Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government Committee

Dydd Mercher, 3 Tachwedd 2010
Wednesday, 3 November 2010

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Christine Chapman	Llafur (yn dirprwyo ar ran Irene Jame) Labour (substitute for Irene James)
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservative Party
Veronica German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Ann Jones	Llafur Labour
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservative Party (Committee Chair)

Eraill yn bresennol
Others in attendance

Dr Stephen Davies	Cymdeithas Feddygol Prydain British Medical Association
Dr Andrew Dearden	Cymdeithas Feddygol Prydain British Medical Association
Edwina Hart	Aelod Cynulliad, Llafur (Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol Assembly Member, Labour (The Minister for Health and Social Services
Andrew Powell-Chandler	Pennaeth Polisi Deintyddol, Llywodraeth Cynulliad Cymru Head of Dental Policy, Welsh Assembly Government
Yr Athro/Professor Stephen Richmond	Athro mewn Orthodonteg, Ysgol Ddeintyddol Prifysgol Caerdydd Professor in Orthodontics, Cardiff University School of Dentistry
Dr David Thomas	Prif Swyddog Deintyddol Dros Dro Cymru Acting Chief Dental Officer for Wales
Dr Sarah Watkins	Uwch Swyddog Meddygol Senior Medical Officer

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

Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.11 a.m.
The meeting began at 9.11 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everyone; welcome to today's meeting of the Health Wellbeing and Local Government Committee. I would also like to welcome members of the public and remind them that headsets for simultaneous translation and sound amplification are available in the public gallery. If anybody has any problems using these then the ushers will be able to provide assistance. Committee members, members of the public and witnesses may wish to note that the simultaneous translation feed is available on channel 1, while channel 0 is the language actually being spoken. I would be grateful if everybody—Members, members of the public and witnesses—could ensure that mobile phones, pagers and BlackBerrys are switched off so that they do not interfere with the broadcasting and other equipment. If it is necessary to evacuate the room or the public gallery in the event of an emergency, everybody should follow the instructions of the ushers who will be able to point people to an appropriate exit. I just remind witnesses that the microphones are operated remotely; you do not have to press any buttons, they should magically turn themselves on and off as necessary.

[2] We have received apologises for absence from Irene James today and Christine Chapman is substituting for her. Welcome to the committee, Christine. We have not received any other apologies other than to say that Helen Mary has indicated that she may be arriving late. I invite members to make any declarations of interest under Standing Order No. 31.6. I can see that there are none, so we will move straight on.

9.12 a.m.

Ymchwiliad i Driniaeth ar gyfer Anhwylder Straen Wedi Trawma i Gyn-filwyr y Lluoedd Arfog
Inquiry into Post-traumatic Stress Disorder Treatment for Veterans

[3] **Darren Millar:** I am very pleased to be able to welcome to our meeting today, Dr Andrew Dearden and Dr Stephen Davies, both of the British Medical Association. Thank you very much for the paper that you have supplied to the committee, which has been circulated to members. If you are content, we will move straight into questions on that paper.

[4] You state in your written evidence that because post-traumatic stress disorder is a complex condition veterans require full mental health assessments from fully and suitably trained professionals. Obviously, a general practitioner is usually the first person someone with PTSD will present to, with perhaps a range of different symptoms. How effective do you think GPs are at picking up and diagnosing PTSD? Do you think that they are the right people to signpost veterans with PTSD to an appropriate service?

[5] **Dr Dearden:** Good morning and thank you for the invitation. If I may, I will start on the general practice and then turn over to Stephen for the second stage of that. It is important to recognise that probably 10 to 15 per cent of a GP's workload is mental health. The full range of mental health issues, from mild depression, anxiety and bereavement all the way up to the very serious and long-lasting psychiatric disorders, will almost certainly come through a GP first. So, a large part of that workload will be diagnosis. Any diagnosis is helped by as much information as a patient can give us. For example, they will often come in with headaches. Then we will find that they have just had bereavement or a family break up, which may help to explain what is going on. Any diagnosis requires time—sometimes two or three consultations are necessary—but the more information that we have, the easier it is to diagnose some underlying conditions because, of course, the patient does not always understand what is going on or why it is happening and does not always relate one thing to another.

[6] We feel that GPs are probably the best placed people to begin that initial diagnosis. Of course, there are many other professions that are affected by post-traumatic stress. While we are very pleased that we are looking at it in relation to veterans today, perhaps, in the future we might extend services to include people like ambulance, police or firemen who also put themselves in life-threatening situations. That may be something for the committee to consider in future. Certainly, the important thing is that once it becomes apparent that it is post-traumatic stress, to signpost you need two things: the first is something to signpost to and, secondly, the knowledge that it is there, otherwise you do not know what to signpost. So, those are the three components: the first is the diagnosis, the second is to have something to signpost to, and the third is to ensure that you are aware of it, so that you can pass that on. We feel that GPs are very well placed to do that because they understand the whole patient. Also, they will see a diagnosis over a period of time because people might come in three or four times, presenting with something slightly different each time, and patterns develop as the patients come in. GPs get to know the families, the people, the individuals, their backgrounds and suddenly someone will say, 'By the way, I was in Iraq', and suddenly it will click and off they will go.

[7] **Darren Millar:** You just indicated that someone might come into a practice three or four times. Many of our bigger towns in Wales now have large multi-GP practices. I think of my own practice, for example, where I never see the same doctor twice frankly, because it is generally a case of seeing whoever can fit an appointment in. How big a problem is that in terms of making sure that people get an adequate service from primary care?

[8] **Dr Dearden:** It is about balancing accessibility with the possibility of seeing the same doctor. In other words, most patients, if they have a runny nose, a sore throat or a chest infection, do not really mind who they see, most of the time, but when someone has a chronic disease or something that is really worrying them, they do like to see the same person each time. What I do with my patients is say, 'I am here on a Tuesday and a Friday or a Monday and a Thursday; if you want to come to see me, make an appointment on those days'. In my surgery, we have open access in the morning, guaranteed same-day appointments and we have appointments that are bookable six weeks in advance. However, I am still on holiday sometimes, or away, and occasionally I come to the Assembly to give evidence. From that point of view, continuity is about the doctor making the patient aware of when they are there, but also the patient looking for opportunities of seeing the same doctor each time. With more part-time working, with variations in what people do and with the feminisation of the workforce—more ladies are working in general practice and they have other commitments—that becomes an issue. The counter to that is the single patient record. The general practice has a record that should contain the patient's information—there is a gap around defence and we will come back to that later. If you look back over five or six consultations, even if you have not done them, if they have been recorded well, you will pick up and see things that are happening. That single record is probably one of the most important diagnostic tools in the sense of being able to look back. You will see how many times they have attended, whether they have gone to accident and emergency, used the out-of-hours service or contacted NHS Direct; you will see what they have been saying, what they have been given, what the response was to that treatment and that gives you a picture. Sometimes diagnosis is not made at the first consultation, but after several consultations because sometimes patients want to see if they can trust you first, whether you will listen and understand, whether you will not judge them before they say, 'Well, to be honest, the real reason I am here is this'.

[9] **Darren Millar:** Thank you for that.

[10] **Veronica German:** We have heard evidence that people in the armed forces are automatically deregistered from their GPs if they are out of the country for more than three months. We have had information that just being in the armed forces means that they are

deregistered. They might come back to their family practitioner, as they see it, feeling not very well and then find that they suddenly have to go through the process of re-registering. We have heard that this can feel like another rejection. What do you think that we can do to improve that situation?

[11] **Dr Dearden:** The first thing to say is that the deregistration is an NHS rule. Anybody who leaves my practice for three to six months is automatically taken off. I have a contractual obligation to inform the local health board, which will remove them. If I do not, I am actually in breach of contract, being paid for someone who is not on my list in my area. That can apply to people going to university, people who have moved to the other side of Cardiff or someone who is working overseas for six months.

9.20 a.m.

[12] That is an NHS rule. In a sense you can understand why, as you do not want to pay me for people who are not on the list. I would not mind if you decide that you want to do that; I think that that would be fine. The difficulty, of course, is that, when someone does move overseas, you do not always know how long it is for. The process of coming back on to a list really then depends upon whether the practice is full, whether it is open, and whether it is taking on patients. For example, for the last three years, my practice has been the only one in Wales that has been formally closed, because we opened for four weeks and took on 500 patients in that time. It is almost impossible for a practice to continue like that for more than a month or two at a time. We are now open because the demand has gone off a bit, and we have taken on maybe 400 patients in the last three or four months, which you can deal with, to be honest, even the paperwork.

[13] One question concerns deregistration. That is really a NHS rule, and we cannot change that unless we go back to the NHS contract. In terms of registering people back on, good practice is that if you have a baby, if grandma moves in, or if you get married, if someone is already on your list, you will take on the relative, the child, the grandma and so on. If your list is closed, and you are in other words saying, 'I have enough patients to provide a safe service; more patients now would put stresses and strains on my ability to provide a quality of service', the doctor has an obligation to say, 'Well, I could take on more patients and make more money, but actually I would then be providing a less accessible or lower quality service'. There is a professional issue about how many patients you think you can provide a good service for.

[14] **Veronica German:** The point is that the people we are talking about now are veterans; they are coming back into the country, and they might be suffering from mental health issues. They are already vulnerable. What can we do in particular for those people returning to ensure that, if they cannot go back to the GP they might have expected to go back to, the process is made easier for them to get registered?

[15] **Dr Dearden:** I understand the question. The defence organisations have a form. I cannot remember the letters, but it is an F-something-133, which is a form that the defence doctor fills in and gives to the person. In 17 years as a GP, I have seen one. What asylum seekers very often do now is to come with a whole set of papers, their permission papers, their passport, their letters, their this and that, and they say, 'Here I am'. When you have that information, you immediately know who they are, what background they have come from, generally speaking, and which country they have come from, and that gives you an idea of what is going on. If someone were to come and say, 'I have just come out of the army; I have just come from Iraq. Here is my 133 and my medical records from the army, which suggest I have been here, here and here', that would be immensely helpful. It is very rare that we actually see that, however. For example, in 17 years, I have never had a copy of the medical records from a defence organisation for any patient of mine. They are considered confidential.

So, if I write, I very rarely get a full response with copies of everything. If the patient does not tell me, I cannot ask for it and, of course, the army does not know where they are going. It does not know where they are going to live. It does not know which GP they register with, and I do not always know who to write to. There is a real communication thing there. If they go to an NHS hospital today, I will get a letter, but if they have been to an army one three months ago, I will not have a clue about that.

[16] **Darren Millar:** You say it is deemed confidential, and that it cannot be shared, perhaps for national security reasons or whatever it might be in terms of where they have actually been, but there is GP patient confidentiality as well, which means that you are not supposed to say anything that has been relayed to you—there are sanctions against it. Why is there an issue there? Has that been explained?

[17] **Dr Dearden:** A key point is patient consent. It is the patient's information after all. If the patient says to the army, 'I would like you to send a complete set of my notes', or, 'I would like to have a copy of my complete set of notes and I will take those to my GP', there should be absolutely no reason why that should not be the case, just as you can come to me and get a full copy of your notes. That is perfectly reasonable under the relevant legislation. It would be very helpful, when people come out of the armed forces, with regard to notes, if they could have a copy of any medical information about them. For example, if they were in the SAS and they have been to certain countries, that can be removed, because that is not, strictly speaking, clinical information. There is a lot of medical information about injuries, treatments, backgrounds, experiences, and so on. If someone comes to me with, 'I am getting flashbacks', if I can read in someone's notes that they have been in Afghanistan and Iraq, and that they were in Northern Ireland 20 years ago, I could give a diagnosis in the first five minutes, and not three or four weeks later.

[18] **Ann Jones:** On the deregistering of people, you said that that happens within six months. If you have service personnel going abroad while their family remain, how do you as a GP know? How do you class this six months business? I have not been to my GP for nearly nine months; is he deregistering me because he has not seen me? How do you check whether the people on your list are still in the area? It is an easier way to keep people on the list. How would you know that a person has gone overseas if their family is still in the area?

