



**Cynulliad Cenedlaethol Cymru
The National Assembly for Wales**

**Y Pwyllgor Iechyd a Gofal Cymdeithasol
The Health and Social Care Committee**

**Dydd Mercher, 4 Mehefin 2014
Wednesday, 4 June 2014**

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Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

**Aelodau'r pwyllgor yn bresennol
Committee members in attendance**

Leighton Andrews	Llafur Labour
Rebecca Evans	Llafur Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales

Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales

**Eraill yn bresennol
Others in attendance**

Mark Drakeford	Aelod Cynulliad, Llafur, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol Assembly Member, Labour, the Minister for Health and Social Services
Dr Sandra Sandham	Cadeirydd y Grwp Ymgynghorol Strategol Orthodonteg Chair of the Strategic Advisory Group on Orthodontics
David Thomas	Prif Swyddog Deintyddol Chief Dental Officer

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

Llinos Madeley	Clerc Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk
Philippa Watkins	Gwasanaeth Ymchwil Research Service

*Dechreuodd y cyfarfod am 09:16.
The meeting began at 09:16.*

**Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions**

[1] **David Rees:** Good morning. I welcome Members to this morning's session of the Health and Social Care Committee. We will be taking evidence this morning from the Minister and his officials in relation to our inquiry into orthodontics in Wales. The meeting is bilingual. Headphones can be used for simultaneous translation on channel 1 or for amplification of sound on channel 0. I remind Members to turn off their mobile phones or any other equipment that may interfere with the broadcasting equipment. There is no scheduled fire alarm this morning, so if the alarm does go off, please follow the direction of the ushers. We have received apologies from Kirsty Williams this morning and we have not had indication of a substitute for this session.

09:17

Ymchwiliad i Wasanaethau Orthodontig yng Nghymru: Sesiwn Dystiolaeth 3
Inquiry into Orthodontic Services in Wales: Evidence Session 3

[2] **David Rees:** I welcome the Minister for Health and Social Services, Mark Drakeford, to this morning's session. Minister, would you like to introduce your officials?

[3] **The Minister for Health and Social Services (Mark Drakeford):** Thank you, Chair. Members will be familiar already with the Chief Dental Officer for Wales, David Thomas. I will ask Sandra to introduce herself.

[4] **Dr Sandham:** I am Sandra Sandham. I am here as the chair of the strategic advisory forum on orthodontics.

[5] **David Rees:** Thank you for that. Thank you, Minister, for your written evidence to the committee as part of our inquiry. Obviously, that always leads us to questions, so we will start off with questions. I will start off with Gwyn Price.

[6] **Gwyn R. Price:** Good morning, everybody. Could you tell me your thoughts on whether there is enough awareness, monitoring and evaluation of local health board waiting times for orthodontic care assessment and treatment?

[7] **Mark Drakeford:** Thank you, Gwyn, for that. I wonder, Chair, whether it would be helpful, in setting out an answer to that question, to describe the architecture that we now have in place in Wales to make sure that there is sufficient awareness and oversight of those things. In a way, it is an architecture that has developed as a result of the report that was prepared by your predecessor committee at the end of the last Assembly, and, as a result of the report of Professor Stephen Richmond, which appeared at around the same time, into orthodontics in Wales. So, what we have now, at a national level in Wales, is 'Together for Health: A National Oral Health Plan for Wales 2013-18', which was published just over a year ago. At a national level, we are advised by the strategic advisory forum, which Sandra chairs. That is a forum that is made up of senior professionals in the field of orthodontics. So, we have national advice that comes from that body, we have three managed clinical networks, which are regional organisations, and then we have local health boards, each with its own local oral health plan. So, we have a national, regional and local structure. I think that it has meant that, compared with where things were three or four years ago, there is considerably more attention at the LHB level to the issues of orthodontic monitoring and evaluation. We were able, for example, to provide the committee with waiting times figures, at each of those levels, which I do not think was possible when the predecessor committee carried out its inquiry. That information simply was not collected in a way that could be presented in a reliable format.

[8] So, I think that the system is in place. I think that it already shows that we know more, and that more attention is given to those things. There are some further things that we hope to do in the reasonably near future, which I could describe later, if committee members were interested in that.

[9] **Gwyn R. Price:** Thank you for that, Minister. That was the next question, really: what were the improvements since the inquiry in 2010-11? So, thank you for that update. Do you think that additional funds are required to reduce the waiting lists?

[10] **Mark Drakeford:** Thank you for that question, because it allows me to say absolutely upfront that it is not part of my plan to provide additional funding for a one-off waiting list reduction initiative. I know that the committee has heard that idea, and I know that you will have heard very mixed views on it from professional bodies—the British

Orthodontic Society did not support such an idea, neither did the British Dental Association or Public Health Wales, and neither did some of the regional networks that you have heard from. Others have advocated it.

[11] I am not intending to do that for two main reasons. One is that the report that Professor Richmond prepared, and the work of the predecessor committee, suggested that there was sufficient money in the system to meet legitimate orthodontic need, provided that the system could be made more efficient. I think that there are ways in which the system has already been made more efficient, although there are certainly further efficiencies to be found within it. So, that is my first reason for not providing more money—the money is there, but we just need to make better use of it. The second reason is that, in all the things that we do, there are priorities to be identified and choices to be made. If I did have £1 million—which I do not have, by the way—which is what I think the estimate is of what a waiting list initiative might require, for use in dentistry, then there are a series of other things that I would probably put ahead of orthodontics as priorities for that sort of investment.

