, unless you want me to.

[72] **David Lloyd:** Yr wyf yn eich llongyfarch ar eich tystiolaeth benedgedig hyd yn hyn. Mae gennyf gwestiwn i Kevin Richards yn benodol. Pa wasanaethau mae Plasty'r Gelli Aur yn eu darparu i gyn-filwyr nad ydynt yn cael eu darparu gan y gwasanaeth iechyd?

David Lloyd: I congratulate you on your wonderful evidence so far. I have question to Kevin Richards in particular. What services does Golden Grove Mansion offer to veterans that are not provided by the health service?

[73] **Mr Richards:** At the moment we are looking at using Talking2Minds and Professor Jon Bisson for all the treatments at the mansion, which are different types of treatments than those offered by most of the NHS. There are many types of treatments for post-traumatic stress, but there are many out there that just do not work. We have to find something that works. At the mansion, we are trying to have as many organisations in as we can to find the right treatment in order to treat these disorders as soon as possible. The other thing that we want to do at the mansion, besides treating post-traumatic stress, is to cover the employment aspect. We want to be able to help veterans become civilians again. We want to give seminars and lectures on how to become a civvy. It sounds quite funny, but that is what we need to do. We need to give them employment skills. We need to help them with other agencies such as the Soldiers, Sailors, Airmen and Families Association, SSAFA, and Army, Navy, Air Force Benevolent Funds, to help them through any problems that they have. If they are disabled, they need disability benefits, for example.

[74] We want everything in one location so we can ensure that when they leave the mansion, the post-traumatic stress is sorted out. If they need convalescence, they can stay and can have that. We can give them a job to support their family. We can get them everything that they need to become a civilian again. We have an open-door policy, so if ever they need help or any support they can come to the mansion and get everything there.

[75] **David Lloyd:** Yn dilyn ymlaen o'ch ateb, yr ydych yn dweud nad yw gwasanaethau ar gyfer cyn-filwyr yn cael eu cydlynu'n ddigonol. Y cwestiwn sydd yn codi o hynny yw: i ba raddau gall y sector wirfoddol gyflawni'r rôl hwn o gydlynu gwasanaethau, ac i ba raddau y dylai wneud hynny?

David Lloyd: Following on from that, you say that services for veterans are not co-ordinated sufficiently. The question that arises from that is: to what extent can the voluntary sector fulfil this role of co-ordinating services, and to what extent should it do that?

[76] **Mr Richards:** The voluntary sector needs to collate everything that it can do. At the moment it is fragmented, with different treatments all over the place. As an example, Arfon Williams, the other director, has post-traumatic stress, as I mentioned. He has to travel from his home down in Ynysybwl to Cardiff to the hospital for 40 minutes' treatment with a

psychiatrist and then travel back. Some days it takes him three hours to make the round trip. His wife has said that, by the time he gets back home, he is more stressed out than when he left in the morning. So we need to co-ordinate a better treatment facility to help veterans so they can just turn up when they want to turn up in the morning, can chill out, de-stress, have a coffee, talk to their mates within the forces or other people from the forces, can see the counsellors and get treated. They can then have coffee, lunch, tea or whatever, and leave. In that way, they would be totally de-stressed. However, at the moment, Arfon has got to go down and sit in rows of chairs with other people; he is just a number. He does not feel appreciated for what he has done within the forces. So we need to collate something that is there for them especially.

[77] **Ann Jones:** I think that you have started on the topic that I was going to ask you about, about the current statutory mental services available to veterans with PTSD. How effective do you think that the generic services and specialist services are? Perhaps you could then tell us a little bit about the specialist service for veterans that is needed for the project in Cardiff.

[78] **Dr Clarke-Walker:** Do you want me to answer?

[79] **Ann Jones:** Either of you can answer. Perhaps you would like to go first.

[80] **Dr Clarke-Walker:** In the British Journal of Psychiatry, Simon Wessely published a paper stating that he felt that 50 per cent—this was in 2005—with PTSD were treated. However, I feel is that that is a grossly over-optimistic assessment. From talking to my colleagues and to people in the independent sector, I know that you can regard the number of people who are being treated as the tip of the iceberg; in reality, it is just the tip of the iceberg that is being treated. It is a lamentable situation. It is just totally, unacceptably poor. That is it in a nutshell, really.

[81] **Ann Jones:** Kevin, do you have anything to add?

[82] **Mr Richards:** No, I agree with the doctor. What we need to do is find the treatments that will work and help the veterans as best as we can. I have something written down here that I would like to read out—bear with me. As an armed forces charity, we feel it is the duty of our nation to ensure that these Welsh warriors who have given us protection, who have suffered and are still suffering, receive the best care that we can give them. That is what we aim to do. That is what they need. We need to show them that the Government acknowledges what they have gone through, and their sacrifices. They would feel appreciated if that does happen.

[83] **Dr Clarke-Walker:** To put on my medical hat, I went to a school of pharmacy, and I studied a pure degree in pharmacology, so you probably think that I would think that pharmacology is the great halo. In PTSD, pharmacological intervention does not cure; it does not successfully address the symptoms. It puts a plaster on, but the wound is still there below. There is no doubt about that. The research is clear about that. It is the psychological interventions that are really what is required.

[84] **Darren Millar:** Are you saying that there is too much of a drug-based response at the moment?

[85] **Dr Clarke-Walker:** I think that one of the problems is that the pharmaceutical agents have a very good promotion base in the pharmaceutical industry. I worked in the pharmaceutical industry before I went into medicine commercially, so I know what it gets up to. Psychological treatment does not have the research funding that a pharmacological agent has, so it really is an ugly duckling. If I had, let us say, less than 1 per cent of the money of

just one major drug company that would transform the research database to show how good psychological therapy is, and there are some very good alternatives out there. The evidence shows that you can successfully treat people psychologically. At the end of the day, you co-ordinate. The message is that people need to be on a co-ordinated front in identifying who has the needs, but then those people need to be put in front of those who can successfully treat them. Diagnosis can be really acute and I have to say that diagnosis—it is not relevant to your question, and I can answer that later, but the point is that diagnosis is academic. What we really want to do is save these people's lives and treat their conditions.

9.40 a.m.

[86] **Helen Mary Jones:** You will all be aware of the all-Wales veterans' mental health service that is being developed, using a hub-and-spoke model with six community veteran mental health therapists deployed throughout local health boards. Do you feel that that arrangement will meet the needs of veterans who have mental health needs and particularly post-traumatic stress disorder?

[87] **Mr Richards:** Post-traumatic stress is starting to come out more, and there are a lot more people self-referring now, but, as Liam Fox mentioned, I think that it is a time-bomb waiting to go off. The fuse is lit and if we do not defuse it now, it is going to go off within a certain number of years. That will be a burden on the NHS with the numbers of people coming through, because, as before, people used to hide the fact that they were suffering. It is out in the open now and so they feel a lot better talking about it. We will see a vast increase in the numbers coming through GPs and so on.

[88] I think that every GP should have something to state that a patient is ex-forces. In reality, the medical documents will be from the military anyway so GPs can see that they have served, but the GP still needs to make a mental note of it. We have been approached by GPs who have said that they have three or four people on the register suffering post-traumatic stress, and asking whether we are able to help them. The patients have said that they feel safer in a military environment, with veterans treating veterans, because they understand each other. They find that treatments like that will work for them and so that is what we have to do. We must not think of post-traumatic stress now but for the future of the armed forces, and what will happen round the corner. Carol will explain that now.

[89] **Ms Richards:** I want to say a few words about my experience as a mother. My son is 16 years old. He is a corporal in the air cadets, and his ambition is to make his career in the RAF. Like his dad, he is a caring individual. For me, as the mother of a young man who wants to serve his country, should he need treatment for trauma because of the mental effects that conflict can cause, I want the assurance that it will be available to him on his return and that he will not have to fight for the treatment that should be made available to him in Wales near his home and his family. If the correct treatment and care for PTSD were made available within Wales, in a peaceful environment such as Golden Grove and its country park, without the need to wait any length of time, I believe that the problems that PTSD causes for the sufferer could be lessened, which would relieve the pressure on the resources of our national health service. I can see only that that would be advantageous to us all. We cannot change what has happened in the past, but we can attempt to offer our forces veterans and their families a better future.

[90] **Mr Richards:** There is just one last thing that I want to say. What we have to realise is that these guys are suffering now. I mentioned the Korean veteran who came to us, who is still suffering. Some of these young lads of 18 or 19 years of age could be suffering for the rest of their lives. When they become senior citizens, the AMs and politicians who will be responsible for looking after them may not even be born yet. All they would know about Afghanistan and Iraq and all that suffering would be what they learned in history lessons at

school. We need to ensure that something is put in place now so that the politicians of the future can carry on the work that you are doing today.

[91] **Darren Millar:** Thank you very much for that. The clock has almost beaten us. You have already answered many of the questions that we wanted to put to you. I have just one final question. If there was a single recommendation that you could make for improving services for veterans suffering from PTSD, what would it be?

[92] **Mr Richards:** Mine would be dedicated facilities where all agencies can come together to ensure that veterans receive every bit of care that they deserve, and for that to be achieved at certain main locations throughout Wales.

[93] **Dr Clarke-Walker:** I agree that it needs to be co-ordinated. I am sorry, but I am not going to be politically correct with my next point. Having worked in the NHS for many, many years and had discussions with senior management in the NHS, I know that—and one person told me this off the record—there is a vast excess of people on extremely high salaries and extremely good pension schemes, but, unfortunately, the management that runs NHS trusts are bosses, not the servants of the people on the front line, the clinicians and mental health professionals who are treating these people. I think that it is a highly expensive and inefficient way of doing things. My apologies for that, but I think that you need some sort of para-NHS type environment in which it is the clinicians, involved with the management, who take on that mantle and move things forward. At the end of the day, we have to do this as cheaply as we can but with the optimum results. That is where I am coming from. That is my defence.

[94] **Darren Millar:** You have no need to apologise for your evidence at all.

[95] **Mr Richards:** May I say one last thing? We have received information about a soldier suffering post-traumatic stress. An occupational therapy counsellor in Aberdare sent the information to us and asked whether we could help him because she could not do anything for him. We have passed that on to Talking2Minds to treat this young soldier who needs help.

[96] Finally, we had an e-mail yesterday from America, and there are two major American post-traumatic stress charities. One is in Houston, Texas and the other in California, and they wish to partner with Golden Grove Mansion Appeal. They are large charities dealing with post-traumatic stress in the States. They wish to associate and partner with us with a reciprocal agreement. We could then help to treat American and Canadian forces at the mansion. As you probably know, historically, it was an American air force hospital in the second world war. Plus, going the other way, we can send our Welsh men and women to America, to Houston, Texas, for treatment with them. So, we hope to work closely with them.

