



Department  
of Health

# Dental Contract Reform Engagement Exercise:

## Detailed Findings

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# Contents

Introduction	5
Executive Summary	6
Paper 2: The clinical philosophy – Detailed findings	12
Paper 3: The measurement of quality and outcomes – Detailed findings	46
Paper 4: The remuneration approach – Detailed findings	66
Appendix 1: Responses to the Engagement Exercise (published separately)	85
Appendix 2: Glossary	86

# Dental Contract Reform Engagement Exercise:

## Detailed Findings

**Prepared by the Dental Contract Reform programme**

# Introduction

The Department of Health (DH) conducted a dental contract reform engagement exercise from June to August 2014. The exercise has been used to inform development of the next stage of reform. The Government set out in the Coalition Agreement a commitment to further increasing access and improving oral health, particularly of children, by reforming the primary care dental system.

Just over 90 dental practices have been testing key elements needed to design a reformed dental system. Piloting began in 2011 and the practices are testing a pathway approach to prevention (clinical philosophy), measures of quality and outcomes and new forms of remuneration. Earl Howe, the Minister responsible for dentistry, announced this spring that 2015/16 would see the launch of a new stage of reform with a limited number of prototypes testing variants of a possible new system. He also announced that this prototype stage would be preceded by and informed by an engagement exercise.

4 papers were published as part of the exercise which explored the key elements and themes of dental contract reform. These papers were:

Paper 1: Overview

Paper 2: The clinical philosophy

Paper 3: The measurement of quality and outcomes

Paper 4: The remuneration approach

The exercise was aimed largely at the dental profession but open to anyone who wanted to respond. A number of principles underpinned the engagement exercise including the fact that the reformed system must:

- include a remuneration approach that supports good clinical practice and access
- work for patients, providers and commissioners.

The early findings from the engagement exercise, which included a report from the events held with pilot practices to share the responses received, were published in November 2014 [see <http://www.pcc-cic.org.uk/article/dental-contract-reform-engagement-exercise-early-findings> ]. To complement the interim report, this final report takes a qualitative rather than a quantitative approach, providing a more detailed analysis of the responses in answer to the questions posed in Papers 2, 3 and 4. It is intended that the 2 documents should be read together. The final report is being published at the same time as proposals for prototyping.

A redacted list of all the responses received to the engagement exercise, along with the organisations that contributed them, is given in Appendix 1 which is being published separately.

# The engagement exercise: Detailed findings

## Executive summary

### **Paper 2: The clinical philosophy**

The responses to the clinical questions showed that the concept of a preventive pathway is liked by dentists, dental teams and patients but it was suggested that its introduction would require a significant shift in both thinking and practice. Practical concerns around implementation included:

- how remuneration would be handled
- patients may not be interested enough in their oral health for a preventive system to work
- whether a preventive system might inadvertently increase inequalities
- changing patient expectations and behaviour
- skill mix: a practice needed the right balance of skill mix to deliver the pathway effectively. Introducing this skill mix would probably require new business models, and would present particular issues for small and isolated /rural practices
- software-related issues – efficiency, cost and dental team training

### **Simplifying the pathway (question 4)**

Over a third of respondents felt that the pathway was straight forward and should not be simplified further. Of the suggestions put forward, most were issues that had already been addressed in Version 3 of the pilot software and accompanying guidance.

### **Encouraging compliance with National Institute for Health and Care Excellence (NICE) guidelines (question 5)**

The main factors identified as key in encouraging compliance with NICE guidelines were:

- remuneration / contractual incentives (although compliance with NICE guidance is currently a contractual requirement)
- patient education / information to overcome the prevalent expectation for 6-monthly appointments
- professional education.

### **Exercising clinical judgement and changing pathway recommendations (question 6)**

Respondents wanted to be reassured on 2 points: first, that there would be no medico-legal repercussions arising from deviating from software recommendations provided there was evidence of clinical justification; and second, that “overriding” software recommendations would not subsequently be used to penalise dentists.

### **Meeting the needs of vulnerable / high need groups (question 7)**

The main patient groups identified as potentially facing difficulties with the preventive pathway approach were: the elderly, children, people with special needs, non-English speakers, irregular attenders and people from lower socio-economic groups. Of these, older people, those disinterested in prevention and patients in care/nursing homes were identified as 3 key groups where applying the pathway approach could pose particular difficulties. Suggestions to overcome these included:

- making care homes more aware of the importance of oral health and providing training to care staff
- legislation and the need to improve the situation regarding consent and charge exemption for patients who are accompanied by carers. Clarification of perceived conflicts in the Mental Health Act in respect to carers' role in oral health would be welcome, as some have concerns that invading a patient's mouth with a toothbrush may constitute assault

### **Measuring changes in oral health for community dental service patients (question 8)**

Respondents felt that the red, amber, green (RAG) rating being used in the pilots was valid for the types of patient generally seen by the Community Dental Services (CDS). However, the amount of change would be smaller than in the general population as the priority is often to prevent or delay deterioration rather than achieve oral health improvement. Other concerns centred on patient (and carer) compliance and the fact that many patients are referred for one-off treatments, not continuing care. Suggested ways of demonstrating oral health change included:

- Decayed, Missing, Filled Teeth (DMFT) scores
- applying the British Dental Association (BDA) casemix model
- using a quality of life index
- measuring the number of repeat episodes of sedation and/or general anaesthesia
- achieving a measure of patient compliance
- measuring disease levels / impacts of oral conditions (current indicators are disease rather than health focussed)
- using proxy measures for oral health environments plus individual measures (as many patients are resident in care homes).

### **Patients who are reliant on carers (question 9)**

The consensus was that the pathway approach was still applicable to patients reliant on carers. However, since the key to assisting carers was making things as easy as possible for them to deliver care, it was important that there was flexibility as well as clarity.

## **Paper 3: The measurement of quality and outcomes**

The 3 main strands to measuring quality in healthcare services are clinical effectiveness, patient experience and safety. This approach is recognised by the World Health Organisation and other international bodies.

The majority of respondents agreed that these 3 domains were the right areas.

Many of the respondents who answered “No” went on to say that they did in fact support the general principle of the domains but wanted to make a comment (the design of the survey was such that they could only make a comment if they ticked the “No” option).

A typical concern was that outcomes are dependent on the patient and whether s/he complies with advice. Patient experience was perceived as subjective. So for both clinical effectiveness and patient experience, this group of respondents thought the areas were right but were concerned that they are complex to measure.

A third group of people thought that the indicators based on these 3 domains were wrong. Their concerns about patient compliance and subjectivity were the same as the “Yes, but” group, but they thought that the problems were so great that the indicators would not work.

### **Outcomes versus process indicators (question 2)**

20% of respondents agreed focusing on outcomes was correct. 14% felt process was more appropriate (as this measures what dentists actually do) and 30% of respondents wanted to see both (because this was not seen as an either / or option – both types of measure were important).

The greatest concern, regardless of views on the focus, was that outcomes were dependent on patient compliance.

### **Indicators for patients with additional needs (question 3)**

Just under half of respondents thought there were other considerations and wanted to see indicators for vulnerable groups reported. The 2 main suggestions were either to have a special set of indicators for vulnerable groups, or to use the same indicators with different thresholds / weightings.

### **Process indicators (question 4)**

Most respondents ticked the “No comment” box for this question. This might be because the majority of respondents had already stated that they were happy with outcome focused indicators in response to earlier questions. Where ideas were put forward the overwhelming majority suggested that indicators should be based on some or all aspects of Delivering Better Oral Health (DBOH).



### **Clinical effectiveness indicators (questions 5 & 6)**

- **Caries and Basic Periodontal Examination (BPE)**

There was broad consensus that there should be indicators for caries; however, although many people acknowledged that periodontal disease is a main aspect of oral health, they questioned whether BPE was appropriate as an indicator or the best measure.

- **Other areas of clinical effectiveness**

Nearly half of the respondents ticked the “No comment” box for this question. Of those that did provide an answer, there was little common ground on what the other areas should be.

### **Patient experience (questions 7 & 8)**

Nearly two thirds of respondents said the existing indicators covered the right areas. As with responses to question 6, there was no clear consensus on alternatives.

### **Other views / ideas about ways of assuring and promoting clinical quality (question 9)**

The most popular proposal was the use of Dental Reference Officers (DRO) or some sort of practice inspection by a clinically qualified person. Other ideas included benchmarking or peer review type approaches. Some respondents made the point that some or all of this could be, or is already being, done by the General Dental Council (GDC) or Care Quality Commission (CQC). A small number of respondents suggested clarification of service expectations under the NHS.