[12] **David Rees:** In relation to that, Minister, clearly we heard evidence on the issue of whether treatment is aesthetic or whether there is a need for work. Do you think that the demand for cosmetic, or aesthetic, treatment in orthodontistry is actually greater than it should be, and how do you intend to balance the workload?

[13] **Mark Drakeford:** Just to be completely clear, the NHS has never been, and has no prospects of being, able to provide orthodontic treatment that is essentially simply cosmetic in nature. What we do is to provide orthodontic treatment where there is a clear clinical need for such treatment to be provided by the National Health Service. You will know from evidence that you have had already that this is governed in the system by the—. I will make sure that I get this right now—

[14] **Mr Thomas:** The IOTN—the index of orthodontic treatment need.

[15] **Mark Drakeford:** Yes, the index of orthodontic treatment need.

[16] **Mr Thomas:** That was developed by Stephen Richmond and colleagues, when he was working in Manchester. It is used widely across the United Kingdom. All UK countries use the IOTN as a method of describing what need is. So, IOTN 5 is severe need, and IOTN 4 is great need. Then there is also 1, 2 and 3; 1 is no need, limited need, and whatever. All UK countries use that system to make sure that patients—children especially—can access orthodontic treatment based on that scale. The scale at the moment is that all children with an IOTN score of 4 and 5 would be offered treatment and also that children with an IOTN dental health component of 3 and an aesthetic component of 6 would be offered that treatment. So, that is how we assess the need at the moment.

[17] **Mark Drakeford:** So, no child is offered orthodontic treatment where the need is entirely cosmetic. There is a small group of children in that category 3, where there is a clinical need for it, but there is also some aesthetic component to it. I know that you have heard different people argue that if we were not to offer treatment at all at level 3, that would release some limited capacity into the system for better, more rapid treatment at levels 4 and 5. I have discussed this at some length with the chief dental officer and others and my own view at the moment is that it is right for us to continue to offer some level 3 treatment, because for some young people the cosmetic dimension of it, if it is not attended to, has other sorts of impacts on their lives, for example bullying and those sorts of things. If people's appearance is such that they get hostile attention from others, even though there is no clinical component to it, it is right that, where there is a serious issue of that sort, the system is open to considering it.

[18] **David Rees:** We now have questions from Lindsay, Leighton and Elin.

[19] **Lindsay Whittle:** I certainly do agree, on the demand for cosmetic treatment for adults, that if you want the Hollywood smile, you pay for it and that is up to you. Thank you for enlightening us on the issue for young children because that was going to be my second question, but you have answered it.

[20] I wanted to come back to the issue of waiting times. I may regret saying this, but in 38 years as an elected public representative, I have never had an issue with dentistry—no constituent has ever come to me before. *[Interruption.]* If I could finish. *[Laughter.]* However, I understand that that is not the same across the whole of Wales and I do not think that that is fair. I think that everyone across the whole of Wales should have that similar treatment. I have seen photographs of queues of people when a new dentist has set up in rural parts of Wales and people have travelled miles and miles to get there. That cannot be right—they should have access to a good service within a reasonable distance of their homes. You mentioned that if you had £1 million, you have other ideas, and I would be interested in those as well, but how can you ensure that we get this equitable service across Wales, because it cannot be right that just because of where you live, you do not get a proper dentistry and orthodontic service?

[21] **Mark Drakeford:** I will make a start on that, Chair, and I might ask Sandra to amplify the answer. I accept that there are some inequities of provision across Wales and that we need to do more to ensure that there is equitable access to orthodontic services. The last committee's report put particular emphasis on driving efficiency through addressing the number of assessments—the assess-and-review procedure—in orthodontics, which led nowhere. They were quite a source of lucrative activity for orthodontists, but, essentially, people were just seen and nothing, in terms of treatment, followed from that. Now, over the last four years, there has been a 59% reduction in the number of assess-and-review appointments. That, I think, is a major efficiency gain. It means that there are 500 more people receiving orthodontic treatment, and those are essentially children—so, 500 more children have received orthodontic treatment in Wales in the last year, for which there are figures, than would have been the case when the last committee reported. There were 2,000 additional units of orthodontic activity commissioned by LHBs in that year compared with the position three years previously. So, there is already, as a minimum, a 6% gain in the system. We think that there are more efficiencies to be squeezed out. There are too many retreatments in the system.

09:30

[22] Around 13% of all orthodontic treatment of children is for children who have already had one course of orthodontic treatment and then re-present themselves and they often do not have to go, necessarily, back through the system, as they just get re-presented directly to the orthodontist. So, in its paper to you, Public Health Wales said that there are some people getting more than one bite of the cherry here, while others are waiting too long to get the first course of action. We think that about 13% of all orthodontic activity is in that category and we can do more to reduce it.

