Health, Wellbeing & Local Government Committee

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Inquiry: Orthodontic Services in Wales

Submission on behalf of the South East Wales Managed Clinical Network in Orthodontics (MCN).

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Background

Orthodontics is the speciality within dentistry concerned with growth, development and the treatment of anomalies of the dento-facial complex. These anomalies cover a wide spectrum and an efficient and effective orthodontic service requires input at different skill levels and in different locations within primary and secondary care.

Treatment is undertaken on an out-patient basis with appointments at about 6 weekly intervals over 18 to 30 months depending on the severity of the malocclusion

General Dental Practitioners (GDPs): Most orthodontic treatment is carried out on referral from GDPs and as such they are the gatekeepers of the service. To be effective in this role GDPs need training in the application of the Index of Orthodontic Treatment Need (IOTN). Historically some GDPs carried out simple treatments on advice from their local consultant but this has largely disappeared with the new contract.

Dentists with a Special Interest (DwSIs): Some GDPs have taken on increased numbers and range of orthodontic patients as a special interest. These dentists are not on the specialist list and have traditionally trained on a sessional basis with their local consultant with whom they have maintained contact for treatment planning and advice. Formal part time training programmes are now available leading to a Diploma in Primary Care Orthodontics. Increasingly some of these dentists with, and without, formal training are working independently in referral practices.

Specialist Orthodontic Practitioners: These specialists work within the primary care setting and are on the specialist list having undertaken a full time 3 year training programme. They are the work horses of the service and are able to take on a full range of patients outside of the very complex and multidisciplinary cases. Orthodontic Specialist Practices are independent businesses requiring a massive input of personal capital. As such there are issues of economies of scale that may conflict with policies for accessibility.

Specialist Orthodontic Practitioners in the Community Service: These specialists are salaried working within the Community Dental Service and have the same training and working range of other specialists. Their role is to provide accessible specialist care.

Hospital Consultants: Have undergone the same 3 year training as other specialists and then an additional 2 or 3 year training in the management of very complex and multidisciplinary problems. Their role is advice to GDPs, GMPs, Specialists and Hospital colleagues from all disciplines. Treatment is restricted to the highly complex and multidisciplinary cases that can for example in the case of children with cleft lip and palate involve a number of interventions throughout childhood and adolescence. Most consultants have a significant teaching role with trainee specialists or orthodontic therapists in addition to on-going education of GDPs and these units may take on some relatively "routine" cases for teaching purposes.

Orthodontic Therapists: A relatively new class of orthodontic manpower, therapists are trained Dental Nurses who undergo an additional, largely work based, 1 year training programme. They are trained in many of the manual skills of an orthodontist but not diagnosis or case management. They can only work under supervision but the rather loose legislation only prescribes that this should be a "dentist" which leaves potential for inappropriate use.

South East Wales: The particular problems of provision of orthodontic services in SE Wales are related to geography and access and are not dissimilar to problems elsewhere in Wales.

There is good provision of Specialist Orthodontic Practice around Cardiff and along the M4 corridor but very little elsewhere. Traditionally patients have needed to travel down the valleys to access care. This leads to increased pressure on those hospital units distant from accessible specialist practice both in terms of new patient referrals and to take on treatments outside of the normal hospital range.

The mechanism used for establishing the new orthodontic contract was based on cases finished during the period October 2004 to September 2005 i.e. patient starts during 2003 and effectively fixed these referral patterns. The resources for orthodontic management of valleys patients was therefore fixed into the budget of the then Cardiff LHB.

Practices expanding during the period 2003 to 2005 were effectively awarded contracts representing their 2003 starts rather than the volume of their patient care at the start of the contract in 2006.

It was recognition of these issues that has led to the establishment of the SE Wales Orthodontic Managed Clinical Network involving all

clinicians and the three Health Boards - Aneurin Bevan, Cwm Taf and Cardiff & Vale.

Questions for Consideration

1. The new contract has led to better targeting of orthodontic treatment by elimination of the small number of mild cases under treatment. Overall there has been reduced provision of orthodontic care in part due to the fixing of activity at 2003 levels. This has led to an increase in waiting lists in Specialist Practices most of which report a "dead" period towards the end of the financial year when their contracted Unit of Orthodontic Activity (UOA) allocation has been exhausted and they are unable to start new courses of treatment. A number of practices report waiting lists that represent more than the UOA contract value for the following year.

This has in turn led to increased referrals to Hospital Units as well as the additional referrals for second opinions for "dispute" situations where patients have been turned down for NHS care under the new guidelines to eliminate mild cases.