### **Assessing patient safety, clinical effectiveness & patient experience (Question 10)**

- **Patient safety**

The most common responses were: i) that this was an area of responsibility of the CQC ii) that Dental Reference Service (DRS) type inspections could play a role; or it could be monitored by incidents or never events reporting.

- **Clinical effectiveness & patient experience**

Many respondents felt that this question overlapped questions 6 and 8, and so either repeated or referred back to their previous answers. On clinical effectiveness, respondents felt that the reintroduction of the DRS would be effective and that an area that should be looked at is the longevity of treatment. For patient experience, most respondents felt that a questionnaire based survey would be the most effective method of getting feedback.

### **Quality measures for high risk patients (question 11)**

Many people reiterated responses they had given to previous questions. Process indicators were felt more appropriate than outcomes, given the engagement and compliance difficulties associated with this patient group. Some respondents suggested ring-fencing could be reserved for the high risk / high need patient group.

## Paper 4: The remuneration approach

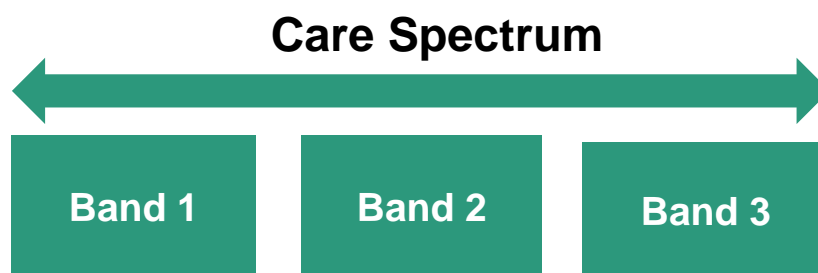
The engagement exercise was based on the following assumptions:

- there will be a pathway approach
- Dental Quality and Outcomes Framework (DQOF) will feature with all options
- overall NHS expenditure will remain unchanged, as will the scope of NHS care
- there will be a commissioned system where contract remuneration remains capped
- contract assurance and financial recovery
- there will be the ability to flex levels of service
- patient charge revenue (PCR) will continue to be raised as now
- mixing of private and NHS dental care will remain unchanged.

The broad options for remuneration that exist are:

- *Full activity*: the current contract based on units of dental activity (UDAs) is an example of an activity based contract
- *Full capitation*: the current pilots are an example of a capitation based approach
- *A blend of capitation and activity*: providers would be paid based on number of patients cared for and activity delivered. There is no current example of this remuneration approach.

Views were sought as to which elements of the care spectrum should be covered by capitation and which by an activity payment (see diagram below).



### Percentage of the contract value to be used for DQOF (question 1)

The majority of respondents favoured a level of 10% or less.

### Options for remuneration and how the associated challenges can be managed (question 2)

Over half of respondents preferred a blended system, i.e. a mix of capitation and activity.

### Elements of the care spectrum to be covered by capitation (question 3)

There was no limit on the number of suggestions that could be made in answering this question. Some responses included one or more of the key themes listed below:

- Preventive care and advice – favoured by over a third of respondents
- band 1 / basic dental care
- examinations / routine treatment
- oral health
- urgent / emergency care
- everything including complex care
- everything excluding complex care.

#### **Safeguards for high need patients (question 4)**

Respondents were asked an open ended question and were free to include as many suggestions as they wanted. Answers may therefore have included one or more of the following key themes identified from all the responses:

- monitoring
- appropriate remuneration
- capitation weighted to higher needs patients
- additional resources
- payment per item to safeguard higher needs patient
- amended UDA banded system
- refer high needs patients to specialist clinics

# The engagement exercise: Detailed findings

## Qualitative analysis of responses

### Paper 2: The clinical philosophy

This paper posed 9 questions:

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 can be simplified whilst maintaining its clinical integrity? (please relate any response to your experience with or knowledge of the pathway)
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?
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?

There were 109 valid (ie where data had been entered) responses to the questions in this section. The breakdown of these responses was as follows:

Question 1	99%
Question 2	97%
Question 3	97%

Question 4	89%
Question 5	90%
Question 6	91%
Question 7	94%
Question 8	75%
Question 9	74%

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

### Overview

Almost all respondents expressed support for the philosophy of a need and risk-based, preventive approach to care and frequent comment was made that it was already in practice. Despite this widespread support, many respondents gave their support with qualification with some commenting that, although the philosophy is good in theory, and makes clinical sense, there needs to be consideration as to how it would work with patients. Many of these respondents seemed to be highlighting that successful implementation was dependent on patient support and engagement:

*“Preventive dentistry is a very laudable aim, but the majority of people in the UK that I meet just don't care enough about their teeth for that to be totally effective.”* (Dentist)

*“The main difficulty is patient compliance with attendance is poorest amongst those who need it most.”* (Academic)

A few respondents raised the issue of needing to allow patient choice and a few also commented on the potentially negative business implications if a practice had significant number of patients that were not compliant with the pathway approach. One response, while supporting the preventive approach, noted the importance of all care given by the NHS as having equal value:

*“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.”* (National body)

Within the context of supporting the philosophy, some respondents deliberated whether the approach would work for or against equity and addressing inequalities. Many respondents also emphasised the need to take an individualised approach to patients. As well as these emerging themes, there was a good deal of comment regarding what was needed for the philosophy to succeed. The main themes here related to: patient awareness, engagement, information and education; public health; workforce and infrastructure; and contracting. The salient findings relating to each of these themes are considered below.

## **Equity and inequality**

There were mixed views amongst respondents regarding whether the approach would improve equity and address inequality. Some respondents stated that the pathway approach would enable the targeting of patients according to their need and risk which would, therefore, assist in addressing health inequalities:

*“It is also a way of prioritising treatment for high needs patients away from low needs patients.”* (Local Professional Network)

However, other respondents questioned whether all patients would access their dentist, and engage and comply with the pathway approach and some expressed concern that there was a risk of the approach undermining the NHS aspiration of reducing health inequalities:

*“A preventive care pathway will only support those who choose to access dental care with their General Dental Practitioner.”* (National body)

*“We agree with the philosophy of a needs and risk based preventive approach to care and the pathway approach. This does however present challenges for patients reliant on carers, hard to reach groups and those who do not have English language.”* (Dentist)

A few respondents mentioned the importance of patient charging remaining affordable.

## **Individualised approach**

While supporting the need for a systematic and consistent approach, there was frequent comment across all respondents regarding the need for dentists to take an individualised approach and tailor pathway delivery according to individual patient need. Respondent comments indicated that level of risk and likely current and future RAG status was not simply determined by oral health status but by patient capacity to engage, understand and manage their own oral health which could be variable and dependent on multiple factors:

*“It is important to avoid a “one size fits all” approach as there is the potential to miss patients whose oral health needs dramatically change over a short period of time. Such patients may appear to have low risk and thus be prescribed preventative measures and recalls reflecting this low risk.”*  
(National association)

*“...the interim care appointments for high needs/ risk groups are vital to re-emphasise the importance of a preventive approach and reinforce advice.”*  
(Area Team)

Respondents also highlighted the importance of treatment and care being timely and several emphasised it should be based on clinical judgment rather than it being dependent on a computer-based algorithm:

*“The RAG rating system is good and helps to determine risk of disease, however clinicians must be able to override the rating to tailor it to each individual patient.” (Dentist)*

### **Patient awareness, engagement, information and education**

Across all respondents there was frequent mention of the importance of patient awareness, engagement, information and education if the philosophy and pathway approach was to succeed. Respondents described the need for patients to understand the role of their dentist and their own role in maintaining their oral health and why this was important.

Some respondents said that this was especially important as patients were familiar with attending their dentists for treatment rather than prevention. Many described this foundation as being needed in order to deliver the pathway approach and that patients would need to be informed and educated in order to share responsibility for their oral health with their dentist:

*“I think it's important to start with the fundamentals of dentistry (preventive care) with any new and ongoing patient. Without educating and demonstrating this to our patients we cannot expect them to help themselves, and also we cannot expect our treatment to be successful in the long term.”*  
(Dentist)

*“Dental teams need to work with their patients to explain and inform them of their own dental risk and needs and tailor oral care pathways to match this.”*  
(Local Professional Network)

Several commented that this task could not be the responsibility of dentists alone and a couple of respondents commented that dentists may not be well equipped to be effective chair-side oral health educators.