[97] **Darren Millar:** On that note, we will close this part of our meeting and move on with our agenda. Thank you, Dr Clarke-Walker, Mr Richards and Mrs Richards for your attendance today.

9.47 a.m.

Ymchwiliad i Driniaeth ar gyfer Anhwylder Straen Wedi Trawma i Gyn-filwyr y Lluoedd Arfog: Casglu Tystiolaeth
Inquiry into Post-traumatic Stress Disorder Treatment for Veterans: Evidence Gathering

[98] **Darren Millar:** We are running slightly behind schedule, and so we will move on to item 3 on our agenda, continuing with our inquiry. I am pleased to welcome one face that is certainly familiar to us here in Wales and across the UK: Simon Weston OBE, patron of

Talking2Minds. With him are Robert Paxman, chief executive officer and founder of Talking2Minds, Ian Pitchford, trainer and therapy provider from Talking2Minds, and Neil Loughborough and Nicolas Cowan also of Talking2Minds. Welcome to you all, gentlemen. We are grateful to you for attending our evidence session this morning, and we are also grateful for the information that you have already provided in written form to the inquiry.

[99] We have heard a little about your work from the previous witnesses, but it would be helpful if you could give us an overview of the work of Talking2Minds—in a nutshell. I do not know who wants to start.

[100] **Mr Paxman:** I will. About seven years ago, I was diagnosed with post-traumatic stress disorder. I went to the NHS and a couple of charities for help, and I did not find the help that was required. I did not get well from interacting with those forms of therapy. So, I went out and spent several years trying to find a solution to my problem, and I found a guy call Mick Stott, ex-physical training corps, who had developed a programme of neurolinguistic programming, timeline therapy and hypnosis, originally. Very quickly, I lost my symptoms of PTSD—very quickly. I was so shocked by that that I decided to train and find out how the whole process worked. So, over the next couple of years, I then trained with Mick Stott to find out how the system worked, and we have recently set up and started the charitable organisation.

9.50 a.m.

[101] That has been going about three years now. The whole programme has been running for about six years. We have now designed further talking therapies specifically for veterans and it also translates to other groups because we have gone for the worst case studies, if you like. What we are doing is getting fantastic results, so we are continuing to do more of it.

[102] **Mr Pitchford:** As someone who has been a witness to Bob's journey, we met for the first time about three years ago—it may have been a little bit longer than that actually—when we were doing our master practitioner training together. Even in that time, the difference in him is just staggering—absolutely colossal—hence the birth of Talking2Minds.

[103] **Darren Millar:** We have two individuals here who have benefited from and are continuing to benefit from the work of Talking2Minds. Do you want to share your experience as to how Talking2Minds has helped you on a personal level?

[104] **Mr Cowan:** I did 23 years in the army. You have heard of cases, or you have case notes on individuals, and my story is not dissimilar. I went through cognitive behavioural therapy and I also went through the psychiatry side. Within the armed forces, there is much stigma in relation to mental health. There continues to be a real stigma and they try to hide it as best as they can that people are suffering. In fact, I was told to pull my socks up, get on with life or get kicked out, which is an incredible thing to be told when you have witnessed or been involved in the things that you have been involved in within the armed forces.

[105] When I came to Talking2Minds, after all the other therapies failed and I was on very high doses of medication, I could only do part-time work. I went to Talking2Minds, I went on a practitioners' course first and it was amazing. The changes in me were amazing, but at that time, I stayed on my medication. It was only when I went on the change course, which was specific to me, that I decided that I would come off all my medication and I am clean now—I take no medication whatsoever, other than pain medication for my spinal injury. I am completely clean of anti-depressants for the first time in 21 years.

[106] **Darren Millar:** How long did it take to make that transition through the treatment process for you?

[107] **Mr Cowan:** For me, the first process was a five-day practitioners' course where I got an insight into what it was about and everything else, and how to deal with different issues. It was two days for the change, but I decided to stay on medication. It was only later on, when I went back on the change course, that I decided that I wanted to come off the medication, I wanted to be able to think clearly, I wanted to be able to take in all the learning and go further forward with what was happening to me. I came off the medication on the first day of the course. It took about four weeks for the medication to come completely out of my system and I have no requirement for any medication whatsoever.

[108] **Darren Millar:** That is amazing. Did you want to add anything, Neil, in terms of your experience?

[109] **Mr Loughborough:** Yes. I joined the armed forces in 1991, probably as a result of this man here, after knowing what he went through in the Falklands. I joined as a medic. I had a very good career in the armed forces and when I came out, I was given a choice between medical discharge and going back to Kosovo the next day. On the day that I was to make that decision, I had been subjected to three months of being at the Duchess of Kent Military Hospital. I obviously went for the medical discharge because the stigma would have been such that you just would not be able to work in the medical field. Obviously, I had to come out of the armed forces.

[110] When I came out of the armed forces, that was not just coming out of the armed forces, I lost everything from my home to my family, to everything. I soon found myself on the street. I had 10 years of treatment through various agencies—Combat Stress was fantastic with me. It gave me a diagnosis of post-traumatic stress disorder, which was confirmed. However, the comment that stuck in my mind the most was that its staff thought it would be contradictory and would not help me to undergo any further treatment with Combat Stress because it would worsen my condition. As I was a medic in the armed forces, the environment that I found myself in would have been conducive to making my condition worse as it was similar to a medical reception station where I would have treated patients. I thank Combat Stress for the help that it gave me; it is just unfortunate that it was not going to work for me.

[111] Earlier this year, I went on a course with Talking2Minds. In the background, I was still under the trauma health service in Lancashire, which is a pioneering type of thing under a guy called Dave Sandford. I was very apprehensive about whether NLP treatment or whatever Talking2Minds was going to use was going to work.

[112] **Darren Millar:** Sorry, but what is NLP?

[113] **Mr Loughborough:** They use NLP techniques in Talking2Minds.

[114] **Mr Weston:** It stands for neurolinguistic programming.

[115] **Mr Loughborough:** Sorry; I apologise for that.

[116] **Darren Millar:** It is all right; we use a lot of abbreviations as well.

[117] **Mr Loughborough:** I try to steer away from them.

[118] I was apprehensive before I went on it. I can tell you now that after four days of treatment with Talking2Minds, it is a bit like coming out of the cinema after watching perhaps your favourite movie star and thinking, 'Oh, fantastic'. I am a bit more cautious than most people as I worked on the medical side of things, so I had the trauma health service run

DOM assessments in the background. I have a letter in front of me that confirms that they have now discharged me from their service because I have made considerable progress and I now have only a mild form of post-traumatic stress disorder.

[119] Talking2Minds has not just given me a coping strategy or mechanism, but has enabled me to deal with my own post-traumatic stress disorder. The onus is on helping me to deal with it. No money or words can ever passionately say how thankful I am to these guys. It is amazing. I had 10 years of very nice people, all meaning well, and then to be turned around in four days was amazing. I have the assessments, the DOM assessments, I do not have a clue what they mean—I do not propose to tell you that I know what they mean—but I can tell you one thing: I feel a lot happier and my son said, 'Dad, I am really pleased to have you back'. So, I am now a single father and I am living happily with my son in Longridge near Preston. I just wish that other people could get an opportunity like this.

[120] **Darren Millar:** Thank you very much indeed for sharing your stories.

[121] **Helen Mary Jones:** You state in your evidence that the resettlement arrangements are only in place for those with more than six years' service and that many veterans do not have an opportunity to resolve any problems that have arisen as a result of their service. What help do you believe should be offered to people leaving the armed forces, and particularly those who may experience or may be at risk of post-traumatic stress disorder? I am happy for any one of you to start.

[122] **Mr Cowan:** The simple fact is that what needs to be put in place are the correct screening methods, and then there needs to be specific training programmes or treatment programmes for every individual. Everyone is an individual; we do not fit in boxes. I never fitted into all the mental health boxes in the past and it is exactly the same for Neil and other people: we do not fit in boxes; we are humans; we are all different; and, we have different emotions and different things that affect us. Therefore, it is about ensuring that people are screened correctly and debriefed properly when they come back from the theatre, and ensuring that the whole family unit is supported because once the family breaks down, there will be more of a problem for that person who is suffering. It is not just about the mental health side, although it is very important, because the family can suffer from the mental health side as well, and there needs to be that support on both sides. There needs to be a better and more well-thought-out system than presently exists.

[123] I have heard on the radio about Dr Liam Fox and this telephony system. I work in a telephony world for NHS direct and I find it very difficult to understand how they are going to get that to work. If you start chunking someone up and they are on the phone talking about their emotions, how does that nurse or that practitioner at the other end of the phone interact with that person? The other problem that comes from that is every call that is taken has a key performance indicator—they have a benchmark. Nurses will have 12 minutes to deal with that patient. I have had nurses go on courses to improve their work performance because they have been with patients for longer, because they have not hit their benchmark figures. I have had nurses crying because someone has done a countdown, one to 10, that they are going to commit suicide if she does not help them, and she has had to stay on the phone for an hour, an hour and a half or two hours and then she has been given a really hard time. So, whatever they put in place has to be realistic.

[124] **Helen Mary Jones:** You cannot deal with those issues over the telephone.

[125] **Mr Pitchford:** I think that we accept the fact that for any large organisation to be able to offer a level of support, there has to be a level of uniformity in order for it to get the economy of scale out of what it is doing.

10.00 a.m.

[126] However, as Nick says, we have all served in different environments, we have all experienced different things, and different things have happened to us on different days; sometimes they were sustained, sometimes they were not. So, when people come to leave, the ability for them to be able to choose things that are going to help them in order to make that transition is important. Also, very often, a lot of the therapies that you see and a lot of the courses that you go on, for those lucky enough to get some kind of resettlement support, are a 'do to' process rather than a 'do with'. Fundamentally, you end up sitting on the course, having things happen to you and are given stuff. There used to be a World Health Organization advertisement that said 'I can give someone a fish and they can feed their family or I can teach them how to fish and they will feed their family forever'. A 'do with' process encourages people to be able to develop strategies to go on to be able to deal with whatever happens in life.

[127] I quite passionately believe that Neil, Nick, Rob and I, and all the people who Talking2Minds has touched, have mechanisms now not only to deal with PTSD but with lots of other things that face them in life, around building self-confidence and self-esteem, finding re-employment—a whole host of stuff that face people when they leave the armed forces. In turn then, hopefully, for some of those people, this can stop the spiral. We have quite a strong link with a number of charities involved in prisons, and the statistics are freely available showing the number of armed forces people in prison. Helping people get that level of confidence and self-esteem and giving them some kind of debriefing mechanism, and support that is tailored to them, is, I fundamentally believe, key to what we need to achieve.

