Improving oral health in England: Piloting Dental Care

The English experience

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The case for change

1. The changing population
2. The evidence base
The changing population
For each successive 10 year cohort, the probability of retaining 21+ natural teeth at 85 will increase 10-20%
Good Oral Health

The number of sound, undamaged teeth

For each successive 10 year cohort, the mean number of sound and untreated teeth at 65 may increase by between 3 and 6 per person…. All going well!
This is good

- Make it easy to stay healthy
- Consistent preventive messaging
- Incentives for professionals
This is expensive
2. The evidence base

Delivering Better Oral Health
An evidence-based toolkit for prevention
Second Edition
The Review of NHS Dental Services

Health service or dentistry service?

- Disease and treatment - lifetime consequences
- Disease and treatment have - lifetime costs

- 60 years – all about quantity
- Value for money is not more stuff at low price
Recommendations: Priorities and the pathway through care

• NHS dental care should be provided according to a **pathway** that is built around the key priorities of preventing disease and continuing care, but ensuring efficient urgent care if required.

• **Continuing care** carries rights and responsibilities for dentists and patients.

• **Advanced services** should be available, **consequent on** the patient and dentist achieving **good oral health**.
Potential New Patient Pathway

New patient visits dentist

Routine

Assessment of Oral Health

Disease prevention & management

Continuity of routine care

Advanced care

Accepts

Urgent

Definitive pain relief

Recommend Assessment of Oral Health

Declines

Continuing care implies responsibility on patient and dentist

Advanced services available to those with a sound oral environment and criterion based need

Assessment of Oral Health offered to all NEW patients
So what did we actually do?

70 general dental practice pilots were established in summer 2011

Pilots are testing several components:

➢ The oral health assessment and risk screening
➢ A capitation approach
➢ An outcomes approach

............to assess whether they provide the basis for a dental contract and contribute to improving oral health.
Capitation – potential variables

We are testing:
- Age
- Sex
- Socioeconomic deprivation
Supportive “tools”

- New patient visits dentist
- Routine Assessment of Oral Health
  - Accepts
  - Disease prevention & management
  - Continuity of routine care
  - Advanced care
- Urgent Definitive pain relief
- Recommendations
  - Assessment of Oral Health
  - Patient Assessment
  - Patient self-care plan
- Entry criteria
- Complexity Assessments
- Quality Indicators
- Patient Assessment
- Risk Screening
- Patient self-care plan
- Care Pathways
- Recall intervals
The patient’s risk status for each domain is determined as follows:

**Red risk status**
Allocated if there is active disease, this cannot be modified by patient factors.

**Amber risk status**
Amber risk status is allocated if there is an amber clinical factor, or if there is a green clinical factor but a co-existing patient factor which increases risk e.g. a patient with no caries would still be classed amber if there was poor plaque control.

**Green risk status**
Green risk status is allocated to those with green clinical factors and no patient factors which increase risk.
Quality is a necessary part of future dental contracts and it will take time to get a quality system that is solely outcome based. Quality is defined as covering three domains:

- Clinical effectiveness
- Patient experience
- Safety
The DQOF working group followed the process outlined below working back from first principles to define indicators that support the consensus within dentistry that good oral health is the ideal clinical outcome:

For a patient to be in good oral health, we mean:

- They are free from pain
- They have good functionality and aesthetic form to their teeth – They can “eat, speak and socialise”*
- They have clinically assessed good oral health now and we are confident that this will continue into the future

*(World Health Organisation 1982)
# Clinical Effectiveness Outcome Indicators for payment (60%)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Points – MAX:600</th>
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<tbody>
<tr>
<td>Active decayed teeth (dt) aged 5 years old and under, reduction in number of carious teeth/child</td>
<td>150</td>
</tr>
<tr>
<td>50% Under 5s active decay (dt) improved or maintained</td>
<td></td>
</tr>
<tr>
<td>Active Decayed Teeth (DT) aged 6 years old and over, reduction in number of carious teeth/child</td>
<td>150</td>
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<tr>
<td>75% over 6’s improved or maintained</td>
<td></td>
</tr>
<tr>
<td>Active Decayed Teeth (DT) reduction in number of carious teeth/dentate adult</td>
<td>150</td>
</tr>
<tr>
<td>75% improved or maintained</td>
<td></td>
</tr>
<tr>
<td>75% patients with BPE improved or maintained at oral health review</td>
<td>75</td>
</tr>
<tr>
<td>50% patients with BPE 2 or more with sextant bleeding sites improved at oral health review</td>
<td>75</td>
</tr>
</tbody>
</table>
Other DQOF Indicators (40%)

