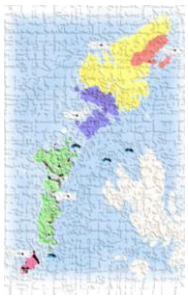

CÙRAM IS SLÀINTE NAN EILEAN SIAR

WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

REDESIGN OF DENTAL SERVICES IN UIST

PURPOSE OF REPORT

1. This paper assesses the outcome of the public engagement process in respect of the redesign of dental services in Uist; outlines how the IJB's preferred model can be taken forward; and asks that a final decision be taken in respect of service design.

COMPETENCE

2. The proposals set out in the paper have been subject to a financial assessment. There are no additional revenue costs associated with the proposed service model. Capital is reserved to the Health Board and is provided within the report for information only. There are no immediate HR issues emerging from the report. A full Equalities Impact Assessment has been undertaken and is attached at Annex A. There are no legal issues emerging from the report.

SUMMARY

3. The IJB has deliberated on the redesign of dental services in Uist and has examined a range of options in respect of future service delivery. At its meeting in March 2017, it indicated that its preferred model, which had been selected from a range of options, was a single hub located in the Uist and Barra Hospital but with outreach capability. The IJB further agreed to consult on this proposal.

4. An analysis of the consultation findings was reported to the IJB in December 2017 and it was noted that a final Equality Impact Assessment (EQIA) would be carried out. This paper includes the findings of the EQIA, along with additional recommendations for reform.

RECOMMENDATIONS

5. It is recommended that the IJB:

   a) agrees to the recommendations from the Equality Impact Assessment, outlined at paragraph 18;
   b) agrees to the hub and outreach service model, and issues direction to NHS Western Isles to implement that model in line with available resources.

Ron Culley
Chief Officer, Health and Social Care
CÙRAM IS SLÀINTE

BACKGROUND

6. The redesign of dental services in Uist has been a matter of interest to NHS Western Isles since 2014. At that time, the Chief Administrative Dental Officer identified core weaknesses in the current service arrangement, identifying both environmental issues (quality of clinical space) and clinical support issues (emerging from the dispersed service arrangement), which required to be addressed. These arguments were pulled together as part of a report to the Health Board Corporate Management Team. The broad proposal at that time was to bring all dental services in Uist into a single integrated hub, located in the Uist and Barra Hospital.

7. This also aligned with both the property strategy and the clinical strategy of NHS Western Isles, which proposed the development of clinical hubs across the Western Isles and which identified the Lochboisdale dental clinic in particular as having major weaknesses. The Health Board's Property and Asset Management Strategy was focused on rationalising the number of physical assets and recommended that the development of clinical hub sites would be the best means of delivering safe and effective services.

8. Since then, a number of formal engagement events have supported the service redesign process. A development day was held in the summer of 2015, which was focused on the transformation of the Uist and Barra hospital into a hub capable of hosting multiple health services, including general practice, dentistry, and the local Scottish Ambulance Service. The main priorities emerging from that initial development session were:

    a. Ensuring that any new arrangement had effective resuscitation, stabilisation and life-saving capability;
    b. That the local Scottish Ambulance Service should be co-located to maximise opportunities for inter-agency working;
    c. That the Benbecula Medical Practice be located within the hub to ensure effective use of GP time across the practice and hospital floor, and improve patient access.

9. While there was less support for the development of dental services within that arrangement, further engagement work was taken forward on that matter, mostly with the Locality Planning Group. A long list of potential options for reform was developed and endorsed by senior management, after which the Locality Planning Group (LPG) reduced those options to three:

    a. The refurbishment of existing sites;
    b. The development of an integrated hub with outreach capability; or
    c. The development of a central hub with satellite clinics in the north and south of the island.

10. Set against this background, a formal Options Appraisal Event took place on Tuesday 29th November 2016. The event was well attended, with a mix of community representatives, patients, stakeholders and staff members participating. The Scottish Health Council was present, and has provided guidance throughout the process.

11. A three site option was the heavy preference emerging from the event. The event also highlighted ongoing concern about the displacement or removal of key hospital services as part of the hub option and concern about accessibility issues, including transport arrangements.