[128] **Helen Mary Jones:** We have asked other witnesses this question, and some witnesses have said that there were other countries where the debriefing and support that people get when they leave the forces is much better than what is available to people leaving the armed forces in Britain. Do you have any experience of other countries that we might take a look at where we would see them do it better?

[129] **Mr Weston:** The Americans obviously do better in the fact that they accepted that mental health after combat was a much more serious problem. We in Britain started the research into that. We handed all the research over to the Americans, and they took it on. Vietnam became a real problem for them, hence the term 'going postal'—a lot of it was due to Vietnam veterans. They took it far more seriously than this Government. When I was in hospital back in 1982, contact had been made because a lot of Northern Ireland veterans were suffering from mental health issues as a result of the stress of walking through the streets, through your own people, knowing that you might have to shoot somebody. You might a mistake and kill an innocent civilian—which did happen far too often—but it was unfortunate, because the people were armed. Those guys came back with terrible stress and it really impacted on the families. We knew that there were mental health problems but we chose to do nothing about it. It was a case of stiff upper lip. I remember reading about one highly placed and outspoken royal saying, 'These people do not suffer from mental problems, they are just showing a lack of moral fibre'. It is about as helpful as giving somebody a bottle of chips.

[130] It is not going to help anybody if the attitude of those at the top of the hierarchy ignores the problem of the people at the bottom. How is it that everybody that seems to suffer always comes from the ranks and never from up above? There is a better system put in for up above than there is for below. I am not trying to say that it is a 'them and us' situation, but there is clearly a better mop-up system. I suffered for 24 years and I had to largely suffer in silence, because the military chose to ignore PTSD. It only was allowed to exist after 1987. All the veterans who suffered in 1982, all the people who suffered in Northern Ireland, all the people who suffered in conflicts and policing actions before that were largely ignored. I have

met people from the second world war who were brutalised by the Japanese who, if it was not for Combat Stress, would have received no mental health help whatsoever.

[131] The big problem is that it has become a stigma for the guys. The guys would not present before, because there was nobody to present to. Then, after 1987, they would not present because it was a stigma and it would ruin your career. However, largely, what has happened over the years is that people chose to bury it. It was expensive to deal with, because we were looking at lots of psychiatrists. If it is going to come down to just sheer economics, the cost of putting somebody through lengthy treatments through the NHS, which can take three or four months, costs thousands of pounds a month. Based on what I have heard and what I know from friends of mine who have been through it, guys who did Northern Ireland and the first Gulf war, then came out and went in to the UN to do bomb disposal for eight or nine years, saw lots of horrific things. One of them has been having treatment for three months and they have to give him continued treatment, because they are not even scratching the surface of it. It is hugely costly.

[132] At this moment in time everybody is looking at cost. The human cost is devastating, the family cost is crippling, because of the amount of people who are falling apart. We have seen far too much violence. PTSD is not just one of these mental health problems where people fall apart just because they are falling apart; the drink, the drugs, the crime, the violence, the family breakdown, the cost to the country is far greater than people are even imagining. They pass it off by saying 'You do not know what you are talking about' because I have no qualifications. Hang on, let me just tell you, I have had 30 years of qualifications. I have lived with it, I have seen it, I have been involved in it. The fact of the matter is that the cost of Talking2Minds is miniscule when you consider the effect. You are seeing live cases here of people who have been through it.

[133] I went on one change programme, not for myself but because I was paid for it as a witness, and there was one young man there who tried to commit suicide by police officer. He was shooting a shotgun in the streets trying to get the police to shoot him. Three days later, I have never seen a chap happier. This was a man who was totally lost to himself, had nothing left in his mind that he could give to himself or to anybody else. He had given up. All of a sudden, after three days, there is a man walking around who cannot do enough for everybody else.

[134] I saw another chap who had not stopped drinking for 23 years. He had not had a drink for four days on the course, and he had been drinking every single day before then. His wife was there with him and she could not believe the change in him. If we just look at that cost alone, just the cost of what it takes, financially, to get people back on the straight and narrow, I cannot see that there is any other argument.

[135] **Mr Pitchford:** If I may, Simon, I will give you an update on the gentleman who was running around with a shotgun trying to get a police armed response team to take his life for him. He saved up a considerable amount of money—he has been working as a bricklayer and plasterer—managed to buy himself a small boat and he has had it coded in order for it to be able to go to sea. He is currently on a yacht master development programme for motored craft, and he has just got a loan from the bank, having submitted his business plan, to be able to run fishing trips. All of that is within the form of the process. We have not only supported him during the initial change work but, as a result of our volunteers, he has gone from someone who was at a very low ebb to now being someone who is generating his own income and looking to employ people.

[136] **Darren Millar:** You clearly have some fantastic individual stories. Where were your therapies developed? Were they developed in the States? You have referred to the States.

[137] **Mr Weston:** The United States has a great attitude. It has a greater and far more rounded approach to everything. Helen Mary Jones asked a question on this earlier on. One of the best things that can be done is to have a whole, rounded approach but do it collectively rather than as separate groups with separate income streams. A great friend of mine works in this area as well, and he does a lot of things called mental health first aid. We have all seen people have breakdowns in the workplace; he deals with all of that. He went to the States on my advice and the Americans took him—all he had to do was find his travel, they paid for everything else—and he came back knowing that there were at least five or six therapies that he could directly employ to help. It is not to just use one thing or to think that there is one cure; there is not. We try to find cures for problems. We think that we have one brush that will sweep or paint every textured wall. We cannot do that.

[138] I hate to bring it down to simple terms like that when we are talking about people's lives, but, at the end of the day, that is how we have to look at it. There are so many things that we can do, but we need to bring a collective thought process to it. Psychiatrists are trying to protect their little world because they have trained for so long—in some ways you can understand that—but they need to be working far more with people who are doing things that, in many cases, are having a greater success rate.

10.10 a.m.

[139] **Mr Pitchford:** At the heart of what we do is neurolinguistic programming, and something called spectrum therapy, which has been developed within the UK. Essentially, neurolinguistic programming has been for around for 40 to 50 years. What we have done over the last four or five years is to evolve it and the language that is used within it in order to work specifically with vulnerable communities. I am sure that if you were to Google 'NLP', you would see lots of places where—and I see some nods around the table—it is not necessarily that great but it is very much a 'do with' process. It is an emotional coaching process and it very much empowers the individual. Now, we are fortunate enough that, because of the initial pilot programme that Rob was on, and the dedication and level of interest, we have managed to evolve what we do. Forty years ago, it came from the States, but it is now very much homegrown and what we do currently is quite bespoke to Talking2Minds.

[140] The issue that we face is, essentially, I suppose, that we fit into the category of complementary or alternative therapist, because it is a talking approach. So, because of the various medical guidelines, we sit outside of what appears to be the usual or the more traditional pipeline, which is some kind of counselling, then perhaps some kind of psychotherapy with a psychologist and then on to some kind of medication probably, with a psychiatrist. That one-size-fits-all pipeline approach maintains a level of stability—as it did for these gentlemen—but, because it does not get to the root cause and truly help, it does not really deal with the issue. Sometimes that level of stability is not necessarily that great. If you always do what you have always done, you will always get what you have always got. We sit outside that traditional framework. We are quite happy for anybody to come and look at what we do. We are in the process now of trying to liaise with a medical ethics committee in order to establish what we do, and we are also currently in negotiation with, or starting negotiation with, the National Institute for Health and Clinical Excellence. It will never be able to approve us, but, hopefully, it can endorse what we do and so we can be regarded more as part of the medical mainstream.

[141] As Simon said, it is about bringing together a mix of different number of approaches. There are many things for which you can produce evidence that they work, but they sit outside the traditional medical model currently.

[142] **Mr Weston:** When does it stop being alternative, given that it works? We have had

alternative comedy: it is either funny or it is not, it is either comedy or it is not. If something works and it is changing people and making people better, then does it stop being alternative and become more mainstream? What do we have to do to make sure that people see this as a genuine cure? That is the big question that we are all asking ourselves. In some cases it cures, in other cases, especially with Neil, it brings it down to a point where it can be lived with. We have to find a way for it to stop being classed as 'alternative', because when we see that word we all start thinking of the 1960s and everybody looking like hippies. It is not about that; it is about genuine cures.

[143] **Mr Pitchford:** Fundamentally for us, the point in time when we become non-alternative and mainstream is when we receive some statutory funding for what we do, because then there is a level of endorsement. While we may sit outside the traditional medical model, there is a level of endorsement and support that what we are doing is achieving things for people, which it is. This morning we could have brought along any one of 300 or 400 people who would have a very similar story.

[144] **Darren Millar:** I am very conscious of the time. The clock is really against us and we have a number of questions here that we will be covering. The issue of NICE is very interesting, and perhaps you can move on to that, Veronica.

[145] **Veronica German:** Yes. You have just been talking about NICE and how you could not be approved by NICE as such because you are alternative. Is that the reason? Is it about a base of evidence, is it because you have not built that up?

[146] **Mr Pitchford:** Yes, and it is about evidence over time. It is about having an evidence base over a period of time, so it will not happen overnight for us. We are using assessment tools that are endorsed by the World Health Organization for measuring trauma and mental health, which are also endorsed by NICE. We will have our first academic peer review paper later this month, and for that level of endorsement it is just a continual process to gather that level of information and to provide that level of statistics to NICE.

[147] **Mr Paxman:** Certainly, in terms of time, we have case studies now over five and a half to six years. NICE wants 15 years' worth of empirical data.

[148] **Veronica German:** That was going to be the subject of my next question.

[149] **Mr Paxman:** That is just not feasible really, given the current levels of post-traumatic stress disorder out there, is it?

[150] **Veronica German:** No. You said in your evidence that you have treated civilians as well as members of the armed forces. To what extent do you think it is necessary to provide a specialist armed forces service rather than one for anybody who is suffering?

[151] **Mr Cowan:** A lot of things that we do in the armed forces, as you will see in the paper that I gave you, are covered by the Official Secrets Act 1989. You cannot talk about them. Therefore, the service needs to be specific to service personnel and it needs to be specific to what those people have seen and been active in. We have all had therapy from people who have never been in the services and when you say to them, 'I did this, and I did that', they will look at you in shock and say, 'Oh, that is really bad'. You are thinking, 'Well, I know, that is why I am here, so there is no point in saying it to me, I really do know that'. That is the kind of response that you get from people who have not lived the same life that we have. We have a completely different ethos.

