

Something for everyone in Steele report

22 June 2009

The review of NHS dental services in England led by Professor Jimmy Steele has been published today. It provides a comprehensive run through the problems with the current arrangements from the points of view of patients, the profession and the NHS. There is little to argue with in the balanced analysis of where we are now and how we got there, although not everyone will agree with all of the conclusions and some of the recommendations will certainly need particularly careful scrutiny.

Speaking on the day of publication, John Milne, Chair of the BDA's General Dental Practice Committee, said:

"The BDA is pleased that this report has been published. Professor Steele and his team have clearly listened carefully to patients, dentists and primary care trusts. We have an opportunity to learn from the difficulties of 2006, and it is vital that opportunity is taken.

"The report's recommendations appear to be far reaching. They describe a new approach to dental care that dentists hope will mean a move away from the target-driven arrangements that are currently in place. Clearly, the detail of how that approach will be delivered will be vital.

"What is important now is that the Government pilots properly the changes it makes and engages fully with the profession and patient groups as we move forward. The BDA looks forward to playing a full part in that process."

In his ministerial statement, Andy Burnham, Secretary of State for Health said 'The government accepts the recommendations in principle, subject to working through the detail of their financial implications. The report recognises the more difficult future fiscal environment, and rightly puts an emphasis on piloting, cost containment and more efficient ways of working. With that in mind, we will begin work immediately to set up the pilots and develop plans for further implementation, working closely with the profession as we do so'. This was reinforced at the press conference by the Secretary of State who indicated that he wished to work with the BDA. The Department of Health press release said that 'the Department of Health will now work with the NHS to develop national quality measures for NHS dentistry and discuss with the dentistry profession how to take forward the recommendation that dentists should provide a longer guarantee for some work, and pay for a replacement if the treatment fails prematurely'.

The review group believes that local commissioning was the right thing to do as it allows the NHS to develop the most appropriate services and target resources to where they are most needed. But much needs to be done to improve it. Professor Steele exhorts all parties to work together to develop the detail and seize upon the opportunities that are offered by the dental access procurement initiative now getting under way to pilot new contractual and quality frameworks. From our point of view, this means that the Department of Health and the NHS need to engage with the profession centrally and locally without delay. The BDA will be watching carefully to see how they take up our stated commitment to work hard to develop new arrangements to deliver improved services and stable working conditions.

The report

It is important to look at the recommendations in the context of the report. This is an edited, first-sight summary of the main conclusions and recommendations.

The current situation

Diagnosing the problems, and recognising that many dentists are providing an outstanding level of care to NHS patients, the report nevertheless stresses that patients' trust and satisfaction with NHS dentists has diminished significantly over the last 25 years as a result of confusing information and lack of understanding of what is and is not available on the NHS. As highlighted in the Health Select Committee report, *'too many people find it difficult to access services and [] when they do access services, there is unwarranted variation in the quality of the care they receive'*. Patients want to feel that they have time to ask for advice, information and explanation of treatment options and look for a good 'bedside manner'. They want trust and control. But the report acknowledges that transmitting messages about cost and payment, NHS entitlements and private care are particularly challenging in an already difficult clinical environment; and that charges create a particular expectation in patients' minds of receiving something tangible and physical and a fear of being given unnecessary or expensive treatment.

The report concludes that those who work in the service should provide a positive experience for patients and improve both relationships and oral health. Clarity, information, communication and time would help to deliver this.

From the dentist's point of view, the report acknowledges the complexity of clinical decision-making, particularly when combined with considerations of cost, the lack of evidence base, the possibility that the patient's priorities may not be aligned with long-term oral health and the need to run a business. The flaws and uncertainties of the current contract and the resulting professional frustration are well described, but the report faces up to the effects of perverse incentives in this and other systems.

The NHS's side of the story is also told: the rushed, unprepared introduction of the changes in 2006 at a time when PCTs were undergoing upheaval, their lack of understanding of dentistry and the pressure on them of access, patient charge and UDA targets.