12. The IJB was subsequently asked to identify its preferred option from the three service models that had been considered as part of the options appraisal workshop. While mindful of the fact that the local community favoured a three site model, clinical factors led the IJB to propose a single centre with outreach capability as its preferred model of delivery.

13. The IJB further agreed that this proposal would be subject to public consultation, the findings of which were reported at its meeting in December 2017. The IJB noted the feedback from the public consultation and agreed that a full Equalities Impact Assessment should be undertaken ahead of a final decision.

EQUALITIES IMPACT ASSESSMENT

14. A full Equalities Impact Assessment (EQIA) has been undertaken in order to establish whether any groups who are protected in law would be disadvantaged by the proposal and to consider what mitigating actions could be taken in these circumstances. The EQIA uses information elicited as part of the public consultation process.

15. The Equalities Impact Assessment is attached at Annex A. It identifies a range of positive impacts, which include:-

- **Clinical Environment**: The new service would be capable of delivering quality improvement in view of an enhanced clinical environment, which will support the dental team to work more closely together and which will benefit from on-site facilities such as a Central Decontamination Unit and Radiography.
- **Efficiency**: Situating the dental team within a single hub environment should improve overall efficiency. A dispersed model does not deliver the same level of time efficiency as seen in group practice. A more efficient service is always desirable, and in Uist it is necessary to reduce the number of people who are currently not registered and unable to access a dentist. Further work on this matter is outlined at Annex B.
- **Sustainability**: The integration of dentistry into an integrated hub should enhance the overall sustainability of the service. Based on experience from within the wider primary care system, service sustainability is greater within hub arrangements rather than dispersed practices.

16. On the other hand, the EQIA process highlighted a range of potential negative impacts, including:-

- **Community Relations**: It is evident from the engagement work undertaken that there is considerable local opposition to the reforms. Since the community has expressed its support for a three site service, the move to a central location could impact on already strained community relations.

- **Service Access**: The main negative impact of the reform is on service access, given that the new service will be located further from the geographical extremities of the islands group, meaning some patients will have further to travel. Older people are more likely than the rest of the population to have mobility problems, and may also become frailer as older age progresses. Adults with disabilities may also experience mobility barriers. Some children may require longer periods out of school in order to attend appointments. It may act as a disincentive to materially disadvantaged people.

Mitigation

17. As part of the EQIA process, a number of possible mitigating actions were considered but ultimately not proposed. For example, an extension of NHS Western Isles' Patient Transport Policy was considered as a means of addressing patient access issues but rejected on the basis that a) the number of people living in communities outside the nationally-prescribed 30 miles radius is small b) the policy requires patients to meet the first £10 of expenditure, which is likely to be greater than the cost of public transport and c) there were potential regulatory issues in that patient transport is intended to cover the cost of accessing secondary care.

18. Nonetheless, a number of recommendations have been made, as follows:

EQIA Recommendations

1. It is recommended that NHS Western Isles develops a domiciliary care and outreach policy for dental services which details who is eligible for the service, the range of clinical interventions that will ordinarily be provided, the support that will be provided to qualifying patients who nonetheless require treatment in the central hub, and how the policy will be communicated.
2. It is recommended that NHS Western Isles continues to work closely with local schools to promote oral health strategies like Childsmile and to ensure that outreach programmes are used to ensure educational disruption is minimised.
3. It is recommended that NHS Western Isles promotes subsidised travel schemes as part of the implementation of the new service arrangements (e.g. Scottish Government subsidy of bus travel for older people and Comhairle-subsidised community transport options delivered by Tagsa Uibhist).
4. It is recommended that within service delivery arrangements, patient scheduling is aligned with public transport times, to ensure that those travelling furthest for dental care are afforded appropriate flexibility.
5. It is recommended that low income families are considered within the aforementioned domiciliary care and outreach policy for dental services in order to mitigate against material disadvantage.
6. It is recommended that the Integration Joint Board continues to commit to community engagement processes and evaluates its wider community engagement activity by the end of 2018/19.