### **Public health**

Respondents commented regarding the wider contribution that dentists could make to public health:

*“With over 1 million contacts a week dentists are exceptionally well placed, skilled and equipped to contribute to the wider public health agenda... Oral health promotion, prevention measures and identifying health risks such as diabetes and oral cancer.”* (Local Dental Committee)

*“...dentists and the dental team are ideally placed to provide prevention and promotion messages to patients, such as smoking cessation advice, healthy eating advice or advice on sensible alcohol use. In this Area Team there is a drive to deliver the NHS Health Checks through dental teams.”* (Local Professional Network)



Respondents also stated a need for a wider public health framework to underpin the philosophy and supporting dentists in their delivery of primary care dental services. A few cited the value of water fluoridation and several referred to targeting early years and school settings as a priority (a few respondents also cited the example of the Childsmile scheme in Scotland).

*“...other health care workers, for example pharmacists, should continue to participate in oral health care advice for patients.”* (National body)

*“Public health initiatives have not gone far enough and dentists alone will not resolve the high incidence of preventable oral disease.”* (Community Dental Service)

### **Workforce and infrastructure**

Respondents referenced workforce and infrastructure issues as important in ensuring the effective implementation of the philosophy. Regarding workforce, comment was made about the need to have a workforce and skills mix that could meet patient needs in the primary care setting. Comment was also made regarding the need to have the space, IT and software support and training, for the pathway to be implemented effectively:

*“Pathways need to have facilities for efficient and effective communication (e.g. IT systems) exchange, to allow training and enhanced clinical work to be undertaken in primary care.”* (Local Professional Network)

### **Contracting**

Respondents described the need for the new contract to take account of the time needed to implement the pathway approach effectively and to acknowledge the time needed to make the transition to a new way of working.

## Question 2: What would be the challenges of applying this approach in your practice?

### Overview

Most respondents described the challenges of applying the preventive pathway approach in their practice. The challenges commonly identified by respondents were:

- scale of change and patient expectations
- time and cost; patient need
- engagement and motivation
- skill-mix, workforce and training
- IT requirements

The main findings relating to each of these challenges are described below.

### Scale of change and patient expectations

Many respondents commented on the scale of change proposed and how this needed to be managed and communicated effectively to facilitate the transition. In particular, respondents stated that patient expectations would need to be managed to ensure patients can understand and engage effectively in the preventive pathway approach:

*“...patients need to be willing to accept preventive care.” (A National body)*

*“It will require a huge sea change in patients’ expectations and responsibility.” (Dentist)*

*“The most significant challenge centres around the change in approach from what the attending base has become accustomed to and what they will then experience.” (Dentist)*

*“When patients attend a dental practice, they are expecting treatment and often will not understand or appreciate the long term clinical pathways that are now being proposed. ... Some patients will be non-compliant.” (Dentist)*

*“They (patients) don’t fully understand why NICE guidelines should be applied ... and feel money is taken off them unnecessarily if more frequent visits are needed or that they are being rationed appointments if on longer recall intervals.” (Dentist)*

Several respondents also said there was a need for patient information and a few respondents described a need for a national communications campaign to support the service change, especially in the transition period:

*“This will require considerable short and medium-term investment in national communication campaigns and locally-based information and support for the public.” (Local Dental Committee)*

*“Change to a needs based service from what can currently be a demand led service will require careful communication pathways - centrally and locally and ultimately within a practice.” (Dentist)*

*“The proposed preventive approach to care will represent a considerable departure from patients established interaction with their dentist and the wider dental team, and the BDA is strongly of the view that DH, in conjunction with PHE, undertakes a significant public information campaign to ensure that patients are aware of the changes to be made in practice.”  
(National body)*

### **Time and cost**

Along with the scale of change and patient expectations described above, across all respondents there were numerous references to the time and cost implications, for both dentists and patients, of adopting and implementing the preventive pathway approach. Respondents referred to the time needed to:

- manage change and explain the new approach to patients:

*“It’s a paradigm change so time to gradually adapt coupled with good communication, training and tools will be key.” (Dental software supplier)*

- deliver a preventive pathway approach and, in particular, undertake an oral health assessment (OHA):

*“Prevention is taking time.” (Dentist)*

*“Undoubtedly, having to complete an initial OHA for all patients would be very time consuming and impact on waiting times and access for patients.” (Local Professional Network)*

*“TIME TIME TIME coupled with remuneration system that recognises the time and effort this requires tailoring advice to patients delivering it in a way each patient will understand.” (Dentist)*

A few respondents commented on the risk of dentists engaging in patient selection in order to control time and costs. For patients, some respondents also referred to likely increased access and waiting times and whether patients would be willing to give this time and pay for preventive advice:

*“If a system is introduced that requires longer appointments initially this may cause irritation for many patients if they have to wait even longer before they can be booked in.” (Dentist)*

*“Patients who pay for their NHS treatment are suspicious whether they are getting value for money as they usually feel that dental charges cannot be justified for just giving advice.” (Dentist)*

The cost implications for dentists needing to take more time to deliver prevention was raised by several respondents along with the cost of workforce/ skills-mix changes and introducing new IT systems.

### **Patient need, engagement and motivation**

Many respondents commented on patient level of need, engagement and motivation and the implications for practice. Where a patient had a higher level of need, for example, as a consequence of age or social or medical reasons, respondents questioned the willingness of dentists to take on higher need patients:

*“Depending on the practice profile and dentists perception of any remuneration model, they may start to select patients to create a low maintenance green patient base, rather than encouraging a more mixed patient risk profile including higher needs (red) patients and seeking to gradually move patients from red to amber to green.” (National body)*

Along with the willingness of dentists to take on higher need patients, respondents queried whether these patients would also be ready to engage:

*“If we can shift the balance to more care for the reds so that the cost of looking after the green and high ambers decreases but that will not happen as the greens tend to want more care simply because they care.” (Dentist)*

*“The main challenge is persuading the patients to accept it; especially “red” status patients which is where the OH improvement is needed.” (Dentist)*

*“I think the challenges are going to be motivating the high need patients, with multiple disease processes to get them to accept a preventative care plan.” (Dentist)*

*“We have a high urgent treatment throughput with many in our patient base difficult to motivate regarding taking responsibility for their oral care.” (Dentist)*

Most CDS respondents highlighted that patients may be carer-dependent and, where this was the case, engagement could be dependent on carer willingness, motivation and understanding.

These respondents frequently identified people with special care needs as likely to have engagement difficulties with the pathway approach:

*“I see many patients with some sort of special need and often with third party input e.g. carers. Getting third party support is difficult and needs to be taken into account.” (Community Dental Service)*

*“...For the pathway to succeed in the CDS, carers will be an integral part of the pathway...”(National association)*

One respondent referred to the needs of people whose first language was not English:

*“The patient base is largely from minority ethnic communities without a tradition of attending the dentist except in an emergency situation, for many English is not the first language.... Engagement, communication and understanding may well be poor as a result.” (Dentist)*

### **Skill-mix, workforce and training**

Across respondents there were numerous references to the importance of having the right skill-mix and workforce in order to deliver the preventive pathway approach successfully:

*“This pathway can only be successful with the widespread introduction of skills mix and a variety of dental care professionals within practices. It is not financially viable for dentists to be engaging in all aspects of the care pathway and the use of dental therapists and oral health educators will need to increase. This presents challenges around workforce planning and education and training for existing teams.” (Dentist)*

*“Dentists could become team leaders, delegating simple treatments and prevention to therapists, hygienists and extended duties DCPs. This would release dentists to undertake complex treatments. However if the skill mix isn't available then the dentist will still need to provide all treatments.”  
(National body)*

*“The skill mix has to change. A therapist/hygienist is essential to any 2+ chair practice. Also it would be advantageous to train nurses with extra responsibilities regarding FI (fluoride) varnish application and OHE.” (Dentist)*

Respondents questioned what would happen where practices did not have the capacity or physical space to employ a wider team and a few respondents raised the risk of future under-employment for dentists. The need for education and training was identified by many respondents, with comment that dentists and their teams needing education and training in the new system and approach, including IT training.

