Shaping the Future of Restorative Dentistry For the North of Scotland

A Report from the NHS Highland Workshop
Wednesday 30th June 2010
This report provides the reader with an insight into the events of the NHS Highland Restorative Dentistry Workshop which took place in Inverness on 30th June 2010. It summarises the presentations, the facilitated sessions and the outcomes from the day and gives an indication as to the further work required to inform the debate to “Establish a Regional Service for Restorative Dentistry in the North of Scotland”.

Intentionally, the report does not contain any recommendations for the North of Scotland Planning Group. Recommendations will form part of a full and final report which draws on the evidence base and the findings from consultation across all six North of Scotland Boards. It is anticipated that the full and final report will be presented to NoSPG by the end of 2010.

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5. Mapping the Patient Journey
6. Future State

Appendices

Appendix 1 Opportunities Summary
Programme

01/10 Coffee and Registration  09.30

02/10 Introduction and Background  10.00 Helen Strachan

03/10 Restorative Dental Service - NHS Highland (A presentation form Clinical and Managerial Colleagues in NHS Highland)  10.15 NHSH

   i) The Secondary Care Perspective
   ii) The Primary Care Perspective
   iii) What the Data Tells Us

Refreshments  11.00

04/10 Facilitated Session:

   Identify Issues  11.40 Janet Harris
   Identify Value
   Identify Waste
   Identify Gaps

05/10 Group Work; Value Stream Mapping and Ideal State  12.00

   Lunch  12.30

06/10 Facilitated Session; In Pursuit of Direction  13.15 Janet Harris

   Helen Strachan

   Identify driving forces
   Cluster and model driving forces
   What are the competencies
   Skills analysis
   Create options and end state
   Create value statements
   Priorities through option appraisal end states

Refreshments  15.15

07/10 Blinds spots and Next Steps  15.30 Helen Strachan

   Action Planning: Local, Regional and National Challenges

   Close  16.30

Chaired by
Helen Strachan, Regional Manager, North of Scotland Oral Health and Dentistry

**Facilitated by**

Janet Harris, Service Improvement Manager, 18 weeks Transformation and Redesign Programme

**Present**

Dean Barker, Consultant in Restorative Dentistry, NHS Grampian
Ruth Davidson, Dental Hygienist, NHS Highland
Martin Donachie, Consultant in Restorative Dentistry, NHS Grampian
Adrian Farrow, OMF Consultant, NHS Highland
Anne Frame, Operational Manager (Dental), NHS Highland
Elaine Goldsmith, Dental Practice Adviser, NHS Highland
Adrian Hart, Consultant Orthodontist and Chair ADC, NHS Highland
Linda Kirkland, Business Transformation Manager, NHS Highland
Cathy Lush, Clinical Dental Director, NHS Highland
Maimie Thompson, 18 Weeks Local Programme Manager, NHS Highland
Larry Walker, Senior Technician, NHS Highland
Nicola Watt, Department Administrator, NHS Highland
Praveena Madhaven, Public Health Researcher, NHS Lanarkshire
Sam Rollings, Specialist Registrar, Restorative Dentistry, NHS Grampian
Suzanne Blacker, Specialist Registrar, Restorative Dentistry, NHS Grampian
Steven Hutchison Chief Dental Technologist/Maxillofacial Prosthetist and Technologist
Tom McWilliam, Assistant Clinical Dental Director, NHS Highland
Margaret Brown, Head of Service planning, NHS Highland
Annemarie Walsh, Unit Operational Manager, Aberdeen Dental School

**Apologies**

Ian Bashford, Medical Director, NHS Highland
Roseanne Urquhart, Head of Healthcare Strategy, NHS Highland
John Herrick, Director of Dental Services, NHS Highland
Ruth Freeman, Consultant in Dental Public Health, University of Dundee/NHS Highland
Derek Leslie, Chair of the National Task and Finish Group, NHS Highland
Ian Ross, Head of eHealth Infrastructure Services, NHS Highland
Andrew Hall, Joint Head of UHI BSc Oral health Science, Senior Lecturer/Honorary Consultant, NHS Tayside, Honorary Consultant NHS Highland
Isobel Madden, Joint Head of UHI BSc Oral Health Science, Assistant Director General Dental Practice Education NES, Honorary Specialist Practitioner (periodontology), NHS Highland
3. Introduction

The Restorative Dentistry service across the North of Scotland is struggling to meet demand and the North Boards are experiencing considerable pressures to comply with the Scottish Government’s 18/52 referral to treatment standards.

