

INQUIRY INTO ORTHODONTIC SERVICES IN WALES

Consultation by National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

National Office
Swyddfa Genedlaethol

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INTRODUCTION

BMA Cymru Wales is pleased submit evidence to the Health and Social Care Committee's inquiry into orthodontic services in Wales.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales offers the following responses to the specific issues on which the committee is seeking views, as follows:

Access for patients to appropriate orthodontic treatment, covering both primary and secondary care orthodontic services, and whether there is regional variation in access to orthodontic services across Wales.

On the basis of interpreting access to such services in terms of local availability and, where available, current waiting times for the commencement of treatment, BMA Cymru Wales notes that access to specialist orthodontic care is more of a challenge in rural areas within Wales. We would consider this is because the numbers of patients in need of treatment within such more sparsely-populated areas is not sufficient to support the provision of standalone specialist practices. As such, we would suggest that more creative solutions are needed to address this.

We observe that there are regional variations in the provision of orthodontic care throughout Wales, and also variations in waiting times for patients to undergo NHS treatment between different sectors of the service i.e. between primary care General Dental Services/Personal Dental Services (GDS/PDS), primary care Community Dental Services (CDS) and secondary care Hospital Dental Services (HDS).

We also note that the ability to offer assessment and treatment to the current 12 year old cohort (on which needs assessments are usually based) is influenced by pre-existing lengthy waiting lists in primary care in most parts of Wales.

Secondary care waiting times for new patients are mostly less than, or around, 36 weeks. This is because orthodontic assessment is monitored under a Referral to Treatment (RTT) target. We would note that some areas are, however, still struggling to reach this target. In our view, this is due to a lack of capacity within

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the service which we believe is exacerbated by recruitment difficulties relating to both the attractiveness of posts and restrictions in local recruitment.

Waiting times for treatment in secondary care (which are not governed by an RTT target) are, however, much longer. We note that colleagues in many parts of Wales (e.g. South West Wales, Cardiff and North Wales) report there being large numbers of patients with a significant need for treatment which is translating to waits of between two and three years when matched to the capacity that is locally available.

The effectiveness of working relationships between orthodontic practices and Local Health Boards in the management of local orthodontic provision, and the role of Managed Clinical Networks in helping to deliver more effective orthodontic services in Wales (e.g. effective planning and management, improvement in the appropriateness of referrals and performance management, workforce arrangements).

In our view, relationships between Local Health Boards (LHBs) and orthodontic practitioners appear to have improved with the establishment of Managed Clinic Networks (MCNs). We would note that it is a contractual requirement in some areas for local practitioners to be actively involved with their Local Orthodontic Committee which in turn has representatives on the MCN.

There are MCNs in South West Wales, South East Wales and North Wales. They contribute, in their localities, to their associated Strategy and Planning Groups for Dental Services and Oral Health, as well as feeding in to the All Wales Strategic Advisory Forum.

Both the South West Wales MCN and the South East Wales MCN have referral management systems in place and utilise referral guidelines or protocols that have become established throughout their networks. The North Wales MCN is, in our assessment, not quite as mature as those in the south, but it is in the process of harmonising existing locality referral guidelines and producing a common referral form to be rolled out across the network.

All three MCNs recognise the importance of ensuring the referral base is appropriately informed and educated in order to reduce inappropriate referrals.

Whether the current level of funding for orthodontic services is sustainable with spending pressures facing the NHS, including whether the current provision of orthodontic care is adequate, affordable and provides value for money

Sustainability of current levels of funding in all areas of the NHS is clearly a taxing question for service commissioners. In our view, the current contracting arrangements ensure resources are directed to those with a demonstrable need. In some areas, however, we observe that historical under-funding of orthodontic provision has led to the development of lengthy waiting lists and there are therefore concerns over whether or not orthodontic treatment can be provided within a reasonable time-scale.

We believe it should be noted that orthodontic treatment which is not carried out within an ideal time-frame, may, as a result, be more complex and of longer duration. It is also our observation that objective need (as opposed to demand) appears to be out-stripping capacity in many areas of Wales.

