RCS
FACULTY OF DENTAL SURGERY

Department of Health Consultation: Dental Contract Reform

Faculty of Dental Surgery response

Paper 2: the clinical philosophy

1. What are your views on the philosophy of a need and risk-based, preventive approach to care?

The Faculty of Dental Surgery supports the overall philosophy of a need and risk-based preventive approach to care as it effectively advocates good dental practice. It should be noted that this type of approach is already used effectively within the Community Dental Service and Special Care Dentistry.

More generally, we believe preventive oral hygiene and mouth care should be encouraged by carers and teachers in early years settings. The national Childsmile nursery, school and dental practice programme in Scotland has proved successful at reducing oral health inequalities and improving oral health among children, their families and the nursery/school staff delivering the project. We suggest a similar programme should be rolled out across England. In addition, other health care workers, for example pharmacists, should continue to participate in oral health care advice for patients.

Although we support the preventive care pathway approach as it will support patients and encourage access to the highest quality of care, all the care provided by the NHS is an equally valuable part of that service. Intervention to tackle dental health problems must remain affordable to promote good oral health and tackle inequalities.

3. Using this pathway approach, would there be any challenges associated with engaging with patients in your practice?

There are specific challenges to engaging with patients requiring Special Care Dentistry and specialist dentistry more generally. Often dentists have to engage with carers who may have different opinions or cultural expectations, which affect their views on what dental and oral care is needed. For example, some carers promote total independence and the freedom to choose to have, or not to have, treatment done and/or oral hygiene procedures. In such circumstances, dentists need to carefully balance oral health needs against a patient's mental and physical wellbeing when treating patients with special care needs, and carefully discuss options with family and carers.

4. From what you have seen of the pathway, do you think that the current pathway could be simplified whilst maintaining its clinical integrity? (please relate any response to your experience with or knowledge of the pathway).

We are supportive of the pathway as the evidence or best practice based approach should lead to greater consistency of positive outcomes and clearer communication for patients. In particular, the red/amber/green (RAG) assessment will help to emphasise prevention and empower patients as it is very easy to understand. However NHS England needs to monitor compliance with the pathway by professionals, to help ensure the most effective treatment for patients. As we discuss elsewhere in our response, it is also important that all dental professionals are involved in designing, generating and managing any outcomes data associated with monitoring of the pathways in the new system.

With regards to simplifying the current pathway, there is a danger of dumbing it down so much to achieve perceived efficiency that it is not effective. For the Special Care Dentistry pathway, it would be helpful to add "provision of an Oral Care Plan" on returning to general dental practice.

More generally, the pathways should contain contingencies if they do not go according to plan, or patients decide to skip parts of the pathway. For example, if patients do not attend regular oral health checks, there will likely be a continuing need for adequate capacity within dental emergency departments to treat these patients if they develop serious issues. The Faculty of Dental Surgery is keen to continue supporting the specialist societies to work with NHS England in the design of appropriate pathways.

6. How can clinicians be encouraged to exercise clinical judgement and change care pathway recommendations?

Clinicians can be encouraged to exercise clinical judgement and change care pathway recommendations through mentoring, monitoring and regulation. This approach should also be emphasised in education and training programmes, and through professional standards.

8. Are there better ways than those described of demonstrating oral health changes for community dental services patients?

In order to demonstrate oral health changes for community dental services patients, validated disease specific quality of life tools should be used. Furthermore the World Health Organisation International Classification of Functioning, Disability and Oral Health, which is currently being developed, could help to measure functioning and disability, thereby helping to identify oral health changes.

12.Do you have any general comments or issues you would like to raise?

We recommend that oral medicine is defined as a separate clinical pathway in the pathway approach model as patients with relevant diseases are often referred initially to Oral and Maxillofacial Surgery services of District General Hospitals, rather than directly to oral medicine units. This pathway should be developed in collaboration with Oral and Maxillofacial surgeons to ensure a joined-up approach.

More generally, it will be important that dentists in primary care have clear guidelines on when and where patients should be referred to tiers 2 and 3 for specialist advice and/or treatment. The specialist societies will continue to work with NHS England to develop these referral guidelines.