At their meeting on 14th April 2010, members of the North of Scotland Planning Group (NoSPG) reaffirmed their commitment to the North of Scotland Oral Health and Dentistry work stream. With regard to services for Restorative Dentistry, members agreed that quick fix solutions were not an option and that “A Regional Service should be formally established for Restorative Dentistry” thus ensuring:

- Public Value for money
- HEAT Targets (Health, Efficiency, Access, Treatment) are met
- Service Quality Outcomes are uniform and agreed across the North
- Compliance with the 18/52 Referral to Treatment (RTT) standard
- Unified corporate and clinical governance issues are addressed
- There is equity of service across the North
- A unified approach to the delivery of Restorative Dentistry Services across the North

3.1 Clinical Benefits

The perceived clinical benefits of a regional approach to the delivery of Restorative Dentistry services include:

- **Support to Clinicians**
  - decision-making
  - emergency management
  - skill sharing
  - inclusivity

- **Patient and Access Benefits**
  - less travel to access expertise
  - more rapid access
  - better distribution and utilisation of resource
  - shorter waiting times

- **Educational Benefits**
  - shared learning
  - common learning pathways
  - development and maintenance of skills
  - inclusivity and the sense of belonging to a wider network

- **Governance**
  - setting standards
  - audit
  - improving and adjusting standards

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1 North of Scotland Planning Group, Item 20.10, 14th April 2010
3.2 Consultation and Timescales

The high level project plan below outlines the process for consultation with the NoS Boards and the intended timescales for reporting:

The plan included the requirement for workshops to be held in each of the three mainland Boards. The first of these workshops was held in Inverness on Wednesday 30th June 2010, with key stakeholders from NHS Highland attending. Facilitation for the workshop was provided by Janet Harris, Service Improvement Manager, 18 Weeks Improvement and Transformation team.

Following discussion with Dr Annie Ingram, Director for Regional Planning and Workforce Development, it was agreed that the timescale for the full and final report to NoSPG could be extended until December 2010. The additional two months would allow improved data gathering from Boards, seen as essential to the evidence base, to be completed and analysed. A brief update on progress will be provided for members of NoSPG for their meeting in September.
4. Current Service – The NHS Highland Perspective

NHS Highland has a historical, longstanding Service Level Agreement with NHS Grampian to deliver two sessions per month in Restorative Dentistry. Regrettably, for some time, Grampian Consultants have been unable to commit to these sessions due to the increase in demand in Grampian, annual leave, conflicting local holidays etc. Consequently, NHS Highland has had to rely on the services of a visiting Locum. Like the NHS Grampian Consultants, he also sees new patients only – no treatment sessions are provided. Treatment planning and advice is provided to General Dental Practitioners, many of whom have intimated that they do not have the skills to carry out the sometimes complex treatment required for their patients. The patient pathway then becomes confused as GDP’s re-refer to one of the substantive consultants, our out of the area, for treatment to be provided.

Presentations reflecting the current service in NHS Highland were delivered by representatives from Primary and Secondary Care teams, lead by Ms Linda Kirkland, Business Transformation Manager/General Manager for Surgery at Raigmore Hospital, Inverness.

In her introduction, Ms Kirkland defined the lack of a permanent, fixed capacity service as being the main problem with the Restorative Dentistry service in Highland. She proposed that it would be beneficial not to spend too long looking at issues with the current service, but to concentrate of identifying practical solutions which provided the patient in Highland with a service that was equitable with other NoS Boards, sustainable and affordable.

