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Evidence to the inquiry into orthodontic services in Wales

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Orthodontic Services in west Wales

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Orthodontic Services in west Wales

I firstly describe my experience of orthodontic provision in west Wales, and my understanding of current availability of the service in this area.

Background

I moved to west Wales in 1987 following appointment to a full time post as consultant orthodontist in Morriston Hospital, Swansea. At that time there were very large and growing waiting lists for consultation and treatment in the hospital service. In collaboration with the District Dental Officer of the day (who later became the first consultant in Dental Public Health for the area), we set about defining a role for the hospital which complemented rather than duplicated provision in specialist and general dental practices.

As Clinical Director of the Maxillofacial Unit I contributed to the development of what has become one of the leading centres in the UK for the multidisciplinary treatment of head and neck problems. I was at the same time acutely aware that, particularly west of Swansea, there were insufficient resources outside the hospital for the treatment of routine cases no longer deemed suitable for hospital care.

Although the Maxillofacial Unit grew during this period the hospital budgets were relatively inelastic whilst the NHS General Dental Services were at the time non cash limited. Accordingly, in 1997, I decided to withdraw some of my hospital commitment and establish a specialist orthodontic practice in Llanelli. In 2000, I went on to establish another new specialist practice in Carmarthen and to drop my remaining sessions in Morriston Hospital following appointment of a new consultant there.

Orthodontics in the primary care sector

Both practices flourished following the recruitment of hospital trained dentists with a special interest in orthodontics (DwSIs). They were growing rapidly when the new dental contracts were imposed in 2006. The contract value awarded was based on earnings during an earlier reference period and it effectively cut our NHS income and treatment capacity by around 40%. The reason for this has been well described in evidence by the British Orthodontic Society to a Parliamentary select committee. In summary, cash flow under the old fee per item of service system was poor. Payments were made on completion of treatment, which could often be two years or more after commencement. It took a newly established practitioner around three years to reach a steady income. A full time associate who only joined us part way through the reference period therefore realised a very low contract value.

As well as reduction in NHS provision due to the low contract values awarded to growing specialist practices, the new contract directly reduced provision by general dental practitioners. Especially in rural west Wales many used to provide simple orthodontic treatment, often to the prescription of a hospital-based consultant. Although some consolidated their orthodontic work into a contract for UOAs (Units of Orthodontic Activity), the majority did not and this contribution has been lost. Further loss of capacity can be expected when the policy of not awarding contracts to non-accredited DwSIs is implemented by the Health Board.

Before the new contracts were imposed, we were all assured that existing levels of activity would be maintained, and that we could look forward to working collaboratively with Health Boards to further improve services. In Carmarthenshire the result turned out to be a substantial drop in NHS funding for orthodontics which has never been restored.

Formal appeals against the low contract values were rebuffed. The first Mid and West Wales Orthodontic Review Board in 2006/7 suggested raising the threshold for acceptance of NHS cases to bring demand and supply closer to balance, but this would have required a change in primary legislation.

Provision by the salaried services

At the same time that NHS orthodontic treatment volume in specialist and general practices has seen reduction, treatment capacity in the Hospital and Community Dental Services has also been cut.

Several Community Senior Dental Officers who provided a significant volume of orthodontics have left the service. A full-time hospital consultant who provided substantial treatment and advisory services in Haverfordwest, Carmarthen and Aberystwyth retired. This had been long anticipated. Belated attempts to recruit a successor were made. These were unsuccessful; no attempt was made at reconfiguration of the isolated multicentre job to make it more attractive.

Funding has now been transferred to enhance the hospital service in Swansea, but attendance at that centre requires a huge travel commitment for patients from west Pembrokeshire or north Ceredigion.

Waiting times and access

All three specialist practices in Dyfed now have very large waiting lists. In 2006 under the old contract, the wait to be seen with NHS funding in my practices was three to six months with patients only taken off the list when capacity to treat them was available. With a low contract volume and a referral rate exceeding funded treatment capacity by a factor of several times, the waiting lists have grown inexorably. **In Carmarthen it would now take over seven years to see and, where appropriate, start to treat all the patients that have already been referred to us** assuming our UOA contract continues unchanged.

For cases requiring complex multidisciplinary planning and treatment, there used to be excellent back up from the hospital service. Cases would be referred to the appropriate consultant in the most appropriate centre. Following retirement of the west Wales based whole time consultant orthodontist, there was a long period during which there was no hospital based treatment service at all available for even the most complex cases of dento-facial dysplasia. Now, following imposition of Referral Management Centres by the Health Board, cases are again being accepted for all hospital specialties, but delays are very much greater and cases are liable to be redirected away from the consultant or hospital of choice by administrative staff, resulting in further delay receiving appropriate advice and care.

Conclusion

Orthodontics is capable of reliably providing enhancement to dental health, function and aesthetics which given appropriate on-going care can last a lifetime. Its' place within the NHS is beyond question, and it is greatly appreciated by patients and their families. The new contractual arrangements have reduced the supply of NHS orthodontics in west Wales to a point that the population is now inadequately served.