PROPOSED SERVICE MODEL

19. It is intended that the proposed service model takes its point of departure from the Scottish Government's recently published Oral Health Improvement Plan[1]. This plan describes a number of important policy objectives which will be adopted by the Public Dental Service in the Western Isles:

    - At present, patients can receive a basic check-up every six months. However, six-monthly appointments with the dentist for all patients regardless of their state of oral health are not supported by the clinical evidence. Under the Scottish Government's proposed system of preventive care, patients will be seen according to their oral health risks. This may mean that many people will no longer have to attend every six months if they have good oral health and a healthy lifestyle.
    - As at September 2016, 91% of the Scottish adult population were registered with a dentist and almost three quarters attended in the previous two years. The Scottish Government is seeking to exploit this level of patient interface to promote routine general health checks to assist in the early detection of long-term chronic diseases such as diabetes. It will also allow patients to receive advice and treatment on how to manage their health at the earliest opportunity.
    - Current projections suggest that the proportion of people aged 65 and over increasing by 53% between 2014 and 2039. At present, one in five of the population of Scotland aged 75 years or more is not registered with a NHS dentist. The Scottish Government has identified a substantial gap in domiciliary care provision, both in care homes and for patients who may be confined to their own homes.

20. This national policy context supports our service design arrangements in the Western Isles, whereby dental services are delivered from multi-functional integrated health hubs with outreach capability and which focus on prevention. The Western Isles Dental Centre is situated within the campus of the Western Isles Hospital; the Harris practice is situated in the local NHS hub; and it is proposed that dental services migrate to integrated hubs in the new St Brendan's and redesigned Uist and Barra Hospital.

21. In terms of outreach capability, we are seeking to become more responsive to those patients who are least able to access dental care, particularly frail older people and disabled people. To that end, we will operate an outreach model that will be capable of routinely delivering care to people in their own homes or in care homes. The former is already supported across the Western Isles and recent work has been focused on growing this service offer, to better respond to the needs of an ageing population.

22. To further embed our outreach capability, NHS Western Isles has invested in two portable dental suites, which will allow a portable dental chair and unit to be temporarily established in different sites across the Western Isles. In principle, clinics could be set up in a care home, or a GP surgery, and would provide a temporary base to deliver dentistry to highly localised communities. In order to deliver this outreach effectively, it will be targeted at those most in need of a tailored and responsive service.

[1] https://beta.gov.scot/publications/oral-health-improvement-plan/

23. Finally, there will be a continuing focus on prevention, in line with Scottish Government policy. Childsmile in particular will continue to provide a programme of toothbrushing and fluoride varnish application at nursery and primary school. An enhanced outreach capability together with ongoing partnership working with schools should help further embed this programme of work.

24. Our service model is grounded on the idea that some parts of the population will have good oral health and will not require regular attention. The infrequency of appointments for people in this category also reduces the impact of those travelling from more remote parts of Harris, Lewis and Uist.

25. By co-locating in multi-functional health hubs, we are also future proofing were there to be a closer alignment between dental registration and the delivery of health-checks, as outlined in the oral health plan for Scotland. In the hubs intended for Barra, Uist and Harris, dentistry would be co-located with general practice and other health services.

Uist Service

26. It is intended that the service in Uist is situated within this general operating framework. At present we have clinics in two locations - Lochmaddy and Linaclate (the Lochboisdale clinic was closed by the Health Board in 2017). In addition, there is a surgery in the Uist and Barra Hospital, available to visiting specialists. The service operates with three full time dentists and one full time therapist; there are a further eight dental nursing staff. Sterlisation is provided by Central Decontamination Unit at the Western Isles Hospital.

27. The population of Uist at the last census was 4,848, of which 3,501 (73%) people are registered with a dentist. This compares with 91% across Scotland as a whole. The demographic profile of patients varies across each practice, with South Uist having the highest proportion of patients over the age of 75.

28. Our aspiration is to provide high quality dental care in Uist, which is safe and effective and delivered by a professional team. We want to be able to deliver dental care in a high quality clinical space, including a welcoming service environment which delivers a satisfying patient experience. Finally, we want our service to be sustainable so that we can meet our financial obligations and continue to attract and retain the best quality staff.