4.1 Supporting Data – Ms Margaret Brown

The average number of patients referred to the Restorative Dentistry Service in NHS Highland in the period 2008/08 and 2009/10 is 160 patients/year.

DEMAND

<table>
<thead>
<tr>
<th></th>
<th>2008/9</th>
<th>2009/10</th>
<th>Ave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total referrals</td>
<td>184</td>
<td>187</td>
<td>186</td>
</tr>
<tr>
<td>Removals</td>
<td>28</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Net Demand</td>
<td>156</td>
<td>165</td>
<td>161</td>
</tr>
</tbody>
</table>

REFERRAL SOURCE

The source of referrals includes Dentists in Primary Care, Consultants in the Acute Sector, and others. The distribution of referrals from these sources was illustrated as follows:

<table>
<thead>
<tr>
<th></th>
<th>2008/9</th>
<th>2009/10</th>
<th>Ave</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentists</td>
<td>151</td>
<td>149</td>
<td>150</td>
<td>80.7</td>
</tr>
<tr>
<td>Consultants</td>
<td>31</td>
<td>35</td>
<td>33</td>
<td>17.7</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>184</td>
<td>187</td>
<td>186</td>
<td></td>
</tr>
</tbody>
</table>
REMOVAL REASONS

Patients were removed from the waiting list in accordance with the Government policy. By far the greatest number of patients was removed because they failed to attend a booked out-patient appointment.

<table>
<thead>
<tr>
<th>Reason</th>
<th>2008/9</th>
<th>2009/10</th>
<th>Ave</th>
</tr>
</thead>
<tbody>
<tr>
<td>DNA</td>
<td>14</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>No longer wants treatment</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Died/Moved away</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Removed by the consultant</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Seen in another clinic/ treated</td>
<td>7</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

ACTIVITY

The distribution of activity for the period reviewed was shown as follows:

<table>
<thead>
<tr>
<th>2008/9</th>
<th>New</th>
<th>Return</th>
<th>DNA</th>
<th>DNA rate</th>
<th>N:R ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Grampian</td>
<td>39</td>
<td>85</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting Locum</td>
<td>113</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>93</td>
<td>24</td>
<td>9%</td>
<td>0.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2009/10</th>
<th>New</th>
<th>Return</th>
<th>DNA</th>
<th>DNA rate</th>
<th>N:R ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Grampian</td>
<td>25</td>
<td>93</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting Locum</td>
<td>128</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>153</td>
<td>93</td>
<td>22</td>
<td>8%</td>
<td>0.6</td>
</tr>
</tbody>
</table>

QUEUE

A total of 57 patients were reported to be waiting from a first new outpatient appointment as at 18th June 2010. The number of patient waiting and the total waiting time was illustrated thus:
Mrs Lush summarized the many challenges facing NHS Highland which would impact on a
Restorative Dentistry Service: NHS/Private tension, geography, skills, patient experiences, the
need to optimise resources, and < 45% adult registrations.

**NHS/Private**

- Alignment of Consultant treatment plans with Statement of Dental Remuneration
- Time delays associated with prior approval
- Costs of surgery time
- Will the market impact on network development?

**Geography**

- Distant from Dental School & Hospital
- Distribution population
- Travelling costs & time
- Limited public transport networks

**Skills**

- Skills gradient & stock take
- Informal practice /service networks
- Formalising training /mentoring opportunities
- Linking training opportunities to NHS service provision

**4.2.1 A Patient’s Story (1)**

Patient 1 was initially referred to the Restorative Dentistry service in April 2005. She was seen in
the outpatient department in December 2005. The results of her visit at that time were
inconclusive and an Orthodontic referral was advised.

The patient was re-referred in February 2007, post Orthodontic opinion and again the outcome
from this referral was inconclusive. In June 2009, Patient 1 was referred to Glasgow Dental
Hospital (GDH). She was seen there in September 2009 whereupon a Consultant to Consultant
referral to Orthodontics was made. The outcome from Patient 1’s appointment in January 2010
provided no help and in March 2010 she received a letter from GDH saying that they were unable
to provide treatment.