- Patient Experience Indicators for payment (30%)
  - collected by independent survey through Dental Services

- Safety Indicators (10%)
  - 90% of patients for whom an up-to-date medical history is recorded at each oral health review
Advanced care pathways

The NHS (Steele) review recommends:

- Complex and resource-intensive services should be provided
- Subject to nationally agreed professionally agreed evidence based (where possible) guidelines
- Patients should be offered the advanced services from which they will benefit, consistent with evidence based guidance where possible and best practice guidance where not.
Advanced care pathways

- Indirect restorations
- Metal based partial dentures
- Endodontic treatment
- Advanced periodontal care

Now completing work on minor oral surgery and paedodontology
Gateway to advanced care services

➤ **Entry level criteria** have been developed for each of the initial 4 advanced care services, to ensure that patients will only be offered care from which they will benefit.

➤ **Complexity assessments** have been proposed using existing evidence bases and best practice guidelines to determine 3 levels of practitioner competency for the delivery of advanced care.

- Care provided within the competencies of a general dental practitioner (GDP)
- Care which can be provided by a GDP with additional competencies as evidenced by formal training or the equivalent
- Care which requires the competency of a specialist
Clinical Pathway Review

- Review the utility of the pathway with clinicians involved in the pilots.
- Improve and simplify the clinical pathway approach whilst maintaining the concept of identifying need and risk, and delivering evidence based care.
- Increase the efficiency of the pathway approach to help deal with the impact on the availability of patient appointments seen in the first year of the pilots.
Overall Pathway and Applicability

Concept is good, basic logic is sound

Works Well

- Like structured exam
- RAG good for communication
- Aids transfer of responsibility
- Like concept of patient and dental team actions

Does not work well

- ICMs not always appropriate
- Full Pathway not always appropriate:
  - Young patients
  - Edentulous
  - Domiciliary / Sedation
Recommendations

- Revise the pathway to provide an option for patients who are currently unwilling or unable to accept the offer of professional preventive activity.
- Training for the whole team considered a key issue.
- Software clunky.
- Patient care plan needs reworking.
- Some risk assignment needs amending.
Patient attends

Standard Risk Assessment

Personal Preventive Advice

Offer Professional Preventive engagement

Engagement agreed

Patient unwilling or unable to accept

ICMs and treatment based on pathways

Treatment limited by risk based on pathways

Urgent Risk Assessment

Urgent Care and Personal Preventive Advice

Option to enter standard pathway

DRAFT
Implications

- Software issues are currently introducing inefficiencies in the pathway
- Skill mix seems to support the delivery of this model
- Need to identify good practice and need to give confidence about direction of travel
- SMART working sharing of efficient practice and innovation
Implications (contd)

➢ Cultural change and training

➢ Relationship with patient charges – will influence patient behaviour

➢ Work towards a defined offer to patients

➢ Play back practice population needs and risk profile
Evidence and learning

Some basic questions

1. Can it be delivered?
2. Do patients like it?
3. Do dentists feel like they are doing the right thing?
4. Do patients get and respond to the risk message?
5. How should the pathway be adjusted?
6. What happens to disease treatment – it should change?
7. What happens to more advanced care?
8. Is it affordable?

These are not clinical trials, but part of an iterative process
Q5. Generally speaking, how does your overall experience of NHS dental care at this dental practice in the last 9 months compare with your previous experience of NHS dental care? Was it better or worse, or about the same?

Base: All patients and carers/guardian/parents of patients (3,760).
And patients changed

Q7. Changed how you care for your teeth/gums? %

- Yes - A great deal: 30%
- Yes - A fair amount: 26%
- Yes - Just a little: 23%
- No - Not at all: 20%

Net ‘Yes’: +53

Q11. How helpful was advice?