In addition, patients should have access to clear information about the level of training dentists have received in the tier 1, tier 2 and tier 3 levels of proficiency. We were disappointed that the Law Commission's recent draft Bill to give professional regulators the power to annotate their register and indicate specialisms or other qualifications will no longer be advanced. This would have enabled patients and professionals to easily identify and check the status of a dentist in the different tiers of proficiency. We hope any future Government after the general election in 2015 will prioritise this legislation. In the absence of legislative change, we hope that the Department of Health and General Dental Council will consider how else to communicate to employers and the public a dentist's relevant skills and experience – this will be a particular issue for dentists with enhanced skills.

Paper 3: the measurement of quality and outcomes

1. **Do you think that the areas of clinical effectiveness, patient experience and safety are the right ones for the Dental Quality and Outcomes Framework?**

We agree that clinical effectiveness, patient experience and safety are appropriate for the Dental Quality and Outcomes Framework. However for Special Care Dentistry, it is also important to consider family or carer experience, engagement and expectations, alongside the patient experience.

2. **Do you think that the focus on outcomes is correct or should some indicators measure process as well?**

We strongly believe that the focus on outcomes will drive improved processes and patient care. It is important that any new outcomes data is led by the dental profession to encourage clinician support and to ensure a robust methodology. Any new audits and data need to be properly funded and consideration needs to be given to how clinicians are encouraged or mandated to participate. There should also be a central registry of audits in primary care to check that outcomes data is being collected.

3. **Are there any other considerations that would apply to devising indicators for patients with additional needs, often seen in community dental services?**

For patients with additional needs, it is important to ensure that all communication tools are developed in user friendly versions and all possible methods of communication are considered e.g. pictorial tools, videos, apps.

It is also imperative that each clinical pathway has modifiers for Specialist Care Dentistry to manage patients with complex medical and mental health needs and identify increased challenges to the provision of care.

9. **Aside from the sort of measurement approach outlined in this paper, do you have other views and ideas about ways of assuring and promoting clinical quality?**

We recommend that the GDC introduces revalidation as soon as possible to ensure minimum standards are met by all dental professionals. This will provide the opportunity for dentists and managers to discuss performance; and reflect on good/poor practice, thereby promoting clinical quality.

Clinical quality outcome measures will only be meaningful and have a positive impact on health care if they are:

- Patient friendly - access and communication should be measured. Continuity of care within the dental team, seamless care, referrals and transition of care from childhood to adulthood are all areas which patients have raised as being important to them. Furthermore oral care plans for vulnerable patients should be incorporated into heath and social care plans.
- Part of everyday practice - for instance, morbidity and outcomes could be included in training portfolios and log books so that trainees can learn from their quality of care and improve where needed. Open accounting and comparison of outcomes should also be encouraged across all sectors of dentistry by using audit tools such as the Peer Assessment Rating (PAR) or the Index of Complexity, Outcome and Need (ICON) that are being considered in orthodontics.
- Related to general and specific risk/morbidity factors that are preventable and evidence based

- Implemented consistently by method (e.g. text/telephone call/proforma/online) and timing – for example, a homecheck follow-up telephone call the day after surgery is a useful way to collect valuable audit data on outcomes for surgery, is reassuring for the patient, and optimises treatment.
- Implemented as procedure specific and the same for all health sectors by using the same coding and reporting systems –examples of procedure specific indices are provided in answer to question number 10 (a) below.
- Monitored effectively – data should be analysed consistently and re-audited to check compliance and specificity.
- Collected appropriately - there should be an agreed reporting system for results, with a consensus on consequences of poor outcomes

10. What monitoring tools and indicators can be used to assess:

a. Patient safety?

We believe that the reporting of never events and serious event recording should be improved across all sectors of dentistry. In order to ensure consistency in reporting, there should be agreed outputs, such as incident reports, shared learning and training records. We welcome the Care Quality Commission's review of its approach to dental inspection and hope that the new focus on learning and improvement will lead to improvements in patient safety. The collection of data by the CQC should also help to increase transparency around standards in dental practices and units.

b. Clinical effectiveness?

We suggest that, along with audits and peer review, general indicators and treatment specific indicators could identify levels of clinical effectiveness. For example, the Index of Orthodontic Treatment Need and the recently developed Index of Orthognathic Functional Treatment Need that are used to assess need and eligibility for treatment could be utilised as a monitoring tool for clinical need and effectiveness.