Patient 1 initiated a formal complaint to her MP and to NHS Highland about the service she had
received. This initiated further contact with the Associate Medical Director for Dentistry in
Glasgow and an update received that she was due to commence treatment in June 2010.

**The patient**

- Challenging
- Facial palsy
- Degree anxiety /phobia
- Failing restorations
- Advanced wear
- Reduced vertical height
- ? Orthognathic surgery required

**Issues**

- All agreed complex
- Multi disciplinary plan
- 4 NHS Consultant appoints & 1 Private Consultant appointment for assessment in 2 Boards
- Inequitable distribution specialist services

Patient experience
- Signposting
- Referral criteria
- Treatment v assessment
- Managing the ‘inappropriate referral’

4.2.2 A Patient’s Story (2)

Patient 2 is a patient with a challenging previous dental history. He had been seen at Dundee Dental hospital and had attended several GDPs. Treatment for F/F had been unsuccessful. The patient stated that he was unable to eat comfortably. In addition, he complained of persistent discomfort and had aesthetic concerns.

Patient 2 was referred for a restorative opinion, which brought an inconclusive response. He made a formal complaint and was re-referred. The patient was again seen by a Restorative Consultant in Dundee and returned to primary care (caveat), having received no treatment. Patient 2’s dentist again re-referred him to the specialist service. Treatment is now due to start in September 2010.

The Primary Care Vision for Restorative Dentistry

Given the challenges discussed and the issues resulting from the patient stories above, the vision for a Restorative Dentistry service in Highland, at least from the Primary Care perspective, was founded on:

- Consultant led clinical networks
- Linked training & mentoring
- Treatment & assessment
- Skills developed & optimised
- Use of NHS H premises
- Prioritisation clinical need

4.3 The GDP and Consultant Orthodontist Perspective – Mr Adrian Hart, Consultant Orthodontist

Mr Hart, Consultant Orthodontist and Chairman of the NHS Highland Area Dental Committee presented the views of GDP’s, based on feedback he had received from them. In particular, practitioners in Primary Care were concerned that:

- No treatment was undertaken locally by the visiting Consultants from NHS Grampian. Only new patients were seen in the clinic and treatment plans returned to GDP’s for them to initiate. Some reported that they felt they did not have the necessary skills to delivery the prescribed treatment plan.
- Some GDP’s reported that the treatment plan proposed by the Locum Consultant was unrealistic in practice.
- Dialogue with the Locum was not possible due to the timing of his visits to Inverness.
- Attention was drawn to unmet need. GDP’s would refer if more patients if they felt there was a service.

From the Consultant Orthodontist Perspective, Mr Hart was concerned that:
• Joint consultations difficult to arrange given the infrequency of clinics
• No treatment carried out – only new patients were seen in clinic
• There is some difficulty with regard to Implant Funding

Mr Hart referred to a Needs Assessment for Restorative Dentistry carried out by Dr C Jones, Consultant in Dental Public Health, approximately 12 years ago. The report at that time recommended that a Restorative Dentistry service equating to 3 days per month was needed in Highland. Mr Hart considered that:

• Demand is Historic
• The Needs Assessment is outdated and should be repeated
• Needs assessment must engage all stakeholders

Mr Hart proposed that there was an opportunity for partnership working with colleagues in the Centre for Health Sciences Dental Outreach Teaching Centre and a split post, NHS Consultant: Senior Lecturer (40:60) should be considered as per Colwyn Jones’ recommendation.

4.4 Restorative Dentistry and the OMF Service – Mr Adrian Farrow, Consultant in Oral and Maxillofacial Surgery

Mr Farrow’s presentation emphasized the linkages between OMFS/Oral Surgery/Orthodontics & Restorative Dentistry. He drew attention to the risks associated with looking in isolation at the recruitment of a Consultant in Restorative Dentistry, and advised that failure to understand this role as part of a whole system service would result in a “domino effect” and the potential for adverse reactions in the other specialties.