[19] **Dr Dearden:** That is a very good question. The first thing is that GPs do not deregister people unless we know that they are going to move. Most people will tell us that they are moving somewhere. GPs do not automatically check. We will sometimes ring people and find out that they have moved to the other side of Cardiff and someone else is living in their house, but they just have not told us because they want to stay on the list. The other thing is that, in the past, health authorities have in the past written out to patients and asked, 'Are you still there?' If those letters are not responded to, the people they have been addressed to have been automatically taken off the list. I have had people come to me, sit down and say, 'You are my GP', but I have gone on to my computer and found that their registration with me has been closed. When I said, 'Did you respond to this letter?', they tended to reply, 'Well, no; it was official letter and I do not tend to respond to those', or they cannot read English, or they cannot read, or they have been away.

[20] **Darren Millar:** Can I just clarify this, because as I understand it, what we are talking about here is not the general picture, but the fact that when somebody goes into the forces, they are automatically deregistered. Is that correct? That is what we have been told so far.

[21] **Ann Jones:** I cannot see how that happens.

[22] **Dr Dearden:** What happens is that if the GP is aware of it, we have to inform the local health board, right? However, if someone moves away and we are not aware of it, unless

they or defence staff tell the health board, they will probably stay on the list. It is an odd system in the sense that someone might be automatically deregistered and I will not know about it. Let us say that I am sitting here today as your doctor, and you come in to see me today and you are going to Iraq tomorrow, but you do not tell me that. I do not know to write to anybody to say that you should be deregistered. So, it is not me as the GP who says this, unless you tell me, 'I am now going overseas for four years', in which case I would be obliged to inform the local health board that that is the case. Now, the only other question is whether the defence organisations tell the NHS, and that is done above practice level.

[23] **Ann Jones:** Where does the data protection of that individual come in if the defence people or the local health board have decided that people are no longer in the area? Where is that individual person's data protection?

[24] **Dr Dearden:** To be perfectly honest, I do not know, because that is something that really does not involve the general practitioner, or indeed—

[25] **Ann Jones:** Well it does if your patient has been deregistered and you do not know. The first you will know about it will be when you type the name into the computer and find that they have been deregistered. That does affect you; it must affect your payments as well because, if you have a patient list of 100 and the health board suddenly deregisters 10 of them, you are not telling me that you are not going to query why you have lost that tenth of your payment.

[26] **Dr Dearden:** Well I have got about 7,500 patients and about—

[27] **Ann Jones:** It does not matter what the number is. I was doing it in simple terms.

[28] **Dr Dearden:** Sure. I was going to explain that I have got about 7,500, and in my area, about 100 patients leave my list every month. Now, some of those will have moved, some will be students, and others will be mobile populations. It is quite difficult for me to work out exactly why people have moved. They could have just moved to a different part of the country. I am not told why, because some will just want to register somewhere else. So, for the 100 people who leave and the 120 who join, the difficulty is that I have do not have information as to why each one has moved, whether it is out of choice, because they have moved countries, moved jobs or whatever. As to people being taken off automatically, it is not the general practitioners that are taking people off the list because they have gone into the army. So, someone, somewhere, is telling the LHB, because it will do it automatically. When someone comes in to me, I have to re-register them if they have been taken off the list. I have to go through the process of registration, because what sometimes happens is that when someone is taken off my list, the notes are requested.

9.30 a.m.

[29] So, suddenly we pick it up because they say that they want someone's notes, and we think, 'Hang on a second—why do you want their notes?' Then we contact the LHB, which says that it is because they have been taken off the list, and when we ask why, if they are just around the corner, we are told that it is because they have not responded to a letter or something of that nature.

[30] **Andrew R.T. Davies:** Does that discrepancy in the sharing of information go back to a bygone era of the military health service? There used to be a comprehensive health package and, once you signed up, the military took care of you, as it had its own medical corps in parallel to the NHS. What you are telling us today is quite alarming, as maybe things have not caught up. In a bygone era, you could almost understand it, because there was a comprehensive military health service that did not depend so heavily on the NHS.

[31] **Dr Dearden:** That is probably fair to say. More and more, the NHS is becoming involved in the services, and people are no longer in the armed forces for as long as they used to be. It used to be your life: you went in aged 16 and came out aged 55. Now, five to 10 years is not an unusual length of service. Now, you could be sent to quite stressful areas because there are fewer armed service numbers and there seems to be an increasing number of places that you could be sent. In addition, the health services within the armed forces have been not run down exactly, as that is the wrong phrase, but they are certainly less than they used to be. The armed forces committee within the BMA is very conscious that the services are not as well developed or as well provided as they used to be. For example, when someone joins the army, they are asked to fill in quite a detailed medical history, so that the army knows exactly who, what, when and where in relation to the person. Coming back the other way, the information is nowhere near that comprehensive.

[32] **Andrew R.T. Davies:** So, really, with the reorganisation that has gone on, the military medical service needs to catch up with provision in the civilian NHS today. Maybe if that catch-up took place, many of the issues that we are discussing here would be rectified. That could be as simple an act as passing a form on to you on a person's discharge, rather than assuming that the military medical service has done its bit already.

[33] **Dr Dearden:** It certainly would be helpful if that were the case. I often find a six or 10-year gap in people's notes. I can sensitively ask where that person was for six or 10 years, but if someone has been in prison, they may not want to answer that question. If someone has been in the army, they may not want to answer that. On one occasion, someone who had been in prison told me that they had been elsewhere doing other things, because they did not want that on their medical records. Having gaps of six or 10 years is not common, but, when it is there, it is quite noticeable.

[34] **Andrew R.T. Davies:** Finally, you said earlier that you have been practising for 19 years, and that, in your experience, you have seen only a handful of these forms. So, you have identified a problem and, Dr Dearden, you are very proactive in the BMA. Should the BMA have raised this with the various bodies? This is not the first time that this has come to light in this committee. Why has no action been taken to rectify what, to me as a lay person, seems to be a relatively simple problem of not sharing information?

[35] **Dr Dearden:** It is a relatively simple problem for us, as well. The difficulty is that the solution does not lie with me. It is not within my capacity to change it.

[36] **Andrew R.T. Davies:** You must have had an answer, when you have raised it, though. I am just wondering whether you can make us privy to that answer, so that we can understand it.

[37] **Dr Dearden:** Generally, there are three options. The first is that the defence organisation does not always know where to send the information, to be fair, unless the patient tells them which doctor they are registered with. The second is that they could give it to the patient and ask the patient to pass it on. The third is that I can request it, but I have found that, doing that—and I have probably done it five, six or seven times in the past decade—the response that I get back is at most a letter. I do not get copies of someone's medical history, and I have never been given a good reason why. Maybe there is not a copy available, which is fine if that is the case. If some of these people have had problems, even if it is just had a major accident, they could still have post-traumatic stress from that, and so it would be helpful for me to know that they were in a three-truck pile-up, for example. That need not have been in Iraq, as it could have been just down the road, but it is still helpful for me to know why they are having flashbacks. That communication is one of the issues that I would really like to raise and highlight with you. It would be ludicrous to think that the Heath

hospital would not tell me something for five years, but it is possible for that to take place the other way. I do not want to criticise the defence organisation because of that; I am simply suggesting that it seems odd in today's world that the patient's single lifetime record that I hold could have a gap of a decade in it.

[38] **Ann Jones:** In your written evidence, you state that in clinical practice there is little provision or support for awareness rising or signposting, and then you go on to say that you think that the NHS in Wales should facilitate that. How do you envisage the NHS facilitating that?

[39] **Dr Davies:** It is partly about training. As a concept, PTSD is fairly straightforward to diagnose. Once people know about it, it is not difficult to diagnose, as there are simple screening questionnaires. This is one PCL, which stands for PTSD check-list. It is a single-page questionnaire that can be completed in about five minutes or so, and it gives a diagnosis based on DSM-IV, the 'Diagnostic and Statistical Manual of Mental Disorders'. The slight difficulty is that PTSD is not the only psychiatric disorder that you see in veterans. In 60 to 70 per cent of cases, PTSD does not occur alone, so it is often co-morbid with depression or substance misuse, which can complicate the picture or even dominate the picture so that the PTSD is missed.

[40] On signposting, in some areas of Wales, there are mental health liaison nurses in primary care and, hopefully, the GP will have easy access to someone who has a bit more experience and who will know which services are available locally and nationally. However, that sort of thing is not available in all areas. I guess that the services vary very much, geographically, in Wales.

[41] **Ann Jones:** You mentioned the training element. Are medical students currently being trained to identify post-traumatic stress disorder in war veterans?

[42] **Dr Davies:** It is variable. Students' experiences vary depending on their clinical attachments. Certainly, in Cardiff, where Professor Bisson works, they often get some exposure to it. I work in the medical school in Swansea, and it is certainly mentioned. Students are given introductory talks on that and information about where to find more resources. I guess that more could be done to raise awareness specifically about servicemen, and maybe attachments to give experience of working with servicemen and women.

[43] **Ann Jones:** Should we increase the amount of training given to students so that they are better trained to identify the needs of veterans and to treat their mental health issues? Should it be a specific module that they have to pass before they can graduate?

[44] **Dr Davies:** It would be a great idea to have specific modules, yes.

[45] **Dr Dearden:** Perhaps I could give a slightly more general view. The difficulty is that if you had a specific module for everything that you could think of, medical student training would be 10 or 15 years long. What you could do is look at those people who are likely to be the diagnosis points. For example, you could look at medical students but you could also have a look at the VTS training of GPs, because that is another three or four years—

[46] **Ann Jones:** What is VTS?

[47] **Dr Dearden:** Vocational training schemes. Excuse me. When a doctor decides to be a GP, they go into a training scheme, which currently takes three years, but we are trying to extend that to five years. That might be another opportunity to do some more training, specifically for those who are more likely to be the diagnosers.

[48] **Ann Jones:** How do you know that you are likely to be a doctor who might diagnose post-traumatic distress order? If you have said that general practitioners are well placed to diagnose that, surely every general practitioner should be trained in that. You cannot say that somebody who practises in Cardiff will see more cases than someone who lives in Llanrhaeadr-ym-Mochnant.

[49] **Dr Dearden:** Sorry, I did not explain that very well. What I meant was that when you choose to be a GP, you choose to be a diagnoser. It is likely that people who have post-traumatic stress disorder will go to their general practice. So, those who have already self-selected themselves to be trained as GPs are well suited for training in the kinds of things that they are likely to see. For example, GPs really need training in paediatrics, minor illnesses, obstetrics, child protection, psychiatry, and so on, because those are the things that the people walking through the door will present with. So, I apologise, as what I meant was that, when someone goes into a GP training scheme, they have already said, 'I will be the diagnoser of any patient who walks through my door, or I will signpost them on'.

9.40 a.m.

[50] **Ann Jones:** Should that be a module for those people who say that they are going to be general practitioners? You say that you want to do it but then, when I say, 'Is that the answer?', I get the feeling that you do not want to put more on to people. Yes, you say that training is the answer but you are not prepared to put people through that.

[51] **Dr Davies:** I think that there are levels of training and that surgeons should be able to diagnose PTSD. If a burns surgeon has someone in front of him saying, 'Flashback nightmares', they should be able to do it. There is basic training for all medical students and, yes, there may be specific areas for general practitioners and psychiatrists, and the complexity will vary. Modules do not have to last for months; someone could spend a day working on it with service personnel.

[52] **Ann Jones:** What about refresher training? Do you think that GPs should undertake refresher training on a regular basis to indicate—

[53] **Darren Millar:** We have heard, for example, that PTSD is a relatively newly identified problem—since the early 1990s—so many older GPs working in the NHS will not have had formal training to identify it. Is that an issue? This refresher training issue is really important.

[54] **Dr Dearden:** With revalidation and appraisal, all doctors should spend anywhere between 30 and 50 hours a year in refreshing training. Some of that will be very specific and some will be quite general. Most of it, at the moment, is self-led. As it is professional training, there are many modules—for example, the *British Medical Journal* learning site, or the General Practitioners Committee training site, where people can go in and do a 30 or 40 minute electronic tutorial. That certainly is one way that it can be done. Recently, the chairman of the GP committee in Wales wrote to every GP asking them to be aware of this particular condition, the services that were available and so on. To be honest, even this committee, the report and the inquiry will raise the issues.

[55] There is always the question of keeping up with something that is newly described. Anything that is new in the last 10 or 15 years will not have been taught at medical school. For me, for example, anything that has been described in the last 20 years, I will not have learned about as a student. There is a constant professional need, not just to keep up with new diagnoses but also with new treatments, which is a real struggle, on occasion. It would certainly be something that we could suggest. I apologise if I gave the impression that training is not part of the answer. What I was simply saying is this: there are so many areas that we

could ask people to be trained in, that what we need to do is make available the training and then make available the opportunity to be trained. Every time that I spend an hour on training, that is an hour that I am not seeing patients. That is the constant balance for someone who is on the front line but wants to constantly be kept up to date with things.