[152] **Mr Paxman:** Certainly, we are not looking at the stories; the stories to us are irrelevant. They are just a route into helping somebody to reframe their thought process.

Somebody who would start indulging in the story is doing the client no good whatsoever.

[153] **Mr Loughborough:** That is very true. From a personal perspective, with a lot of the treatments that I went through before—cognitive therapy, all the psychological analyses and everything else, whatever their fancy names—I came away feeling worse, because I had to explain the terminology. Chair, you asked, 'What does NLP stand for?' Well, if I was to give you directions on a barracks and tell you to turn left at the RQMS, and then give you a list of abbreviations, I would have already lost you on the first turn. Therefore, if I am trying to have free-flowing therapy, it cannot be done on the one-to-one basis that I need. The therapist at the trauma health service said that he does not have the time, the energy, the money or the funding required to get me to a stage where I could open up enough to be able to be helped. The four-day course was intensive and to add to that—I am aware of the medical background to establishing things, but I am also aware of the personal aspect of this. As medics in the armed forces, one of our jobs is to look after the health of the troops, and I do not believe that it stops when we go out and sign off from the armed forces. I think that it carries on. Had we been equipped with what Talking2Minds is doing now, I believe that a lot of people would still be alive to this day. A lot of my friends, a lot of people who I—it is hard for me to say that, but that is the truth of it.

[154] As for documentation and notes on the background, that is the same reason why I believe that the trauma health service should document carefully. I asked it to do the DOM clinical assessments in the background with the GADs and so on. I have no understanding what that means. If you are a clinician you will understand it. I asked them to monitor it closely, because I believe that every case should be documented very carefully, independently, and not only of Talking2Minds, so that everybody can work together. When I go to a health service in Preston in Lancashire, any of my conditions will automatically be put down to post-traumatic stress disorder. The health service is no longer looking at the individual, but at which is the quickest route of getting treatment, not at what the original problem is.

10.20 a.m.

[155] **Mr Pitchford:** As someone who works as a therapist, I would support these gentlemen in what they have said. Building up a level of empathy and rapport with someone and getting that permission to work with them is obviously a lot quicker when you have a military client. However, as somebody who works as a therapist in the arena, I also work with civilians, with wives, and with the children of PTSD sufferers, who believe that it is their fault that Daddy is so angry. So, as a therapist, I think that we can comfortably work across the spectrum, but, for our clients, it is important that the person whom they are working with has had some connection with the forces. We also have a number of therapists who are wives of servicemen, or daughters of servicemen, or who have worked within the Ministry of Defence. It is about not having to continually explain the language.

[156] **Darren Millar:** The clock has beaten us. I know that you have referred in your paper to some pilot work that you are doing with CAIS up in north Wales, and we will put those questions to you in writing, just to get a little bit more information about that if we can. There is one final question that I think you need to ask, Lorraine, which is a very important one about the services being developed here in Wales.

[157] **Lorraine Barrett:** Yes. I am not sure whether you are able to take a view on this, but there is an all-Wales veterans' mental health service currently being developed using a hub-and-spoke model, the main part of which will be based in Cardiff and then six community veterans' mental health therapists will be deployed within the other local health boards. Do you think that that arrangement could meet the needs of veterans with mental health needs and also with PTSD?

[158] **Mr Pitchford:** I think that it depends on who they are signposting people to. Is six enough? Probably not, but that is just a wet finger in the air. I think that it would be about who they could support, who they could fund and who they could signpost people to.

[159] **David Lloyd:** I just have a quick question. I am very impressed with your evidence. I am also a GP and if, as part of the committee review, we end up recommending this form of therapy, we need exactly what you do to be spelt out, because, as a committee, I do not think that we can get away with having a series of recommendations that talk in a woolly fashion about various therapies that may or may not be alternative. If we are trying to convince various authorities that what you are advocating should become mainstream provision, we have to have a clearer handle on what you actually do. Is it possible to have a further paper taking us through exactly how you deal with people and spelling out the therapies? We need that if we are going to recommend these therapies with their various titles, which are alien to me as a medical practitioner. It is going to be very strange for me, as a conventional medical practitioner, to start advocating therapies that I know nothing about using titles such as NLP, which I have heard about for the first time today. So you are asking a lot for this committee then to say, 'Right, we are going to go completely down that track', when we do not have a handle on what you are on about.

[160] **Mr Pitchford:** We could put something in writing, but I think that the easiest thing to do is to invite you to one of the change programmes and for any member of the committee to come and spend a day with us. A document can only give so much information, and I think that it would be far better to come and see what happens and, more importantly, to get a feel for how it all works, and that would then bring the words to life.

[161] **Darren Millar:** The clerk will work with you to see whether we can arrange for a delegation from the committee. I have one very final question. How are you funded at the moment, given that you are not branded as mainstream?

[162] **Mr Paxman:** Gentlemen such as these are funding us.

[163] **Darren Millar:** It is literally individual fundraising, donations—

[164] **Mr Paxman:** Following the course, some of the guys go away and start fundraising for us to get other chaps through the programme.

[165] **Mr Pitchford:** I canoed 750 km down the Yukon river in an endurance race in May, which was very traumatic, in order to raise money, and it is events such as that that raise the funding.

[166] **Darren Millar:** What does it cost to put one person through your programme?

[167] **Mr Paxman:** Less than £2,000, and that includes the palliative care side as well, so that we can keep reintroducing people into the programme should they need a little bit of extra work around something else in another problem area in their life that may present at a later stage.

[168] **Darren Millar:** Thank you very much indeed for your time, gentlemen, we have really appreciated hearing about your therapies. Thank you.

[169] We will take a short recess before we move on to our next item.

Gohiriwyd y cyfarfod rhwng 10.25 a.m. a 10.30 a.m.
The meeting adjourned between 10.25 a.m. and 10.30 a.m.

[170] **Darren Millar:** Welcome back. We will continue with the Health, Wellbeing and Local Government Committee meeting. There is one piece of news for those Members who have not heard: an announcement has been made today by the Secretary of State for Defence about PTSD services across the UK. We will have to find some more information about that and circulate it to Members. Reference was made to a helpline and to the extension of mental health nurses throughout the UK, so we will have to find out the impact of that in Wales and see what the implications will be for our committee recommendations.

10.31 a.m.

Ymchwiliad i Wasanaethau Orthodontig yng Nghymru: Casglu Tystiolaeth
Inquiry into Orthodontic Services in Wales: Evidence Gathering

[171] **Darren Millar:** Without further ado, we will move on to item 4 on our agenda today, continuing with the inquiry that we started a fortnight ago into orthodontic services in Wales. I am very pleased to welcome Dr David Thomas, consultant in dental public health for the national public health service, and Dr Hugh Bennett, who is also a consultant in dental public health in the national public health service. I thank you for your paper, which has been circulated to Members. We will ask you some questions on the evidence in that paper—and some evidence outside of that paper as well, probably.

[172] In your written evidence, you say that there has been an upward trend of annual expenditure on orthodontic treatment in primary orthodontic care, and yet the committee has heard evidence that access for patients has reduced over the past few years. Can you explain the disparity? Is it becoming more expensive? If so, why is it becoming more expensive? Is it cosmetic issues? What is it?

[173] **Dr Thomas:** First of all, Chair, we need to go back to the old contract and remember that it was based on an item-of-service payment, and a non-cash-limited approach. However, the new contract takes a cash-limited approach with the activity based on a reference period of 2004-05. The reason for the increase in spend on orthodontics is twofold: the first is inflation, and the second is that there was a bulk payment to orthodontists, or dentists who completed orthodontics after 2006-07, and that would appear in the statistics as a big increase in the amount spent on orthodontics. If you look at the statistics now, you will find that the spending is fairly flat.

[174] **Darren Millar:** Okay, so it has been flat and it was that injection of cash to clear things up that was the cause. Is that right?

[175] **Dr Bennett:** Yes. If you go back before 2006 and the new contract, you will see that there is no doubt that the amount of spend on orthodontics under the old contract was increasing way ahead, proportionately, of the rest of the spend in the NHS and in general dental services.

[176] **Dr Thomas:** It was something in the region of 15 per cent.

[177] **Darren Millar:** It was as much as that, was it? Was that for cosmetic reasons? Are our teeth suddenly getting worse?

[178] **Dr Bennett:** Prior to the new contract, you were in a non-cash-limited environment, so an orthodontist's practice could expand and see as many patients as it wished to see. Now that we are in a cash-limited environment, the local health board has the responsibility for that budget and also for planning the services within that budget, so the scope for expansion simply is not there unless the LHB can find an injection of cash. However, other things have

happened as well: the new contact has changed behaviour in orthodontics, and I think that you know that there has been a national review. I do not know what the status of that review is at the moment.

[179] **Dr Thomas:** I think that the committee may have already had sight of the paper. It has been to the Minister and she has written back to the chairman of the review.

[180] **Dr Bennett:** What that report indicates is evidence of more assessments being done and, not only assessments, but the same patients being assessed year on year, so those are some of the changes in behaviour.

[181] **Darren Millar:** Yes, we have heard that.

[182] **Dr Bennett:** In my view, you are not getting value for money. There is also some evidence of multiple referrals. We are in a catch-22 situation. If you are a referring dentist and you know that there is a waiting list, you tend to do one of two things. You may refer patients earlier to get on to the list, further compounding the problem, or there is some evidence to suggest that dentists are referring to more than one orthodontic practice. So, there are definitely inefficiencies that have grown within the system because of the nature of the new contract.

[183] **Dr Thomas:** Clearly, we know how many children in Wales actually need orthodontics. There is some fairly cogent evidence and, in fact, you will be seeing the architect of this evidence later on in your inquiry, but we know how many children will generally need orthodontics each year.

[184] **Darren Millar:** So, it should be fairly predictable.

[185] **Dr Thomas:** It is reasonably predictable, but it does vary for a number of reasons. Some children grow at different rates to other children, for example, and although the need for orthodontics is equal across all social strata, deprived children tend to access orthodontic services less for a number of reasons. The No. 1 reason is that they may have more decay in their teeth, but another may be that orthodontic specialists are placed in areas of affluence, not in areas of deprivation.

[186] **Darren Millar:** That is because of the private business opportunities.

[187] **Dr Thomas:** I think that it is how their practices have developed.

[188] **Darren Millar:** On secondary care orthodontic services, we have heard that there are significant waits for some people in some parts of the country. I think that it was up to two years in parts of south and west Wales, for example. Has the spend increased to cope with demand on the secondary care side?