He referred to the 2006 SIGN guideline on the management of head and neck cancer (SIGN 90. Management of Head and Neck Cancer, 2006), which recommended that individuals with head and neck cancer should be managed by a multidisciplinary team of specialists including a Restorative Dentist. Likewise, the OMFS.OS specialists often play an important role in the multi-disciplinary management of a number of Restorative cases.

Mr Farrow acknowledged the NoSPG agreed strategy to appoint a second OMF Consultant to be based in Inverness. He raised the question therefore, that if the plan is to/were to be fully implemented whether one Consultant in restorative Dentistry would be sufficient and considered that NHS Highland should be looking to appoint at least two to complement OMF colleagues.

He also posed the question that, if NoSPG ever considered moving the current, single OMFS Consultant in NHS Highland to NHS Grampian whether we would still require a consultant Restorative Dentistry?

(Mr Farrow illustrated his presentation with a number of clinical slides to demonstrate the clinical benefit to patients of a multi disciplinary approach. These slides were not available for inclusion in this report).

4.5 Dental Laboratory Services in NHS Highland

Although no formal presentation was given, the two Dental Technicians based in Inverness participated in the workshop. They currently provide a service for Orthodontics and Oral and Maxillofacial Surgery, and have limited Restorative Dentistry experience. The laboratory work for patients from NHS Highland being treated in Grampian is carried out by the laboratory staff at Aberdeen Dental School.
The technicians described how the training programme for Dental Technicians has changed in recent years with Technicians now required to train to a level that allows entry to the register with the General Dental Council (GDC). There is a view among some Technicians that there is a shortage of trained technicians and new graduates entering the NHS. Although qualified to replace dentures etc, new graduates lack the practical, workplace skills associated with previous training programmes.

Training for Maxillofacial Prosthetists and Technologists (MPT), historically an offshoot of Dental Technology is offered at postgraduate level. Regulation of the MPT profession is fairly new and the role carries out the technical and Clinical work relating to the rehabilitative prosthetic work carried out after surgery or congenital conditions (i.e. Prosthetic ears, eyes, noses, cranioplasty and Osteotomy planning). The training involves 2 years of postgraduate university training followed by 2 years of Vocational Training in an approved unit. The training is completed by a final interview and numerous case studies to show clinical competency.

Since joining NHS Highland in December 2008, an MPT qualified Dental Technician; Steven Hutchison has been working to get the patients previously left without a service back into managed treatment. This service is currently delivered from the Orthodontic Laboratory at Raigmore Hospital. A lot of the patients were left completely without care and others sought treatment at other units, with considerable time and expense incurred as this was mainly done in Glasgow. Some of the patients were without new prostheses for 4 years as they could not afford the time and expenditure to travel to another part of Scotland. The neglect caused by this meant considerable time had to be spent to rehabilitate the extra-oral implants that are placed to support the prosthesis and in one case an implant went mobile, fortunately only the outer section, which was quickly remedied by Mr McKerrow, one of the ENT Consultants at the time.

This may be only a small part of the Maxillofacial/Restorative service and it is one which is not normally recognised as the care given in this field is rehabilitative and does not cure disease. But it is important because patients are reliant on service provision for the rest of their lives. The youngest patient for whom a prosthesis has been provided for in Raigmore is 15. Therefore, the need for a reliable service provision can be a very long time.

4.6 Stakeholder Reflections

Stakeholders were invited to reflect on the forgoing presentations, to consider three or four areas for improvement that emerged from the presentations and to share these with colleagues by means of anonymous “post-its”. The results were collated with six recurring themes emerged:

- Strategic Approach
- Staffing
- Accommodation and Equipment
- Protocols and Signposting
- Training and education
- Improving linkages with the Centre for Health Sciences and the UHI
Strategic Approach:

- Identify strategic locations in Highland for delivery of outreach clinics. Fort William and Caithness
- 70% Group Approach
- Develop Raigmore to become a Head and Neck Service Cancer Centre

Accommodation and Equipment

- Accommodation and Equipment to provide treatment
- Consultant Premises
- Equipment