[56] **Ann Jones:** You probably made the case but, so that I do not put words into your mouth, is there a case for including a note in veterans' health records to highlight the fact that they have served in an armed service?

[57] **Dr Dearden:** From my point of view the answer is absolutely 'yes'. It is a very important part of not just their mental health but possibly even their physical health. They could have come up against injuries, diseases, infections or other things. So the answer is absolutely 'yes'. That depends, of course, on the doctor being aware that that is going on—we have talked a little bit about how that might be the case—and patient consent. They may simply not wish that to be part of their record, and we have to balance their good versus their desires. It would be much better, in any clinical situation, for people to know that.

[58] **Ann Jones:** Given that you think that there is a case to flag that up, would it make it easier for you to diagnose post-traumatic stress disorder years down the line? If person A had the marker saying that they had served in the armed forces and person B did not want it included, and they presented with similar symptoms—no two people present with exactly the same symptoms—would you look for post-traumatic stress disorder with person A before you would look for it with person B, because you know that person A has served in the forces?

[59] **Dr Dearden:** I will answer the question and then ask Stephen to supplement my reply. I think that the answer is 'yes'. Some of the other markers that we put down on people's notes are very helpful. For example, if I know that someone was on a child care register when they were in their early years and they come to see me at the age of 16, 17, 18 or 19 with other difficulties, I wonder whether the fact that they were on the register is starting to have an impact. So, yes, the more information that I have about background, illnesses, diseases, treatments and problems, the easier it is for me to try to diagnose other issues. The more information that I have, the better. If I know that they have been in the army, it will trigger consideration of other things, in the same way that if someone comes to me with a fever and they have just come back from an African country, I think 'malaria'. It is helpful for them to say 'I have just come back from wherever', which leads me down a tropical disease line.

[60] **Dr Davies:** If you were seeing somebody with sleep problems or difficulties going out and it was flagged up in their notes that they were ex-services, it would be to the forefront of your mind. Conversely, you occasionally get people who claim to have been in the armed forces who have not, and it might also be helpful from that point of view.

[61] **Christine Chapman:** Are arrangements for priority treatment of veterans within the NHS effective, and could they be improved?

[62] **Dr Davies:** It is less widely known about than it could be, first of all. What is practically available varies a great deal from area to area. In Newport and in the Hywel Dda Local Health Board area I am told that there is virtually no waiting time for brief psychological interventions, whereas in Swansea we have substantial waiting times. There are also significant waiting times in north Wales. So, it depends in part on what is available locally, and that is very variable. The second thing—Andrew referred to it earlier—is the issue of equity of access to services. Yes, it is very important that ex-forces personnel should have access to a first-class service, but so should everyone else: firemen, policemen, ambulance personnel, whatever—

[63] **Ann Jones:** Sorry, that is twice that this has happened, Chair. Firefighters and police officers are not all men, Doctor.

[64] **Dr Davies:** Yes, sorry. I beg your pardon. Thank you.

[65] **Ann Jones:** Firefighters, police officers, ambulance personnel.

[66] **Dr Davies:** Thank you for correcting me; I corrected myself earlier, but thank you for reminding me.

[67] I think that everyone should have a first-class service. Some people are a little uncomfortable about people from one occupational background having a service that is perceived as being better than that for other people. It is hard to think of other occasions in the health service where what service you get depends on what job you have done.

[68] **Christine Chapman:** This is the first time that I have been on this committee during this inquiry. Are we talking about certain types of conditions? You said something about certain conditions related to the fact that people had been in the military. There could be some tension around that. Could you say something about that, Andrew?

[69] **Dr Davies:** I am not sure that I quite understand the question. Could you repeat it, please?

[70] **Christine Chapman:** Yes, sorry. We are talking about post-traumatic stress disorder, but other conditions could be military-related. Would this priority treatment be for certain conditions or for all conditions if someone has been in the military? How would it work?

[71] **Dr Davies:** The other conditions that we are talking about are things like, in psychiatric terms, depression, alcohol problems and other anxiety disorders. I do not think that we are talking about rarities or unusual things. The rules about priority say that, if there are two people of equal priority, the ex-forces person gets it first. We are not saying that they go to the top of every waiting list. It is difficult to know, in practical terms, whether that really makes a difference, because you would have to go through everyone on the waiting list, match their level of priority and go one place above them. Do you want to add to that?

[72] **Dr Dearden:** Yes. If someone incurred an injury, for example, while in the army, and came to me when they were discharged and said, 'I need orthopaedic follow up', I would say in the letter, 'This person incurred the injury while serving in the military at x point in time'. That would give them a sense of priority, yes.

9.50 a.m.

[73] If it was a case of, 'I've got a sore throat and I need to see an ear, nose and throat consultant', I would not put down, 'And, by the way, this person was in the army'. It is really about whether it was part of the thing, whether it was caused during a certain period of time and we are then asked to make mention of it so that they might be prioritised, again along clinical lines. However, if there are two people of equal situation, the person whose injury or illness was caused while serving would be prioritised in a sense.

[74] **Christine Chapman:** I think that it has gone back to Andrew's point because, obviously, the provision for the health service within the military is different now, is it not?

[75] **Dr Dearden:** It is less.

[76] **Christine Chapman:** There are big changes there, so it is obviously going to be a—

[77] **Dr Dearden:** It is an increasing thing now, yes. Of course, servicemen's families are often taken care of by civilian GPs under contract to the forces, as opposed to strictly force-employed people.

[78] **Darren Millar:** I am very conscious of the time and that we have lots of business to get through today. I ask Members and witnesses to be brief in their questions and answers for the remainder of the meeting.

[79] **Andrew R.T. Davies:** Thank you for the evidence this morning, gentlemen. In your evidence, you highlighted the array of services and the assistance that is provided by the voluntary sector and that that voluntary provision can be quite patchy in some places, depending on the strength of the organisation in that area. How would you suggest better integration with the work that the voluntary sector does so that the statutory and voluntary sectors can come together to provide as good a coverage as possible across Wales?

[80] **Dr Davies:** As I understand it, in terms of PTSD, Combat Stress provides a service that is very good and very valued. I think that it should be seen as something that is in addition to what the health service and the statutory services are providing. It has quite a long waiting list at the moment. The services that it provides are very popular with ex-forces personnel because one of the very valuable things that it does is to provide contact with other people who have been in very similar situation, and some will prefer to go to have treatment with a voluntary group like that. However, I think that we ought not to be depending on that; I think that we should see it as an extra. That is my personal view.

[81] **Dr Dearden:** What has happened—this has happened in mental health services to some degree—is that 20 years ago there was no gap between primary and secondary care, but as the workload has increased, and it just has, secondary care psychiatry has tended to go towards the very severe end of mental health and that means that there is a gap in the middle for the treatment of things that are just above a GP's skill level, but just below what a consultant psychiatrist might want to do. That gap in the middle is widening and very often the voluntary organisations have tried to fill that gap. So, for example, for bereavement counselling, I cannot refer anyone anywhere except to a private organisation. Fortunately, in my practice, I have a counsellor and she is a godsend to be perfectly honest, because she picks up a lot of that middle ground. However, when the middle ground is filled with volunteer organisations, it is not interconnected with either primary or secondary care services. What the pilots that were run in Wales have done is show that when you get secondary and primary care and the middle section together in a room, they start to understand where the boundaries are and how you can get people across them seamlessly. They talked about what each group did, what they did not do and how they could fit together, and then they could almost get people through it in a much more seamless way. So, again, communication between primary care and a voluntary organisation is actually quite poor.

[82] **Andrew R.T. Davies:** I appreciate what you said about the time, Chair, but if I could just qualify this because that splitting of the two so that they move apart goes against what everyone is trying to do. With the voluntary sector coming in and filling that void, is it as simple as maybe the voluntary sector being offered some form of formal contract, like a service level agreement, so that all parts of the chain know what is expected of them and the voluntary sector can then feel part of the process, rather than it just coming in and offering what it can on an informal basis?

[83] **Dr Dearden:** I think that that has been the problem. The problem is that they have kind of mushroomed up on their own, almost without support; they have been created to fill a gap or to meet a need that has become obvious, perhaps we can phrase it in that way. What we need to do in the NHS is to recognise that and bring them on board, or perhaps even go to

them, which might be even better, to say, 'What we need to do now is integrate the service the patient is receiving'. I do not get communications from the voluntary or third sector very often and I do not write to them with information very often because the patient almost goes on his or her own. It may be about administrative support, information technology links that would allow us to do that, communications, letters or inter-agency meetings. We tend to look at service—I provide this, you provide that—but what we need to do is look at the patient and think, 'Where do they go, who do they see and what do they receive, and how can all of those start working together much more collaboratively?'

[84] **Darren Millar:** It sounds as though there is probably a risk of significant overlap in services, if not everyone is quite sure what exists where. However, I am afraid that we are going to have to move on because the clock is really against us.

[85] **Val Lloyd:** I want to touch on, or discuss, the co-morbidity of mental health problems. You have mentioned it in your evidence and also tackled it in answer to a question from Ann. Cutting straight to the question, because of time, what are the barriers to achieving this, how can they be overcome and do you have any examples of good practice?

[86] **Dr Dearden:** Stephen, I think that the co-morbidity issue is your expertise.

[87] **Dr Davies:** With substance misuse being one of the more common co-morbidities, one particular difficulty is that substance misuse services tend to be slightly hived off from the rest of adult mental health services—they are funded and managed separately. While there is a certain amount of commonality in terms of expertise and training, somebody primarily working in the field of substance misuse would not have expertise in PTSD—they might be able to identify it, but not treat it. Similarly, people who treat PTSD and depression do not primarily address substance misuse. The way in which treatment for substance misuse is organised and funded in Wales does not make for an integrated service that communicates well. It is less of an issue with things like depression and post-traumatic stress disorder because they can more commonly be treated in adult mental health. It is worth saying that there is a range of severities with these conditions, but the community mental health teams are very much focused on what they call 'serious mental illness' or 'severe enduring mental illness', and even if someone had severe post-traumatic stress disorder, they would say, 'That is not serious mental illness', as if it were somehow trivial or light-hearted. I think that that is quite a barrier.

[88] **Val Lloyd:** How can we overcome that?

[89] **Dr Davies:** How long have you got?

[90] **Darren Millar:** Not long. See if you can answer it in 30 seconds.

[91] **Val Lloyd:** Perhaps you could drop us line.

[92] **Dr Dearden:** May I just give one example? If we looked back at child protection 20 years ago, we would see that we had lots of agencies doing lots of things, and when you look at those problems again and again, it is all about communicating what each other is doing to each other. In obstetrics, where a woman has a bad heart problem, the obstetrics and the cardiologists get together and do a joint clinic—the lady comes in and they look at the heart and the baby at the same time. It is about that collaborative working and sharing the expertise of specialists. The problem with specialisation is that you do one job really well, but when there are three jobs to do, you either have three people doing it separately or you get them together and ask, 'How can we manage this patient?', not this disease or this problem. I think that that kind of getting together and sharing, talking to others, saying, 'I can do this and you can do that, but let us not cancel each other out', is probably one of the few things that we can

do.

[93] **Val Lloyd:** Going back to what Dr Davies said, you will not do that if adult mental health teams do not consider these problems to be important enough to deal with. I think that what he was saying was that they consider other things to be more important. They presumably have only so much work time and consider other problems to be more serious than the ones that we are discussing.

[94] **Dr Dearden:** What you need is a general practitioner in these areas who looks at the family, the background, the drugs that they are on, the drugs that they could be on and the three illnesses that they have. You have to balance their heart and their asthma, which means that you cannot use certain drugs. By balancing them, you treat the patient as opposed to separate conditions. We need that generalisation of specialist information together, if I can phrase it that way. That is much more patient-centred.

10.00 a.m.

[95] **Darren Millar:** Lorraine, can you take the next two questions?

[96] **Lorraine Barrett:** I just wonder whether you have a view of the hub-and-spoke model that is currently being developed under the all-Wales veterans mental health service. Do you think it is the right approach in addressing the needs of these people?