There has been no improvement in geographical access and in fact referral patterns have effectively been frozen at 2003 levels.

2. Co-ordination and cooperation over orthodontic treatment has been mainly at a personal level between providers and the transference of cases between hospital and specialist practice where patients are more appropriately seen in another setting.

GDPs generally have a poor understanding of the system and tend to be "one stop" rather than discerning referrers. This is compounded by the different approach to waiting lists between hospital and specialist providers.

Hospital Consultants have always aimed at short new patient waiting lists because of their advisory role and in recent years these have been subject to Government targets. This has led to short new patient waiting lists but long treatment waiting lists. Specialists generally see patients when they have treatment allocation available and tend to have long new patient waiting lists but once seen can treat those patients straight away if appropriate. This can compound the problem for an inappropriately referred patient with a complex multidisciplinary problem who may wait for many months to see a Specialist only to be re-referred to the Hospital Consultant. In other cases the opportunity for interceptive measures is lost by this delay in obtaining a specialist appointment.

There has been no overall co-ordination of treatment or even dissemination of information and this with the other problems outlined has been the driving force behind the development of the SE Wales Orthodontic Managed Clinical Network.

3. The latest reorganisation of the Health Boards unfortunately overlapped the end of the first 3 year contract period for the Specialist Orthodontic Practices. Reorganisation led to loss of experience within some Health Boards and, as a minimum, a period of uncertainty regarding structures and roles within the Health Boards.

Practices reported reaching the end of their contracts with no certainty of continuation of those contracts.

Again it is the intention that the SE Wales Orthodontic Managed Clinical Network involving all three new Health Boards will eliminate many of these problems in the future.

4. Cardiff University Dental Hospital (with its associated regional hospital teaching units) has a vital role in the education of future orthodontic specialists and undertakes that role to the highest possible standards.

Orthodontics has a proven mechanism for measuring outcome the Peer Assessment Rating (PAR) that has been used in many studies and audits both nationally and locally.

It is difficult to see a role for the University in monitoring the local orthodontic workforce not least because the University is not "local" to most of Wales.

5. No clinician has reported any knowledge of any Welsh Government short, medium or long term strategies for orthodontics.

The mechanism of the new dental contract being time and cost limited has, however, created problems in terms of strategic development of services.

Levels of provision have been largely fixed at 2003 levels with no allowance for year to year fluctuations or year on year shifts in need. Geographical inequalities have been frozen. Areas with no orthodontic provision in 2003 have no allocation of resources.

Specialist Orthodontic Practices do not have the confidence to heavily invest in equipment and leading edge techniques when they have time limited contracts. The longitudinal nature of orthodontic treatment means that there must be some certainty with regard to continuity of patient care.

All clinicians are concerned that that any change in arrangements must include provision for the backlog of patients in the system and recognition that these patients will all take 18 to 30 months to treat.

Orthodontic therapists will provide a welcome addition to the orthodontic workforce. Most clinicians feel that their value in increasing orthodontic provision (and reducing cost) has, at least in the short term, been overstated. Orthodontic practices and departments need to be specifically designed to maximise the use of therapists and there is little merit in evicting a specialist in order to accommodate a therapist. Work capacity and longevity of the workforce remain to be proven. The fact that therapists can be supervised by any dentist leads to a definite risk of unethically poor supervision of therapists.

6. There is a mechanism for PAR monitoring of outcome for those patients treated under the NHS in Specialist Practice. This amounts to

a sampling of a percentage of completed cases. Systems are also in place at the Business Service Authority, who manages the system, to pick up "outliers" for further investigation.

The salaried services, both Community and Hospital, have no formal monitoring mechanism although have an obligation to audit. Consultants are subject to annual appraisal. There would appear to be no monitoring of the independent sector.

The process of tendering for orthodontic contracts flies in the face of DoH guidelines for good practice and can lead to a quantity and price emphasis rather than quality. Any contract process must include robust quality measures. The very process of short term contracts and tendering can lead to the loss of continuity of patient care.

The view exists that orthodontics is a profession and should be treated as such. The present legal framework and new GDC complaints procedure are sufficient to ensure that patients have the necessary mechanisms to address any grievance.

7. In a multi-facet service each sector has its own issues. Hospitals the recognition of their treatment waiting lists and lack of treatment capacity. Health Boards the need to coordinate and manage contracts on a sub-regional basis. Specialist Orthodontic Practices provide the bulk of orthodontic care and are concerned with the contract process and the backlog of patients. The present inflexible and short term contract is inhibiting investment in those practices and possibly future orthodontic provision.

The solution: longer term, quality orientated, rolling contracts.