29. The proposed model includes the following service arrangements:

    - Where patients have mobility or access problems, care will be delivered at home or through mobile outreach. Where this is not possible, transfer to the hub will be arranged.
    - Where a specialist opinion is required, there will involve a prompt referral to the relevant service, and, where practical, consultant services will be delivered within the Uist and Barra Hospital.
    - We will seek to find appointments to accommodate patients' specific access requirements – for example, the clinic might offer flexible opening hours and appointments will be provided to align with public transport options where

requested. Community transport also plays a role in supporting people to access appointments.

- The best outcomes for patients will be delivered by developing a quality improvement agenda, where clinicians actively engage with other colleagues. Local study and audit groups, training courses and interaction with colleagues will be a routine part of daily practice. A team approach which promotes interaction between dentists, therapists, nurses and hygienists will ensure all staff members work to shared goals and standards.
- The service will be delivered from a high quality clinical space within the Uist and Barra Hospital, with four permanent dental chairs meeting the needs of the entire Uist population.

30. In terms of resources, the revenue cost of the Uist service (£590k) is unlikely to change in the short-term: we have a full complement of staff, which would be fully deployed as part of the operation of the new service. All parts of the Public Dental Service nationally have seen changes in staffing resulting from changes in patient need and demand. In Uist, should staffing change in the future (for example through retirement or staff wishing to reduce hours) it would be prudent for the IJB to consider possible efficiencies, in line with the budget strategy. Presently Uist and Barra have favourable staffing levels: Uist has one dentist per 1615 persons, while in Lewis & Harris the ratio is one per 2876 persons. The ratio of dental nurses to patients is similar.

31. In respect of capital, this matter is reserved to NHS Western Isles. IJB members can be informed, however, that there is a planned investment of circa £350k-£400k in support of the new integrated hub within Uist and Barra Hospital. This redesign work will also involve the co-location of the local GPs and the Scottish Ambulance Service. Importantly, the redesign work will not result in the degradation of resuscitation and life-saving capability.

CONCLUSION

32. The IJB has deliberated on the redesign of dental services in Uist and has examined a range of options in respect of future service delivery. At its meeting in March 2017, it indicated that its preferred model, which had been selected from a range of options, was a single hub located in the Uist and Barra Hospital but with outreach capability. The subsequent public consultation and EQIA indicates that mitigating actions should be taken as part of the implementation of that new service arrangement.

33. Should members of the IJB agree that the mitigating actions outlined above are sufficient to overcome the negative findings of the EQIA process, the IJB would issue direction to NHS Western Isles to implement the hub and outreach model in line with available resources.

Ron Culley
Chief Officer, Health and Social Care
CÙRAM IS SLÀINTE

ANNEX B - PUBLIC DENTAL SERVICE EFFICIENCY

1. Historically most dental treatment in Scotland has been provided by General Dental Practitioners who own and operate their own clinics. For a number of reasons this model has worked less well in remote and rural areas, where population density and average incomes prove disadvantageous. This created access difficulties for many patients.

2. In recognition of this, the Public Dental Service (PDS) exists to act as a safety net. It provides care in rural and deprived areas, it accepts patients with complex medical problems which make them difficult to treat, and it can offer more specialised care than may be found in most GDP practices. The PDS therefore has a balance to find between offering high quality care to the most difficult patients and yet remaining affordable at a time of growing financial pressure on the whole NHS.

3. In Lewis, dental services are centralised to the Western Isles Dental Centre. The Health Board previously operated school clinics and mobile units, which disappeared during school redevelopment. In Uist, a redesign of dental services is currently underway. The preferred model for both IJB and Health Board is a centralised Hub arrangement. This is intended to bring clinicians together for mutual support, and to facilitate sharing of skills and experience. It is also hoped that this arrangement provides greater efficiency and access to service. However, during public consultation the notion that group practice was a more efficient way to deliver care was challenged. The counterpoint offered was that small clinics “know their patients better, and this lets them make better use of their time”. This question therefore requires consideration.

4. One indicator of practice efficiency might be the volume of dentistry a clinician is able to provide. Whilst dentists in the PDS are salaried, Practitioner Services are still able to provide information on the value of treatment each dentist does. This is made available quarterly in Payment Verification (PV) reports. The most recent PV reports available were taken, covering one year (01-10-2016 to 30-09-17). The total value of treatment delivered was totalled, and divided by the number of whole time equivalent dentists. This gives a measure of productivity per head. Capitation fees were excluded, as these are based only on the size of a dentists list and do not relate to activity. All fees generated by locums were also excluded.