[97] **Dr Davies:** I think that it is great, with a few provisos. First—and I will be brief—50 per cent of the staff member's time is going to be spent on brief psychological therapies, which is great, but we have little in Wales to deal with the more complex issues that require more in-depth and lengthy psychological treatment with a high level of expertise. Secondly, there may be some duplication if they are providing these brief psychological therapies, as it may be that they are already being provided in some areas of Wales—Newport being one, as I have mentioned. Thirdly, it is a subtle thing, but there is a danger that, if that service exists, other services will say, 'They do veterans; we do not'. The intention that they will be signposting is clear, but it needs to be sold as such.

[98] **Lorraine Barrett:** Okay, thanks. You also expressed concerns about the capacity of the NHS in Wales to fully implement the all-Wales veterans mental health service. How can that capacity issue be addressed?

[99] **Dr Dearden:** I think the Assembly has probably made the first real step towards that: first, by recognising it; secondly, by recognising the task group recommendations; and thirdly, to be fair, by funding it. Many times, papers come out with no funding, and you almost know that they are going to struggle. The second thing is to decide what you need, what personnel you need, and what services are required. The next question concerns whether we have those. For example, if I want 15 cardiac midwives, they do not exist. So, you then have to go back to the training situation, ask what is required, and then look upstream to see whether you are already training the people who you want or whether you can take people who you have and retrain or modify what they do. In a sense, because we already have quite significant shortages of doctors and nurses and shortages in some of the therapeutic disciplines in the NHS, the difficulty is that we may not be able just to find the additional staff; we may need to take them from other areas. Then you have an issue of replacement. This is certainly the first step. The second step is to ask what is required, and then we need to ensure that we can provide that.

[100] We are in a difficult financial situation, which is why the funding is so important—and all credit to the Assembly for doing that—but as Stephen said, rather than duplicating, we need to look at what we have, look at what we need, and then try to fill the gaps and reabsorb

and redistribute, if that is what we can do. So, it can be done, and I think that we have no doubt about that. The Assembly has already taken the first two or three major steps in that direction.

[101] **Darren Millar:** Okay, thank you for that. On that note, we will close this particular item on the agenda. Thank you very much, Dr Dearden and Dr Davies, for your attendance today and for the evidence that you provided.

10.03 a.m.

Ymchwiliad i Wasanaethau Orthodontig: Casglu Tystiolaeth
Inquiry into Orthodontic Services: Evidence Gathering

[102] **Darren Millar:** We are running slightly behind schedule, so I would be grateful if Members and our witness could be brief in their questions and answers. This item continues our inquiry into orthodontic services in Wales, and I am pleased to welcome Professor Stephen Richmond, who is a Professor in Orthodontics at the Cardiff University School of Dentistry. Members will recall that Professor Richmond is also the chair of the expert group on dentistry established by the Minister for Health and Social Services to look at orthodontics here in Wales. Welcome to you, Professor Richmond.

[103] Thank you for your paper; we appreciate that. It has been circulated to Members. We will go straight into questions on it, if that is okay. The report of the task and finish group suggested that, in terms of the orthodontic workforce, there would be challenges in the future because of the age profile of those practising orthodontics and the number of retirements coming up in the near future. What do you think needs to be done to address the problem that is on the horizon?

[104] **Professor Richmond:** It would be similar to what I highlight in the report with regard to some of the specialist registrar training, which is specialised training for those who wish to become consultants. We have batches coming to Cardiff—we have two intakes in three years, so we have continuity. That means that you have six being developed in a period of nine years. So, I think that we can cope with the potential shortfall, but we must also change the working practice; we have to improve the skill mix. The report talked about using orthodontic therapists, which also has a lower cost base. That means that we should be able to extend, improve and develop our orthodontic treatment across Wales at a lower value. It is basically an economy of scale.

[105] At the moment, we have 135 practitioners in Wales, which I think is far too many. Twenty-seven do no active treatment at all. I think that about 70 do fewer than five or 10 cases a year. So, basically, we have a workforce of 37 doing most of the work. The idea of developing that workforce is to improve the skill mix and introduce orthodontic therapists so that we can extend the service. I think that we can develop a very good service in Wales if we have an integrated service.

[106] **Darren Millar:** So, it is about increasing training capacity, skilling up the workforce and using therapists.

[107] **Professor Richmond:** Yes; that is important.

[108] **Darren Millar:** Thank you.

[109] **Veronica German:** Bearing that in mind, what should the role of general dental practitioners and dentists with a special interest in orthodontics be in future? How do you see

that?

[110] **Professor Richmond:** General dental practitioners are the gatekeepers; they are the people who refer patients in. They are still there, so they will recognise a problem and send it in. We in Cardiff train dentists and one of the competencies is recognising who needs to be treated. That has probably been going for about five to 10 years. That is their role.

[111] Of the people with special interest in Wales, there are quite a few practitioners, and their role is important in providing services, particularly in rural areas. Also, an important thing, which is mentioned in the report, is that they should develop their skills, continue their professional development, and be accredited. At the moment, we are going through an accreditation process—I think that it is being done in west Wales and various other places in the country. It is important that we have a well-trained workforce with qualifications. I think that that is important, because up to now, we have not actually achieved that.

[112] **Veronica German:** Going back to the therapists, the orthodontic national group told us that, of 14 trainee therapists who recently completed their course, only four are known to be currently working in Wales. Does that ring a bell with you?

[113] **Professor Richmond:** I think that it is in the report. It is four to six, or something like that, and that is only the Welsh cohort. I did a tour of some practices a couple of months back and I came across orthodontic therapists who have been trained in England but are working in Wales. It is probably a good thing that there is a mixture, so that it does not all come from one place.

[114] **Veronica German:** So, you do not think we have got a net loss, as it were?

[115] **Professor Richmond:** That is only if you have dental nurses trained in Wales. Clearly, you have English dental nurses trained in Wales and you have Welsh dental nurses trained in England, so you get a mixture. I think that that is reasonably healthy, to be honest.

[116] **Veronica German:** Yes, as long as we have the number that we would like.

[117] **Professor Richmond:** The courses have only been running for two or three years, which means that they are early in their development, although some people in certain practices had foresight and have at least three orthodontic therapists and are moving to four, while other people have two—as in a case I came across recently—and many people have one. That is just in the local part, the south part, of Wales; I have not travelled to the north of Wales, but there may be similar patterns there. It is definitely the way forward.

[118] **Christine Chapman:** The report from the task and finish group says that delivering orthodontic care is more difficult or more challenging in rural areas. What could be done to attract graduates to work in rural areas? It is probably a wider picture, really.

[119] **Professor Richmond:** My report shows a map of the people being treated, with a figure of 80 per cent around the coast, as one would expect. You can see that the difficult areas are in the middle of Powys, in Ceredigion, and in similar areas. They are quite difficult to do. What it needs is reorganisation and planning. What is the shortest distance for going to a practitioner who provides orthodontics? Ideally, for those areas, we could have a dentist with a special interest travel to various places. That would be my approach. It is strange that some people travel enormous distances for orthodontics, but they are happy to do it. I recently came across somebody who comes to Cardiff from Flintshire, and I said, ‘I can refer you to someone in Flintshire’. That person replied, ‘No, I am quite happy to come down every four weeks’.

10.10 a.m.

[120] People do that sort of thing to see their family and friends, but it is not always the case. Some people demand treatment five miles away. So it is a question of planning your services, catching the majority, which is around the coast, and then managing, developing or training practitioners for those people who work in areas that are difficult for people to travel to—

[121] **Darren Millar:** You seem to suggest that perhaps a roving orthodontist might be a—

[122] **Professor Richmond:** That is right—a peripatetic orthodontist. In socialised countries, like Norway, they fly them in to service practices.

[123] **Darren Millar:** Do they really?

[124] **Professor Richmond:** Yes. In Scotland they fly people out to the islands. You can develop those things but I do not think that we need that. It is just a question of rationalising the care, seeing who needs the treatment, seeing where the young population is, planning the services and matching therapists. The only way that you can do that is by having local knowledge, and I do not have the local knowledge in many areas.

[125] **Darren Millar:** I have got visions of four choppers in a chopper. [*Laughter.*]

[126] **Professor Richmond:** People have special problems in Norway so they—

[127] **Christine Chapman:** Are people given certain areas in which to train? Is there an issue there? I know, for example, from my own constituency, that there is going to be a new dental facility working out of the Heath. The idea is to attract people—getting people to say 'I have trained here now; I might think of working here when I graduate'. Is that being followed through in rural areas, too? People do not know what the areas are like—

[128] **Professor Richmond:** I see what you mean. People are always attracted to wealth and social activities—that is in our nature—but some people are dedicated and willing to work out in other areas, or they might like the area. They can only do that if they experience it. If there is a training site, they are more likely to stay there and be happy there.

[129] The other thing that I talk about in my report is the skills mix. That is going to have an effect on practices. If you have four or five orthodontists in one location at the moment, and you introduce therapists, you will not need four or five orthodontists there, because you are increasing the volume. The idea is that those orthodontists will have to move out to satellite units. That is quite difficult to do. I was surprised that there are no real partnerships in orthodontics—it was not allowed in the PDS programme. So, if you are going to develop, you need some partnerships to share the risk and cost of developing new premises. You need the whole raft of sequences so that you can progress these developing practices. They will have to move out, because they will not always have this—there is no need for five orthodontists in one premises, because the dental therapists will be taking that on. So, there will be some natural enlargements of the orthodontic community in rural areas.

[130] **Christine Chapman:** I will move on to my second question. In the report, the task and finish group says that consideration should be given to expanding the orthodontic community dental service. How should this dental service be expanded and what should its role be?

[131] **Professor Richmond:** Most people who attend community orthodontist services are local people who usually walk or travel by bike, and they are usually from less wealthy

affluent areas.

[132] The community service is actually an inexpensive service. As in all walks of life, in dentistry and orthodontics not everyone wants to run a practice. So there are always opportunities for people who are dedicated to social care and working in difficult communities. It is important that there should be an outlet for those sorts of people, rather than just specialist practice or hospital practice.

[133] In the past, people have suggested that community service has not seen wide investment, and people are thinking that it should be provided by a specialist practice. It is one way of doing it. There is a still a role for it, but it has not been actively advertised. One must always remember that it is a relatively inexpensive service, because it is not usually attached to a hospital, with all the associated costs. It is usually running out of one or two rooms in a community centre—a much lower cost base.

[134] **Andrew R.T. Davies:** Thank you for your evidence this morning and for the paper that you provided; it is much appreciated. The task and finish group report suggests that outcomes should be scored by independent examiners, and the committee has heard evidence about concerns regarding how treatment outcomes are monitored. What is your view on that—on the current system and the change proposed?

[135] **Professor Richmond:** As I suggested in the report, with the managed clinical network—the advisory board—within that group, as happens in certain aspects in England, local community orthodontists get together and present their 20 cases, or 2 per cent of the cases, whatever the situation may be. When you measure your own cases, you tend to be favourable, and when you measure other people's cases, you tend to be more stringent. So, the idea is to have an independent assessor. There are quite a few independent assessor groups and orthodontic technicians who arrange a day to come in and measure the models. Then, all the peer assessment rating scores and IOTNs can be discussed later. I think that the independent nature is good.

[136] **Andrew R.T. Davies:** I am probably stating the obvious here, but would you have support in Public Heath Wales to indicate that the contract should be linked to outcomes and the quality of it?

[137] **Professor Richmond:** You are talking to someone who has been strong on the cost quality volume contracts for many years—I was the person who developed PAR scoring. Some people are very keen on the quality, and I think that the orthodontists are as well, because they like to show that they are good orthodontists.

[138] **Andrew R.T. Davies:** Why has it not been linked to outcomes? I have to say, without looking at it, I am quite surprised—

[139] **Professor Richmond:** No, it is part of the new contract. It was supposed to be linked to the new contract but I suppose that it has taken a while to settle down. It has taken a while to develop the systems and put them in place. However, I have been to several areas in England where they have set this up.

[140] **Darren Millar:** It is working well over there, is it?

[141] **Professor Richmond:** The biggest issue is this: if you have a cost quality volume contract, how do you reward the highest quality? You would usually think that you should give them more money, but that is not the way to do it. What you do is you give them more volume in the contract. So, if you have somebody who has 600 cases, give them 1,200 cases. However, you do it at a slightly lower cost, because of economies of scale, but the reward is

that there should be a profit margin on that economy of scale.