General indices for oral health could include: Adult Dental Health Survey, Gingival Index, dental caries and missing teeth. Procedure specific indices could include: third molar surgery-dry socket rate, nerve injury, readmission and repeat treatment.

c. Patient experience?

Monitoring tools and indicators to assess patient experience could include: a homecheck follow-up telephone call the day after surgery for patients undergoing high risk procedures, customer satisfaction questionnaires and use of comments books in waiting areas. In orthodontics and orthognathic surgery, there is currently a discussion as to whether Patient Reported Experience Measures (PREMs) should be used.

12. Do you have any general comments or issues you would like to raise?

We call for a thorough review of the current tools that are used to measure quality and outcomes in dentistry. It is clear that the methods of collecting data for dental care should be improved. For example, improving coding and the definitions within coding would help to identify patient need and the most appropriate location for care. Taking advantage of technology by introducing apps to encourage patients to complete satisfaction surveys in waiting rooms would improve the logistics for collecting data, rather than relying on lengthy paper-based surveys.

Paper 4: The remuneration approach

5. Do you have any general comments or issues you would like to raise?

We believe that remunerating dentists for providing preventive advice will be beneficial to patients and should hopefully reduce the level of intervention required in the future. However the remuneration system must be designed to support and incentivise the delivery of the clinical model and pathways therein.

Although the consultation paper states that there will be no alteration in costs by the introduction of the remuneration approach, this will depend on the idea of flexibility and capitation to work, which will depend on the level at which: (a) Dentists decide on the frequency of return of patients and (b) at what level the capitation is set. It would be useful to see some very robust evidence on this before stating that it will be truly workable.

Annex: Full list of consultation questions

Paper 2: the clinical philosophy

1. What are your views on the philosophy of a need and risk-based, preventive approach to care?
2. What would be the challenges of applying this approach in your practice?
3. Using this pathway approach, would there be any challenges associated with engaging with patients in your practice?
4. From what you have seen of the pathway, do you think that the current pathway could be simplified whilst maintaining its clinical integrity? (please relate any response to your experience with or knowledge of the pathway). If so, which elements could be simplified and how?
5. How can dental professionals be encouraged to follow NICE dental recall intervals?
6. How can clinicians be encouraged to exercise clinical judgement and change care pathway recommendations?
7. Can you see any reasons why the preventive pathway approach described in this paper would pose difficulties in meeting the needs of any particular patient group? If so, can you suggest ways of dealing with these difficulties?
8. Are there better ways than those described of demonstrating oral health changes for community dental services patients?
9. Are there any changes to the approach described that you think we should consider when using it with patients who rely on carers to maintain their oral health on a daily basis?
10. Do you have any general comments or issues you would like to raise?

Paper 3: the measurement of quality and outcomes

1. Do you think that the areas of clinical effectiveness, patient experience and safety are the right ones for the Dental Quality and Outcomes Framework?
2. Do you think that the focus on outcomes is correct or should some indicators measure process as well?
3. Are there any other considerations that would apply to devising indicators for patients with additional needs, often seen in community dental services?
4. If you would like to see some process indicators, what areas should the framework consider?
5. For the clinical effectiveness indicators, do you think the focus on caries and Basic Periodontal Examination (BPE) is correct?
6. What other areas of clinical effectiveness could be included as an indicator?
7. For the patient experience indicators, do you think they cover the right areas?
8. What other areas of patient experience, if any, should be included?
9. Aside from the sort of measurement approach outlined in this paper, do you have other views and ideas about ways of assuring and promoting clinical quality?
10. What monitoring tools and indicators can be used to assess:
    a. Patient safety?
    b. Clinical effectiveness?
    c. Patient experience?
11. What quality measures would enable a practice to demonstrate that they are appropriately treating high risk patients?
12. Do you have any general comments or issues you would like to raise?

Paper 4: The remuneration approach

1. What percentage of contract value do you think should be used for DQOF?
2. We assume there will be an element of remuneration for quality and outcomes. Beyond this element, what are your views on the options for remuneration and how the challenges associated with them can be managed:
    a. Full activity
    b. Full capitation
    c. A blend of capitation and activity
3. If a blend of capitation and activity is used, what elements of the care spectrum do you feel should be covered by capitation and why?
4. What safeguards need to be in place to ensure that patients with high treatment needs are appropriately treated in any remuneration system?
5. Do you have any general comments or issues you would like to raise?