## **IT requirements**

Many respondents described the challenge of meeting IT requirements in order to manage and monitor the pathway approach and, along with the IT cost, identified a training need if new systems were required. A few respondents queried the viability of implementing the pathway approach without an IT system:

*“IT is one of the main issues, there is a need for computerisation. Should this be part of the contract that the practices need to be computerised? It was felt a practice without computers would find the pathway approach difficult to record and navigate”.* (Local Professional Network)

Several respondents expressed concern that an IT-based algorithm should not take precedence over clinical judgment:

*“It would be better if dentists are able to have more say in what a patient’s risk factors actually are rather than a computer programme.”* (Dentist)

Comments were also made that for patients accessing CDS that IT systems should not take precedence:

*“It is our view that for the CDS, I.T. must play a supporting role to the delivery of the pathway, as the complexities and needs of patients accessing this service will be difficult to capture in an algorithm.”* (National association)

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

### Overview

Most respondents stated 'yes' in response to this question. In outlining the challenges, those commonly raised related to:

- patient expectations, motivation and understanding
- flexibility of service response
- time and cost
- skill-mix
- IT
- space

The main findings relating to each of these challenges are described below.

### Patient expectations, motivation and understanding

Many respondents referred to the need to communicate service change so that patient expectations were managed. Respondents described current patients expecting to see a dentist for treatment and on a 6 month recall and that patient expectations would need to be changed to implement a preventive approach successfully:

*“There will be a large initial (and smaller) ongoing need to help patients understand the changed service.” (Dentist)*

Specifically, a few respondents commented that patients were unaware of NICE recall guidance and that a national campaign, to inform and educate in order to realign patient expectations with the guidance was needed. There was also a good deal of comment regarding the need for patients to be aware of and understand the preventive approach which could mean that treatment would not be immediate:

*“Patients are used to coming into practices and having a problem fixed in a short course of treatment. There will be a period of re-education of patients’ expectations regarding the speed of treatment delivery if extensive Oral Health Assessments need to be done first.” (Local Professional Network)*

*“The time it takes to implement the pathway correctly as some patients just want treatment completing as quickly as possible.” (National body)*

*“Although observing NICE guidelines is a current contractual requirement, this can be difficult for patients to accept. Government information campaigns need to focus strongly on the guidelines to support the messages being delivered by dental teams.” (National association)*

*“We would urge that patient information is developed to support the introduction of new NHS contract arrangements, and that this sets out clearly the role of the individual dental team members in providing different aspects of patient care.”* (National body)

Respondents deliberated whether all patients would be motivated or able to engage with the preventive approach and cited, for example, patients from areas of social deprivation or with high needs as less likely or able to engage. A couple of respondents suggested that care plans needed to be available in a range of formats and mediums. Several respondents described potential engagement issues with older people and those in care homes:

*“A key group that may be difficult to engage with will be older people in care homes (or their own homes), as a result of their being less mobile and unable to attend a dentist or their carers not recognising the continued importance of oral health.”* (Local Professional Network)

Some respondents, including almost all CDS respondents, raised the particular challenge of engaging with special care patients who may be unable or unwilling, even if there is carer support, to engage. With these groups, the importance of carer engagement was raised:

*“The term patient engagement should be expanded to include the engagement of carers who will play a key role in the provision of oral care for many patients.”* (National association)

A couple of respondents commented on the need to be aware of cultural differences:

*“There needs to be increased appreciation of cultural differences in relation to oral care, and cultural sensitivities ought to be respected, while possible issues recognised and not ignored.”* (Local Professional Network)

### **Flexibility of service response**

Many respondents highlighted the need for the service to remain flexible in order to be able to respond in a timely way and cater for individual needs and patient willingness / ability to engage:

*“Concessions need to be made for those patients who chose not to engage with routine care, but only seek urgent or unplanned interventions and practice diaries need to be flexible enough to manage this.”* (Dentist)

*“It is our experience that an element of the patient base does not wish to participate in this approach and wish to continue with what they regard as a more “traditional approach”. Clear, consistent communication of the benefits is key to the success of this approach.”* (Dentist)



One respondent commented on the need to take account of a patient's circumstances when determining the service response:

*“...sometimes although there is a logical pathway route for treatment, patients' life circumstances require that an alternative route needs to be taken.”* (Dental Professional)

### **Time and cost**

Numerous references were made regarding time. Respondents commented on the time needed for transition, the time needed by the dental team to implement the pathway approach effectively, and the time for patients in terms of waiting times and the treatment and care process taking longer.

Regarding transition, respondents stated that time would be needed to communicate and explain the service to patients:

*“The major challenge will be that of the time needed to explain the new system to the patient, and for delays as more time will be required when first assessing patients for the first time in the new system.”* (Local Professional Network)

In terms of implementing the pathway approach, respondents stated that prevention needed time, time to inform and educate patients in order that they can take part in the pathway approach effectively:

*“Time is needed to communicate effectively and this approach will need time to explain and help patients work with us to work on their oral health.”* (Dental Professional)

*“It is also important to recognise that prevention takes time. Patients need the time to speak to their dentist and then receive the help and support they need.”* (National association)

A few respondents commented on the time pilot software takes to use and the time it takes for patients to complete the pre-pathway questionnaire in the pilots.

Several respondents commented on the time for treatment and care that patients would need to allow for and whether they would always be willing to accept potentially increased waiting times:

*“The time it takes to implement the pathway correctly as some patients just want treatment completing as quickly as possible.”* (National body)

A few respondents cited the issue of cost and whether patients would be willing to pay for prevention and a couple stated that patients needed to be engaged with the charging scheme:

*“Patients are inured to paying for “something done.” (Dentist)*

*“Patients will need to be fully engaged with the new charging scheme...A system needs to be in place that patients and practitioners are comfortable with without putting at risk the patient charge revenue.” (Local Professional Network)*

### **Skill-mix**

Respondents raised the issue of skill-mix and how a pathway approach would need a skills-mix that included therapists, dental care professionals and nurses. Some respondents also noted the issue of needing patient information and education and education and training within the dental team to aid understanding of respective roles and responsibilities.

### **IT and software**

Respondents commented on the importance of IT and easy to use software in the new system:

*“IT is one of the main issues ...It was felt a practice without computers would find the pathway approach difficult to record and navigate.” (Local Professional Network)*

One respondent commented on the cost of software and the implications for practices limited by size.

### **Premises constraints**

A couple of respondents stated there was a need for adequate space:

*“Within a dental practice setting, a major challenge is having enough space to engage with patients in an appropriate setting.” (Community Dental Service)*

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

## Overview

Respondents were able to give a 'yes' or 'no' response to this question and approximately one third answered 'no'. However, this majority of 'yes' responses does not give an accurate picture as sometimes respondents gave this answer simply so that further comment could be made and not as an affirmative response to the question. Consequently, a number of 'yes' respondents answered that they did not know as they did not have experience of the pathway, or enough information to be able to comment, or it was too soon to decide:

*"More research and information is needed before a judgement can be made on its clinical integrity." (Dentist)*

Where respondents were actually answering 'yes' in response to the question, many of these responses were not commenting on making the pathway itself simpler but on making the implementation of the pathway simpler and easier in terms of software and data management:

*"The main problem is with the software and with the medical (and social) history forms rather than the simplicity of the pathway." (Dentist)*

*"It should be easier for dentists to determine risk factors as this is what we are trained to do. This will in turn make the pathway much more straight forward." (Dentist)*

*"The pathways seem reasonably straightforward but as ever getting it right with the IT and PCR system is a great challenge." (Local Professional Network)*

Therefore, many of the 'yes' respondents did endorse the pathway in principle but often raised concerns about pathway implementation and maintaining access:

*"The pathway is conceptually sensible, the dilemma is the time it takes to undertake the initial assessment." (Local Professional Network)*

*"PMS systems implement the pathway in an over complicated way with a very rigid implementation of the pathway without sufficient attention being taken to individual patient needs. ... changes to the amount of data being recorded and the efficiency of the data capture needs to be simplified to ensure efficient use of surgery time." (National association)*

*“Much of the pathway requires duplication of information that is required as part of good clinical record keeping.” (Dentist)*

Frequently respondents added that this was important to save time in order to maintain patient access. A few of the ‘yes’ respondents expressed concern about the viability of implementing the pathway and maintaining access.

Across these ‘yes’ respondents specific issues were raised, and sometimes suggestions for improvement, regarding:

- OHA
- IT and software
- interim care (IC)
- advanced care
- approaches to implementation (i.e. national roll-out of the pathway)

The issues and suggestions given by respondents for each of these areas are considered below.