[189] **Dr Bennett:** I cover mid and west Wales. The hospital services for Abertawe Bro Morgannwg University and Hywel Dda local health boards are provided from Morriston Hospital, because the further west you go—and I do not think that it is just with dentistry but with a lot of medical specialties as well—you cannot attract specialists or consultants. There is certainly a dearth of them in Pembrokeshire. Recently, Hywel Dda LHB set up a service level agreement with an arrangement for 400 of its patients from west Wales to go to Morriston to receive hospital orthodontic treatment. That will help to take the pressure off from the west, but the problem is that the patients still have to flow eastwards, because we cannot get consultants willing to work in the west. If they are centred in Morriston and are travelling westwards, there is a clinical downtime, because the travel has to be accounted for somewhere in the working day.

[190] **Darren Millar:** We have heard that there are also long waits in parts of south-east Wales, so how will transferring patients from one long wait to another somewhere else make a difference? Is there not a capacity issue here?

[191] **Dr Thomas:** I cover south-east Wales, and it is very interesting to hear that there are long waits there, because we believe that there is sufficient service in south-east Wales to meet all the needs of all the children. Therefore, we believe that it is the inefficiency in the referral system that is clogging up these waiting times.

[192] **Darren Millar:** So, it is these unnecessary referrals that are causing the bulk of the issues, or at least a significant proportion of them.

[193] **Dr Thomas:** Some dentists are referring cases when children are eight or nine years old, when they are still in the mixed dentition stage. Usually, a child does not start treatment until they are 11 or 12.

[194] **Darren Millar:** So, what is being done to stop inappropriate referrals?

[195] **Dr Thomas:** We have set up a thing called a managed clinical network in south-east Wales and Hugh is setting one up in mid and west Wales, and that will look at developing a more cogent referral management system. Hugh can probably describe the system that he has in mid and west Wales.

[196] **Darren Millar:** We will touch on this as we go through the evidence. I am conscious that I am taking up a lot of your time, but the evidence that you are providing is very interesting and sharp, which we appreciate. Perhaps we could come on to the referral system in a little more detail later, if that is okay, but I want to give some other Members the opportunity to ask questions.

[197] **Val Lloyd:** You may have already answered this, but I think that we need to clarify it. Under the new dental contract, do you think that the co-ordination and provision of orthodontic care has improved? If so, could you give any practical examples, or is any further action needed?

10.40 a.m.

[198] **Dr Bennett:** When the new contract came in, I described it as changing behaviours, but it was a learning process for all the local health boards as well because, prior to 2006, they had nothing to do with dentistry. Progress was beginning to be made. I will describe what happened in my area. The old LHBs started to work together, they did a review of orthodontics; on the conclusions of that review, they set up a commissioning framework, part of which was also to introduce a managed clinical network. Then we come to the time of the most recent reorganisation, so there was a bit of a hiatus there, but it has been picked up again and I think that ABMU and Hywel Dda LHBs are working closely together and the profession, led by the lead consultant from Morriston, is intending to resurrect the work on developing the managed clinical network.

[199] There is a lot of co-operation going on, if you like, between the NHS organisations. New dental advisory structures have been set up as well within the health boards and most practitioners are very active in working with those dental advisory structures. Generally speaking, most orthodontists are interfacing well with local health boards, but there are obviously some sort of hang-over issues, I believe, and perhaps a lack of communication between some orthodontists and local health boards. The issues can be traced back, perhaps, to the original reference period where the transfers of money came from the old to the new

contract. There are still a lot of issues to actively work through there.

[200] **Val Lloyd:** We have heard that existing contract arrangements potentially disadvantage the patient who has to wait until 1 April to commence treatment because the practitioner has achieved their units of work or units of activity. It has been suggested that creating some leeway regarding commissioning of treatment across year end might be advantageous and better for the patient. Would you support that view?

[201] **Dr Thomas:** I think that I would support that view. Certainly, you will find that, in the Government review, one of the big recommendations to all local health boards is to improve the effectiveness and efficiency of their commissioning process. Certainly, it is a view that both Hugh and I have advised the local health boards to look at. At the moment, under the PDS regulations and the PDS agreement, the length of the contract does vary from LHB to contractor, from between three and five years, although the way that the regulations are set means that contractors have to deliver their units of orthodontic activity to a percentage total. There is some leeway within the current regulations for overperformance—for contractors both in the general dental services and orthodontists, to overperform up to 105 per cent of their contract. However, I would agree that, given that orthodontic treatment can take up to two years to complete, it makes sense to be more flexible in the commissioning of services so that it would allow orthodontists to plan their treatment load much more effectively.

[202] **Helen Mary Jones:** There is currently a disparity in the unit of orthodontic activity value across different practices within Wales. For example, you suggest that there appears to be an underprovision in the west and an overprovision in the east. To what extent might an all-Wales value assist health boards to redistribute funding appropriately and maximise patient care and patient access within the specialist practices?

[203] **Dr Bennett:** There is no doubt that, if you could do that, it would help the situation. It is probably more difficult to implement than appears at first sight, because the original values were based on the activity of the practices. Each orthodontic practice might have different on-costs, depending on the area in which they worked, to produce similar levels of activity.

[204] **Helen Mary Jones:** Are you talking about the cost of premises and things like that?

[205] **Dr Bennett:** Yes.

[206] **Dr Thomas:** There is evidence within the national review that a standardised UOA rate would be helpful to delivering orthodontic care. What I am trying to say is that that perhaps would be beneficial, but I think that it is a careful piece of work, because what you do not want to do is destabilise individual practices.

[207] **Helen Mary Jones:** However, if we did not let them pay their high rates in Cardiff, they might move to Rhondda Cynon Taf and look after the poor people. With your permission, Chair, I would like to unpack that a bit. What I am hearing from Dr Thomas is that, in the end, we need to move towards a national rate, but you are saying, Dr Bennett, that there are issues with that. Can you explore that a bit more for me? We are talking about differential costs for the practices, so premises costs—

[208] **Dr Thomas:** There are also staff costs. Staff costs in Cardiff are obviously more expensive. Nurses are paid more in Cardiff than they are in Carmarthen, for example. It needs to be done with care so we do not destabilise individual practices.

[209] **Dr Bennett:** I am not disagreeing with David, I am just saying that it is not too easy

to achieve. We would need to move in a phased way towards that if we were going to do that.

[210] **Dr Thomas:** One way might be developing some sort of new way of working that would use a skills mix—using orthodontic therapists, for example, who cost less than dentists, to do the physical work of putting the bands and the wires on children's teeth.

[211] **Helen Mary Jones:** In its written evidence, ABMULHB raised some concerns about the increase in orthodontic activity within the community dental service and its associated costs. It is concerned about whether it can afford it, I suppose. Do you have a view about this?

[212] **Dr Bennett:** There is very little orthodontics done in the community dental services in ABMU and I do not think there is any done within Hywel Dda. That is probably a weakness that we have in mid and west Wales—we do not have specialist orthodontic practitioners in the community dental service. As I understand it, there is only one dental officer within the community dental service in ABMU who provides any orthodontics at all, so I do not know quite where it is coming from there.

[213] **Dr Thomas:** May I just add to that, Ms Jones? We have a number of community dental practitioners providing orthodontics in south-east Wales. They work in the most deprived areas and, actually, the national review found that they actually provided the treatment at the cheapest rates per patient. As part of 'One Wales', obviously, we would want to support the development of the community dental services, so I think that we would support more community dental service provision of orthodontics, in the main.

[214] **Dr Bennett:** I have worked in the community dental service myself and with orthodontic specialists within that type of service. It adds much more strength and a broader base if you have got orthodontics being provided in the three sectors: community, general practice and hospital. The other ability within the community dental service is that the orthodontist is not tied to one location, but can actually move around to different clinics.

[215] **Darren Millar:** That is particularly important in very large rural areas, where you do not want people to have to travel far for services.

[216] **Dr Bennett:** Of course, it is a salaried post that allows you to do that.

[217] **Helen Mary Jones:** Yes, which is why it costs less money.

[218] **Lorraine Barrett:** Thinking about the quality of outcome in terms of health gain and going back to the unit of orthodontic activity value within the contract, it remains independent of the quality of outcome. Do you think that this should be changed? How could treatment outcome in terms of health gain be improved and better monitored?

[219] **Dr Thomas:** I do not know whether the committee knows how quality outcome is measured at the moment. Basically, what happens is that there is a thing called the peer assessment rating. Chair, I will explain what that is. Basically, what happens is that a model of the children's teeth are taken before treatment is performed, and it is a plaster of Paris model, and a number of measurements are taken of the way that the teeth fit together. Then, models at the end of treatment are taken and the same measurements are applied to the teeth. Then, through a bit of jiggery-pokery, we come up with a score and, if that score gets higher, it means that there has been an improvement in the occlusion. That is the objective measure; obviously, you also have patient satisfaction measures as well.

10.50 a.m.

[220] On the regulations, there are regulations that mean that dentists working in the

general dental service are obliged to do a percentage of these scores each year. I think that one of the issues that we have is that LHBs do not monitor these closely enough. Again, my view would be that, if we were developing a new contract mechanism, it would be useful if you had to keep proving that your quality was improving if you wanted a longer contract. So, you would tie quality into the effective commissioning of services.

[221] **Lorraine Barrett:** That is really useful. What would happen then if a particular orthodontist was getting poor results generally? Who is there to do something or say something? What could be the penalty?

[222] **Dr Thomas:** There are two mechanisms: there is the dental services division at the BSA that carries out a national monitoring scheme and the local health boards, through the managed clinical networks, could set up a scheme. If there was an issue relating to poor performance, there are again two routes: one would be through the contractual route, looking at contractual penalties, and the other would be the performance route to try to improve that practitioner's performance through training and education.

[223] **Lorraine Barrett:** Are there generally good results? Is there any evidence that shows any general concerns or are the results generally quite good?

[224] **Dr Bennett:** This is where I think that the development of a managed clinical network is so important. There is a lot of work to be done there because if you are carrying out these PAR assessments, it should be a peer-review process and that would not only allow the scoring to be done robustly, but would allow us to start recording the results. It is weak. I could not give you an answer on what I thought the percentage health gain was for any proportion of orthodontics in Wales. I think that it is a weakness in what we do and I think that the profession does recognise that. It does want to get these managed clinical networks set up, with the administrative side working alongside the local health boards.

[225] The only other thing I could suggest is that the payment for orthodontics is front-loaded; when you start a case, you get paid for the case. I think that some money has to be paid up-front, but a proportion of the payment could be kept back till the completion of treatment and then linked to some sort of outcome measurement or something like that.

[226] **Lorraine Barrett:** That is what you would do with a builder who came to your house; you would not pay the bill at the beginning.