Value (£) of treatment delivered per WTE dentist[2]

	Q1	Q2	Q3	Q4	Average
Western Isles Dental Centre	13,164	11,637	16,630	9,190	12,669
WIDC adjusted*	12,901	9,425	12,738	7,610	10,668
Uists	5,779	7,503	5,904	3,753	5,734
Uist and Barra	6,892	7,058	6,139	4,953	6,260

5. As stated, the PDS is charged with delivering care to the most vulnerable and difficult patients. Income generation is not its primary goal, and so it might be considered 'value of treatment delivered' is an inappropriate measure. However, if we substitute the term 'volume' for 'value' then the PV reports do reflect activity. The reports suggest that within a large group practice clinicians seem able to consistently deliver more care than in the smaller, rural clinics.

6. There is no reason to suppose that this impacts on the quality of care. Indeed, within a group practice it is more likely patients will see different clinicians at different times, and so poor quality care would become apparent sooner. Furthermore, analysis of demographic information indicates that the patients in Uist are no more difficult and time consuming to treat. Finally, all fees for treatment are set by the NHS, meaning there is no variation in fees to explain variation in value.

7. There might, however, be variation in how accurately treatment is charged. To explore this, the PV report also allows us to examine the cost of each course of treatment.

Cost (£) per course of treatment

	Q1	Q2	Q3	Q4	Average
WIDC	42	58	35	40	43
Uist	49	51	51	31	45
Uist and Barra	59	59	57	41	54

8. As indicated above, there is no significant variation in cost per case across the different locations, which implies the treatment being offered is broadly similar. The inclusion of Barra raises the cost per case slightly, which is a reflection of the higher

[2] * WIDC adjusted. Within PV reports activity credited to a dentist will also included some items delegated to Dental Therapists. In WIDC there are three part time therapists, totalling 1.1 WTE clinically. They are included here as another WTE dentist. Treatment delegated to students does not appear in activity data.

Uist and Barra. Some Uist activity, specifically Children's Orthodontic treatment, will be coded to the dentist in Barra who provides this. This would continue to be the case whether a Hub model was developed or not.

value of each individual orthodontic case coded to Barra. The greater value of treatment delivered in WIDC therefore reflects more patients being seen, and more courses of treatment being completed.

9. Across the year in question productivity per WTE dentist in Uist and Barra runs at 58% of each WTE in the WIDC group practice. Whilst we must remember the PDS is primarily charged with delivering high quality care rather than volume, improving efficiency whilst achieving the same quality allows more patients access to care.

10. One further consideration is list size, which requires an understanding of what an 'average' or manageable list would be. NHS Services Scotland has produced some useful information. As of July 2017 they recorded a total of 4,740,793 patients registered to an NHS dentist (about 91% of population). This was attributed to 3383 dentists in 979 practices, giving each a list of 1401 patients. However, the number of WTE dentists is certainly lower; practice owners and some associates will work across multiple sites (being recorded more than once), and there will be part-time workers (those nearing retirement and for health reasons). Further, the Scottish dental work-force includes professionals who may operate on reduced hours (half of NHSWI dentists work part-time). We might more reasonably think there are more like 3000 WTE dentists. This gives an Adjusted National list of about 1580 patients per dentist.

	List Size (registered NHS patients)
National	1401
Adjusted National	1580
WIDC WTE	2330
Uist WTE	1055
Uist and Barra WTE	1059

11. It would therefore seem the list sizes for Uist are smaller than average and it is also evident that there continues to be extended waiting times to access the service, with patients experiencing a wait of between one and two years to register. Again, it appears the current working arrangements are a less efficient way to deliver care.

12. As proposed during public consultation, combining staff into a mutually supporting team pays dividends in time management. With proper support clinicians spend more time delivering care and less taking on non-clinical roles. Urgent and emergency appointments can be shared. On the evidence available, the current provision in Uist does not deliver the same level of time efficiency as seen in group practice.

Colin Robertson
Director Dental Services
Jan 2018