Many young patients miss out on treatment at the optimum time, and treatment outcomes are being compromised because of this. Myofunctional therapy must be provided during the pubertal skeletal growth spurt, and cooperation with traditional appliances may be very difficult for older patients embarking on tertiary education or work. Additional funding will be essential if an adequate service is to be restored.

Questions for consideration

1) *In your view, what impact has the new dental contract had on the provision of orthodontic care? How has the contract had an impact on access for patients to the most appropriate care, wherever they may live in Wales?*

The contract values calculated in 2006 fossilized historical levels of spending on NHS orthodontics. Because of the poor cash flow received by orthodontic practices under the old contract, this did not reflect activity levels as at April 2006 but rather some two years earlier, before considerable growth had occurred. Some of that growth has been reversed with loss of clinician sessions and reduced hours of operation.

Specialist orthodontic advice and services are now less widely available than in 2005, though much of this is not due directly to new contracts so much as contraction and cost savings in the salaried services over the same time period. Many general practitioners who used to provide simple orthodontics with consultant or specialist support no longer do so as no mechanism exists in the new contract for provision of a low and non-constant volume of treatment, and consultant advice is not so readily accessible.

Perhaps the most significant effect of the new contract has been to stifle the establishment and growth of services in areas of high demand/need. The old contract offered a fee scale which, though not generous, was available in a fair way to any practitioner willing to invest in and develop services which could be then be relied on to generate income, repay borrowings and reward enterprise – it was market sensitive. Any new or increased provision now requires Health Boards to divert fixed and overstretched budgets away from other services. The old system still appears to operate successfully in Scotland and Northern Ireland; there the kind of shortage seen in west Wales could not arise because practices are free grow to satisfy demand and keep waiting lists under control.

2) *How effective is the co-ordination of orthodontic treatment across the various providers in Wales (including hospital orthodontic departments, specialist orthodontic practices, general dental practices and community dental clinics)?*

Relationships between orthodontic care providers had been steadily evolving and improving before 2006. A Local Orthodontic Committee had been established to foster improved direct communication between practitioners in all sectors, and it was anticipated that this would in due course evolve into a Managed Clinical network. This has not happened.

For a period of two years, there was no effective hospital orthodontic treatment service available to west Wales' residents. Now that the service in Swansea has been strengthened new relationships are being forged, albeit with difficulty due to the interference of the Health Board's Referral Management Centres. There is little meaningful coordination at present.

3) *How effective are working relationships between orthodontic practices and Local Health Boards in the management of orthodontic provision, particularly in light of the NHS reorganisation?*

The new contracts had a dramatic impact on practitioners' relationship with the NHS. Under the old system there was practically no management interference and local management costs were very low. The locus of control was firmly with the practices; they were free to develop services and respond to unmet treatment within the national fee scale available to all.

We are now faced with constant meddling by the Health Board, and much time needs to be devoted to preparing bids for new services or continuation of existing services. Health Board devised protocols require time to be wasted on cosmetic box ticking. The Board employs staff to run a Referral management Centre which specialists and general practitioners agree has only had a negative impact on service provision.

Contract changes, together with the closing down of several treatment centres, have destabilised and degraded provision. The Health Board's vision of a Managed Clinical Network would appear to be dictatorial control by them based on bureaucratic concepts, often of dubious provenance. There is no attempt at a consensus style of management. Professional consultation and involvement in management decisions has been non-existent, token or highly selective at best

A particular problem exists for orthodontic practitioners seeking to retire. In the past specialist orthodontic practices would be sold as going concerns and cases transferred by outgoing to incoming practitioners. The HB seems to lose sight of the fact that current contract payments only fund activity in the preceding month; patients in mid treatment cannot be assured continuity of care if contracts are abruptly terminated or reallocated. They have effectively destroyed the resale value of NHS orthodontic practices: this is causing great stress to practitioners planning retirement.

4) *What is your view on the role that local University teaching departments can take in ensuring the highest standard of orthodontic care is provided by the local orthodontic workforce?*

Most useful postgraduate education in orthodontics is provided on a UK or international basis with orthodontic providers travelling widely to improve their knowledge and skills. Courses to acquaint local general practitioners with the orthodontic indices governing NHS eligibility could be useful as surveys show that knowledge levels amongst GDPs are currently low.

A training course for orthodontic therapists is available locally. Places are in short supply and so far only one therapist from west Wales has been trained here. We may need to look at financially supporting therapists to be trained in England. Central funding to support therapist training would be of great assistance in getting them deployed in our practices as rapidly as possible.

The Royal College of Surgeons now runs a three year training programme and qualification for dentists wishing to develop a special interest in orthodontics; one of our associates is enrolled on it. This qualification should be recognised by the Health Board for DwSI accreditation purposes.