### **Oral health assessment**

The oral health assessment (OHA) is the most time-consuming element of the pathway and brings together information supplied by the patient (via completing the medical and social history questionnaires) and the dentist (via clinical examination and direct patient questioning). There was general consensus on the need for the OHA to be as simple and straightforward as possible:

*“OHA must be as straightforward as possible to ensure that it does not become burdensome to complete.” (National association)*

Some respondents said the OHA was currently overly burdensome and too long for both dentists and patients in terms of number of questions and time taken and this also affected the quality of data capture and could work against patients giving accurate information and dentists readily identifying risk<sup>1</sup>:

*“There are too many questions in the oral health assessment. This needs to be simplified.” (Dentist)*

*“The oral health assessment itself is too long and also requires considerable communication time with patients.” (Dentist)*

Many respondents made suggestions relating to collecting less information and most of those made have been incorporated into V3 software. New ideas included: removal of the dental

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<sup>1</sup> These comments are almost certainly based on V2 software, not V3

sepsis question, the introduction of a 2-phase periodontal assessment, using BPE in the first phase to identify risk, and assessment of bleeding on probing plus 6 point pocket chart for those patients who opt for further treatment in the second phase.

Questions were also raised by respondents regarding the medical and social history questionnaires and how well they worked as a tool for eliciting information from patients.

One respondent said that the questionnaires ask a number of important questions but in their present form<sup>2</sup> can cause confusion for patients and suggested as a solution,

*“Allow the dentist to highlight relevant risk factors by direct patient questioning, simplifying the OHA and removing the need for patients having to complete a difficult and time consuming questionnaire.”* (National association)

One respondent, commenting on the RAG system, questioned whether patients with non-modifiable factors (for example, diabetes, historic tooth surface loss) should be amber-rated given that they would not be able to achieve green status and, therefore, may become demotivated. The respondent proposed that introducing two green categories (light and dark) with the light green RAG score to be used, where applicable, for patients with non-modifiable factors.

A couple of respondents suggested that it may be appropriate to involve the wider dental team in the initial screening.

Many of the comments and suggestions made by respondents about the OHA also related to IT and software issues and these are considered in the next section.

## **Software**

Many comments made by respondents related to software issues and some responses appear to be based on use of V2 software as the improvements suggested have already been incorporated into V3 software. Respondents wanted systems/software that were easier, more flexible and responsive than the current ones:

*“In the current pilot, PMS systems implement the pathway in an over complicated way with a very rigid implementation of the pathway without sufficient attention being taken to individual patient needs.”* (Dentist)

*“Streamlining some of the software systems in practice and utilising IT to capture the medical and social history details in an intelligent way that allows risk factors to be assessed.”*  
(Trainee dentists)

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<sup>2</sup> Again, this is almost certainly based on V2 software, not V3

*“The software needs to be modified to make data collection simpler and less arduous.” (Dentist)*

*“The feedback from the Pilots is that the OHA is too click heavy.” (Dentist)*

*“The PMS user interface in its current form is too complicated and involves too many screens and mouse clicks. ... The focus could change from a user interface that uses a fixed path to one which uses a fuzzy logic approach. This would enable a pathway to be presented which fits better with the circumstances of the patient being assessed.” (National association)*

### **Interim care**

A couple of respondents made comments about IC appointments with one suggesting that ICs should be renamed as “recall appointments” based on the patient’s risk status. Another respondent raised a question about IC appointments and patients with chronic periodontal disease:

*“It is unclear as to whether IC appointments are for patients with chronic periodontal disease. This should really be classed as necessary treatment as Chronic can have acute phases.” (Dental Care Professional)*

### **Advanced care**

Several respondents identified specific issues relating to the working of the pathway and referrals to advanced care. The responses indicated that further information and guidance is needed to explain the entry point to advanced care pathways, the 3 tier system (levels of complexity), and the referral criteria. Comment was also made that account needs to be taken of the limited service provision that might be available:

*“Advanced care and referrals is causing confusion. ... The OHA should flag treatment that is considered as advanced care to assist with treatment planning leaving the clinician to decide the most appropriate way to deliver the treatment locally.” (National association)*

*“The area where I believe there is still uncertainty is the interface between the basic preventive care pathway and treatment and specialist pathways and the 3 tier system. Further detail is required regarding the entry point to these pathways and the referral criteria which will be applied.” (Dentist)*

### **Approaches to implementation**

A couple of respondents commented on approaches to implementation, that is, the national roll-out of the pathway and suggested that a gradual approach is taken:

*“If the pathway were implemented gradually then there would be less dramatic pressure on the appointment book. Could it ... be introduced for under 18s first?” (Local Professional Network)*

## Question 5: How can dental professionals be encouraged to follow NICE dental recall intervals?

### Overview

Respondent answers to this question were divergent and indicated that understanding of NICE guidance on dental recall intervals may be quite variable and that there is some confusion. Some respondents questioned the validity of the guidance.

Some respondents advised that the answer to managing appropriate recall intervals lay with the pathway:

*“If dentists follow this pathway then the judgement around appropriate recall intervals ought to occur automatically. If patients have a true understanding of their individual risk and how that has been determined then the recall would follow accordingly.” (Dentist)*

One respondent commented that having a high volume of patients on a 3 month recall pattern is common in the CDS where perhaps the most significant barrier to adherence to NICE recalls is lack of resources.

Where respondents were comfortable with encouraging compliance with NICE guidelines, 3 main suggestions were made:

- remuneration / contractual incentives (although compliance with NICE guidance is currently a contractual requirement)
- patient communications, information and education – there was a feeling that a large number of patients expect to be seen every 6 months (indeed, some people perceive this to be a “right” and part of the NHS dental offer), and if they are denied this they may go to another practice
- professional education and training to make clear that NICE guidance is evidence-based and overcome professional scepticism and medico-legal concerns.

### Remuneration and contractual incentives

The consensus was that the reformed system should provide the right balance of incentives and measurements to encourage compliance:

*“If practices are working to a fixed budget there would be no incentive to see patients more frequently than they require as this would have a cost implication. Conversely if a proportion of contract value is assigned to quality and outcomes high risk patients will be seen more regularly to ensure compliance and oral health improvement or stability.” (Dentist)*



Specific suggestions included:

- a DQOF indicator which measures actual recall periods achieved (with due allowance for deviation where clinically justified)
- an access indicator (which would have the same effect indirectly as the above) by rewarding practices for meeting access targets
- linking payment to the number of unique patients seen over a 24 month period

It was felt that a capitation-based system would encourage longer recall intervals as more patients could be on the practice's list and managed appropriately.

A small minority of respondents appeared to be unaware that compliance with NICE guidelines is already a contractual requirement for NHS dentistry.

### **Patient communications, information and education**

Many respondents perceived a key barrier to implementation of NICE recalls was patient, rather than professional, resistance:

*“One of the most significant challenges to the success of the reforms will be to change the public perception of the need for 6 month recalls”* (National association)

Changing public perception around the need for 6 month recalls was seen primarily as a central responsibility (DH/NHS England). The consensus was that the dental profession would need robust support via a major national dental public health initiative/media campaign to tackle this issue successfully.

The importance of changing patient expectations and understanding was underlined by the concern about the consequences of patient dissatisfaction and the potential impact this might have on a practice's business. Some dentists are reluctant to implement NICE guidelines for fear of upsetting and losing patients – often the ones who have regularly attended the practice over many years:

*“I have always done this and all of my principals over the last 15 years of GDP associate work have been opposed to it as essentially you are turning away your responsible, motivated, regular attenders who are mostly a pleasure to treat to try to help new patients, however many people in this group are irresponsible, poorly motivated, poor attenders who show little interest in their dental health once they are out of pain and often are difficult to treat, fail to attend appointments and don't put enough value on their oral health and so moan even about low NHS dental costs. This is my direct experience over 15yrs as an NHS GDP. It is difficult to help those who are not motivated to help themselves.”* (Dentist)

It was suggested that patients who wish to be seen more frequently should have the option to pay privately for this.

### **Professional education and training**

Quite a few respondents suggested that there is widespread professional scepticism about the current NICE guidelines [see <https://www.nice.org.uk/guidance/cg19>], with some respondents arguing that the guidance:

- has a flawed evidence base (especially around 24 month recalls, where there were felt to be risks to patient care and consequently medico-legal concerns)
- is confusing and conflicts with other published guidance (eg oral cancer, DBOH)
- is about keeping costs down and suppressing demand in a cash limited system.