[23] There is a lot of wastage in orthodontic treatment from people who do not complete the course of treatment. They start it and then, because—Janet has spotted what happens—people do not like what you need to do with orthodontics, wearing the braces and all of that, so they do not complete. They can then re-present themselves. There were about 630 treatments of that sort in the last year, for which we have figures. We think that it is possible to at least double the efficiency gain that we have made so far. If we were able to do that over the next two years, then the system would be broadly in balance. That would mean that we would be better able to attend to the needs of those places where orthodontic services are least

available. It is not easy to provide orthodontics on the spot in more remote or rural areas, because these are very expensive facilities to set up. However, there are things that we can do in the future in terms of teledentistry and some of the things that we can do in primary care, so that, if someone does need to travel, they travel only for those things that they really need to travel for and we do far more as close to where people live as possible.

[24] **Lindsay Whittle:** What about a mobile service? Is that possible?

[25] **Dr Sandham:** A mobile service was in operation many moons ago, but the equipment that is needed and the sterilisation and services that you need make it very difficult in a mobile service for orthodontics. The other issue about adding to the waiting list is the fact that with some dentists, patients will exert pressure on them to refer them for orthodontic treatment and they will refer them to several orthodontic places, so, when they get picked off the earliest list, they are still resting on other lists. Hopefully, with the new introduction of referrals, we will be able to spot those patients as well. So, that will improve it. In terms of the employment of dentists with special interests, if they can be positioned in rural areas, that would improve access as well. Certainly, in north-west Wales, we have dentists with special interest areas and they go and visit the consultant orthodontist for training and then go out and provide that in their geographically isolated areas.

[26] **Mr Thomas:** May I just add, Chair, that the Government is working very closely with a number of health boards to ensure a more flexible approach to commissioning? Sandra has mentioned dentists with special interests, but I should mention also that we have a new breed of therapists called orthodontic therapists who are supervised usually by specialists. So, that is another mechanism that we can use, certainly in those places where it is difficult to get a specialist to go and set up. A specialist obviously needs to have a patient base that they can develop their finances around. Obviously, if we have orthodontic therapists who are supervised by specialists, they can go out on a hub-and-spoke basis and help treat and sort out this issue.

[27] **David Rees:** Thank you. We have Elin and Rebecca who want to ask follow-up questions on this.

[28] **Leighton Andrews:** May I just ask—

[29] **David Rees:** On this issue—is it a follow up question?

[30] **Leighton Andrews:** Yes. When you were talking about equalities and inequalities in terms of services, if you had that magical £1 million, you said that you would not be inclined to spend it on orthodontics and I just wondered what your view would be on spending it on, say, fluoridation instead.

[31] **Mark Drakeford:** In general, Chair, if I had the £1 million, a higher priority for me, among a number of other priorities, would be more preventative dentistry among those communities where we have high levels of dental inequality that is not now to do with provision, because there is dentistry available, but where children simply are not presented by their families for the dental care that would lead to better oral health in the future. So, a greater priority for me would be to make an inroad into that than into orthodontics.

[32] Leighton asked very specifically on the issue of fluoridation. Fluoridation is a very controversial matter. People have strong views on it. The Government has no current plans to bring forward legislation in that direction. You will have heard, probably from the chief dental officer, and certainly from David's predecessor, Paul Langmaid, whom I worked closely with and who was a very strong advocate of fluoridation, that the evidence from Birmingham, which has had fluoridation for half a century is that it has the best oral health

among children of any part of the United Kingdom, and that the fluoridation makes the biggest impact of all among the most disadvantaged children in that population. It is not a matter that Government is going to take forward at the moment, and it might not even be that Government is the best place to start that debate, but a debate on fluoridation and the contribution that it could make to the oral health of the most disadvantaged children in Wales will be very worth having.

[33] **David Rees:** Okay. We go back to waiting lists, and Elin has the next question.

[34] **Elin Jones:** Roeddwn jest am fynd yn ôl at y pwynt yr oedd Lindsay wedi ei godi ynglŷn â'r anghyfartaledd o ran yr amseroedd aros. Mae'r tablau yr ydych wedi eu rhoi yn ddefnyddiol iawn o ran cymharu perfformiadau byrddau iechyd, ac maen nhw'n amrywiol iawn, onid ydynt? Mae rhai byrddau iechyd ac ardaloedd ag amser i driniaeth o lai na dau fis, ac mae eraill wedyn, fel yr un yr wyf i'n gyfarwydd ag ef, sef Hywel Dda—ac mae lot o rieni yn cwyno wrthyf am wasanaeth orthodontig o ran pellter ac o ran amser aros—ac Abertawe Bro Morgannwg ac Aneurin Bevan hefyd lle mae'r amser aros yn ddwy flynedd ar gyfartaledd. Felly, mae'r gwahaniaeth yn y perfformiadau yn sylweddol. Ym mha ffordd yr ydych chi fel Llywodraeth yn dadansoddi pam mae gwahaniaeth yn y perfformiadau? O dan yr un math o gyfundrefn gyffredinol, pam mae hyn mor wahanol yn yr elfennau hynny? Nid rhywbeth gwledig *versus* trefol ydyw, nage?