What NHS dentistry should do

A major plank of the recommendations is the defining of priorities for resource allocation and the development of a clear pathway of care leading to oral health as the outcome and the means by which the success of NHS dentistry is measured.

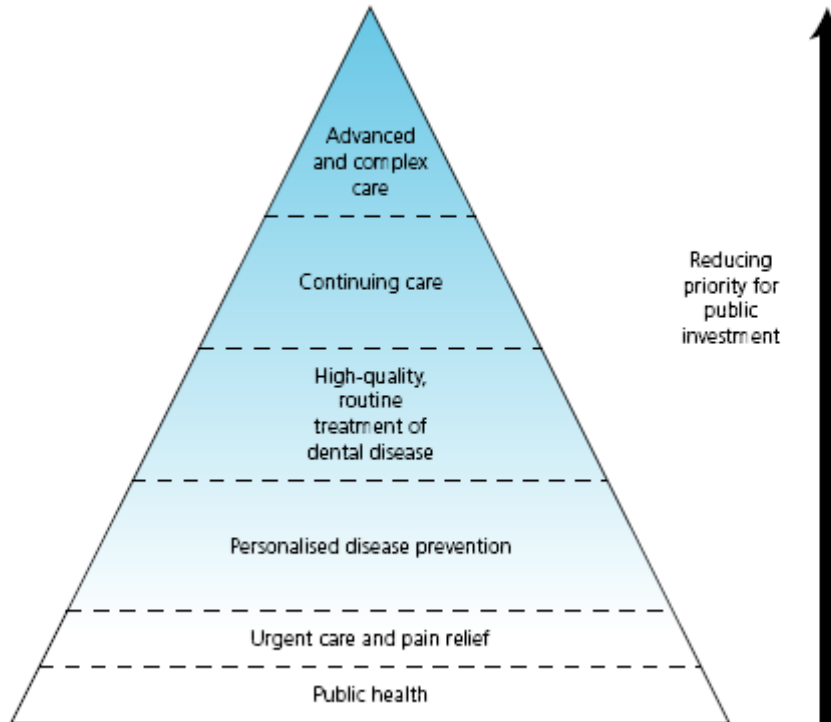
The introduction echoes what the profession has been saying for years when it says *'So long as we see value for taxpayers' money as measured by the number of things done to patients, the production of fillings, dentures extractions or crowns, rather than improvements in health, it will be difficult to escape the cycle of intervention and repair that is the legacy of a different age'*. Good oral health, it says, depends on more than just access: prevention and high quality provision are also essential; the dental team should work towards a clear, common oral health goal.

The review develops a suggested overall ambition for NHS dentistry, together with broad principles and national priorities on which to base change, designed to provide patient-focused services and high quality care, to resolve some of the anxieties in the profession and to deliver improved oral health for commissioners. All parties must accept their responsibilities to each other: the profession, patients and the NHS.

Priorities

Investment should be targeted to where risks are managed, needs highest and benefits greatest:

Figure 5: Priorities for public investment in oral health

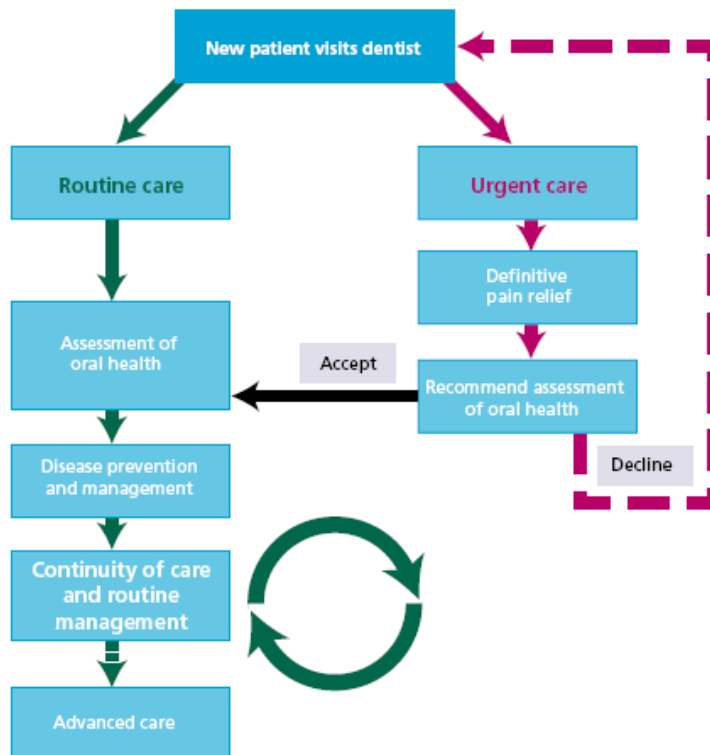


The report stresses the importance of ensuring clear access pathways for vulnerable and special needs groups as well as those who do not routinely seek care. Differing needs require a range of different delivery methods.

Pathway of care

Advanced, complex and expensive treatments should not be seen as an automatic right for everyone; entry is dependent on professionally derived clinical guidance, based on evidence or, where there is insufficient evidence, best practice, with clear evaluation and entry criteria. Progression through the pathway and a visible reduction in risk will be key performance indicators for NHS dental providers. Advanced care should be delivered only by those dentists able to provide such treatment to a high standard. Contracts should be designed accordingly.

Figure 4: Proposed patient pathway



Contracts

The report explores the nature of contracts with the aim of helping dentists take back responsibility for their primary role: the delivery to patients of excellent clinical care. This would entail blended arrangements including payment for continuing care (the number of patients), activity and quality, as well as using the workforce more imaginatively. Quality payments would be dependent on reaching minimum targets and then demonstrating improvement. Complex treatments need to be provided to a high quality to minimise the risk of failure and so contracts would have two parts: routine care and advanced services with clear incentives for improving health, access and quality.

The review team stresses that the change in emphasis from quantity to quality will be a considerable challenge for the profession; it will require a different mindset and a different approach to care. Some examples of quality metrics built around the pathway might include:

- The rate of new patients progressing to continuing care
- The proportion of new patients or of returning patients whose risk is lowered (as demonstrated by a move to longer recall intervals)

- The increase or decrease in the rate of restoration, across a sample of patients, year on year
- The proportion of continuing care patients seen in out-of-hours emergency services
- The rate of antibiotic prescription

There is also a call for a formal scientific assessment of the efficacy of routine scaling in the absence of severe periodontal disease.

Laboratory work is touched upon, with the suggestion that a number of possibilities, including direct payment by the patient to the lab or a voucher system, and passing on the statement of conformity to the lab, are worthy of consideration in the longer term.

The main recommendations

- The government and the NHS should reaffirm their commitment to NHS dentistry, recognising the importance of good oral health to good general health across a lifetime.
- PCTs and the NHS should communicate clearly how to find and what to expect from a dentist through the most appropriate media.
- PCTs should provide an accessible and effective service offering definitive urgent care with built in quality measures, specifically including low levels of antibiotic prescription.
- Dentistry should be commissioned and delivered around a staged pathway through care which supports basic national priorities; allows and encourages continuity of relationship for those who want it, built around the most appropriate recall interval for the patient and using oral health as an outcome.
- The pathway should be staged and based around: making urgent care available; assessing risk and preventing disease; routine management of disease; monitoring in continuing care; provision of advanced services intended to restore and maintain quality of life.
- New patients seeking treatment should receive a standardised initial assessment of their oral health, their prevention and treatment needs. This should be accompanied by a written report to be given to the patient.
- There should be a defined route from urgent care or for new patients towards continuing care arrangements if they wish, but through a formal oral health assessment.
- The rights and responsibilities described in the NHS constitution should underpin and be articulated for patients in continuing care. These should be nationally applied and include the right to return to the dentist for urgent care if required and dental checks and treatment as deemed appropriate by the dentist.
- Complex and resource intensive services should be provided, but subject to nationally agreed guidelines.... For some services, a stable and low risk oral environment would be a pre-requisite.
- Strong clinical guidelines should be developed to support dentists and patients through specific pathways of treatment. These would allow determination of thresholds of treatment, ensuring that some of the costly and complex care can be targeted to the patients where it will provide greatest benefit.
- Research and development priorities should be focused on strengthening the evidence base within the pathway approach.
- Every opportunity should be taken to place oral health firmly within public health and vice versa, with activities such as diet improvement and smoking cessation