[142] **Andrew R.T. Davies:** Given that there are different monitoring levels in the private sector compared with work done in the NHS, do you have any concerns over the work that is undertaken by the private sector, if the monitoring of that work is different from what the NHS—

[143] **Professor Richmond:** I must admit that I do not know much about the private sector; it only accounts for about 2 per cent of all orthodontic treatment.

[144] **Andrew R.T. Davies:** Is that 2 per cent in Wales, or 2 per cent in the UK?

[145] **Professor Richmond:** Generally, it is 2 per cent anywhere. It is very difficult to quantify, because it is never recorded in any way, so it is always an estimate. I put the iOrthodontist app on my iPhone, which, at 59p, was a waste of money, so do not do it. [*Laughter*.] I am aware of some specialist orthodontists in south Wales, but the app said that there were about 50 people offering private orthodontic services, which really surprised me. Most of the private activities probably relate more to adults than to children.

[146] **Andrew R.T. Davies:** So the size of the market, if you like, or the provision, is about 2 per cent.

[147] **Professor Richmond:** I would have thought that it would be 2 per cent of the overall figure, but it is very small, yes.

[148] **Val Lloyd:** I have a question about funding and commissioning orthodontic activity. We heard a range of evidence on this, and some witnesses have suggested that standardising the value of the unit of orthodontic activity would be helpful in delivering orthodontic care. The reason that they gave was that they wanted to ensure that resources were distributed appropriately. Do you share this view? Do you think that the UOA is currently set at an appropriate level?

[149] **Professor Richmond**: As I say, it is all part of how you are going to develop and manage the service. At the moment, there is a range of UOA values from £58 to £74—with £74 being towards west Wales, which had all the problems that I mentioned and discussed. If you have a high value, you buy less treatment; that buys 200 to 400 fewer treatments a year than anywhere else in Wales. So, there should be some standardisation.

10.20 a.m.

[150] In England, it is supposed to be standardised at £61, but there are some high values and some lower values. In Wales, it is £74 to £58. It would be nice to go to £61 or £62. That would be great, but, if you are developing cost efficiencies or economies of scale with orthodontic therapists, you can go lower, depending on the volume. That is, so long as the profit margins for the orthodontists are not comprised, because there is no point in trying to put people out of business; they need to maintain a healthy profit, develop their practice and they need to have some profit to develop these satellite units. Therefore, there has to be some compromise on that.

[151] So, I would be favour of standardisation, with the caveat that it depends upon the volume that they are provided with. I would like to see much fewer practitioners—around 37—treating more than 300 cases a year, which is three to four days' work a week. When I first saw the figures, nearly 9,000 treatments were being done by 135 practitioners, which is about 65 patients each, which is less than a day's work. You think to yourself, 'That is not efficient', and that is even if you take rurality into consideration. Then, when you start

looking at it in detail, you find that there are lots of practitioners who are not treating patients. They are doing what we call review and assessing, or reviewing and refusing treatment.

[152] **Val Lloyd:** We have heard that from other witnesses.

[153] **Lorraine Barrett:** I have a question about referrals. We have had quite a lot of evidence that suggests that there are inappropriate referrals, particularly early referrals, and some duplicate referrals as well. There has been a question raised about the training of orthodontists with regard to applying the index of orthodontic treatment need. I wonder whether you have a view on this. Do you think that there is an issue with inappropriate referrals? Do you think there is a need for training or better training?

[154] **Professor Richmond:** The data suggest that there are very few inappropriate referrals, but they are self-reported and therefore need to be monitored. I run courses every year for practitioners on the index of treatment need, and most of the orthodontists will be very familiar with the index, and some of them will be calibrated. I do not think it is necessary for all practitioners to calibrate, but the practitioners should be aware of how it is done. The way that I do it, and I have recently done stuff for Ireland and Holland, is to train the key people and then they cascade it down. That is the way it is done.

[155] The data suggest that very little unnecessary orthodontic treatment is done. It is about 0.4 per cent. The other issue is that there are many early referrals, which I do not quite understand. They seem to have come from certain practitioners, through certain orthodontists or other practitioners, and sometimes from themselves. It is not one of these areas where you can introduce a blanket ban and say, 'You must not do this'. The whole idea of putting academic detailer in there is to target these people and ask, 'Why are you doing this? What is the reason for it?' It is very peculiar that, for example, in one location, there are five orthodontists, and one of them gets all the early referrals. It is not uniform across Wales; it occurs in certain areas. I do not have the actual practitioner data, but it seems to be occurring with individual recipients of referrals. So, it is easy to detect and to stop.

[156] **Lorraine Barrett:** Is there pressure from parents, do you think? In the same way that some patients want to see a consultant no matter what, do they—

[157] **Professor Richmond:** Not at the age of nine. I was looking through some of the studies that I did in 2000. The average age of patients receiving orthodontic treatment in 2000 in Wales was 15. Many see that figure and think that means that treatment is running late and that the waiting list must be long, but the average age of patients is now about 12 or 12.5, which is almost ideal, according to how we currently think. So, we are running at the right levels. Why there is this issue with early referrals is a mystery. It may be to do with training, but it is not a general problem; it arises among certain individuals. I have detected who the individuals are receiving them, and it is just a question of checking where they—

[158] **Darren Millar:** We have been told in the past that, because of waiting times, someone might refer to three or four different orthodontists, because they think that they have a better chance of being seen that way.

[159] **Professor Richmond:** That happened in Liverpool about 15 years ago. Liverpool had long waiting lists, and so ended up with a lot of early referrals coming through, as people would be referred early. In the report, there is a yellow section in which I talk about repeat referrals. There are strange things happening with early referrals. They seem to be generated by other people, they are not associated with treatment, and they also come from similar postcodes. There were about 2,000 from one area in Wales that resulted in no treatment at all. Then there are other habits, whereby certain practitioners do a great deal of assessments and refusals. That does not make sense, because if you see 100 individuals, on average, a third

will need treatment, and the rest will not need treatment, but to have no one having treatment is strange. That is probably a fallout from the changeover to the new contract in 2006. Where practitioners had existing contracts, the unit of orthodontic activity was tripled—the unit of dental activity is £22, and the UOA is £66. So, the cost of orthodontic assessment was more than the cost of the original assessment, and there were probably about 27 people just doing assessments only. This assessment payment is used to refer a case to an orthodontist. However, there is some strange activity, because sometimes there are around 15 cases coming from the same postcode. I have looked up the postcodes on Google, and those areas do not have blocks of flats; they are normal housing estates.

[160] **Andrew R.T. Davies:** The report from the task and finish orthodontic sub-group says that there are long waiting lists at the moment for initial consultation and treatment and that funding is required to tackle these waiting lists. Do you believe that it is just about putting more money into the system to tackle these waiting lists and, if so, would that money be best spent in the primary or secondary sector?

[161] **Professor Richmond:** What I have suggested is two phases. We need to tighten up access to orthodontists and, in phase one, I think that I have said that people should only get one course of treatment. Also, the number of assessments should be substantially reduced; it is enormous at the moment. There are issues with waiting lists to some degree. At the university dental hospital in 2005, we had about 951 new patients a year. Just after the change of contract, that went up to 1,450; it increased by 55 per cent. Since then, it has come down. The recent levels, for 2009-10, are about 12 to 15 per cent of the 2005 values. So, what you have had in the interim, with the change of contract, is a shifting of patients from one service to another, which, hopefully, should settle down. Within the report, I suggest that there should be sufficient money, just about, to treat about 32 per cent of the population, and, if we do the modernisation and skill mix, up to about 35 per cent of the population. To get to that level, there is a bit of a backlog to clear, which may take a year or two. In order to move forward it would be nice to start clearing some of that out so we can develop a full service without the legacy—

[162] **Andrew R.T. Davies:** So, in essence, the drag is almost like the legacy factor. If you could clear the backlog you really would move forward.

[163] **Professor Richmond:** Yes, you can move forward.

[164] **Andrew R.T. Davies:** It is not the case that you would get rid of that backlog and, once the money dried up, you would build up a new one, is it?

[165] **Professor Richmond:** No, the idea is that there should be sufficient money in the system to drive that system and to move forward and develop it.

[166] **Andrew R.T. Davies:** So, to challenge that legacy factor, and this might be an unfair question, do you have a feel for what volume of money we might be talking about to clear that backlog so that the service can move forward on its new footing?

[167] **Professor Richmond:** My view is that it would be about £1 million to £1.5 million.

[168] **Andrew R.T. Davies:** So, it is £1 million to £1.5 million.

[169] **Professor Richmond:** Something like that. However, I would not put that in until we have put everything else in place, because I think that you need to have phase one, as it written down in the document, implemented first. We need to do that first and make sure that the service is efficient, and all of the assessments that result in no treatment are stopped, and then move forward.

[170] **Andrew R.T. Davies:** Okay, thank you.

[171] **Ann Jones:** Going back to the report again, the sub-group suggests that managed clinical networks should be established across Wales. How do you see these assisting health boards in planning and managing of orthodontic services?

[172] **Professor Richmond:** Obviously, they should have local knowledge and they know what their case loads are, what is coming in, what is changing, how many new patients there are, and what the degree of activity is in all services, both in primary and secondary care. I think that that is invaluable. Within that, they need to consider quality issues; they need to know what quality of treatment is being produced by practitioners.

10.30 a.m.

[173] However, the managed clinical networks are purely advisory because local health boards are buying the care and they are the bodies that are responsible for it.

[174] **Darren Millar:** That brings us to the end of this item. I thank you very much, Professor Richmond, for your evidence and for the copy of your report. It was extremely helpful and will continue to be so as we formulate our recommendations following the inquiry. We are very grateful for the time that you have given us. Thank you.

[175] We will take a two-minute break now before we move on to the next item on our agenda.

Gohiriwyd y cyfarfod rhwng 10.30 a.m. a 10.34 a.m.
The meeting adjourned between 10.30 a.m. and 10.34 a.m.

Ymchwiliadau'r Pwyllgor i Driniaeth ar gyfer Anhwylder Straen wedi Trawma i Gyn-filwyr y Lluoedd Arfog ac i Wasanaethau Orthodontig: Tystiolaeth gan Lywodraeth Cymru
Inquiries into Post-traumatic Stress Disorder Treatment for Veterans and Orthodontic Services: Evidence from the Welsh Government

[176] **Darren Millar:** The next item on our agenda continues with our inquiries into post-traumatic stress disorder treatment for veterans and orthodontic services in Wales. I am pleased to be able to welcome the Minister for Health and Social Services, Edwina Hart, to the committee this morning. Welcome, Minister. I also welcome Dr Sarah Watkins, the senior medical officer and head of mental health and vulnerable groups for the Welsh Assembly Government, who is going to be here for the part of the meeting on post-traumatic stress disorder.

[177] I thank the Minister for the paper that has been supplied and has been circulated to Members and, as usual, we will go straight into the questions on that paper, if we may.

[178] Minister, the committee has heard evidence that many veterans are very reluctant to engage with the services that might be able to help them overcome PTSD. We have heard this from veterans themselves and from some of the support agencies working with veterans. What work is the Assembly Government undertaking at the moment to increase awareness of PTSD and the services available to treat it in Wales, among veterans and their families in particular?

[179] **The Minister for Health and Social Services (Edwina Hart):** Thank you for that

question, Chair. We now have the annual operating framework targets that expect health boards to take account of the needs of veterans when planning services. I think that that is a very important development. I have also established the mental health and wellbeing services, which follows the success of the community veterans mental health services. The pilot and the new service alert health and social care bodies to the particular mental health needs of veterans. As the new services develop, they will also be fully integrated into health and social care. We have to recognise that, with veterans, we are not just talking about their health needs, but their wider needs in terms of social care provision, housing and all of those other dimensions. We have also disseminated widely information to GPs on this and we have had referrals from veterans' families and from community mental health teams.

[180] I think that the new service is there and is offering services to veterans, but I do understand what you are saying, that they may be reluctant to access the services. We do have very good links with the Ministry of Defence and we have good links with veterans' organisations, so we would also want them to encourage veterans to access our service. Of course, we have an established network across Wales.

[181] I do not know whether Dr Watkins wants to comment on some of the issues relating to GPs and so on, and their awareness of the issues.

[182] **Dr Watkins:** In terms of families, I will just mention that we do expect mental health services, as part of a holistic assessment, to take into account the needs of families and, indeed, carers. That is a key part of planning for all mental health services and all people in Wales, and particularly veterans, as we know that this is a real issue.