Elin Jones: I just wanted to go back to the point raised by Lindsay about inequalities in waiting times. The table that you have provided is very useful for comparing the performance of health boards, and they do vary greatly, do they not? There are some health boards and areas that have a time to treatment of less than two months, and there are others, one of which I am most familiar with, namely Hywel Dda—and a lot of parents complain to me about the orthodontic service in terms of distances and waiting times—and Abertawe Bro Morgannwg and Aneurin Bevan, where the waiting time can be an average of two years. So, the difference in performance is substantial. How are you as a Government analysing why that difference in performance exists? Under the same type of system generally, why is it so different? It is not a rural versus urban thing, is it not?

[35] **Mark Drakeford:** Mae mwy nag un rheswm, rwy'n siŵr, y tu ôl i'r ffigurau sydd gennym. O dan y wyneb, mae rhai pethau sy'n digwydd yn yr ardaloedd hynny yn wahanol. Er enghraifft, rydym yn gwybod, yn Abertawe Bro Morgannwg, fod mwy nag 20% o'r plant sydd ar y rhestr aros o dan 11 oed. Mae Public Health Wales yn dweud yn ei bapur ei fod yn gallu mynd yn ôl i weld pam mae hynny'n digwydd, ac mae'n dweud ei bod yn *practitioner-specific* a bod rhai deintyddion jest yn rhoi pobl ar y rhestr aros yn rhy gyflym, ac mae pobl jest yn aros ar y rhestr nes cyrraedd yr oedran pan mae'n werth iddynt gael eu gweld. Rwy'n siŵr y bydd David neu Sandra yn gallu esbonio pam nad yw pobl yn cael triniaeth yn y maes hwn cyn iddynt droi 11—wel, mae Sandra'n gallu dweud mwy na fi.

Mark Drakeford: There is more than one reason, I am sure, behind the figures that we have. Under the surface, some of the things that are happening in those regions are different. For example, we know that, in Abertawe Bro Morgannwg, more than 20% of the children on the waiting list are under 11 years of age. Public Health Wales says in its paper that it can go back to see why that is happening, and it says that it is practitioner-specific and that some dentists are just putting people on the waiting list too quickly, where people stay until the age at which they are worth seeing. I am sure that David or Sandra will be able to explain why people do not receive treatment in this area before they are 11 years of age. Sandra can say more than I can.

[36] **Dr Sandham:** Nid wyf yn rhugl.

Dr Sandham: I am not fluent.

[37] I am a learner. I am hoping that I have the gist of it, so I will try to answer it. I think that the thing is that the waiting times vary because, in the primary care setting, they are waiting a long time to be assessed, but they are treated quickly, whereas in the hospital setting, they are seen quickly but wait a long time to be treated. It is the way that things work with payments, especially in primary care.

[38] **Elin Jones:** Sorry to cut in, but, in Hywel Dda and Abertawe Bro Morgannwg for example, even the primary care assessment-to-treatment time is two years.

[39] **Dr Sandham:** Yes, that is what I am saying. In primary care, it is longer.

[40] **Elin Jones:** All right, okay. Sorry; I thought it was the other way around.

[41] **Dr Sandham:** In secondary care, it is longer than the treatment time of it. So, it does vary, and there are ways in which we are looking at that.

[42] **Elin Jones:** I know that it varies; that is why I am asking the question. Why does it vary? That is what I am trying to get at. I take the point you made about early referrals by dental practitioners, and where the waiting lists are long, there may be an incentive, and pressure from parents who know that the waiting lists are long, to get their dentists to put people on the lists. I did ask in a previous evidence session whether there should be a minimum age, so that children cannot not be referred on to treatment waiting lists or assessment waiting lists until they are 11 or 12?

[43] **Mr Thomas:** I can answer that. There is a very small percentage of younger children who need early intervention. Some children need to have treatment, where their top teeth are behind their bottom teeth, and that can be fixed very quickly, very early. Other children have severe craniofacial anomalies and need early treatment that is then followed up by more sophisticated treatment. It is around 2% of the population that needs to be seen early. So, it would be very difficult to introduce a regulation that did not permit people to be referred early.

[44] **Dr Sandham:** Additionally, some patients are referred for an opinion. If, say, they have a carious tooth in one quarter of their mouths, they may be seeking to find out whether early extractions would be beneficial. It might be possible to sort that with teledentistry.

[45] **Mark Drakeford:** May I add one point on that? There is a second strand of explanation as well as just the referral patterns that lie behind them, which, in some ways, is more relevant, particularly to the Hywel Dda position. I would like to reinforce something that you have heard already, and which was said yesterday in the debate on primary care on the floor of the Chamber. Through the telehealth technologies fund this year, we are investing money to have new electronic referral systems in place for community pharmacy, optometry and dentistry. I believe that that will expose more clearly and directly some of the anomalous referral patterns that lie behind some of these figures. So, if it is, as Public Health Wales says, because of specific practitioner behaviour, at the moment that is quite difficult to spot because of the way in which information is collected. When it is all being done electronically, that will come to the surface very fast indeed and will allow the managed clinical networks to go to those practices and say that the way in which they are referring people is simply outside the parameters of the way in which their peers in the same part of Wales normally would act. Therefore, we would be able to tackle those behaviours in that way.