[227] **Anne Jones:** In your written evidence, you mention the need to cut out waste within the current NHS orthodontic provision across Wales. Could you provide us with any examples of efficiencies that can be made within the current system, and specifically within current resources, so that we could treat more patients? Do you have any such examples?

[228] **Dr Thomas:** I am not so sure that we have examples, but we have ideas that could be introduced in terms of the effective commissioning of services. For example, at the moment, each provider of orthodontic services gets a contract that says, 'Mr Snooks, please provide 7,000 units of orthodontic activity'. You get a total of 21 units of activity to do an assessment and treatment of that patient or you get one unit just to assess that patient. Theoretically, you could just do 7,000 assessments, if you wanted to. However, obviously, orthodontists do not. It seems to me that, logically, we need some more information within the contract. Would it not be useful to know how many patients we started to treat, how many patients completed treatment, and for that to be included within the contractual mechanisms?

[229] **Darren Millar:** So, those things are not measured.

[230] **Dr Thomas:** No. The data is available for us to look at—

[231] **Darren Millar:** That is outrageous, is it not?

[232] **Dr Thomas:** That is an issue.

[233] **Helen Mary Jones:** 'Rip off' is the phrase that comes to mind.

[234] **Ann Jones:** It is outrageous, is it not? Do you think that the Government should fund a one-off initiative to address the backlog of patients waiting for orthodontic treatment?

[235] **Dr Bennett:** I have said in my paper that, for whatever reason, we have a backlog now and we can look at ways of changing the contract and driving efficiencies, but that is going to take time. I think that you could reach a steady state. Looking at the needs assessments we have done on the national review, our belief is that there is a lot of capacity within the system and probably just about enough to cope with the need across Wales. Sorry, but I have to ask what your original question was.

[236] **Ann Jones:** I was on about the efficiencies, but I asked whether you thought that the Government should do a one-off initiative.

[237] **Dr Thomas:** I think that we need to identify funds and there are a number of issues with that. It may well be that some funds may need to be identified at a Government level, but we have to remember that there could well be savings within the dental budgets at LHB level as well, so we need to be working with the local health boards on that issue. At the moment, a lot of our local health boards are at their limit with their dental spend, given that access has improved as well. However, there may well be some spend that, if it came back to the Welsh Assembly Government, could be used to fund the orthodontic—

[238] **Dr Bennett:** I think that you have to put some one-off funding in to get rid of that backlog.

[239] **Dr Thomas:** It is only a small amount of funding that is required, however, and Professor Richmond's report highlights that and also indicates the amount that it should be.

[240] **Ann Jones:** If we were to put that one-off funding in to reduce the backlog, should that be tied to better efficiencies? Obviously there are 7,000 units and you could just do 7,000 assessments. Should we be targeting the funding and making sure that it is there, or just giving them the money to do with it what they will?

[241] **Dr Bennett:** What you have to do is take up the recommendations that are going to come out of the national review, and get those recommendations implemented. If you follow those recommendations, they will drive up efficiency within the system.

[242] **Dr Thomas:** We had a similar problem within the GDS where additional monies were put into the system and all that we could see was that some patients were being recycled. It is easy to recycle patients under this contract—it is easy to reassess. One of the problems that we have—again, the evidence is in the national review and also my specialist registrar review—is the amount of recycling in terms of assessments that takes place. Another efficiency would be to disallow repeat assessments of children so that that would encourage people to do more treatment.

[243] **Darren Millar:** Dr Thomas, you referred to Professor Richmond—it was Professor Richmond, was it not?

[244] **Dr Thomas:** He was the chairman of the national report.

[245] **Darren Millar:** What was the cost that he suggested might be tied to clearing a backlog?

[246] **Dr Thomas:** I could not tell you without looking through the report, but I could probably send you that information.

[247] **Darren Millar:** We will get a copy of the report, but it would be useful for the record today.

[248] **Dr Thomas:** I cannot remember off-hand, I am sorry.

[249] **Veronica German:** In your written evidence, you say that health boards should be looking at spending on a needs basis rather than being reactive. Some of the issues that we heard in the evidence last time concerned parents' aspirations and what they thought should be done and could be done. Do you think more work is needed to improve awareness among parents of the criteria for NHS treatment? Should Public Health Wales be responsible for that?

[250] **Dr Thomas:** I think that we are responsible for that, and we are working on a local basis. Public Health Wales has been at the forefront of setting up local oral health groups and oral health advisory groups across all the new local health boards. Hugh can talk about mid and west Wales, but in south-east Wales we now have three local oral health groups that include representatives of all parts of the profession, such as orthodontists, hospital dentists and primary care dentists, and also community health council members and primary care officers from the LHB. One of the key things in all three of my oral health groups is a communication strategy for patients and parents to deal with both general dental services and orthodontics, about what people's rights and expectations should be. So, we are working locally with that.

[251] **Dr Bennett:** We are doing that in mid and west Wales through our new dental advisory structures; we are all going to develop communication strategies. I think that it would help the individual practitioner because the average general dental practitioner, sitting in his surgery, can come under quite a lot of pressure from a parent. The new thing with the present orthodontic contract is that it does set out quite strict criteria and all our needs assessments. When we say that we think that there is enough capacity in the system, it is on the basis that the referrals that are being made are based on those criteria. However, as soon as you wander away from the strict application of that, you start to create a demand.

[252] **Dr Thomas:** I will offer a piece of evidence. My specialist registrar analysed the data in the south-east Wales report. You will all know of the index of orthodontic treatment need that is used as a score system and that a score of 1, 2 or 3 is generally thought to be not that needy. Fifty per cent of referrals in south-east Wales were for 1, 2 and 3. Obviously, a lot of those who were referred were not treated by the orthodontists; they just had an assessment. However, if you think about it, those were 2,000 units of activity for the assessment of children who probably did not need to be assessed.

11.00 a.m.

[253] **Veronica German:** At the last meeting, we heard that training may be necessary for dentists on those scores and who they should be referring. Is it because of that, or because of pressure, or is it a combination of both?

[254] **Dr Bennett:** I think that it is a combination of both. There is no doubt that there is a role for the postgraduate department in providing training in initial orthodontic assessment.

However, there is no doubt that part of it is the pressure that can be put on the individual practitioner.

[255] **Dr Thomas:** The other thing we can do, through the development of managed clinical networks, is to develop better referral management processes—a better referral pro forma—so that dentists have less of a choice about who they refer. They can then be absolutely clear and can point out to parents that there are specifically strict criteria for the referral of these cases to consultants. I see that a consultant has just popped into the room now, but one of the key issues, of course, is that parents will say to dentists, 'I have a right to be referred to a consultant for a second opinion'. That puts dentists in a difficult position.

[256] **Veronica German:** Right. I would like to take this a bit further. In your paper, you talk about the potential for low-health and possible excessive commercial profit attached to some orthodontic treatment. I presume that is along the same lines?

[257] **Dr Bennett:** Yes. The point being made is about people getting into the system who are treated by us, but who do not meet the criteria. That is the simple point we are trying to make.

[258] **Veronica German:** It is siphoned off into the private sector to do something that does not really need to be done, necessarily.

[259] **Dr Thomas:** It would fall into the cosmetic range that is not supported by the NHS.

[260] **Darren Millar:** That was a remarkable figure; you said that 50 per cent of the referrals would not qualify for further treatment or secondary care treatment. Has that percentage increased over the past few years? Are the trends showing us that it is—

[261] **Dr Thomas:** I am not sure that that measure was even looked at, you could probably ask Jeremy when he sits down in his seat, but I do not think that that was measured before 2006.

[262] **Darren Millar:** It was not measured at all, so we cannot tell whether there is a trend here or whether it is consistent with the pre-2006 figures.

[263] **Lorraine Barrett:** Yes. Just to say that if a dentist says to a parent, 'Under the criteria, I cannot refer your child', they will then write to their Assembly Members. [*Laughter.*]

[264] In your evidence, you talk about the need to balance the priority of orthodontic care against other dental and general health services. So, what do you think should be the priority for the Welsh Government in making the best use of NHS dental resources?

[265] **Dr Bennett:** The dental health of children in Wales is generally the worst in Great Britain. We estimate that around 8,000 to 9,000 children receive a general anaesthetic in Wales. The figure for the greater Birmingham area is 900, so we have a huge problem with dental decay. The Assembly Government is funding Designed to Smile, the child oral health improvement programme, so I think that it is trying to put orthodontics into perspective with those very basic and very real needs as well. However, I think that I also make a point in my paper that orthodontics has to be a core part of NHS dental provision. It is just about getting the balance right. That is why we always come back to need; we can assess the need and I think that the planning should be strictly based around that assessment of need.

[266] **Lorraine Barrett:** I would like to add one quick question based on personal experience. I never hear anything about the damage that thumb-sucking does and I have never

seen it being addressed as part of any campaign related to dental care. Is it a possible cause of a lot of the problems? Is there more thumb-sucking in Wales than in the greater Birmingham area? I do not know. Is there a real problem?

[267] **Dr Bennett:** I hesitate to give a clinical opinion with an orthodontic consultant sitting in the room.

[268] **Dr Thomas:** I think that that might be better addressed to the orthodontist.

[269] **Lorraine Barrett:** It can be quite serious because you cannot get rid of your thumb like you can your dummy.

[270] **Dr Thomas:** May I just add something to Hugh's answer? In south-east Wales, we spend roughly £11 million on children's dentistry. In Blaenau Gwent, and other deprived areas, 65 per cent of our children have active untreated decay and we spend £5.5 million of that £11 million on orthodontics. I still think there needs to be a debate about priority. I agree with you that we need to deliver orthodontic services, but there needs to be a debate about where our priorities lie.

[271] **Darren Millar:** I have one final question. If there was one problem that you thought needed to be addressed as a priority, what would it be and what would your solution be? We know we have got problems in terms of waiting lists and so on, but, if there was one specific problem that you thought was a priority to identify, what would it be and what would your solution be to that?

[272] **Dr Thomas:** It goes back to what we talked about earlier; that is, I think that we—

[273] **Dr Bennett:** Historically, there has been a lack of strategic planning in orthodontics and, indeed, any sort of planning in orthodontic provision, really. We would like to see orthodontics planning and strategies based on need rather than demand and an insistence on quality outcomes to demonstrate the measurable health gain.

[274] **Darren Millar:** That is excellent. Thank you very much, gentlemen. That was an excellent evidence session: you were to the point, very sharp and provided lots of information. We really appreciate it.

[275] That helped us catch up on our time. We will just wait for the next witnesses to be shown to the table.