- Very helpful: 48%
- Fairly helpful: 30%
- Neither/Nor: 9%
- Fairly unhelpful: 1%
- Very unhelpful: *

TOTAL: Helpful: 78%
TOTAL: Unhelpful: 1%
Q3. To what extent do you agree or disagree with each of the following statements about the care pathway currently being piloted in your practice?

Base: All dental care professionals (320)

Overall attitudes towards the care pathway

**PRACTITIONERS**

- Compared to before the pilot, the new way of working has the potential to improve the oral health of patients:
  - % Strongly agree: 49
  - % Tend to agree: 43
  - % Neither/Nor: 5
  - % Tend to disagree: 2
  - % Strongly disagree: 0
  - % Don’t know: 0
  - Total: 92

- Compared to before the pilot, the new way of working enables better care to be provided to patients:
  - % Strongly agree: 37
  - % Tend to agree: 43
  - % Neither/Nor: 13
  - % Tend to disagree: 3
  - % Strongly disagree: 0
  - % Don’t know: 0
  - Total: 80

- Compared to before the pilot, I have greater professional satisfaction:
  - % Strongly agree: 23
  - % Tend to agree: 33
  - % Neither/Nor: 27
  - % Tend to disagree: 9
  - % Strongly disagree: 5
  - % Don’t know: 4
  - Total: 55
**Views about the use of RAG ratings**

**PATIENTS**

- **1% (1%)**
  - The ‘traffic light’ ratings make it **more difficult** for me/patients to look after teeth and gums (oral health)

- **41% (22%)**
  - The ‘traffic light’ ratings make **no difference** to how I/patients look after teeth and gums (oral health)

- **58% (31%)**
  - The ‘traffic light’ ratings make it **easier** for me/patients to look after teeth and gums (oral health)

**PRACTITIONERS**

- **0%**

- **19%**

- **75%**

N.B. Figures in brackets refer to data based on all patients (3,760)

Patients: Q14. Which of the following best describes your view about the use of ‘traffic light’ ratings?
Base: All patients and carers/guardian/parents of patients who can remember using traffic light ratings (2,011)

Practitioners: Q10. Which of the following statements best describes your view about red/amber/green status?
Base: All respondents (320)
Do the RAG ratings look sensible?

- Maybe too many amber adults?
- This might mean wasted time/resource
The impact of the Self-Care Plan

The Self-Care Plan has...

66% (23%)  
...changed how I look after my teeth and gums

29% (10%)  
...made no difference to how I look after my teeth and gums

N.B. Figures in brackets refer to data based on all patients

Q19. Which of the following best describes your view about the Self-Care Plan you were given?
Q20. And which of the following best applies to you?
Base: All patients and carers/guardian/parents of patients who were offered or given a self care plan (1,293).
Changes to the skill mix in the practice as a consequence of the care pathway

Q19. Consider changing the skill mix?
- Yes, definitely: 55%
- Yes, probably: 30%
- No: 8%
- Don't know: 8%

Q20. In what way?
- Increase use of therapists: 50%
- Train nurses in fluoride application: 18%
- Increase use of nurses with additional skills: 15%
- Train DCPs to do ICMs: 12%
- Employ oral health educator: 9%
- Less reliance on associates: 9%
- Train staff: 6%
- Fewer dentist sessions: 6%
- Reduce number of denists: 6%

Q19. Would you consider changing the skill mix of staff at some point if the new way of working becomes permanent? Base: All providers (40).
Q20. How might your practice change the skill mix of staff in the future to help deliver the new way of working? Base: All providers who say ‘yes’ at Q19 (34).
How did practices spend their time?

Initially 70% OHAs, down to 25% after 12 months
• Patients and professionals like it
• It has altered what is delivered (+ve and –ve)

So what now?

➢ The OHA and pathway have been reviewed
➢ Algorithms in the software will be adjusted to help patient flow and remove redundancy
➢ The need for interim appointments has been reviewed with new advice
➢ The pilot arrangements will gradually be adjusted the effects measured or modelled
➢ Plus 25 more pilots from April 2013
Life would be simpler if we were all Giant Anteaters (Edentata)?