[46] The second explanation is not to do with demand, but supply. It is to do with the fact that, as Lindsay mentioned in his question earlier, there are parts of Wales where it is more difficult to get orthodontic treatment on the spot. With regard to the hub-and-spoke model that Hywel Dda has now developed—and it was a controversial retendering process that it went

through—one of the things it should deliver, and it says it will deliver, is that the assessment side of orthodontics will be done in primary care by a new cadre of dentists with enhanced skills, as they are now called, in orthodontics, who practise in Ceredigion, for example, so that children will not be sent routinely on long journeys simply to be assessed. They will, for very specialist treatment, still end up having to travel, but the travel should be a minimum. Therefore, some of the waits that you see here should be ironed out as part of that approach.

[47] **Mr Thomas:** As an aside to that, Hywel Dda Local Health Board has taken on board this issue. The referral to assessment time was 18 months, but it is now nine months. As you may be aware, it has carried out a large number of regional, local assessment sessions in Aberystwyth and Haverfordwest. I was in Carmarthen on Monday, and it assured me that it is going to be letting the new orthodontic contracts in those far-flung western areas of Ceredigion to mop up some of the issues relating to referral-to-treatment times.

[48] **David Rees:** May I expand upon that? Clearly, you are looking at ways of reducing the referral-to-assessment times, but would a consequence of that be that you might therefore increase the assessment-to-treatment times?

[49] **Mark Drakeford:** No, that should not be a consequence, because it should mean that less of very expensive people's time is being spent doing unnecessary assessments, thereby freeing up their time to carry out the treatments that only they can provide. Perhaps I could take a moment to explain the workforce side of this. I very much see the future of orthodontics in the way in which I see the future of dentistry as a whole, really.

09:45

[50] We need to grow a new cadre of orthodontic therapists and dental therapists—people who can do the more routine, straightforward side of the job, so that much more highly trained people are not spending their time doing things that someone else could do. If you can displace time from a dentist into a dental therapist who is perfectly able to do inspections and routine fillings under the supervision of a dentist, that dentist will have time to do things that you really need a dentist to do, including, for those people who have a special interest in it, more orthodontics in primary care. That will draw people back from secondary care, meaning that consultants are only doing the things that only consultants are able to do.

[51] Generally in the NHS, we have too many people providing services to people whose needs are well below their professional competence, because the system acts a sort of escalator—you are always being passed up the hierarchy of the professional structures—and we need to act to try to drag that in the opposite direction. Dentistry is a good example of that, because the General Dental Council has recently liberalised some of the rules that mean that properly trained and competent dental therapists will be able to do more in the future, and be able to do it under their own authority, than in the past. Sandra is in charge of an experiment that we are running in north Wales to do just that.

[52] So, as we draw people down, there are people who are being seen by dentists today for orthodontics who will be seen by dental therapists in the future, and there are people who are being seen by consultants today who will be seen by dentists with special interests. That will mean that we will have a more rational approach to it, so that people who need to see a consultant—those are essentially children with not just disfigured teeth, but children with cleft and palate conditions, and children who need maxillofacial surgery alongside dentistry, who have really serious needs, and who really need quicker access to consultant services—those people will be able to get consultant time, because consultant time will have been freed up to do more of that, as the more routine stuff will be done by people capable of doing it.

[53] **David Rees:** Rebecca, you wanted to come in on this.

[54] **Rebecca Evans:** I have just a quick question. Is there the appetite among dentists to become dentists with enhanced skills?

[55] **Mark Drakeford:** I might ask others to answer. The general point is that any change in professional practice where a bit of professional turf—if I can put it in that rather pejorative way—is opened up so that other people now get to do what only you were able to do in the past is inevitably not always an easy thing to achieve. However, on the question of whether there are dentists with an interest in this, I turn to Sandra.

[56] **Dr Sandham:** There are certainly dentists with an interest in orthodontics. A lot of people have been doing clinical attachments with consultants and specialists in the past. This is a nice way to recognise them and their skills. What it has done, though, is that it has eliminated the dabblers, because you used to get a lot of dentists that used to do odd bits and bobs. That has tended to cease, and the concentration is on people who have a special interest and have done some training in that aspect.

[57] **David Rees:** Will we have sufficient numbers, because one of the bits of evidence that we have received is a question over the recruitment and training of orthodontists, and consultants in particular? There was concern over that.

[58] **Mr Thomas:** There are nine national training numbers for orthodontists in Wales, and they are filled each year. I work very closely with the regional postgraduate dental dean and also with local health boards on their workforce numbers. There are sufficient orthodontists, I believe, in the system in terms of training; it is whether we are able to recruit them to the areas that are hard to recruit to. I do not think that dentistry is alone—it is quite difficult to recruit consultants in west Wales and north-west Wales in all medical and dental specialties. However, I believe that the numbers are there to deliver the service if we can recruit them.

[59] **Lindsay Whittle:** May I ask whether you offer incentives? What would you do with that £1 million? [*Laughter.*]

[60] **Mark Drakeford:** There is no plan to offer particular incentives to draw people further west. As the chief dental officer said, there are people there. It is not one of those areas such as psychiatry where we simply cannot fill posts; we are able to fill them. The answer is less trying to draw people further west than making sure that we do everything that we can to use the skills of people who are available locally to do more, because they can do more, and to do more things remotely through teledentistry and the other things that we will be able to do in the future, and therefore to minimise the need for young people themselves to travel.