[183] I think that the new wellbeing service also takes that into account and, indeed, it specifically takes into account the needs of families. It is one of the key outcomes of that service to expect—

[184] **Darren Millar:** May I just ask what sort of support is available for families?

[185] **Dr Watkins:** The support would be in terms of giving practical advice really. So, you would not just see the veteran. After doing a holistic assessment, under what we call CPA—the care programme approach—we would expect the family to be brought in, to be part of the team and to be used as a resource, but also for the family to be offered emotional support. It can be very difficult if people become irritable or if their sleep pattern is disturbed—all the things that you have been hearing about.

[186] **Darren Millar:** Thank you for that.

[187] **Edwina Hart:** Do we want to comment at this stage, Sarah, on the development of the care pathway? I think that that might useful for the committee.

[188] **Dr Watkins:** Yes.

[189] **Darren Millar:** Yes, that would be good.

[190] **Dr Watkins:** Working with the MOD and, in fact, the steering group of the wellbeing service, we have provided a draft Wales-specific care pathway that includes PTSD, but it is actually for all conditions because, as we know, it is not just PTSD that veterans may suffer from—some people have very significant, severe injuries. It needs to be very clear what happens to them when they are discharged from the services, because it is a major concern of organisations that people should not be discharged from the services, or indeed the health services in the armed forces, which are excellent, and come back to nothing. What we have worked on, with the MOD, is ensuring that there is a real care pathway approach that has been

disseminated fully to each of the local health boards in Wales, so that they are clear about what should happen at what stage for any injury.

[191] **Darren Millar:** That is very important. We will come to the PTSD part of that and the transfer of care later on in our questions. Before we do that, let us just go to Veronica German on general practitioner issues.

[192] **Veronica German:** We know that GPs are often the first port of call for people and for most veterans, but we have heard in previous evidence sessions, and again today, that GPs are not always aware of a patient's military background. We heard today from the British Medical Association that not only that, but even if they ask for information from the MOD on their previous medical history, the notes are not always forthcoming. In fact, they get very brief evidence. So, if they are not aware of where they have come from, they might just see a gap in their notes and it is a bit of a guess then—they could have been in prison, they could have been in the forces, but they do not really know. What can be done to work with the MOD so that the GPs can get this information?

10.40 a.m.

[193] We have also talked about the fact that they have been deregistered and have had to register again. They may or may not be with the practice that they were with before—there seems to be a lack of communication, and people are falling through the hole. That is what we have heard, anyway.

[194] **Edwina Hart:** In terms of the MOD, there is some specific care pathway that should deal with some of the information issues, but the way to deal with all this in the transition is through the flow of information to GPs. We are satisfied that the MOD is now willing to facilitate the proper transition of records so individual can be dealt with holistically.

[195] We have also been trying to increase awareness among GPs more generally with the Royal College of General Practitioners, which produces an information leaflet about the health care needs of veterans for practitioners across the UK. I am also aware that some GPs will have an interest in these issues, while others will not. What we are trying to get is a wide knowledge base using the Royal College of General Practitioners, the Royal British Legion and Combat Stress to advise GPs in the form of literature about the particular issues. The point is well made about the information that GPs require to be able to assess the individual. We hope that we are overcoming that now—is that not so, Sarah?

[196] **Dr Watkins:** Yes. The MOD has also identified this as a real issue, so the critical thing is that the notes come back and, having got them back and put into the GP's notes, ensuring that the armed forces record is included and clearly marked as such so that, when the GP pulls up the patient record, that will pop up. That helps with identifying, as you were discussing earlier with Dr Dearden and Dr Davies, this possibility as something that you need to be considering in an individual.

[197] **Ann Jones:** Just on that point, what if the person does not want to have that information on their record? Dr Dearden this morning almost indicated to me that he would like to see that as a way of diagnosing perhaps. By how much would it cut the diagnosis time if we were to have that flag up on armed forces. It may not be post-traumatic stress disorder; it could be something else, but we immediately rule everything out because it involves the armed forces. What about the person who does not want that; where is their data protection?

[198] **Dr Watkins:** People do have a right to data protection, but equally, if somebody has had a medical condition, doctors need to know about it. Normally, the data would be protected and individual health conditions would be listed. It would be unusual if somebody

had a serious injury to exclude that information, because you would have to go through quite robust procedures. For example, in the case of somebody who has had a shrapnel wound to their stomach, you have to know about that if you are, at a later time, trying to diagnose the cause of their severe abdominal pain—to remove that information would be dangerous. There is a balance, I think, so that, when people have consultations or have certain issues that are confidential, they will normally be kept confidential between doctors, but they will not be excluded from the notes.

[199] **Darren Millar:** It has been suggested that a simple flag on a person's records to say that they have served in the armed forces without any further detail might be sufficient because, at some time, somebody could present with symptoms that may be related to a traumatic experience that happened 10 to 15 years ago, during their time in the forces. So, even if you do not have to go into all of the specific details of a person's medical record, do you think that there is merit in an opt-out scheme in which everything is transferred unless they opt out, and then, as a minimum, there may be a little flag that states, 'Ex-forces personnel'?

[200] **Dr Watkins:** We could discuss that. I see no reason not to discuss that with our primary care colleagues to see how practical it would be. As you say, it may be that the IT systems could do that fairly quickly, easily and efficiently. So, we will take that back.

[201] **Darren Millar:** Okay, thank you.

[202] **Andrew R.T. Davies:** I have two things to ask about. During this inquiry, when I initially thought about the papers just being passed between the military and a GP, it seemed a quite logical thing to do, but the more you actually think about it, you find that there is scope, if it is flagged up on the record, for a simple diagnosis to be made of, 'Oh, military, right; it must be PTSD'. That is a very real concern because, given the pressures in the primary sector and the time that they have to have with the patient to build up a picture—and I am not saying this is a general point across all GP surgeries—there is a risk of falling into a comfort zone, in that you see the flag and you instantly give a diagnosis based on that flag. That is a very real concern.

[203] **Edwina Hart:** You have made the case, really, for the proper transfer of records, so that GPs can see the full records to take a holistic approach to what might be wrong with an individual, whether it is a shrapnel wound, mental health issues or anything else. That is why, if a GP is to give proper service, they need to have access to the records. Flagging up might be good for historic cases, when those things come back, but I concur with you totally that GPs really need to know what has happened to an individual so that they can help them when they return to civilian life and into the primary community health system.

[204] **Andrew R.T. Davies:** You said there is good understanding between the Ministry of Defence and your good selves now, so it seems that there is progress in the sharing of information. Is that happening now, or is it an aspiration to happen in the future? Do we have a date of when it is going to happen?

[205] **Dr Watkins:** We are having excellent discussions with the Ministry of Defence and the wider UK Government on this. There was the health and military liaison workshop that the Minister held in March, which brought together the executive level team from the armed forces, the veterans champions in every local health board and representatives from the Department of Health. So, we are working very closely together to ensure that we have the best possible services for veterans returning to Wales.

[206] **Andrew R.T. Davies:** We do not have a definitive timeline for that move to a better understanding and sharing of information, do we?

[207] **Edwina Hart:** We very much hope that the MOD is arranging that, so that individuals' records are transferred to us properly. If there are any particular issues, we would want to take them up, but our understanding is that there should be the necessary flow of information, just as, if you move from Glasgow to live in Cardiff, your medical records would be transferred from one GP to another. There should be no difference in the transfer of records just because you happen to be in the military.

[208] **Andrew R.T. Davies:** That is happening now, is it?

[209] **Edwina Hart:** Yes. The reality is that they are having the records.

[210] **Dr Watkins:** It is improving, however, and the MOD, from which the records must be obtained, has now agreed that that has to improve and it has to get the full record back to the community.

[211] **Darren Millar:** That is important, because we have heard from the evidence that the information is not always passed on or passed on in a timely fashion. There can be large gaps because of national security or other reasons that prevent the sharing of information. It is encouraging to hear that there have been recent improvements.

[212] **Val Lloyd:** Minister, you very helpfully provided information in your written evidence on the new mental health and wellbeing service for veterans. However, the committee has received evidence from the BMA that the NHS in Wales does not have the capacity to implement that new service in terms of either staff scales or overall resources. Are you confident that the new service will be able to meet the demand?

[213] **Edwina Hart:** As far as I am concerned, the clinical needs of veterans with PTSD have to be met by the NHS in Wales as part of its core commitment, and it should be undertaking that role. Clearly, as with any new service, elements of staff training will need to be identified to ensure that staff have the appropriate skills and competencies to manage this very specialist work, Val. An integral part of the service is a programme of staff development, which I think will help to ensure that it runs efficiently. We also have a new training week for new community veterans mental health therapists planned, once they are all in post. This will involve clinical guidance on the identification, assessment and management of PTSD for military veterans. We are also involved in veterans care working to aid recovery within the military. So, we are doing all the right things to deliver the service, and I hope that the service will be effective and efficient and serve the needs of the veterans.

[214] **Darren Millar:** It is fair to say that it is difficult to determine exactly what capacity will be needed, because we do not know where veterans are located, because this flag is not used at the moment.

[215] **Edwina Hart:** Each LHB has a duty, however, and we now have the champions in the LHBs to take matters forward. Of course, a lot of the voluntary sector organisations that veterans engage with also engage with us in health. So, we do start to identify whether a group of people with particular needs is emerging, because the voluntary sector organisations advise us of it.

[216] **Val Lloyd:** You also tell us that, although funding from the MOD was provided for the two-year pilot scheme, it has not been forthcoming for the new veterans mental health and wellbeing service. Are there reasons for that? What is the likelihood of any funding in future from the MOD? Is it contributing to mental health services in England?

[217] **Edwina Hart:** Well, obviously the MOD does make grants to Combat Stress. We are

aware of that. I cannot really speak for the Ministry of Defence. I have written in very strong terms to ask it to reconsider its position, but it did not agree, and we recognise that this is not a devolved matter. We have noted the announcement of funding for 15 extra nurses across England to take its total to 30 nurses, and that is the equivalent of funding only two nurses in Wales, which puts that funding into perspective.

10.50 a.m.

[218] **Darren Millar:** The Secretary of State for Defence recently announced an improvement in mental health services in England, with the introduction of a 24-hour helpline. What impact does that have in Wales? Is there a consequential in terms of investment from the MOD?

[219] **Edwina Hart:** Do you want to talk about our current arrangements, Sarah?

[220] **Dr Watkins:** We already run, and are quite proud of, our community advice and listening line—or CALL—which is a 24-hour service available—

[221] **Darren Millar:** Is that is a general service?

[222] **Dr Watkins:** That is a general service. So, there is already operating in Wales a place to which we can, and do, refer veterans. However, this is, as far as we are aware, a UK veterans' helpline, so veterans will, in addition to what they would have had before, also have access to that helpline. There is now quite good availability of 24-hour advice. The plus point of the Welsh line is that it also has a database of all local services and facilities in Wales. Ringing the core mental health line means that you can find out what is available to you locally, which is extremely helpful.

[223] **Darren Millar:** The difficulty is that we have heard that veterans like to contact veteran-specific services, do they not? Is there any way of patching calls from Wales through to our service, flagging them up as veterans' calls?

[224] **Dr Watkins:** As I said, it is a UK helpline, so I do not think that that is an issue. The veterans would be able to ring it. You are right, I think, that the British Legion would pass them on. It may well be that the helpline's volunteers and trained people are ex-service personnel; indeed, Professor Jonathan Bisson is ex-service personnel, which is why veterans have welcomed his service so much. They will be able to ring that line and, yes, information can be shared. It is already shared, for example with NHS Direct Wales.

[225] **Darren Millar:** There is no duplication in terms of what is being done with your line, because it is more general, is there?

[226] **Edwina Hart:** No.

[227] **Dr Watkins:** It is additional, in the sense that they now have two options. This is something that we provide for the whole of Wales. We have incorporated a number of other helplines; for example, the drug and alcohol misuse helpline is also run from there. We have tried to do this as efficiently as possible in Wales, which is why we think that our model is a particularly good one that other people need to learn from.

[228] **Val Lloyd:** How well known is this service?

[229] **Dr Watkins:** The CALL helpline or the veterans' line?

[230] **Val Lloyd:** Both.

[231] **Dr Watkins:** The helpline has periodic advertisements, and it gets tens of thousands of calls a year. It could be better known, because it does have to repeat that advertising. I would like to say that every GP in Wales knows about it—they should, but I could not, hand on heart, say that they do. We have periodic pushes, and the person who runs that is based in Betsi Cadwaladr University Local Health Board and does that regularly, because we are aware that a helpline is no use if you have not heard of it.