Currently, we understand that around half of the spend on child dentistry in Wales is directed towards orthodontic services. However, given that many children in Wales have high levels of tooth decay, there is a need to consider the extent to which this is justified given the financial resources available, particularly in the present financial climate. Some funding, for instance, might be more effectively spent delivering fluoridation of the mains water supply – a policy which the BMA strongly supports across the UK. Amongst our members who work within orthodontic services in Wales, there is general agreement that consideration should be given to diverting available resources to those with the greatest dental health needs by raising the threshold for NHS treatment to Index of Orthodontic Treatment Need (IOTN) levels 4 and 5 and excluding grade 3 (which currently takes in to account the aesthetic impairment).

It should perhaps also be considered whether some general practice dentists are referring patients too early, because they know that their patients may have to wait a long time for treatment, meaning that orthodontists are not being asked to carry out treatment at a time that is most appropriate in a child's development.

In relation to the tendering process used for awarding contracts, we note that its use is designed to enhance value for money. However, we believe that care needs to be exercised with the weighting system used in order not to lose sight of the quality of care of the clinical service being provided, as opposed to just the cost.

Whether orthodontic services is given sufficient priority within the Welsh Government's broader national oral health plan, including arrangements for monitoring standards of delivery and outcomes of care within the NHS and the independent sector.

It is the view of BMA Cymru Wales that progress towards the fulfilment of the recommendations of the previous report in 2011 entitled '*Orthodontic Services in Wales*' that was produced by the Assembly's former Health, Wellbeing and Local Government Committee may provide a useful measure of the priority given to orthodontic services in the broader national oral health plan.

We would consider that appropriate contract monitoring is required for quality assurance and protection of the public, but also note that quantitative contract monitoring is an easier undertaking than qualitative contract monitoring.

Within primary care, practitioners use Peer Assessment Rating (PAR) scores to assess their outcomes – both for the NHS Business Services Authority (BSA) and LHBs. In our view, a system where the outcomes are scored independently is the most robust.

We note that the BSA monitors standards of care provided under GDS/PDS using a traffic light system on five selected cases – an approach which appears to us to work well. Since May 2013, we also note that the BSA has been carrying out an exercise in monitoring the completion of orthodontic treatment. This has been involving a sample of contract holders with higher than average reported incompleteness rates after 36 months or more. In relation to secondary care providers, we note that they are actively engaged in local, all-Wales and national outcome-based audits.

The independent sector appears to us to be less well monitored. We are concerned that this allows those without specialist qualification or local accreditation (as would be required to hold an NHS contract) to offer treatment, often with competitive marketing by orthodontic companies. We would suggest that this should be addressed and those providing care who are not on the specialist list should be appropriately accredited.

We believe it is important that resources are used to fund evidence-based interventions that deliver a quality, demonstrable and quantifiable health gain.

The impact of the dental contract on the provision of orthodontic care

The 2006 dental contract uses the IOTN to direct care to those with the most need. It also fixes the volume of activity in each year for each practice.

With improvements in dental health and awareness, we observe that there may as a result be more of a demand from those with an appropriate need. However, we would also note that there has been no accompanying increase in dental contracts over the same period. We are also concerned that long waiting times to be assessed in primary care can delay transfer to secondary care, where this is appropriate for patients.

More recently, the introduction of new rules limiting the number of assessments and reviews is ensuring that all practices now direct resources towards treatment and this is improving efficiency. The current contract system, however, assumes a practice offering NHS care is in a steady state and there appears to be limited flexibility for new start-ups or wind downs. It is the view of BMA Cymru Wales that contracts must be of sufficient duration to ease the difficulty of attracting new providers who wish to invest and settle in local communities.

BMA Cymru Wales is concerned that the award of multiple contracts in the same Health Board, and/or neighbouring Health Boards, to the same provider risks a monopoly on orthodontic provision. Furthermore, we are concerned that the tendering process in primary care tends to favour corporate bodies as they have greater ease of access to business-type resources and greater experience of how such procurement processes operate from within their organisations.