*“We have major concerns about the promotion of NICE recommendations for recall intervals. We do not believe that it is safe to see some patients only every two years. We remain convinced that an absolute maximum recall interval of 12 months should be applied to those with the lowest risk.....The profession totally rejects current recall guidelines as they are designed purely to save money and are wholly detrimental to patient care.”*  
(Local Dental Committee)

This scepticism appeared to be rooted in doubts about the robustness of the evidence base. Respondents pointed out that NICE guidance suggests recall intervals of more than 12 months for some patients, but that oral cancer screening guidance suggests that no one should have a longer recall interval than 12 months.

*“The NICE guidelines are unfortunately a contradictory document that leaves a cynical taste in the mouth of many practitioners. Suggestion of a 24 month recall has little or no scientific basis and all patients we have discussed this with suggest this is tantamount to being abandoned by the system. Given the doubling of incidence in oral cancer cases including a younger cohort (often those who have lower risk factors for caries and periodontal disease) a 12 month recall would be a maximum and this sits well with every colleague that this has been discussed with. As for a child recall of up to 12 months this conflicts with the evidence based (level 1) advice given in the current DBOH (2) which clearly impresses upon the dental team that the twice yearly application of topical fluoride is expected. Something that is also emphasised via PDS+ practice metric.”* (Dentist)

The doubts expressed also reflected dentists' personal professional experience:

*“On a more personal note I wonder if green patients only remain green due to the frequency of recall because I have noted regression into amber on a number of occasions following increased recall interval.”* (Dentist)

*“When I graduated in 1995, we were taught that heavily restored dentitions should be seen at least every six months. In the past I have extended recalls only to be proved incorrect and in one case a patient needed root canal treatment. The patient questioned if it would have been better to see him earlier and potentially avoid extensive treatment.” (Dentist)*

Some respondents felt that professional compliance was a generational issue - and therefore one that would disappear when dentists trained in the NICE regulations became the majority:

*“It will happen over time – new dentists are all trained on NICE recall intervals and as a FD trainer, I see this as becoming much more of the normal practice in any case.” (Dentist)*

*“As a young dentist I cannot see what the problem or barrier is to following the NICE recall intervals” (Dentist)*

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

### Overview

Many respondents felt that whilst dentists should not be encouraged to change pathway recommendations per se, deviations from the pathway could and should happen if there was robust supporting clinical evidence. The view was that the clinician's prime responsibility is to ensure that the care provided is in the patient's best interests, rather than blindly following an IT algorithm:

*“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.”* (National body)

*“Dentists need to be educated regarding the pathway and how it works including the available guidance, best practice and evidence based dentistry that underpins the pathway. Some have no confidence to override the pathway and others override on opinion and not sound reasoned judgement. Those dentists who are up-to-date with current clinical teaching are more likely to have the confidence to come to their own decision.”* (National body)

Many respondents commented on the possible reasons why some dentists were reluctant to deviate from pathway recommendations:

*“As has been demonstrated by the various contract pilots, even where dentists are relatively protected from financial risk and have been instructed (on more than one occasion) to override the clinical pathways as necessary, there is an instinctive reluctance to do so. As is so often the case, setting a normal way of doing things undermines innovation and inhibits clinical freedom.”* (Local Dental Committee)

Medico-legal concerns were identified by many respondents as a key factor in making clinicians adhere to software recommendations. Fear of litigation or professional censure has the effect of encouraging dentists to transfer responsibility to “the system”. This led to the suggestion that some form of agreement should be reached with the professional indemnity providers regarding the medico-legal status of the pathways and what is reasonable to do (or not do) in given circumstances.

Other respondents commented on the irony of this question given the previous one (Question 5) about ensuring compliance with NICE guidelines, and felt there was little point in having clinical pathways if these were to be continually overridden.

## **Training, education, guidance and ongoing professional support**

Many respondents identified a significant need for education and training about the pathway and how it works in terms of its presentation in software. Respondents said this should be aimed at the whole dental team, not just the dentists. Timing was also identified as an issue and it was considered important that clear guidance on exercising clinical judgement and changing care pathway recommendations is made available from the outset:

*“There needs to be a period of training of practitioners and practice personnel before introduction of any reformed contract so that all involved in the care pathway understand the clinical philosophy which underpins it.”* (Dentist)

*“The Evidence and Learning report highlighted that there was some confusion at the commencement of the pilots and that dentists followed the software too closely, and this was a consequence of insufficient clarity for practices on how the software should be used.”* (National association)

Suggestions made in terms of content included: central guidance, case studies illustrating instances where the overriding of pathway recommendations is justified, examples of good practice and the underpinning evidence base:

*“clear guidance on the usage of the software is vital to its utility at the heart of the care pathway.”* (National association)

*“(dentists) should also be encouraged to remain up to date with the current evidence base.”* (National organisation)

*“What would help here is a series of common examples outlining situations where clinical common sense has prevailed.”* (National body)

A couple of respondents highlighted the importance of maintaining professional confidence in their own clinical judgement and suggested further ongoing support could be provided via mentoring and professional networks or informally eg chat rooms:

*“Clinicians should feel supported to exercise their own clinical judgement..... (they) need to feel that their opinion, expertise and experience is still valued.”*  
(A National body)

*“Dentists (need) confidence in their own abilities, experience and judgement”*  
(Community Dental Service)

## **Appropriate pathway, software flexibility and the assurance process**

Respondents recognised the need to balance and reconcile flexibility and risk:

*“The pathway needs to be flexible enough to allow GPs to use their clinical judgement whilst monitoring any outliers who may pose a risk to patient care.” (a National body)*

Similarly, the software needs to be sufficiently “user-friendly” so that changing or overriding pathway recommendations is quick and easy.

Many respondents highlighted the need for the assurance process to allow for pathway deviations where these can be clinically justified:

*“The monitoring system needs to be sympathetic to the appropriate use of clinical judgement. If you are likely to be an outlier due to the demographics of your practice then there may be a discouragement to change a care pathway.” (Local Professional Network)*

One respondent suggested that benchmarking could be a useful tool here.

### **Incentives**

There were many comments about incentives – both carrots and sticks. The general consensus was that there should not be penalties for overriding software recommendations provided this can be clinically justified. The second main theme here was that the training, education and ongoing support mentioned above should be underpinned by, and aligned with, appropriate incentives:

*“(there is a need for incentives)... whether these are financial or other methods, which encourage deviation from the prescribed pathway when relevant and in the patient’s best interest. This is an area that could possibly be linked in to the “Quality” aspect of the remuneration. Potentially, areas of professional esteem, professional rewards and recognition (non-financial) should be devised to encourage relevant deviation of pathways where applicable in patient’s best interests.” (Dentist)*

*“A system that does not penalise spending time on prevention.” (Dentist)*

*“...a system which will address both quality time spent with patients on prevention and also meeting treatment need.” (Dentist)*

## Question 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?

### Overview

Most respondents stated 'yes' in response to this question. The main patient groups that respondents identified as potentially facing difficulties with the preventive pathway approach were: elderly people, children, people with special needs, non-English speaking people, irregular attenders and people from lower socio-economic groups. In different ways, respondents seemed to be articulating that the greater the gap between the patient (whether in terms of expectation, motivation, ability, understanding) the more likely the preventive pathway approach would pose difficulties. However, one respondent pointed out that even where patients may be unable to participate in the pathway, they should still derive benefit from the underlying philosophy:

*“Patients accessing community dental services, some of whom have very complex needs, may be unable to participate in the pathway but should still benefit from the clinical philosophy.”* (National association)

In outlining the reasons why the preventive pathway approach could pose difficulties in meeting the needs of particular patient groups, those commonly raised related to:

- patient expectations
- motivation
- ability and understanding
- attaining and maintaining oral health
- time and cost
- timely recall
- treatment

The findings relating to each of the reasons are described below and the potential difficulties described.

### **Patient expectations, motivation, ability and understanding**

Many respondents described potential difficulties in patients understanding and accepting a changed approach to the service. In particular, respondents referenced frequently elderly people as a group who may struggle to adapt to service change:

*“Problems with buy in to preventative care may occur in some patient groups (e.g. the elderly who do not see the need for change when they have already kept their teeth this long).”* (Local Dental Network)

Lower socio-economic groups and irregular attenders were also often cited as groups who may be less likely to prioritise oral health:

*“I treat patients who have high treatment needs due to oral health being a low priority in their lives.” (Dentist)*

As well as being less willing or motivated, respondents identified the main patient groups as potentially less able to engage with a preventive pathway approach. Regarding elderly patients, respondents explained that they may be less able to comply with a preventive approach if, for example, they were frail or carer-dependent. The need, therefore, for this group to have carer and/or family understanding and support in order to facilitate access was often referenced.