[232] **Lorraine Barrett:** Minister, we have heard evidence about veterans who have committed crimes and who are in prison. Can you confirm that the new mental health and wellbeing service will be available to veterans in Welsh prisons, including those in Her Majesty's Prison and Young Offenders Institution Parc, which is privately run? Also, will Welsh veterans held in English prisons receive the mental health services that are provided to English veterans?

[233] **Edwina Hart:** Veterans in prisons in Wales receive the healthcare services that are available within the relevant local health board. However, Parc prison is different, because there is a contract there. The contract position, as I understand it, is that a company provides the services. So, in Welsh prisons we typically have nurse-led services and occupational therapy services, and we are planning to develop the care pathway, with individual care plans for prisoners. We have taken that holistic approach. Clearly, I cannot comment on issues regarding English prisons as the issue is not devolved to me.

[234] **Lorraine Barrett:** We have had evidence to suggest that, with the right specialist intervention, veterans with complex post-traumatic stress disorder who are in the criminal justice system can be helped to avoid prison and be prevented from committing further crimes. Can you say something about any services that you might be developing to help veterans to avoid going down that road?

[235] **Dr Watkins:** At an early stage, we developed Prison In Reach into all prisons, including Parc, and that includes mental health services. I would expect all mental health services to be able to treat post-traumatic stress disorder. Post-traumatic stress disorder is not confined to the military. If a terrible thing happens, anybody can suffer from PTSD—for example, if you are a train driver and somebody jumps in front of the train, there are significant problems. Generic services are able to provide to a certain level and then, for people who have more specific, specialist needs, there is this additional service. You can seek support and advice—whether you are a GP or a consultant psychiatrist—to support them, or if you need specific, complex interventions, they can be provided by that service. That is how we are approaching it. Prisoners in Welsh prisons are indeed eligible for that. So, yes, you are right; some people have complex needs and they should be addressed. We would expect that to happen as a matter of routine, whether you have been in the military or any other—

[236] **Darren Millar:** Obviously, we should aim to prevent them going to prison in the first place, so as soon as they present in the criminal justice system there should be an opportunity for intervention. This takes us into Dai's area of questioning on substance misuse, and then we will come back to Andrew.

[237] **David Lloyd:** As we have heard in evidence, many veterans experiencing post-traumatic stress have many additional problems, particularly with substance misuse. We have heard evidence that substance misuse services lack capacity and are, perhaps, poorly co-ordinated. What has been done to address that? Do veterans receive priority treatment for substance misuse services?

[238] **Edwina Hart:** On substance misuse, we have a service framework to meet the needs of people with co-occurring substance misuse and mental health problems, and co-ordinating

between services is crucial in this area. The funding streams for mental health and substance misuse are both in my portfolio. At the present time, I am not going to combine them; I think that I will keep them as they are. Mental health services have been strengthened within the NHS to the benefit of all service users, because we have ring-fenced funding, and the substance misuse action revenue fund has been increased—I think that it is nearly £28 million this year. That is a huge investment, as the fund started off at £3 million in 2003-04. So, we certainly have some issues around that.

[239] As with other health conditions, veterans are eligible for priority treatment for substance misuse services for conditions related to their service. Some of the issues that arise on this are centred on the lack of knowledge about the availability of services and people's understanding of issues around priority.

[240] **Darren Millar:** There has been a lot of concern about capacity, I think that it is fair to say for substance misuse in general, and not just in terms of access for veterans. You say that there is a lot of extra investment, but has that gone into boosting the availability of residential rehabilitation facilities, for example, for substance misuse? Where has the extra £28 million gone? Where has it been targeted?

[241] **Edwina Hart:** It has gone into mainstream services.

[242] **Dr Watkins:** Yes, across the piece. Some has gone into residential rehabilitation, but the bulk of it has gone on treating more patients. The number of people being treated has gone up enormously. I cannot quite remember the numbers, but I can send you the information. I have a feeling that it was something like—

[243] **Darren Millar:** We need a range of treatment options, do we not?

[244] **Dr Watkins:** Absolutely. That is central to our substance misuse and alcohol misuse strategy. For veterans, it is not just about illicit substances; a lot of this is about alcohol misuse, particularly the interaction with PTSD and how that can make people more aggressive. As you will be aware, there are also issues with homelessness and people dropping out altogether. This is critical, which is why, in some ways, having heard the earlier debate, I would say that it is a priority for veterans. If they do present they will be treated as a priority group.

11.00 a.m.

[245] **Darren Millar:** Veronica, you wanted to come in there, did you?

[246] **Veronica German:** Yes. I was just going to say that what we seem to have heard, and not just today but previously, is that the patient is not treated as a whole. The patient might have mental health issues and substance or alcohol misuse problems and one person can treat this, and the other can treat that, but it is done completely separately. In other walks of life, and I have heard this from other people as well, if you have a mental health issue, you will not be accepted into substance misuse therapy and vice versa. I have heard that from a number of organisations.

[247] **Dr Watkins:** Our guidelines are very clear that that must not happen. So, while I will not say that it never happens, our comorbid condition guidance makes it very clear that services have to work together for individuals. You need to define, however, which service takes the lead. If, for example, somebody has schizophrenia and a substance misuse problem, then the mental health services would lead. If somebody's first problem is opiate misuse and they also have depression then the lead would be with the substance misuse services and the mental health services would support them, but they must work together. That is made crystal

clear if you read our substance misuse framework. It is an issue that is brought up time and again by service users, so we have put out the framework, and, in fact, we launched it twice because we thought that it was so important. That is partly because, I will admit, the first time that we launched it, people were saying to us, 'Oh, we have not heard of that', so we did it again and this is a message that we are pushing very hard. Services are stretched and it is a reality that we have to push that agenda. However, from the Government's perspective, we are giving that clear message all the time.

[248] **Veronica German:** People have said to me in other arenas that it is a funding issue: 'Oh, we are only getting money to do this, therefore we are not going to do anything to do with that'.

[249] **Dr Watkins:** No, the LHBs have been told that that is not what we expect. We expect priority according to clinical need, and they have to treat all conditions. That is the holistic principle of mental health services across the piece.

[250] **Darren Millar:** Andrew, do you want to ask about the co-ordination of services?

[251] **Andrew R.T. Davies:** Yes, but I would like to first ask a question on finance, because we have received evidence previously about the money you have put in, which, I think, is about £480,000, which was given to the LHBs on the basis of the population that they serve, rather than according to the number of veterans that reside within the LHB area. I appreciate that that would be a very forensic way of trying to put money in, and that that information was not available to you at the time, but, in future, given the better dialogue that you have now with the Ministry of Defence and the flagging system—historically, Wales, and the Valleys in particular, has been a recruiting ground for our armed services—are you confident that if you are able to put in more money, or a sustainable income, specifically to deal with this issue, you would be directing it more forensically to those LHBs that may have a higher demand for that money, rather than distributing it on a crude population basis?

[252] **Edwina Hart:** I think that we can be assured, now that the LHBs have champions on veterans' issues, that they will be looking individually at their areas, what information they have, and who is coming into their areas and accessing services. Therefore, with those arrangements in place, we might well have requests to look at how we allocate the money. If this is an area that the committee wants to explore, I would be more than happy to look at that in the future.

[253] **Andrew R.T. Davies:** Thank you. I have a question on voluntary services. We have heard this morning from the BMA and other organisations. We have heard about their expertise, and the Royal British Legion is a classic case. In some areas, voluntary organisations are integrated within the statutory sector to provide a service, while in other areas they just wish to provide a service on their own. Are you happy with the way that the expertise that the voluntary sector can provide is being integrated into the overall picture of programmes and care that you can provide within the NHS in Wales?

[254] **Edwina Hart:** Yes. I very much hope that the new steering group that I have set up will do more work in this area, because you are right that the work that goes on between the voluntary sector and the statutory sector is excellent. I think that there will be a mixed pattern across Wales. We have the involvement of Combat Stress and the Royal British Legion in a number of key areas, but I hope that we can do far more work with the voluntary sector as time goes on, and that is definitely the instruction to local health boards. When you look now at the local health boards in terms of who is on those boards, they have a representative from the third sector and I would expect them to be quite proactive in following through on some of this particular agenda.

[255] **Andrew R.T. Davies:** Would you be minded to support more formal service level agreements with the voluntary sector so that voluntary organisations can understand their obligations in terms of the provision of services and the expertise that they might be able to provide, and develop that expertise and those services, or do you think that it should continue on a more informal basis and that organisations should be called in as and when the local champion, for example, or the service board, thought it was necessary?

[256] **Edwina Hart:** We have an enormous amount of service level agreements with the voluntary sector across the piece, although I am not necessarily talking about organisations in relation to veterans. We have dealings across the piece with the voluntary sector in relation to mental health services, and we tend to work through formal SLAs, so that is not an issue. If a local health board thought it appropriate to work with an organisation that represented veterans, an SLA would be a matter for it.

[257] **Darren Millar:** So, if a treatment is found to be clinically effective, whether that treatment is residential or whatever—we have had some interesting evidence about neuro-linguistic programming, which we are going to explore further—would you be happy for LHBs to engage with organisations to purchase those services?

[258] **Edwina Hart:** LHBs already have SLAs with a wide range of charities to provide services, so we are not talking about something different from what we have had previously; it is just that we are talking about services for veterans and LHBs have not perhaps had formalised arrangements with veterans' organisations. The NHS is bound to look at treatments that are clinically effective and are proven, because the public would not want us to invest in treatments that are not clinically proven.

[259] **Darren Millar:** Yes, absolutely. Thank you for that. If there are no further questions on the veteran-related services for PTSD, we will move onto the orthodontic services inquiry, if we may. Thank you, Dr Watkins, for your help.

[260] I welcome to the table Dr David Thomas and Andrew Powell-Chandler. Dr Thomas is the acting chief dental officer and Andrew Powell-Chandler is the head of dental policy, and both are from the Welsh Assembly Government. Welcome to you, and thank you for your attendance today.

[261] We have received a paper on this particular issue from the Minister, so we will move straight into questions on it. In the written evidence, Minister, you say that, given the spending pressures that are being faced across the public sector, orthodontic provision has to be placed in the context of other dental priorities. What are the dental funding priorities for Wales?

[262] **Edwina Hart:** Our starting point should be that we need to recognise that an individual has to be dentally fit before undergoing any orthodontic procedures. So, the important issue is to make sure that people attend their dentist and have good oral health. Orthodontics has to be part of the wider process, in my opinion. I do not know whether Dr Thomas wants to add anything.

[263] **Dr Thomas:** Local health boards are responsible for providing dental services and commissioning dental services and so, in a wider context, they need to use their local oral health planning processes to prioritise the development of these services.

[264] **Edwina Hart:** There is one service area that I know that the committee will be concerned about. When we look at Wales, there are areas where there is no difficulty in accessing orthodontic services. It is important that we recognise that local health boards should look at the cross-boundary issues in terms of orthodontics, and at how you perhaps

need to cross boundaries in order to provide the service.

[265] **Val Lloyd:** We have had evidence, Minister, which has suggested that additional, one-off funding is needed to address the long waiting times for treatment that some patients face. Do you agree that the backlog should be addressed and, if so, are there any additional resources that you could make available for it?

[266] **Edwina Hart:** You will have seen the report that has been provided to me. Our first job is to look at the efficiencies that have been identified in the report and then move on to the question of whether that will that free up any additional capacity to allow us to deal with some of these issues. Some local LHBs have undertaken specific examinations of what they need to provide and specific initiatives in terms of cash, but this is an on-going process. I set up the group, it is now working and there is further work going on—that is the way forward in this area.

11.10 a.m.

[267] **Val Lloyd:** The British Orthodontic Society suggested that it would be appropriate to have a referral-to-treatment target for orthodontics. Have you given any consideration to introducing that type of target?

[268] **Edwina Hart:** I wonder if Dr Thomas wants to comment professionally on this.

[269] **Dr Thomas:** Yes. The RTTs or referral-to-treatment times do show some patients waiting for hospital dental treatment because you do not see an RTT in primary dental care. We have written to the local health boards asking for data and information about this issue. We have also agreed with the dental profession that the application of a 26-week target is inappropriate, but we understand that there is a need for a policy that does not have an open-ended nature to the treatment. One of the things that we are doing through the dental division is working with the Welsh Dental Committee on this issue.