We would also suggest that clarity is required for the management of those referred in their 18th year as to whether the date of referral, or the date of assessment, should determine their eligibility for NHS treatment in primary care (assuming, that is, that they have a demonstrable orthodontic need).

We note that there is a minimum Unit of Orthodontic Activity (UOA) value below which appropriate safe, quality care is not achievable. In our view, the UOA must take into account fixed costs. Examples of such costs include, amongst others: estate; patient's dental chair; operator and assistant stool; specialist equipment; consumables including appliance components and auxiliaries; laboratory costs; patient/practice records; environment and procedures that are compatible with Health Technical Memorandum (HTM) 01-05; support staff salaries; treating clinician and/or supervising specialist. We would further note that this has not been determined in Wales.

Additional information:

We also offer the following background information, including on key elements of orthodontic services:

Orthodontic services

Eligibility for NHS treatment is decided by the IOTN. This is a system of objectively measuring the severity of the malocclusion or tooth derangement. It ensures that purely cosmetic treatment, and treatment that results in no long-term dental health benefit, (IOTN 1, 2 or less than 3.6) is not offered under the NHS in either primary or secondary care.

The threshold IOTN level at which NHS treatment can be offered is set out in national contracts for primary care providers. There is currently some provision for psychosocial needs as a result of a marked aesthetic impairment (3.6 and above). The vast majority of cases under treatment have an IOTN of 4 or 5 with a definite need on dental health grounds.

Remuneration for primary care providers is delivered via contracts which allocate fixed annual blocks of UOAs. One UOA is awarded for an assessment, with a further 20 UOAs being awarded when a patient starts their treatment (defined by the fitting of an appliance). The value of a UOA varies throughout Wales according to the local contracts negotiated. There may also be specialists paid different UOA values within the same locality.

More recently, the number of assessments claimed, and the number of reviews provided (which also attract one UOA), has been reduced to one per patient. This helps to ensure resource is directed towards treatment activity in primary care rather than repeat assessment and review activity.

Hospital orthodontic departments have a greater advice and supervisory role. They only accept cases for treatment which are of a complex or multi-disciplinary nature, and which cannot therefore be treated in a primary care setting. The exception to this is those hospital units with postgraduate students, and Speciality

Registrars (StRs) working towards becoming specialists. As part of their training, they treat primary care-type cases to prepare them to become primary care specialists of the future or to enter post-CCST¹ training to become consultants. StRs are appointed by the Welsh Deanery for three years (a course of orthodontic treatment takes 2-3 years). They spend up to two days per week at the same district general hospital (DGH) with the remainder of their training at a dental hospital.

Orthodontic provision

A mixed model of provision is desirable i.e. hospital-based specialists (consultants), primary care-based specialists (specialist practitioners), salaried CDS dentists with experience in orthodontics, and orthodontic therapists. Those who are not registered orthodontic specialists require adequate training and on-going supervision (by an orthodontist on the specialist list) to ensure they are working within their competence. Supervision must be by an appropriately trained and registered orthodontic specialist, at appropriate intervals and with appropriate scheduling i.e. an orthodontic specialist cannot be available to supervise multiple non-specialists at the same time as treating their own patients.

The model of a single specialist supervising non-specialists can, in our view, be professionally isolating and contrary to clinical governance recommendations.

Successful and efficient treatment with a quality outcome is the product of the same specialist who planned the treatment, and then completed or supervised it over a period of 2-3 years. There is evidence that cases with multiple operators take longer for treatment to be completed.

There is a high level of public trust in the NHS. Often, in our experience, patients do not understand or are not aware of the various levels (and competencies) of the individual carrying out their orthodontic care. When they are dissatisfied, they can often be reluctant to raise concerns – especially in areas where there is limited provision, for fear of losing access to treatment.

¹ Certificate of Completion of Specialist Training