Protocols and Signposting

- Development of Relevant Protocols
- Treatment Plans that take into account NHS Regulations
- Define Unmet Need:
  - Needs Assessment
  - Grampian Model
  - Approx for speed
- Signpost the patients

Training and Education

- Developing Skills in Primary Care
- Development of Practitioners in Primary Care with Enhanced Skills
- Training for GDP’s to enable delivery of treatment plans locally

Improving Linkages with CHS/UHI

- Joint working with C4HS
- Qualified Staff at CHS:
  - Use their skills
  - Pilot referral clinics within IDC
  - Play to strengths
- Working with Centre for Health Sciences Senior Lecturer
- Use local Consultant Services at U.H.I.
5. Mapping the Patient Journey

Stakeholders were asked to agree the components of a high level map of the patient journey and to identify barriers/constraints and opportunities relating to the pathway. The following was agreed:

Referral Journey / Info Flow

- GMP
- PC Dental Services
- Paper Referral
- Paper Triage
- Assessment Diagnosis Specialist
- Consultant Treatment Plan
- Treatment

2nd Opinion

April 09 – March 10

April 10
May 16
June 16
July 12
Aug 10
Sept 19
Oct 16
Nov 17
Dec 14
Jan 18
Feb 18
Mar 23

Unmet Need?

Capacity

Source | Condition?

- GUM
- Prosthetics
- Conservation
- Specialist Practitioner / DWSI
- NHS24

GUM
- CDS
- SDS

Consultant
- Assessment
- Treatment Plan
- Treatment
- Review

Capacity
- Info
- Capacity
- Forever?

Skills / Communication Defined Protocols

Governance
- Risk
- Equity
- Safety

= Barrier/Constraint

= Pathway

= Number of referrals per month April 09 to March 2010
Feedback from stakeholders present:

- History is history – we can’t change that and need to move on
- We need to find a new way of doing business. GDPs should be shown the respect that is shown to GMPs.
- There is a real risk of undermining enthusiasm of those working in the service if a sustainable solution cannot be found
- There are Parallels between NHSH and NHSG in terms of looking at unmet need

6. Future State

Two groups were formed and asked to consider how the service could be designed differently in the future. The outcome from the discussion is summarized below:

6.1 Output from Group Discussions

Goal:

The goal identified by stakeholders was to have:

- a contemporary, technologically comprehensive service, local to the populations of Highland and consultant led – including appropriately funded infrastructure (nursing/technical/admin/equipment).
- Support for Head and Neck service as set out in SIGN 90 guidelines.

1. Equity of access and safe across Highland
   - 21st century
   - Quality
   - Primary Care
   - Assessment and Rx
   - Technical (all appropriate support)
   - Local (accessible)
   - Sustainable service
   - Technologically comprehensive

2. Development of MCN locally, regionally and nationally
   - Enhanced skill practitioners
   - GDP education
   - Virtual and actual consults and reviews
   - Clinical assistants
   - Curricula for E.S.P.
     - Diploma
     - MSc Courses
     - Local Clinical Training
3. Development of salaried services

4. Fully integrated with Primary Care

5. Sustainable

Want/Need – Can’t differentiate between “want and need” - One and Same

**How**

- Consultant(s) with appropriate supporting infrastructure - funded
- Education/support
- Assessment and treatment plans that can be delivered locally
- Integrated team approach (MCN)
- Governance clearly defined and agreed

**Opportunities**

- Standard referral template for Restorative Dentistry
- Video conference/technology
- Telemed/e-referrals
- Referral guidelines for periodontology available in Grampian. Need protocols for all subspecialties to be agreed across the NoS.
- Look at the SDR & payments in Primary Care versus Secondary Care,
- Explore the Glasgow model of patients paying for treatment in secondary care.
- ‘Specialist’ in Restorative Dentistry could provide the pre-payment report?

**Knowledge Required**

- Need to define what is basic restorative dentistry (especially oncology support SIGN and NICE guidelines). Does HHB have one (a Restorative service)?
- Who is referring?
- How many patients are they referring?
- Skills of referrer?
- Complaints – How many for Restorative Dentistry and why?
- Resolve the issues of funding treatment e.g. chrome dentures
- Explore European models of care.