[270] **Darren Millar:** Why do you think that the 26-week wait target is inappropriate? I mean, that is an awfully long time to wait for treatment, is it not?

[271] **Dr Thomas:** We listened to the previous speaker. There is an issue about when treatment is necessary and obviously if patients—certainly child patients—are being referred early, that would be completely inappropriate because they need to wait two or three years for the teeth to come through in their mouths to be treated anyway.

[272] **Darren Millar:** They are being referred early because of the long wait, are they not? It is a catch-22 situation, is it not?

[273] **Dr Thomas:** I am not so sure that that is the whole reason. There may be some merit in that, but there are other considerations in that parents might be concerned about appearance and might be putting pressure on primary care practitioners to get an opinion.

[274] **Darren Millar:** Yes, we have heard about the cosmetic pressure—the American teeth syndrome, as some people described it.

[275] **Christine Chapman:** In your written evidence, you say that the demand for orthodontic treatment has increased and you suggest that this could be driven in part by cosmetic rather than health benefits. How have you determined that there has been an increase in demand for orthodontic treatment and the reason behind the increase?

[276] **Edwina Hart:** We only have to look at the cash on this issue—I look at Andrew

Powell-Chandler in terms of the vast increases in the budgets. We only started using the index of orthodontic treatment need in 2006. Do you want to explain to the committee what that is, Andrew?

[277] **Mr Powell-Chandler:** As the Chair just referred to, it may be about American teeth syndrome and people's desire to have nicer smiles and so on. That is quite hard to quantify, but if you look at the budgets to start with, in the last decade, spending on orthodontics has almost trebled in England and Wales. We know that in 2005-06, we were spending £7.8 million on orthodontics; in the last year, it was up to £12 million. So, that shows an increase and although we have introduced the index of orthodontic treatment need, which gives a marker, if you like, and those who are above that can get the treatment, the number of treatments is still going up and that suggests that there are more people in the system. There does need to be some caution in terms of interpreting the data because they are still in the early stages—some of these data are experimental—but we know that the amount of orthodontic work that is being done is going up and that the proportion of spend in terms of the total dentistry budget that local health boards have is increasing as well.

[278] **Christine Chapman:** Do you think that more work is needed to improve the awareness among patients of the assessment criteria for NHS treatment? If so, who should be responsible for that?

[279] **Edwina Hart:** I think that we all need to be involved, from practitioners to the local health boards, and Assembly Members also need to be aware of it so that we can advise when we get queries from our constituents. So, the answer to that is a clear 'yes'.

[280] **Andrew R.T. Davies:** Minister, the ability to attract and retain staff and dentists in rural areas is identified as an issue in your paper, and very often it is far easier to identify the problem than to rectify it. Could you give the committee an idea of what action your department is taking to try to rectify this problem in recruiting and, above all, retaining specialists in rural and deprived areas?

[281] **Edwina Hart:** In terms of workforce planning, it is only Betsi Cadwaladr LHB that has indicated problems with orthodontic recruitment for 2009 and 2010. The others are fairly confident on that. There were issues around ABMU's regional surgery service that there was a caveat on orthodontic therapists appointed to support the delivery of treatment due to recruitment difficulties for medical appointments. Hywel Dda LHB has acknowledged fully that it needs to help its capacity in that area. Those are the reports that we are receiving on it currently and we are working with the local health boards on that. Do you want to say any more about that, Andrew?

[282] **Mr Powell-Chandler:** I was only going to add that this committee has already looked at workforce planning in the health service and social care, and dentistry is now part and parcel of that. So, it is looking at it in the wider scope of things. It is also part of the Wales medical and dental workforce committee, which in turn is reporting to the modernisation programme board. So, dentistry might have been looked at outside that, but it is now being looked at alongside all the other professions as well.

[283] **Andrew R.T. Davies:** So, you have identified the problem, you are working with LHBs to try to rectify it, but there is now an interim period—there could be a longer interim period, depending on how long it takes to rectify that problem. So, what action is the department taking, along with LHBs, to try to offer a service while these problems are being sorted out?

[284] **Edwina Hart:** I alluded earlier to the fac that we have been encouraging them to look at cross-border issues, to see whether somebody else would be able to help and assist with the

service. It would not necessarily be satisfactory for patients, because of the distance to travel, but we have asked them to look at that as a whole, as opposed to looking at individual compartmentalised areas.

[285] **Andrew R.T. Davies:** So, when you talk about 'cross-border', just for clarification, you are talking about the borders of the LHBs, and not the England and Wales border.

[286] **Edwina Hart:** Yes, we are talking about the borders of the LHBs, because it is important that we maximise the use that can be made of the resources that we have in Wales.

[287] **Darren Millar:** It has been suggested by some witnesses that satellite provision might be something that could help to solve these problems, particularly in parts of Powys, for example, or Ceredigion. Is that something that you are prepared to look at?

[288] **Dr Thomas:** As far as I am aware, local health boards in those areas are already looking at that issue and will be developing plans in the future. The development of orthodontics is based on the old contract, where orthodontists chose to set up. At the moment, under the new contract, orthodontists' contracts run for a certain period and a lot of those contracts run out at the end of this financial year, so there are opportunities for the LHBs to renegotiate.

[289] **Ann Jones:** Witnesses expressed concern that contracts between the LHBs and certain providers do not take into account the quality of the treatment. Whose responsibility should it be to ensure that health boards monitor and act on the peer assessment rating? For example, is this a role for public health or for the managed clinical networks?

[290] **Dr Thomas:** In terms of quality, the contracts do include the PAR index, which is the measure of quality that orthodontists use to look at the way that the teeth now interdigitate. In terms of who should be doing that, many witnesses have suggested that it should be run through managed clinical networks, where groups of orthodontists get together with independent assessors to talk about how we are going to improve quality using the independent assessment process.

[291] **Christine Chapman:** In its evidence to this committee, Public Health Wales did suggest that there has been a lack of strategic planning with regard to orthodontic care. What is your response to that?

[292] **Edwina Hart:** It is absolutely correct; that is why I commissioned the review. We all recognised that there was an issue. My officials recognised it because we were getting to grips with dentistry, but we had not got to grips with the orthodontic end. Public Health Wales was absolutely right, but I do think that the development of the managed clinical networks will create a very efficient referral management process to reduce early, multiple and inappropriate referrals. We are getting there, slowly but surely, in terms of the development of this service and the management of it.

[293] **Darren Millar:** Of course, we do not need to hear from Dr Thomas on that because he has given evidence already.

[294] **Dr Thomas:** In a previous life, I was the public health person who might have suggested that. [*Laughter*.]

[295] **Veronica German:** In the report from the task and finish orthodontic sub-group, there are 10 recommendations for the Welsh Assembly Government. Have you decided if you will be implementing all of those recommendations? If not, why not? Where are we with those, basically?

11.20 a.m.

[296] **Edwina Hart:** They are actually very good recommendations. I am grateful to the group that put this report together. What it has undertaken in this report is an awful lot of work on top of the day job. I have accepted the need to look in detail at each of the report's recommendations, and that will be done as part of the implementation process. We are already looking at issues about the discretionary charging of patients for missed appointments and the availability of NHS e-mail addresses—that is already under way. There are, of course, potential cost implications and possible changes to legislation that we will need to consider. I am responding to them all, and I would be more than happy to update the committee in due course, when we have made final decisions. I am, obviously, conscious of the financial pressures from these recommendations.

[297] **Veronica German:** Talking about financial pressures, some of the recommendations refer to inefficiencies in the current system. If any cost efficiencies are made as a result of implementation, will they be—

[298] **Edwina Hart:** They will be in the dental budget. I have already indicated that that will be there for 2012. This will be reinvested into that budget.

[299] **Veronica German:** Will that be in the general dental budget, or in the orthodontic budget?

[300] **Edwina Hart:** In the LHB dental budgets, which are ring-fenced. That is the whole budget.

[301] **Dr Thomas:** LHBs would then have the responsibility of deciding on priorities, because priorities do vary.

[302] **Darren Millar:** In terms of your response to the task and finish group's report, our report will hopefully be published fairly soon—

[303] **Edwina Hart:** Yes, and I will ask the implementation group to take into account the committee's report when it implements the report that it has done for me.

[304] **Darren Millar:** That is terrific; thank you.

[305] **Ann Jones:** How will you ensure that health boards implement recommendations aimed at them? I think that I know what the answer will be, but we need it on the record.

[306] **Edwina Hart:** We do need it on the record, because local health boards will be part of the implementation process. Local health boards and those involved in dentistry in this area are interested in ensuring that this policy agenda is moved along. That will be important. We in the Assembly Government expect the necessary updates, and if we do not get what we want, we will have to directly intervene.

[307] **Darren Millar:** This is my final question, you will be pleased to know, Minister. What is the timeline for establishing the implementation group, and who is going to be included within that group's membership?

[308] **Mr Powell-Chandler:** We thought that it would make sense to wait until this committee had produced its report, so that we could ensure that the terms of reference of the implementation group took everything into account. You report in four to six weeks' time, so I would imagine that we would be setting it up after that. On representation, it would be the

normal people involved in terms of cross-representation of all those—

[309] **Darren Millar:** The usual suspects.

[310] **Mr Powell-Chandler:** There might be some new faces, but it would certainly represent the orthodontic profession, its representative bodies, local health boards and patient groups.

[311] **Andrew R.T. Davies:** As someone who has led a sheltered life, I would like to understand the point that the Minister made in saying that she would intervene if LHBs do not implement the recommendations. Given that constituency or regional AMs receive correspondence when constituents have an issue, and then address it to your good selves, what type of intervention could a constituent or an Assembly Member expect from the Minister or her department in an LHB that is not meeting the recommendations?

[312] **Edwina Hart:** It is my job to ensure that they are meeting the recommendations. I doubt very much that a member of the public will write to say that an LHB has not adopted all the recommendations. Members of the public are more likely to write to you about problems that they are having with the service. My job is to ensure that we have the reports in from LHBs. My officials will then go through the reports to make sure that they are implementing the policy as agreed. If they are not implementing the policy as agreed, the first port of call would be for officials to discuss it with the relevant executives within the LHB. The next stage would be for discussions to be held with the chief executive, the chief executive of the NHS and the chair—they would be coming in to have a very pleasant cup of tea with me. At the end of the day, we need to ensure, now that we are getting to grips with these issues, that they actually do it within LHBs.

[313] We have to acknowledge that LHBs are massive organisations and that dentistry is a very small part, in budgetary terms and in terms of activity, of the whole organisation. That is why it is very important that my officials and dentists are on top of it. The intervention would be that direct. I can decide what I want to do in terms of targets; I can look at that agenda. So, when the committee reports and I look at the implementation group, I will ensure that we have terms of reference that reflect these issues.

[314] **Andrew R.T. Davies:** So, they will come in for a cup of tea and you will make them aware of their obligations.

[315] **Edwina Hart:** In the real world, I always make LHBs aware of their obligations and I deal with them appropriately. You will find that LHBs understand their obligations. Sometimes, there are difficulties within LHBs; they come to you and say, ‘We cannot quite do that; we have recruitment problems’ and you have to be open and acknowledge that there will be some issues. However, at the end of the day, it is my job as Minister to ensure that, when we set policy in the Assembly Government, it is adhered to. I do not like it when it is not adhered to and I get very frustrated, but there are mechanisms for dealing with it.

[316] **Andrew R.T. Davies:** I am just conscious of the cancer targets, for example; they were not met in September.

[317] **Darren Millar:** We are discussing orthodontics now; I think that that is for another time and place.

[318] **Andrew R.T. Davies:** It is the recommendations.

[319] **Darren Millar:** If we make recommendations about targets, or if you want to raise something that is specifically related to orthodontics, that is fine. There will be other

opportunities to question the Minister on targets in other fields.

[320] Are there any further questions on orthodontics? I see that there are not. That brings us to the end of this item. Thank you, Minister, Dr Thomas and Andrew Powell-Chandler for your assistance.

[321] We have a few papers to note. I take it from Members that they are noted.

11.26 a.m.

Cynnig Trefniadol
Procedural Motion

[322] **Darren Millar:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37.

[323] This will allow us to consider our draft report into local safeguarding children boards and the terms of reference for our committee inquiries into NHS reviews in Wales. I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.26 a.m.
The public part of the meeting ended at 11.26 a.m.