This need was also highlighted in relation to children, and people with special needs.

Regarding non-English speaking people, the requirement for interpretation and translation was noted by respondents. A couple of respondents also described cultural and/or religious beliefs as potentially a barrier to engaging with the pathway approach.

Depending on the nature of the deficit patients faced, respondents suggested advertising, information and education, and training (for example, of carers) to support patients in understanding and engaging with the service.

### **Attaining and maintaining oral health**

The challenge of particular patient groups attaining and maintaining oral health was referred to frequently by respondents.

Many respondents described some patients as potentially having greater difficulty in attaining, or being unable to attain, good oral health and that for some maintenance could also be a difficulty. Where respondents thought this could be a difficulty, concern was often expressed that patients should not have treatment delayed or withheld. In this regard, patient groups that were commonly cited by respondents as at risk were elderly people, people with special needs, and people with long term and chronic conditions:

*“In theory the Special Needs patients should benefit from this approach, but may be denied some treatments due to having Amber RAG ratings, which might actually assist them maintaining oral function in the future e.g. crowns.”*  
(Local Professional Network)

*“We believe it is crucial that patients with long-term and chronic conditions are provided for under a system that focuses on the movement of patients through the red-amber-green (RAG) progression. Those patients with conditions likely to inhibit their progression to improved oral health must be provided for within a robust remuneration system.”* (Local Dental Committee)



A potential challenge of maintaining oral health in middle-aged and older people where restorative work is or will be needed was described by several respondents. The issues raised here were whether:

- patients could attain the RAG status for restorative work to proceed
- the system would allow / enable substantive restorative work to be undertaken
- access to specialist restorative care was available

Where patients were dependent on carers to attain or maintain oral health, there was frequent reference to the need for carers to be trained and educated to understand the importance of oral health.

Several respondents highlighted a need to have ready access to specialist care, not necessarily in a secondary care setting, and a couple suggested specialist care, where appropriate, being undertaken on a shared-care basis.

### **Time and cost, timely recall and treatment**

Overall time and cost implications of the preventive pathway approach for patients, carers, and professionals were considered by respondents. Respondents commented on the time needed for:

- transition
- prevention by the dental team to implement the pathway approach effectively
- patients, in terms of waiting times and the treatment / care process taking longer

Respondents also commented on the variability of patients' oral health and their ability to maintain it which meant that some patients require greater time and investment than others in order to try and achieve the same oral health results. Some respondents questioned whether patients would pay for a preventive consultation and have the time to invest in the pathway approach.

Many respondents raised the issue of timely recall and deliberated whether the pathway approach and recall guidance could be sufficiently fine-tuned to cater for patients whose oral health status may change significantly in a short period of time. The needs of both children and elderly people were highlighted:

*“(for children) a gap of a year could mean a completely different family circumstance and horrendous deterioration due to changed habits.”* (Dental Professional)

Some respondents questioned whether patients would wait to achieve improved oral health status before treatment commenced.

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

### Overview

There was a mixed response to this question with respondents answering 'yes' and 'no' in about equal measure and a few respondents stating they did not know. Amongst the respondents who answered 'yes', there was some deliberation as to how readily (or appropriate it was) to apply the preventive pathway approach to community dental services (CDS) patients. Across these 'yes' respondents the common issues raised related to: the role of CDS, developing appropriate indicators, and the role of carers. Each of these issues is considered below.

### Role of Community Dental Services

Many respondents commented on the role of CDS and how it differed from general dental practice, and the consequent implications for how CDS patients should be considered:

*"The services are different and should complement each other."* (Dentist)

*"CDS dentists ... have specific skills and expertise in particular regarding Paediatric and Special Care Dentistry."* (National body)

Several respondents described CDS as not necessarily providing continuing care and, therefore, the pathway approach would not be applicable:

*"Some CDS clinics are for secondary care and entirely treatment based e.g sedation clinics."* (Dentist)

*"It should be remembered that a lot of patients are referred to the community for one off courses of specialised treatment and not for continuing care that would allow a pathway approach to be applied."* (Local Professional Network)

### Developing appropriate indicators

There was widespread discussion amongst the 'yes' respondents regarding the development of appropriate indicators including whether applying clinical indicators would be feasible or appropriate:

*"We feel that the general practice approach will not be entirely suitable for the oral health needs of community dental services patients. A successful approach would incorporate a greater degree of flexibility in order to accommodate the range of medical needs and disabilities experienced in this sector."* (National association)

*“CDS patients are often only involved with the service for one course of treatment therefore measuring change in clinical indicators would be problematic.” (Local Professional Network)*

*“More process measures may be appropriate for patients reliant on others and unable to influence their own oral health.” (Dentist)*

*“...proxy measures of oral health ... e.g. proportion of residents with oral health care plans; proportions of carers trained in oral health; evidence of healthier diet choices within care homes, proportions of homes who have accepted training programmes in oral health care, etc.” (Community Dental Service)*

Where respondents considered it still relevant to apply clinical indicators, many commented on the potentially different starting point for CDS patients, often with higher social or medical needs and, therefore, needing more time and resource:

*“Any clinical indicators applied to CDS clients need to take into account the barriers to improving health many of these patients experience. Therefore clinical improvement may be smaller than in general population despite following a similar preventive care pathway.” (Local Professional Network)*

*“CDS patients are often referred because of high disease levels therefore indicators based on e.g. dmft would need to be appropriate.” (Local Professional Network)*

When considering special care patients, some respondents suggested that they should still be managed within a risk-based, preventive system but its application and indicators used should take account of different expectations regarding improvement in oral health and the potential issue of securing patient compliance. A few respondents referred to the RAG system and its applicability to CDS patients:

*“The RAG approach is a good start, but it needs to be more flexible. It has been the experience of our local community dental services that they struggle to maintain many of their patients at amber with little or no chance of moving them to green.” (Dentist)*

*“The use of the RAG rating is perhaps the most challenging element of the pathway as, for many CDS patients, the priority is to prevent or delay deterioration, rather than to achieve improvement. Measures of success in the service might include overcoming patient fear and lack of cooperation, achieving a measure of compliance, and supporting patient lifestyle improvements ...” (National association)*

Suggestions were also made by a few respondents about other indicators and tools that were potentially relevant and useful:

*“... 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.”*(National body)

*“Clinical outcomes for these patients will broadly be the same as those in practice (in terms of reducing caries risk and improving gingival health) but there are other key indicators to demonstrate oral health change that may be specific to this group, such as reduction in prevalence/intervals of repeat general anaesthetics for dental treatment.”* (National body)

A couple of respondents referenced the BDA special care case-mix model as relevant whereby the additional time and resource required to work with CDS patients could be recognised by using this weighting system.

### **Role of carers**

Respondents mentioned frequently the importance of the role of carers with CDS patients. Comment was often made that patients may not have a consistent carer and carers could be short of time which could mean that they did not understand a particular patient's need or have knowledge of a patient's oral health history if attending a dental appointment. Numerous references were made about the need for carer awareness and training in order that they could support oral health needs effectively. Several respondents commented additionally on the need for care homes to have a standardised, systems approach with oral care plans in place:

*“...we need to engage with the training of carers and care home providers to show how to brush teeth, the need for extra strength fluoride toothpaste and how to look after dentures.”* (Dentist)

One respondent commented specifically on the needs of patients in residential accommodation or those with cognitive impairment or dementia who have weight loss and that this is frequently a function of masticatory ability/discomfort and, therefore, information and advice was needed for carers to address this issue.

A couple of respondents also commented on the needs of children and raising awareness in schools regarding the importance of oral health.

## Question 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?

### Overview

Most respondents answered 'yes' to this question. There was general agreement that the approach described was still applicable to patients reliant on carers but, to be successful, it needed to be more flexible and easy (both to understand and deliver):

*“The key to assisting carers is making things as easy as possible for them to deliver care.”* (Local Professional Network)

*“The approach needs to be as simple as possible to carry out and understand.”* (National body)

One respondent commented about the need for a good understanding of this area and adequate evaluation of how the pathway approach works in practice with patients who are carer-dependent. The general issues that many respondents raised were:

- taking a holistic, multi-disciplinary and integrated systems approach
- involvement and training of carers (including consent issues)
- measuring and monitoring

Each of these issues is discussed in more detail below.