[61] **Mr Thomas:** It is important to make the job attractive. We have been having some issues with other specialities in dentistry. Clearly, one of the things that consultants want to have is colleagues to talk to and work with. So, it is important to have links to other units, bigger units or academic units, so that consultants can not only do the job of treating people, but also do the research and development with colleagues. So, it is important to make the job attractive. I would come and work in west Wales; there is no doubt about it because I love the place.

[62] **Elin Jones:** It sounds like Siberia at times as though nobody wants to go there at all. It is not that bad. [*Laughter.*]

[63] **Mark Drakeford:** It is not at all.

[64] **Mr Thomas:** It is lovely.

[65] **Darren Millar:** I just wanted to ask, Chair, about the contracts around orthodontics. Obviously, you mentioned, Minister, that you want to see people enhancing their skills and a more developed dentist workforce across Wales, which are very welcome things indeed. We have heard about experiments in north Wales and people dabbling on the periphery as well, but clearly there has to be a proper framework in place, on which all of these things can hang. The contracts at the moment, from what we have heard in evidence sessions, simply do not appear to be fit for purpose. People seem to be paid at the start of a course of treatment, not at the end; it is not outcome based or quality based in terms of the work. We have had people griping sometimes about the length of the contracts and the ability of the smaller practices to be able to invest in order to deliver on those contracts. I know that you are doing some work with England on an England-and-Wales basis to review the contracts. Can you bring us up to speed on where that is and how you see that fitting in with the other things that you talked about?

[66] **Mark Drakeford:** Thank you for that question. I think that there are three different elements to it that go on in parallel with one another because we cannot afford simply to wait until the review of the contract as a whole. That is a piece of work that is being conducted on an England-and-Wales basis with the Department of Health. It is not due to report until 2016-17, so it is relatively still in its infancy and is being scoped in terms of what a renegotiated contract would need to cover. We are involved in that through the strategic board that Sandra chairs, which will give us advice. So, we are part of it, but it is not an immediate solution to some of the issues that Darren raised.

[67] The second thing is that we are looking to reform some of the regulations within the existing arrangements. I am particularly interested in the point that Darren mentioned, which is that we pay, at the moment, upfront for the whole cost of an orthodontic treatment. So, 6% of children in Wales receive orthodontics and 37.5% of the dental budget for children is spent on that 6%. So, that 6% of children get a very, very big slice of our budget. The average cost of a course of orthodontic treatment is £1,300. The orthodontist gets that upfront at the start of treatment. So, there is very little incentive to complete treatment because there is no payment attached to completion. It also means that if you fail to complete a course of treatment and then take yourself to another orthodontist, that orthodontist gets paid a second time over for a course of treatment that you paid for in full, but was not completed by somebody else. I have read the evidence that you have received and I think that it is quite persuasive that we need to change the way in which payments are made so that people get money upfront, because orthodontists are making an investment in all of this, but that there is also a proportion of that payment tied to the completion of treatment as well. I think that will remove some perverse incentives in the system that you then see reflected in some of the figures that I gave you earlier.

[68] Then there is the third issue that Darren mentioned, where there is a tension, it seems to me. You want to give orthodontists contracts that give them confidence to invest. As contracts come towards the end of their time, you want them not to stop developing their services because they are afraid that they will not get the contract and therefore there is no incentive for them to do that. So, I do not have a difficulty with contracts that go beyond the five-year standard that we started with. The tension then is as to how you guarantee quality in those contracts. Some of the evidence that you have heard is that there are monopoly suppliers of orthodontic treatment in some parts of Wales. While we want to have sufficient stability for orthodontics to be an attractive proposition to suppliers, and one in which they can invest, we cannot afford to have a system in which people will feel that they will go on being paid regardless of the quality of what they provide. So, we have to try to balance those two things. The contract is the way that we do it. We provided advice to local health boards, issued in May of last year, as to how they can, on the one hand, ensure that there is sufficient stability to have a growing supply where we need it and, on the other, to use the mechanisms

that are in there for peer review and other quality mechanisms to make sure that nobody feels that regardless of how good the service they provide is, because they are the only ones doing it, they are guaranteed to go on having that income into the future.

[69] **Darren Millar:** So, in terms of the quality issues that you have identified and the changes to the existing contracts in terms of when payments are made—at the start, completion or perhaps interim payments if it is a complicated piece of work—what is the timescale by which you expect to complete that piece of work?

[70] **Mr Thomas:** I think that you are aware that Professor Richmond did a report in 2010 and the Minister has asked Professor Richmond to redo that report, which is due now in the summer—probably in the next couple of months, hopefully. In terms of the changes, we will be giving advice to the Minister on changes to the regulations as soon as that report is published, along with obviously any recommendations that this committee makes. The time that it takes to consult on the regulations and to implement them will be the time that it takes.

[71] **Darren Millar:** Clearly, there is a quality element to the payment profile. If the payment profile shifts so that there is a payment at the end of the completion of the work, there will be an incentive to complete the work in a timely manner, which should then free up some additional capacity.