11.06 a.m.

Ymchwiliad i Wasanaethau Orthodontig yng Nghymru: Tystiolaeth gan y Byrddau Iechyd Lleol
Inquiry into Orthodontic Services in Wales: Evidence from LHBs

[276] **Darren Millar:** We will move straight into item 5 on our agenda, continuing with our inquiry. I am delighted to be able to welcome to the table Professor Jeremy Knox, who is the lead orthodontist for cleft lip and palate and consultant orthodontist at the Abertawe Bro Morgannwg University Local Health Board, and Emma Procter, the head of primary care in Aneurin Bevan Local Health Board. I know that you have not long arrived in the Senedd, so I hope you have managed to catch your breath ready for our interrogation—well, it will not be quite an interrogation, but our questions.

[277] **Ann Jones:** We are getting our own back. [*Laughter.*]

[278] **Helen Mary Jones:** Be very afraid.

[279] **Darren Millar:** That is right. [*Laughter.*] We are very grateful for the written evidence you have already provided to the committee. If it is okay, we will go straight into some questions on your evidence.

[280] There is currently a disparity in the unit of orthodontic activity value across numerous practices in Wales. The Hywel Dda Local Health Board suggests in its evidence that an all-Wales value of the UOA might assist local health boards in being able to redistribute funding appropriately, particularly in those areas where it is very low at the moment. What do you think are the advantages and disadvantages of doing that? Do you want to answer first, Professor?

[281] **Professor Knox:** Yes, Chair. That was an anomaly that not many people were aware of. I think that it was one of the outcomes of Professor Richmond's recent review that there was a huge disparity in the UOA value. I think that was a reflection on the old fee-per-item system, whereby some practitioners were providing a number of items within their orthodontic treatment and others fewer. So, with the calculations that were introduced in the transition from the old to the new contract, that was reflected in the disparity. However, intuitively, it makes a lot of sense for everybody to be paid exactly the same for providing exactly the same treatment.

[282] **Darren Millar:** So you would support the national value option.

[283] **Professor Knox:** Yes, definitely.

[284] **Darren Millar:** The evidence that we received in the last session suggested that there are different premises costs and different fixed costs that people might face in certain parts of the country and that, therefore, a single value across Wales might be inappropriate. What do you think, Emma?

[285] **Ms Procter:** If you were looking to do something like that, you would need to use a phased process, as in some other areas of the NHS where funding has been looked at. Practices have been funded in a certain way historically. They have built that into their bottom line and it influences how they run their businesses. So, if you were to look at any form of change, you would need to do it over a considerable period of time.

[286] **Darren Millar:** Thank you for that.

[287] **Helen Mary Jones:** Yes, I think that tells us a lot, does it not? The Betsi Cadwaladr University Local Health Board said in its written evidence to us that creating some leeway regarding the commissioning of treatment across the year end might be advantageous and helpful, particularly with regard to access for patients. Do you have a view on that?

[288] **Ms Procter:** There is already leeway built in—certainly, in my experience of managing contracts within the Aneurin Bevan area. We have introduced a tolerance rate, which enables some treatments to last longer than others. So you are not totally driven by when you claim—because, with orthodontics, you claim up-front. That enables practices to, perhaps, perform slightly fewer treatments one year and slightly more the next year, so you are not driven by a certain timescale.

11.10 a.m.

[289] **Helen Mary Jones:** If that leeway does not exist elsewhere, it does not necessarily

mean that we need to change the system, just how the health board is interpreting the system. If you can do it, presumably other health boards can.

[290] **Ms Procter:** I can comment only from the perspective of my own health board, I am afraid, as I do not know how that is implemented elsewhere.

[291] **Darren Millar:** Do you have anything to add, Professor Knox?

[292] **Professor Knox:** In south-west Wales, there is a slightly different scenario in that a number of the specialist providers, both in Swansea and west of Swansea, have less contract than they have the capacity to deliver. What you find in the majority of those practices is that they have met their contract value early within the cycle and are just serving that contract for the remainder of the cycle. So, for example, it could be busy from April through to the summer and, thereafter, much less busy. It is not so much a problem of fitting the contract in within the calendar year in south-west Wales as one of not having enough contract time to fill the calendar year.

[293] **Helen Mary Jones:** That is interesting.

[294] **David Lloyd:** We have heard that there is an issue of children being referred too early to specialists, resulting in a number of units of orthodontic activity being wasted, allegedly, by repeat assess and review appointments. If you agree with that assessment, what action would you say is needed to reduce the number of early referrals made to specialist practices?

[295] **Professor Knox:** Within south-west Wales, we did a fairly thorough review of orthodontic services in 2006-07 and, within that, we established referral guidelines and access criteria for each of the providers. That proved very useful, and we had a system that worked beautifully for a number of years. Problems then arose further west on our patch, where there was more demand or need than there was capacity to treat, and there was then a cross-border flow that overwhelmed the system in the Swansea area.

[296] You find that, as soon as the referring practitioner is aware that there is a waiting list for treatment, they try to introduce people into that system earlier to take account of that. I think that we have got two problems: one is referrals that are too early, and the other is referrals that are inappropriate. Both those may be overwhelming the system or giving us much more of a severe picture than is the reality.

[297] The only way to manage that is through referral guidelines but, to be honest, practitioners are inclined not to adhere to those and are more inclined to refer wherever and whenever they can. The only way of really managing it is to provide a disincentive to referrers so that, if they refer inappropriately, the cost of the assessment comes out of their contract.

[298] **Helen Mary Jones:** That is an excellent plan.

[299] **Darren Millar:** Do you want to add anything, Emma?

[300] **Ms Procter:** The only other point that I would make is on multiple referrals. Where there are long waiting times in some practices, it may be that several referrals are made to several different orthodontists, which will create blockages in the system.

[301] **Darren Millar:** That is several referrals for the same individual, so that they are added to a number of waiting lists.

[302] **Ms Procter:** Yes.

[303] **Helen Mary Jones:** You can see it from the dentist's and the family's point of view: if you refer to a number of different practices, you will finally get through to one. However, do multiple referrals not lead to multiple assessments, or would you just go along and be assessed by the first one who could see you?

[304] **Professor Knox:** You should do, but it does result in that same person appearing in the figures of two or three different providers.

[305] **Helen Mary Jones:** So, that inflates what the waiting list looks like, because it might be the same young person on two or three waiting lists?

[306] **Darren Millar:** Potentially, you would then not get a picture of need and demand on that basis.

[307] **Professor Knox:** It could be inflated, yes.

[308] **David Lloyd:** My point was to try to flush out need and demand, or 'wants' versus 'needs'. I just want to confirm whether there has been a steady and significant rise in the demand for secondary care orthodontic services—yes or no? If there has been a significant rise in demand, is it down to inappropriate referrals?

[309] **Professor Knox:** There are two different answers to that, and I will answer from a south-west Wales perspective, because the model of delivery in south-west Wales is significantly different from that in the south-east. As part of the review that we did a number of years ago, we established fairly clear and distinct access criteria for treatment within the hospital dental service and within primary care. We recognised that the primary care specialist should treat the majority of patients who have an established treatment need and who require complex orthodontic care, and we saw the hospital service as a service that treated a lower volume of patients but who have much more complex treatment needs. In Abertawe Bro Morgannwg University LHB, we now accept for treatment within the hospital service only those patients who require multidisciplinary care and who have significant skeletal problems. That establishes distinct remits.

[310] On the referrals, as part of the process, we suggested that the specialist practitioner be the gatekeeper for secondary care in most instances, and that worked nicely until that system in primary care became overwhelmed. Of the audited referrals that we get in the hospital, the access criteria for treatment have been adhered to almost 100 per cent, which is good, and the referrals that we receive are largely appropriate, so that system is working. As a result of restructuring the hospital dental service workforce, we have now addressed all our demand and need for treatment.

[311] The worry that I have is that, because we have a logjam in primary care within the specialist service, a proportion of those patients waiting for treatment will ultimately need hospital treatment, and those patients are at risk of significant disadvantage while they are waiting for care. On the point about establishing referral guidelines and access criteria, the system works well until you get that logjam.

[312] **Val Lloyd:** Can I look at it from a parent's perspective, possibly? Do you think that more work is needed to improve awareness among parents of the assessment criteria for NHS treatment? If so, who should be responsible for that? Although that is a question that we are all interested in, I am linking that into some of my constituency work.

[313] **Professor Knox:** Surprisingly, many patients are already aware, and they come in

with the mindset of recognising that their child may not be eligible for treatment under the current guidelines. I do not want to overgeneralise that and say that, for all patients, their parents are aware of that. Ideally, that level of education should be provided by the referrer, but I am afraid that some referrers are more prepared to refer a patient as they are not willing to make that decision or have that awkward conversation. At that initial general practice consultation, they should be saying, 'I do not feel that your child is eligible for treatment and so I am not prepared to refer'.

[314] **Val Lloyd:** Yes, because they are the gatekeepers, really.

[315] **Professor Knox:** They are, yes, but they are more inclined to refer and let somebody else have that conversation.

[316] **Darren Millar:** A financial disincentive, as you suggested earlier, might be a good way to ensure that there is consistency in referrals in future.

[317] **Professor Knox:** Possibly.

[318] **Veronica German:** The Government's 26-week referral treatment target does not apply to orthodontics. What is your view of the introduction of targets for orthodontic hospital waiting times? Is a 26-week referral-to-treatment target realistic given current waiting times? You seem to have addressed yours a bit better.

[319] **Professor Knox:** Yes, we have. The focus of hospital management has been to hit the new-patient target, which we have done. We have needed to put additional resources in to do that, but that seems to have been fairly easily accomplished. On the delivery of treatment, we have narrowed the volume of treatment that we have to accept and so there is no overlap with what is done in primary care in south-west Wales. That has made it more manageable. The third element of the system in south-west Wales is that we have introduced a nurse practitioner role within orthodontics, namely an orthodontic therapist. That allows you, cost-effectively, to employ individuals who can deliver prescribed care under the supervision of a consultant, which frees up the consultant to consult. The technical elements of the treatment can be provided by the orthodontic therapist, and the decision-making part of that process is provided by the consultant. It is a delegated care model, which has worked effectively. It allows you as a department to provide a higher volume of care more cost-effectively while maintaining standards.

[320] **Veronica German:** What kind of timescale are you looking at?

[321] **Professor Knox:** As of today, we have no treatment waiting list. We have cleared that out, as we have just employed two more therapists in the past few months. We are also hitting all targets for new patient contracts.

11.20 a.m.

[322] **Veronica German:** What would be an average referral-to-treatment time for patients?