**Highland model**

- Co-operative approach between practices
- Complex business issues
- Legal company between groups
- The 70% group

Restorative Dentistry incorporates several sub specialties (Endodontics/Periodontics/Implants etc). It is unlikely that Enhanced practitioners will have all of these skills even if training and education is improved. Mono specialists do not bring the flexibility to the service that a trained, accredited Consultant in restorative dentistry brings.
NHS Highland currently has a visiting consultation service only. This gives a sense of paying 'lip service' (and all that it encompasses) to service provision. What we are doing now is detrimental to the patients in Highland. We are storing up problems for later because we cannot provide treatment locally e.g. the removal of teeth as an outcome due to the lack of Endodontic treatment. Dentists are disadvantaged because there is no training & education available locally.

General practitioners need prior approval for treatments over £350. Some items require a Consultant report or specialist opinion (endo/perio/implantology) which could not be given by primary care/tutor staff at the Inverness Dental Centre. Honorary Consultant staff at the Inverness Dental Centre are primarily there to support teaching and may have limited capacity to assume service sessions.
6.2 Benefits and Risks of a Consultant(s) in Restorative Dentistry to be based in NHS Highland:

Stakeholders discussed the perceived benefits and risks linked to a full Consultant led service in Restorative Dentistry, based in Inverness:

<table>
<thead>
<tr>
<th>Consultant Led Service Based in Raigmore</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do Nothing</strong></td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
</tr>
<tr>
<td><strong>Secondary Care/Tertiary Referals</strong></td>
</tr>
<tr>
<td><strong>Education and Training</strong></td>
</tr>
</tbody>
</table>

**Benefits**
- Patients already suffering – adverse outcomes already noticed & will continue
- Quality of care
- Anonymised patient stories paint the picture
- Need complex treatment service
- Need appropriate treatment plan (not discussion)
- Need ownership – continuity of care, clinical responsibility, duty of care
- Need urgent referral service

- Develop outreach clinics in key strategic locations
- Local access to service
- GDP/joint working/obtain treatment plan
- Difficult diagnostic problems resolved early
- Shared care opportunity
- Delivered in place where app diagnostic services available. Tools (CB/CT)
- Delivered by consultant – report needed by SDR

- Appropriate treatment/advice back to referring dentist
- Part of Network
- Enhanced practitioners
- Complex treatment delivery
- Consultant led supervision:
  - Fix/removable appl.
  - Max/max prosth.
  - Extra oral Implants
  - Endo/Perio
  - Prosthesis for Eyes/Ears/Nose
- Training grade and career grade staff
- Clinical assistants
- SHO/DFI’s
- Hygienist/Technicians and New Grades/Therapist
- Specialist Consultant

- Multi disciplinary clinics:
  - Ortho
  - Oncology
  - Trauma
  - Congenital
- Joint working
- Ad hoc (communication access)
- One stop assessment
- Offer up to date service with restorative element
- Increase use of GP’s
- Out of hours
- Nursing

- Governance
- Referral Service
- Treatment Plan Options --- SDR
- Understand Remuneration (Scotland)
- Feedback Mechanism to GDP & outcome configured
- Shared care/support
- Continuity care patients/affordable journeys
- Explore option telemedicine (block)
- Comprehensive assessment
### Risks