[72] **Mr Thomas:** There are some powers that the local health boards have. As you know, NHS regulations in 2006 put down a fixed five-year period for PDS agreements in orthodontics. Then, after that time period, LHBs had the freedom to set the contracts as they saw fit. I am aware that there are some orthodontic contracts let at the moment of over seven years, but the expert opinion that we have had from Professor Richmond and his colleagues is that we could attach quality outcomes to the clauses of contracts when they came up for renewal. So, there is a small mechanism that we can use already. We obviously need to give guidance to the local health boards on doing that.

[73] **Darren Millar:** Thank you for that answer. Minister, you made reference to people starting a course of treatment with one practice and then dropping out and being re-referred for treatment and commencing it with another practice. In some parts of Wales, there is quite a transient population, including in some parts of north Wales with people who relocate with children who are undertaking a course of orthodontic treatment or who are on a waiting list for orthodontic treatment in England then moving into Wales. What reassurances can you give and what clarity can you bring regarding the ability of those individuals, in particular, still to be able to access treatment without further delay as a result of their relocation?

[74] **Mark Drakeford:** Relocation should not matter in terms of treatment in the way that you described. I did not want to imply that everyone who starts treatment with one orthodontist and has treatment later on from somebody else is doing something that they should not be doing, because some people will be doing it for very sensible reasons of moving from one part of the country to another. However, at the moment, what the system does is to provide the first orthodontist with a full reward and the second dentist with a full reward. We just need to rationalise that so that the system responds to people who, for legitimate reasons, do the things that you described, Darren.

10:00

[75] One of the things, Chair, that we have not mentioned much this morning are the managed clinical networks. It was a strong recommendation of the previous committee's report and of the work that Professor Richmond did that we needed to move to three managed clinical networks in Wales. We now have those in place. They have a responsibility for quality of service as well as breadth of service, and, because they are there and functioning

and are doing a good job—which I think was one of the things that most people who gave you evidence agreed on, which they did not in many other areas—then I think we would look to those networks to make sure that in those more anomalous cases that people are not disadvantaged when they should not be.

[76] **Darren Millar:** May I just clarify this, because you did not quite answer this question? If somebody is on a waiting list in Wales or in England and they relocate across the border, how can we ensure that their length of wait is not extended as a result of that and that they are not disadvantaged in terms of access to treatment?

[77] **Mr Thomas:** I think that we need to use the referral management systems that we are developing in each MCN to—

[78] **Darren Millar:** What does MCN stand for?

[79] **Mr Thomas:** It stands for managed clinical network.

[80] We use the referral management systems that are being developed. There are robust mechanisms now in south-west Wales, where you go on to a management waiting list that is managed centrally. So, you use that system to make sure that the waiting time is not extended.

[81] On the previous question you asked about the transfer of cases, that is covered in the regulations. So, people transfer from one dentist to another. There is a proper process for that.

[82] **Darren Millar:** That is if there is ongoing treatment, but what about those people who are waiting for treatment who have not yet commenced their course of treatment? They are the individuals that I am concerned about, because I have had a few cases of that in my constituency.

[83] **Mark Drakeford:** I think it is an important point that you make, Darren, because, unlike with some other conditions, these are children for whom there is only a certain window in which treatment might best be provided. So, I would not want to see a position in which because people move they slide down the snake and have to start waiting from the beginning all over again. I will make sure that I discuss that point more fully, because those could be children who then miss the opportunity altogether, and we would not want to see that happen.

[84] **David Rees:** Could we expand a little on that, because we are also querying—. I just want conformation, Minister, basically. We heard that, with children who are waiting and who are assessed before they are 18 and then reach their eighteenth birthday, there is an issue as to whether they will continue to have that treatment funded.

[85] **Mr Thomas:** The regulations allow that to happen, Chair, already.

[86] **Mark Drakeford:** The regulations are very clear on that, and they are England-and-Wales regulations. If you are on the list before you are 18, you are on the list; you do not fall off the list at 18, but continue through to treatment.

[87] **Elin Jones:** On a point of clarification about what you said about the length of the contracts and what was in the 2006 regulations, you said that there had to be five-year contracts, but then you said that after the first five years there is a flexibility. Is that how the regulations—? For the first five years—

[88] **Mark Drakeford:** It is fixed.

[89] **Elin Jones:** —there is a contract, and then there is more flexibility; it is not in

regulations that it is every five years.

[90] **Mr Thomas:** No. It is in regulations that there is an initial five-year period, and then LHBs have the flexibility to set the contract length for their requirements, based on the needs of the population. In general terms, a lot of local health boards rolled over the contracts for another five years. Some LHBs did it for only three years, and, as I said, there are a couple of local health boards that have contracted for seven years with some providers.

[91] **Elin Jones:** May I just go back to one point that you raised in answer to me on the minimum age of referral into the assessment and treatment for orthodontics? You described the 2% of that population that may need to be referred very early on. Is it not possible in guidance from Welsh Government to health boards and then to dental practitioners that excepting that 2%—those young children who fall into that category—there should not be referrals until the age of 11? I do not know.

[92] **Mr Thomas:** I think that I would have to defer to the experts. I would have to defer to Professor Stephen Richmond, perhaps, to give you a proper answer about that. I can do that.

[93] **Mark Drakeford:** Shall we ask him to think about that point exactly in the work that he is doing at the moment, and about whether guidance of that sort would be useful?