[323] **Professor Knox:** The new patient referral time at the moment will be in the region of two to three months and then, at the moment, that patient could go straight into treatment.

[324] **Veronica German:** What about the rest of Wales? What about Aneurin Bevan?

[325] **Ms Procter:** I think that you need to look at the two different sides of this. What you have in secondary care may be different to that in primary care. You would need to look at the

referral-to-treatment time for primary care as well as for secondary care. I am aware that in the ABHB area, there is a two-year waiting list in secondary care, but in primary care it can vary enormously from three to four months in some practices to others where you wait 12 months to be seen and then 14 months to be treated. So, again, I do not know, with the figures that Jeremy has just quoted, whether that will be the same with primary care waiting times.

[326] **Professor Knox:** Your question was for secondary care, but in primary care what tends to happen is that a practitioner will see a patient only when they have capacity to treat that patient. So, their waiting list is up-front, with all of their patients waiting to be seen. They will see them and then, if eligible and willing to be treated, they will be treated. Whereas, in hospitals, the incentive has been to see that patient, to place them on a secondary treatment waiting list and then to address that treatment as you could. Up until recently we perhaps had a two or three-year wait for that treatment. In modernising our workforce, we have been able to address that.

[327] **Veronica German:** Do you know whether other areas are doing the same, or are you unique in Wales?

[328] **Professor Knox:** I think that we are unique in Wales for two reasons: one is that we have centralised the hospital service, so the unit at Morriston will serve all areas as far west as the Irish sea and all the way up to, and including, Bridgend. All that is centralised. You have the political problem of patients having to travel for that service, but it allows you a more efficient delivery of service.

[329] **Veronica German:** They get the service more quickly.

[330] **Darren Millar:** Why can you not do something similar in the Aneurin Bevan health board area? Why are your patients having to wait two years for secondary care treatment?

[331] **Ms Procter:** I would have to provide a note to the committee on that.

[332] **Darren Millar:** I think that we would appreciate that. Clearly, if you are able to tackle it in one health board area, it seems bizarre that you cannot employ or learn from those mechanisms and apply them elsewhere in order to improve timescales for patients.

[333] **Professor Knox:** May I make one comment?

[334] **Darren Millar:** Yes, of course.

[335] **Professor Knox:** One limiting factor for the delivery of this model is the actual clinical facility that you have available to you. It works on a multi-chair facility that is sometimes not available in existing units in south-east Wales.

[336] **Darren Millar:** I see. To what extent is that a problem in south-east Wales?

[337] **Ms Procter:** Again, I would have to put that in the same response as before.

[338] **Professor Knox:** We need five or six orthodontic chairs to deliver this model. In other units, there may be two or three chairs, so that limits your capacity for delegated care.

[339] **Darren Millar:** So it is premises as well as clinicians being available.

[340] **Lorraine Barrett:** Concern has been raised by ABMU about the increase in orthodontic activity within the community dental service and the associated cost. I wonder whether you share these concerns.

[341] **Professor Knox:** Yes. Within ABMU, there is only one provider of orthodontic services and he is a general practitioner who has had some historic links with the department. This individual provides a limited service for people who would find it difficult to access mainstream services. The access criteria are very similar to a primary care orthodontist but, in addition, he is managing those patients who would find it difficult to get to central Swansea or the other primary care centres.

[342] On the increased cost, I am aware of that comment. I think that the background to that is that there has never been an established orthodontic budget within the CDS budget, and I think that there are concerns that, if this provision of orthodontic care within the CDS was to expand, there would be no accompanying budget to meet it.

[343] **Lorraine Barrett:** How successful has the community dental service been in ensuring that patients have local access to good-quality orthodontic services? I am thinking specifically of those from vulnerable groups, such as disabled people, geographically disadvantaged people and low income families.

[344] **Professor Knox:** I think that it is variable and I think that there had been a problem of skill mix within the community dental service. Historically, there used to be specialists or tier dental officers with orthodontic experience who provided that role. The number of those individuals, I think, has decreased with time and their location within south Wales is, again, quite variable. I think that the CDS provides a great opportunity for providing facilities in the right areas and, as part of a managed clinical network, it is incumbent on us to provide the clinicians with appropriate competence to work in those environments. We have to stop thinking about a consultant working in a hospital or a specialist working in a practice and think as a network. We need to ask how to structure the service to deliver care appropriately and make it accessible.

[345] **Lorraine Barrett:** I do not know whether Emma would like to comment on that. I see that she does not.

[346] **Ann Jones:** What mechanisms do you have in place within your local health boards that allow treatment outcomes and patient satisfaction to be measured? How effective do you think they are?

[347] **Professor Knox:** Within the hospital dental service we have a rolling annual programme of measuring treatment outcomes. Orthodontics is very fortunate in that we have an established and validated measure of treatment outcome, so we are able to measure people's need before treatment and we are able to measure the quality of outcome at the end of treatment, using established indices. That is not a requirement on the department but that happens as part of the audit process.

[348] Within primary care, my experience is that it is a requirement on providers to do exactly the same—to use the same indices to establish treatment need and to demonstrate outcome. The requirement on practitioners to demonstrate the quality of their service, I think, is variable and in some areas practitioners in primary care are asked to sample a certain proportion of their activity and submit those figures. On paper, that structure works very nicely. The problem that you have—it was highlighted by an audit of dentists with a specialist interest in south-west Wales—was that these PAR scores, which measure quality of outcome, presented with cases that had been managed, were erroneous. They were not accurate. Some cases were presented as having 100 per cent improvement whereas anybody who had received validated training in PAR would realise that that was not the case. So, if we are going to use these indices, we have to make sure that they are properly applied and not abused. The structure is there; we just have to ensure that people are trained properly and that there is,

perhaps, an independent method of measurement rather than people measuring their own outcome.

[349] **Ann Jones:** What about Aneurin Bevan health board?

[350] **Ms Procter:** My experience is predominantly with primary care and, again, the PAR scores are reported on the reports that we receive, as are a number of other ratios: there is information about the number of patients that are assessed, the number of patients where treatment has started and where treatment has been completed. There are a number of outcome measures that we can use, although, predominantly, in the first two years of the orthodontic contract, we would have been looking at achievement of UOAs, which is the main currency, and we would have been making sure that practices were achieving the number contracted to them, year-on-year.

[351] **Professor Knox:** May I make one more comment? One thing that is important is that, if we are going to collect these data, somebody acts on it. We have had evidence presented to us that shows, potentially, that the quality of service is not as good as we would have hoped in certain areas. It is then a question of how that is managed. People seem to be reluctant to act on that and to stop commissioning people.

[352] **David Lloyd:** You have touched on this issue. The current financial climate is as it is and there are lots of competing demands on general dental services. It is going to be difficult to expand primary care orthodontic services, given all the competing demands and the diminishing financial situation. Can you suggest any improvements so that we can actively treat more patients in primary care orthodontics?

[353] **Professor Knox:** The first thing that we can do is eliminate inefficiencies in the current system. I am sure that you have heard it a number of times, but the contract value of providers was established on a sample period, but that sample period also looked at general practitioners who may have dabbled a little bit in orthodontics, so their contract would have demonstrated activity that could have an orthodontic tag.

11.30 a.m.

[354] That then was rolled into the new contract. Then you had a scenario where you had a general practitioner who had an orthodontic contract but maybe did not have the competence to deliver care under the new structures, so that is one area that we need to look at. We have evidence that some general practitioners are reviewing patients over and over again to meet their contract value without actually providing any treatment, so that is an inefficiency.

[355] Another inefficiency involves dentists with a specialist interest in orthodontics. These are general practitioners who have not had formal training, but who have had some form of experience in orthodontics. The model of service delivery with these individuals is that they link to a specialist centre or a hospital unit. They have a treatment plan prescribed and that treatment is monitored by the specialist or consultant throughout the course of the treatment. That works well in remote areas, where there are difficulties with access, but it is a very expensive model of service delivery in areas where there is a specialist provider just down the road. That is another area that we could look at for efficiencies.

[356] We have already talked about orthodontic therapists and that, particularly in your salaried services, is a good way of achieving cost-effective service delivery. We have currently trained four orthodontic therapists in the hospital service and four in a primary care setting. The role of the therapist in a primary care setting would be where a practitioner had more contract than he or she was physically able to deliver, so would then delegate part of that. So the orthodontic therapist would then perhaps replace an associate within that practice.

So that is another model that can be considered.

[357] We have already talked about the hospital dental services and the fact that some of the treatment that is provided within the hospital dental service could perhaps be provided more cost-effectively in a primary care setting. A greater centralisation of that hospital dental service would allow some of that resource to be displaced out into primary care. So there are a number of ways that you could look at managing the system, and I think that the key to it is an effective managed clinical network, where you work together to provide a service rather than being in disparate groups.

[358] **Ms Procter:** May I add one other point to that?

[359] **Darren Millar:** Of course.

[360] **Ms Procter:** If you are looking at resource utilisation, just picking up on one of the comments earlier, when you were talking about the patient experience, I would also look at the number of abandoned treatments, because that is very costly.

[361] **Darren Millar:** Thank you. What is the proportion of abandoned treatments?

[362] **Ms Procter:** That will vary from contract to contract but, obviously, given the way that the contract is managed, orthodontists claim UOAs when the treatment starts so, if a patient starts treatment, the money, effectively, transfers for the treatment at that point so then, if the patient abandons treatment, there is no saving to the system, and that resource has been utilised.

[363] **Darren Millar:** I see. That was one of the points raised previously.

[364] **Lorraine Barrett:** What is the percentage of abandoned treatment, where the patient decides not to carry on with it?

[365] **Darren Millar:** Is it monitored at all?

[366] **Professor Knox:** It will be monitored as part of primary care. There are three different areas: there is the patient who completes treatment satisfactorily, there is the patient who never returns or decides not to proceed with treatment—that is fairly rare—and there is also what we call an incomplete treatment. The definition of ‘incomplete treatment’ will depend on the actual practitioner. Lots of orthodontists are perfectionists and, if it is not absolutely perfect, they are not prepared to associate their name with the result, and others will consider the same end point to be satisfactory, and there is a whole range there. It will vary depending on the service provider.

[367] **Darren Millar:** Thank you. That brings us just about to the end of our meeting today. Thank you very much for the evidence that you have provided, it has been very useful, particularly the points on the efficiencies and some of those interesting notes. We really appreciate your time. Thank you.

[368] There are some papers to note, which are the minutes of the previous meeting. I will take it that they are noted and we will close the meeting six minutes ahead of schedule.

Daeth y cyfarfod i ben am 11.34 a.m.
The meeting ended at 11.34 a.m.