National Assembly for Wales
Health and Social Care Committee

Inquiry into Orthodontic Services in Wales

Evidence from the Clinical Director of Q Dental Care Ltd - OS 06

National Assembly for Wales' Health and Social Care Committee Inquiry into Orthodontic Services in Wales.

Response from: Darren Hills, Clinical Director of Q Dental Care Ltd (large PDS Provider in South Wales)

1. 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.

1.1 We contract with Cardiff and Vale, ABMU and Hywel Dda Health Boards to provide primary care services from specialist centres in Cardiff, Bridgend, Swansea and Carmarthen. Access for treatment from a timing perspective is not ideal as there is insufficient primary care funding across all regions to meet the treatment need under the terms of the current PDS primary care contracts, e.g. in our centres there is a delay from referral to the commencement of routine NHS treatment as follows:

- Cardiff: 18 months
- Bridgend: 18 months
- Swansea: 14 months
- Carmarthen: 36 months

1.2 It would be better if possible for all referred patients to be assessed quickly and then have a waiting list for routine treatment.

1.3 Most practices have the capacity to treat additional cases but the contract funding is capped such that only a certain number of cases can be treated each year.

1.4 Various waiting list initiatives have been trialled over the years but without one-off funding to actually manage the backlog, this will always persist and will continue to increase unless additional recurrent funding is also provided. That said, most providers manage the problem professionally and try to ensure that urgent cases are not compromised and patients requiring routine treatment (and parents of) have learned to accept a wait.

1.5 Geographical access obviously varies depending on location. Both primary and secondary care provision is centred in the urban areas so access for patients living in the more rural areas of Mid and West Wales will tend to need to travel to access specialist treatment. Various initiatives to provide more local assessment clinics do however minimise the inconvenience.

1.6 Although most providers cater well for patients of different needs, there is still a feeling that some 18-19 year olds miss out on treatment due to long waiting lists and the fact that most primary care contracts only permit treatment of patients under the age of 18.

2. 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).

2.1 Our working relationship with the Health Boards has always been good and communication when required is effective and timely.

2.2 Although I have no direct involvement with MCNs (as membership is restricted), communication via the Health Boards and LOCs seems effective.

2.3 The issues in all regions are similar and plans focus on ways to obtain maximum benefit from the existing contracting arrangements, e.g. ensure referrals are appropriate, timely and sent to an appropriate provider so that all providers can prioritise the use of the commissioned activity to actually treat eligible patients. Each region seems to customise its approach to issues such as standardised referral forms, referral pathway guidance, use or otherwise of Referral Management Centres, etc which must lead to a duplication of effort. It may therefore be worthwhile adopting a more national and standardised approach to these issues.

2.4 Similarly, there is inconsistency as to how treatment quality is assessed and there is an opportunity to standardise how this is audited.

3. 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.

3.1 Everyone understands the increasing pressures on all NHS budgets and hence the need for prioritisation, rationalization and justification. There is plenty of evidence of the huge psycho-social benefit from appropriate orthodontic treatment to children during their formative years and how this improves life quality, not to mention the dental health benefits, but how this is compared to the benefits of other NHS spend is a political decision. Orthodontic treatment, even when needed, is only appropriate for motivated patients with healthy teeth and can itself be a strong stimulus to improve and maintain dental hygiene and health which is important when considering that the majority of NHS dental spend funds the repeated restoration of the effects of current or past neglect.

3.2 As detailed in the first section, more funding is necessary to meet the current need for orthodontic treatment. If this is not affordable or justifiable, this needs to be transparently communicated to the general population and ways should be sought to better match the funding that is justifiable to the patients most in need of treatment. Possible ways in which this could be achieved include:

- Restricting access to NHS treatment to just the highest treatment need categories (IOTN DHC 4 and 5) so that patients with a lower treatment need don't receive treatment at the expense of those with a higher treatment need.
- Restricting UOAs to just treating patients via a combination of a more refined referral system and screening assessment when first seen.
- Reducing the UOA allocation for discontinued cases (or a contract penalty if discontinuation rate too high).
- Restricting (as appropriate) secondary care treatment to cases which cannot be treated in primary care, e.g. complex multi-disciplinary cases, so that the resources of each are used optimally.
- Encouraging the use of orthodontic therapists as once trained, treatment delivery can be more cost effective.
- Unifying all PDS contracts to the same UOA value.

3.3 It is important to measure the quality of care provided as this is the only way to ensure it represents value for money.

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4. 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.

4.1 The plan does not go into any depth on these issues, concentrating instead on access to general dental services, urgent care and the national oral health improvement plan.

4.2 The BSA collects contract performance data, e.g. number of assessments leading to treatment, number of cases which are PAR scored (but not the actual outcomes), the treatment need of the treated cases, the use of different appliance types during treatment, treatment discontinuation rates and repeat assessments on patients but the general consensus is that very little has been done with this data.

4.3 The BSA also randomly assesses the quality of notes and treatment itself from records by sampling 5 cases per performer every couple of years.

4.4 All providers monitor their treatment outcomes using the Par Assessment Rating Index which has professionally endorsed references of what constitutes good outcomes. Rarely though do Health Boards request this data.

4.5 Independent treatment is monitored by the Healthcare Inspectorate Wales (HIW) but this seems to be complaint driven.

4.6 Providers themselves have recognised the importance of being able to demonstrate quality care provision and voluntarily perform audit and peer review. There is a need to coordinate this data to demonstrate the quality of the service and hence justify its cost.

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

5.1 Although the current PDS orthodontic contract is an improvement on the previous one and has many strengths, e.g. simple to administer/measure and level payment received as work performed, it also has some inherent weaknesses.

5.2 Short fixed term contracts generally are a huge problem as it is virtually impossible to set-up or takeover a practice and recoup the investment within the term of the contract. Ongoing investment also carries a risk to the Provider.

5.3 Contract activity levels and distribution has broadly mirrored those of the pre-2006 GDS activity and hence access inequality remains unchecked. It is difficult if not impossible to establish a new service.

5.4 The UOA rate and contract term varies between different Health Boards and even within the same area. This seems inherently unfair unless justified. There should be financial reward for good quality in terms of treatment itself, completion rates, etc.

5.5 Annual payment uplifts have not kept pace with the increased costs of running an orthodontic business and complying with the various directives issued regionally and nationally over the years.

5.6 The remuneration levels in primary GDS care for extracting teeth for orthodontic reasons is low which seems to provide an incentive to seek alternative solutions which may be less appropriate and more expensive.

5.7 Other more minor problems with the PDS contract itself include:

- There is an inability to penalise patients for missed appointments except by discontinuing treatment which is not desirable except in extreme circumstances.
- Different BSA forms are used for the start and end of treatment – a variation in patient demographic details during this period can lead to the forms not being linked and hence apparent non-completion of treatment.
- The aesthetic component of IOTN remains somewhat subjective and causes the majority of patient appeals which are time consuming to administer.
- Too inflexible in terms of treatment complexity, e.g. as soon as a patient is 10 years old, their treatment automatically consumes 21 UOAs.

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- Most contracts exclude treatment of patients aged 18 or over which is potentially discriminatory.
- Replacement appliance charges are not proportionate to the true and increasing cost of providing this service and are not sensitive to the appliance type – some are much more expensive to manufacture than others.