<table>
<thead>
<tr>
<th>18/52</th>
<th>Patient experience</th>
<th>Support</th>
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</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Quality of life</td>
<td>Oncology</td>
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<tr>
<td>no advice patients</td>
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<td>Ortho</td>
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<tr>
<td>cancer centre service</td>
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<td>Trauma</td>
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<tr>
<td>recruitment PC &amp; SC down</td>
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<td>Dentists with specialist interest</td>
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<tr>
<td>complaints up</td>
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<td>Congenital</td>
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<tr>
<td>Equity of service</td>
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<td>Service degrade</td>
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<tr>
<td>No succession planning</td>
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<td>Professional isolation</td>
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<td>Compromise service in Grampian</td>
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<tr>
<td>Patient risk and safety up</td>
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<tr>
<td>Litigation up</td>
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<tr>
<td>Ongoing cost locums</td>
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<tr>
<td>Unmet need up</td>
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<td>Number of attendances</td>
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<td>Implant</td>
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<td></td>
<td>Corporate threat cancer</td>
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<td></td>
<td></td>
<td>Training – orthodontic, OMFS, Junior Grades</td>
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<tr>
<td></td>
<td></td>
<td>Recruitment retention</td>
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<td>Impact on patient:</td>
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<td>Adverse outcomes</td>
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<td>Quality of life</td>
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<td>PC is advantaged</td>
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<td>Financial risk</td>
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<td>Governance</td>
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<td>Clinical</td>
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</table>

Stakeholders were unanimous in their agreement that at least one, preferably two Consultants in Restorative Dentistry are required for NHS Highland.

- “We can't do it (Restorative Dentistry) in a different way – we are doing it in a different way and it’s not working!”
- “We are just masking the problem”.
- “We need a service here”.

**Report Prepared by**

**Helen M Strachan**  
Regional Manager  
North of Scotland Oral Health and Dentistry  
Final Draft at 19.10.10
# Opportunities Summary

A number of opportunities were identified during the course of the workshop. These are summarized below for ease of identification:

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>By Whom</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic approach to the review of service</td>
<td>NoSPG and NoS Boards</td>
<td>X</td>
</tr>
<tr>
<td>Identify strategic locations in Highland for the delivery of outreach clinics</td>
<td>NHS Highland</td>
<td></td>
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<tr>
<td>Develop Raigmore to become a Head and Neck Centre</td>
<td>NHS Highland NoSPG</td>
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<tr>
<td>Explore the potential to Increase Consultant Capacity</td>
<td>NoSPG and NoS Boards</td>
<td>X</td>
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<tr>
<td>Explore the potential role for Technology in the delivery of Restorative Dentistry</td>
<td>NoS Boards</td>
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<tr>
<td>Establish e-referral system</td>
<td>NoS Boards</td>
<td>X</td>
</tr>
<tr>
<td>Agree standard referral template for Restorative Dentistry</td>
<td>NoS Boards</td>
<td>X</td>
</tr>
<tr>
<td>Develop referral protocols for all sub specialties</td>
<td>NHSH with NHSG and to include NHSH</td>
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<tr>
<td>Define Unmet need in NHSH</td>
<td>NHSH</td>
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<tr>
<td>Explore the potential for closer working with Centre for Health Sciences</td>
<td>NHSH with colleagues in CFHS</td>
<td>X</td>
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<tr>
<td>Pilot referral clinics within IDC</td>
<td>NHSH with colleagues in CFHS</td>
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<td>Look at the SDR and payments in Primary Care versus Secondary Care</td>
<td>NoSPG</td>
<td>X</td>
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<tr>
<td>Explore the Glasgow Model of payment for treatment</td>
<td>NoSPG</td>
<td>X</td>
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<tr>
<td>Identify options for prior approval report</td>
<td>NoSPG</td>
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<tr>
<td>Define what is a basic Restorative Dentistry service</td>
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<tr>
<td>Need more information on referring behaviours and patterns</td>
<td>NHSH</td>
<td>X</td>
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<tr>
<td>Need more information on the skills of referrers</td>
<td>NHSH</td>
<td>X</td>
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<tr>
<td>Explore complaints relating to Restorative Dentistry and why – the voice of the patient</td>
<td>NHSH</td>
<td>X</td>
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<tr>
<td>Resolve the issues of funding for treatment e.g. chrome dentures</td>
<td>NoSPG</td>
<td>X</td>
</tr>
<tr>
<td>Explore European Models of Care</td>
<td>NoSPG</td>
<td>X</td>
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</tbody>
</table>

Short Term - By end of October 2010  
Medium Term - By end of year  
Long term - Ongoing