5) *What is your view on the Welsh Government's short, medium and long-term strategies with regard to the maintenance and development of orthodontic provision? How effective are these strategies in addressing the backlog of patients currently in the system and meeting future patient's needs?*

In common with almost all professionals, I support the criteria currently used to determine eligibility for NHS funding. Most parents when advised of the issues readily accept this logical basis for rationing of treatment resources, which favours those who can benefit most. Raising the threshold for NHS acceptance, as previously advocated by LHBs in west Wales could not be supported as it would exclude many cases which most reasonable parents would strongly feel deserve the opportunity of treatment.

The mismatch between the level of treatment need in the population and the level of funding was pointed out to Health Boards from the inception of the new contracts. Government policy seems to be directed at solving this entirely within present orthodontic budgets. I do not believe this possible.

Assessments the Government have used to estimate the volume of treatment needed probably get the teenage population with an eligible objective treatment need correct. They may considerably underestimate the volume of treatment required by making the assumption that half of those needing treatment will for one reason or another not avail themselves of the service.

Cutting the value of a Unit of Orthodontic Activity (UOA) is proposed. It is difficult to see any rational basis for variation in UOA value, even within the same practice, for practitioners providing full orthodontic services. However, it should be recalled that these values were imposed on us externally and were based on treatment costs under the old system, whose fee scales were not noted for generosity.

In the past many practitioners used only simple, inexpensive though less effective appliances and public funding is still squandered on practices where little or no treatment is provided. Contemporary standards mandate the routine use of expensive fixed appliance systems and the most complex cases (*e.g.* biphasic myofunctional followed by fixed cases) which would have to be treated in two separate courses under the old system must now be treated in a single episode. It could be argued from these two points that fees have already been cut and that increases are appropriate.

NHS orthodontic treatment fees are already the lowest in Europe. NHS cases need to be treated efficiently and effectively though many of the more expensive and often best appliance systems cannot be provided for them on economic grounds. Some further efficiency savings may indeed be possible if secure long term contracts are available to allow practices to invest in training therapists and the infra-structure to support them. I feel the Government overestimates the scope for further efficiency savings which do not impact adversely on quality.

It must be accepted that adequate provision of NHS orthodontics will require the diversion of budgets from other areas of expenditure back into orthodontics. At a time of limited resources and inadequate core dental treatment services, it is perhaps surprising that the Government has chosen instead to fund expensive new initiatives such as *Designed to Smile*.

6) *In your view, how effective are arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector? How could these arrangements be improved?*

The Dental Reference Service of the Business Services Authority continues to audit and monitor the standard of treatment provided in the NHS, and provides an adequate level of quality assurance.

In my thirty year practising life I have seen enormous improvements in the quality of orthodontics provided in Britain, and in the treatment standards which are accepted as the norm. This has occurred solely as a result of the innate professionalism of orthodontists aided by constantly improving technology.

We do not need local quality assurance by Health Board administrators who lack specialist knowledge and are of variable competence. This would not benefit our patients, though it would waste considerable resource in both Health Boards and practices. Instead the Boards should support and fund clinician led Managed Clinical Networks which can coordinate audit and ensure enthusiastic collaboration of all orthodontic providers in striving for ever improving treatment outcomes in both the NHS and the independently funded sector.

7) *If you could draw the Committee's attention to one problem, what would it be? What would be your solution?*

The biggest problem must be the poor availability of orthodontics and huge and still growing waiting lists for treatment. Many patients on our waiting lists are now approaching their eighteenth birthday, when they will be ineligible for NHS funding. We are prioritising these patients for initial assessment and soon they will be a substantial proportion of our activity. Eighteen is far later than the optimum age for orthodontic treatment; growth will have slowed, reducing or eliminating some treatment options such as myofunctional therapy. It is always harder for older teenagers to cope with appliance wear, and tertiary education or work may make treatment delivery impractical.

Funding needs to be directed to treating the backlog urgently, and to sustain an adequate on-going service. Negotiations could be speedily conducted with existing suppliers who can offer work at marginal cost and with built in prospective quality measures. I fear that, even if the problem and its' solution is at last recognised, the Health Boards are not geared to deploy funding speedily and efficiently. [They did hand back £280,000 of unspent dental budget back to the Welsh Assembly Government. That could have taken up to 250 patients off our current waiting lists.]

Current EU law does not require an open tendering exercise for orthodontic services yet Health Boards are insisting on a cumbersome and officious tendering process. Tendering criteria devised by professional administrators are extremely difficult for clinicians to assimilate and find time to comply with. As one example, it gives more credit to produce a voluminous race relations policy downloaded from the internet than to point to the simple fact that as an equal opportunity employer we have a disproportionately large number of ethnic minority employees.

Tendering as conducted recently by the Health Boards is a vast waste of time and resource on both sides, serving no useful purpose. It is inconceivable that new large scale providers could appear *de novo* as the capital investment required would be prohibitive and it would be impossible to recruit essential staff registered with the GDC. Face to face negotiation could quickly establish whether agreement on price and service specification is possible prior to amending a standard NHS, PDS contract.