[94] **Elin Jones:** Yes, that would be useful. It is something that has come up in evidence and in questioning, and it is certainly something that I hear from my area: that there is pressure from parents quite often to get early referrals so that children are seen by the age of 13 or 14, because the waiting list is long, so they are waiting two or three years.

[95] **David Rees:** Darren is next.

[96] **Darren Millar:** I just wanted to ask you a question. You mentioned the managed clinical networks earlier on, which are obviously very welcome. In terms of the number of assessments that people make, it was certainly put to the committee in the third Assembly—and it was suggested that this may be a problem that has been overcome now, but I would like to get your opinion on this—that some dental practitioners will make multiple referrals because of the waiting times in order to improve the opportunity for someone to get access to timely treatment. Are you confident that that problem has now been overcome? It could be inflating waits unnecessarily for people, and giving an artificial picture of demand across Wales.

[97] **Mr Thomas:** I think that that is exactly the point that the Minister has made.

[98] **Mark Drakeford:** It has been reduced, but not overcome. That is what I would say. I think that it is substantially reduced.

[99] **Darren Millar:** How are you policing it?

[100] **Mark Drakeford:** One of the things that I am optimistic about is that, when we move to the new electronic referral system, you will be able to see straight it away. At the moment, it is very hard to spot.

[101] **Darren Millar:** So, the timescale for this system, because you refer—

[102] **Mark Drakeford:** This year.

[103] **Darren Millar:** It is this year.

[104] **Mark Drakeford:** It is money for this year. So, it will be NHS Wales Informatics that will do the technicalities of it, and then the office of the chief dental officer will do the professional back up of it. There is a referral system used in Manchester that we think has some big advantages in driving out some of those behaviours, because the system just would not allow someone to do that. We are going to draw on that with NWIS over this year. It is a substantial area where gains have been made, with a 59% reduction in those things, but it is not eliminated.

[105] **Darren Millar:** It will be in all parts of Wales, will it?

[106] **Mr Thomas:** Yes. There is a manual system at the moment, which started in south-west Wales, where they are starting to identify, as the Minister has already mentioned, that 20% of the 4,000 people on the waiting list are under the age of 11. However, what is difficult to do, when you have a manual list, is then to go through to see how many cases of double counting there are. So, the electronic system will be of significant benefit.

[107] **Elin Jones:** So, if we held a session like this next year, we would have a table that refers to waiting times and the length of waiting times that was consistent throughout Wales—this is not really; the data are not absolutely consistent in terms of being able to compare various health boards—and that could be quite specifically drilled down into.

[108] **Mark Drakeford:** That is the aim: that we will have an all-Wales, national electronic-based referral system, that will allow us to drill down, as you say, below the figures in a way that we are not completely able to do now.

[109] **Mr Thomas:** It brings additional benefits in that we identify all of the referrers, and we can compare the referral rates. So, that would allow us, obviously, to educate those people that are perhaps referring inappropriately to refer more appropriately.

[110] **Mark Drakeford:** Chair, I do not think that I mentioned that the strategic advisory forum that Sandra chairs produces an annual report. The first one, in fact, was published earlier this week. It is available on the chief dental officer's website. It has a set of figures that are more up to date than the ones that you have had here even, which shows that we are certainly in a better position than we were the last time that this committee looked at orthodontics. We will be in a better position again, however, once the electronic system is up and running.

[111] **David Rees:** May I just ask one final question, Minister? We talk about models, and the changing model of service in the sense that we are talking about dentists with enhanced skills. Do you have a rough timescale as to when you expect to see that model becoming more effective, because that also has an implication for reducing the times as a consequence of a greater number of people doing assessments?

[112] **Mark Drakeford:** Again, that is not work that is simply yet to come, because it has already begun and it is already there to be seen in some parts of Wales. It is there to be seen, particularly, in more western areas where the need is more urgent. Sandra might have an idea of how fast we think that we are going to be able to build up that cadre.

[113] **Dr Sandham:** It is very difficult to predict at the moment, because some are in advance of others, as well, at the MCN level but, we are working to improve the situation and we are very pleased with what we have achieved so far, so I am hoping that it will carry on apace as we have done so far.

[114] **Mr Thomas:** I will be issuing further guidance to local health boards on the

commissioning of specialised services using dentists with enhanced skills during this year, probably in the autumn.

[115] **David Rees:** Okay, thank you for that. Do any Members have any other questions? No. Therefore, Minister, may I thank you, David Thomas and Dr Sandra Sandham very much for attending?

[116] **Mark Drakeford:** Thank you very much.

[117] **David Rees:** You will receive a copy of the transcript for factual corrections. Thank you.

10:11

**Papurau i'w Nodi
Papers to Note**

[118] **David Rees:** Are Members happy to note the minutes of 30 April 2014 and the minutes of 8 May 2014? You are. Thank you.

10:11

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r
Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the
Meeting**

[119] **David Rees:** I move that

the committee resolves to exclude the public from the meeting in accordance with Standing Order 17.42(vi) and Standing Order 17.42(ix).

[120] I feel very sorry for the people who have just come into the public gallery, because we are about to go into private session. Are all Members content? I see that Members are in agreement.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth y cyfarfod i ben am 10:12.
The meeting ended at 10:12.*