mainstreamed within dentistry, and oral health risks addressed by wider public health initiatives.

- Patients registered in a continuing care relationship with a practice have an absolute right to return to that practice for both routine and urgent care; it is their own dentist's responsibility to ensure prompt pain or emergency management in the first instance (during opening hours).
- The free replacement period for restorations should be extended to three years and the provider should bear the full cost of replacement rather than the PCT or patient.
- Contracts should be developed with much clearer incentives for improving health, access and quality.
- Payments for continuing care responsibility, blended with rewards for activity and quality should be piloted and then nationally applied. There should be an annual per person registration payment to provide greater security for practices and greater accountability on all sides.
- The capitation payment should be nationally determined, but then weighted in a predictable way to take account of the practice profile.
- Activity payments should have a more sensitive banding structure, less range in value and explicitly recognise preventive activity. There may be a case for specific payments related to taking on new patients where the level of activity initially may be higher.
- Ultimate responsibility for the quality of all dental work should fall on the provider.
- The contract framework should explicitly reward the quality of a service and the outcomes it achieves in terms of improvements to oral health, reflected in patient progression along the pathway, compliance with nationally agreed clinical guidelines and the achievement of expected outcomes. Quality outcomes should be supported by nationally derived quality measures.
- Representatives of the NHS and the profession should develop a common set of national indicators that can then be used locally to measure the quality of process and outcome delivered by providers in a meaningful and appropriate way.
- Contractual schedules should provide for the more complex and demanding treatments to be provided appropriately by dentists skilled and equipped to provide them to a high quality.
- Commissioners should support dentists to make best and most cost effective use of the available dental workforce. PCTs and Deaneries should work together to align their educational programmes to support future models of service delivery.
- Funding should be allocated to PCTs on a per capita basis, adjusted for need by taking account of a number of factors, from April 2011.
- Clinical leadership in NHS dentistry should be promoted actively and included in other NHS leadership initiatives as well as local engagement.
- PCTs should be held to account, as part of the world class commissioning process, for their effectiveness in commissioning dental services, particularly with regard to the PCT's leadership, public engagement and clinical engagement (specifically using Consultants or Specialists in Dental Public Health).
- SHAs should be responsible for ensuring that PCTs have appropriate commissioning teams in place and should provide robust support and advice about appropriate organisational structures where these are lacking. DH should monitor and support this process.
- PCTs should be required to demonstrate good organisation and structures.
- The dental access programme should continue but key recommendations from the report should be piloted through the current round of procurement.
- A clear set of national data requirements is necessary, including data at the level of the individual tooth.

- There should be a clear commitment to ensure that all NHS dental practices are computerised by the end of 2011 in a way that allows easy transfer of data from chairside to NHS Business Services Authorities and PCTs, including to support shared information on quality and outcomes.
- There should be a formal national IT strategy for NHS dentistry, aiming to link all dentists to the wider NHS within five years.
- All parties involved in inspection, certification and regulation should investigate how they can work together to provide robust mechanisms for inspection with the minimum disruption and bureaucracy.
- Patient charges should be simple, fair and provide incentives for patients towards good self-care.
- Finally, there are pointers to implementation of immediate priorities, medium-term actions and longer-term aims.