### **Holistic, multi-disciplinary and integrated systems approach**

Many respondents articulated a need to take a holistic, multi-disciplinary, integrated systems approach to patients' health and care:

*“... it would be very helpful if the review did not consider dentistry in isolation to other health and social care providers; or oral health in isolation to other health issues.”* (Local Professional Network)

*“This group of patients require a multi-disciplinary approach and true engagement and cross-professional working between health and social care. Dental networks need to work closely with other stakeholders e.g. PHE, local authorities, CCGs to target these vulnerable groups to develop oral health programmes designed to manage these specific risks, not only within dental practices, but also the wider community.”* (Local Professional Network)

Comment was also made regarding the general work of CDS in supporting the running of the system for patients who are carer-dependent:

*“...there are many people with mild or moderate additional care needs who can be and currently are managed effectively within the GDS, often with support from the salaried community dental services.” (Community Dental Service)*

*“... work carried out by community dental services outside clinical practice, ,... (includes) community-based oral health promotion programmes, carer training programmes, working with carers and care organisations, working with secondary care providers to provide treatment under GA, working with other health and social care professionals and organisations to promote oral health and improve access to care and ensure that issues such as mental capacity and consent and access and involvement of relevant parties and safeguarding are addressed thoroughly, systematically, properly and consistently”. (Community Dental Service)*

Several respondents highlighted the need for adequate domiciliary care:

*“Commissioners should be required to provide domiciliary care sufficient to meet local needs and demonstrate that this has been done.” (Dentist)*

Regarding care homes, several respondents commented on the need for a systematic approach to be taken whereby care providers were engaged and homes incorporated oral health as part of care plans.

### **Involving carers directly in the pathway approach, training and consent**

Respondents explained that there was a need to involve carers directly in the pathway approach. Carers needed training to understand the importance of oral health and prevention, as well as a better understanding of consent issues in order to support patients effectively:

*“We could input this in to the software in the social/medical history to generate a dedicated care pathway/ home prevention pathway for these patients that may/should include dental care professional education in the place of [patient] residence.” (Dentist)*

*“Ensuring that the full range of individuals involved in a patient’s care are aware of the pathway, the principles of good oral health and the individual patient’s care needs will be critical to the success of the approach in a care setting.” (National association)*

Several respondents pointed out that many people have more than one carer so this needs to be taken into account:

*“A system of a shared appointment to advise carer and patient or tailored advice that can be printed or downloaded for the patient to share with a series of carers.” (Dentist)*

On the issue of consent, a few respondents raised the issue and its importance with carers who may be uncertain of how to fulfil their role and responsibilities in oral health:

*“There is a culture of ‘not forcing’ the patient/client to receive oral care.”*  
(Community Dental Service)

*“There is also a need to clarify some perceived conflicts in the Mental Health Act in respect to carers’ role in oral health, as some have concerns that invading a patient’s mouth with a toothbrush may constitute assault.”*  
(National association)

Many respondents mentioned carer training and developing pathways and accreditation:

*“Oral health care should be a mandatory part of carers training with regular updates.”* (Dentist)

*“Recognised training pathways should be set up for carers.”* (Dentist)

*“... the National Vocational Qualification for carers must include a compulsory module on personal care (which includes oral health), rather than continuing with this an optional addition.”* (National association)

### **Measuring and monitoring**

Some respondents stated that patients who were carer-dependent needed more time for treatment and care and this needed to be recognised in any approach and system developed. One respondent suggested the adoption of the BDA case-mix model:

*“Additional weighting is required for these groups, to reflect the additional time and resources required when working with these individuals and groups. The BDA weighted system adopted by the current salaried services is a very useful approach as it helps to take these additional factors into account.”*  
(Community Dental Service)

A few respondents referred to how patients should be monitored and one respondent suggested using the RAG system to flag patients going into a care home:

*“...a patient that currently scores green who is about to enter a care home should have the score altered to red to reflect the increased risk to oral health when entering a care home. This can always be altered later.”* (Dentist)

# The engagement exercise: Detailed findings

## Qualitative analysis of responses

### Paper 3: The measurement of quality and outcomes

This paper posed 11 questions:

1. Do you think that the areas of clinical effectiveness, patient experience & safety are correct for DQOF?
2. Do you think 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 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:
  - Patient safety?
  - Clinical effectiveness?
  - Patient experience?
11. What quality measures would enable a practice to demonstrate that they are appropriately treating high risk patients?

There were 88 valid (ie where data had been entered) responses to the questions in this section. The breakdown of these responses was as follows:

Question 1	99%
Question 2	88%
Question 3	74%



Question 4	52%
Question 5	93%
Question 7	61%
Question 8	92%
Question 9	60%
Question 10	70%
Question 11	59%
Question 12	67%

## Question 1: Do you think that the areas of clinical effectiveness, patient experience & safety are correct for DQOF?

### Overview

The design of the question meant that respondents could select one of 2 answers:

- i) they are the right areas
- ii) they are not the right areas

If a respondent selected that they thought the 3 areas were the right ones, no further comment was possible. Those respondents who selected that these were not the right areas had the opportunity to provide a free text comment.

### They are the right areas

Slightly over half of the respondents agreed that the 3 domains, clinical effectiveness, patient experience and safety, were the right areas for DQOF.

### They are not the right areas

Less than half of the respondents said that these were not the right areas. However, many of the respondents who ticked “No” went on to say that they did in fact support the general principle of the domains but wanted to make a comment (the design of the survey was such that they could only make a comment if they ticked the “No” option).

A typical concern was that outcomes are dependent on patient compliance and objective measurement:

*“We believe that clinical effectiveness, patient experience and safety are valid domains for a DQOF. However, we are concerned about their measurement. ... ..clinical effectiveness cannot be measured objectively without dental reference officers or an equivalent.” (Dentist)*

*“They are the correct areas, but getting improvements in BPE’s is very difficult to achieve.” (Dentist)*

There was concern that patient experience was a difficult area to measure accurately:

*“Sometimes patients are happy regardless of outcome whereas other patients are very difficult to please” (Dentist)*

*“Patient experience is very subjective e.g. we see emergency patients the same day. This is the norm with us. But could be seen as excellent in another practice that normally makes patients wait longer.” (Dentist)*

Other respondents felt that within the domains more emphasis should be placed on additional sources of evidence to support the indicators. This theme is picked up in responses to questions 5, 7 and 8.

*“Basically yes but more of a reference to Delivering Better Oral Health (DBOH) would be welcomed” (Dentist)*

A third group of respondents thought that the indicators based on these 3 domains were wrong. Their concerns – patients’ compliance, reliance on carer’s views in the CDS and subjectivity – were similar to the “Yes, but” group, but they thought that the problems were so great that the indicators would not work:

*“Clinical effectiveness’ and ‘patient experience’ should not be used in my opinion as; to a large extent they are completely out of the control of either the dentist or practice. For example, a dentist may go out of their way to help a patient improve their oral health and repeatedly provide them with OHI and prevention. But if that patient simply doesn’t care about their oral health (and there are so many patients like this) then their oral health is never going to improve and possibly will even deteriorate over time.” (Dentist)*

*“Clinical effectiveness also depends on the patient response e.g. perio patient experience is very subjective. Every practice and patient should be safe, standard.” (Dentist)*

*“Whilst for most patients these are the right indicators for some CDS patients whilst the correct process is followed – and frequently – it is not clinically effective however hard the dentist tries. It is also difficult to gain the patient views on their experience and we have to rely on the views of the carer.” (Dentist)*

## Question 2: Do you think the focus on outcomes is correct or should some indicators measure process as well?

### Overview

Question 2 asked whether respondents felt that the focus on outcomes was correct, and to consider whether the inclusion of process measures was desirable. Respondents were also free to suggest alternatives.

### Focus on Outcomes

20% of respondents felt that focusing on outcomes was correct. Typical comments included:

*“Outcomes is the most important indicator.”* (Dentist)

*“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.”* (Dentist)

*“Outcomes are the essential measure; process would be complicated, variable and hence open to debate. Improving outcomes for the patient are the most important thing.”* (Dentist)

### Focus on outcomes but consider process too

A theme that emerged for the comments made by respondents was that this was not an either / or option. Many recognised the validity of measuring outcomes but suggest process measures had a place as well:

*“Correct to focus on outcomes as process can be very varied. However, does need to be some consideration of process as otherwise hugely reliant on the quality and accuracy of the data on outcomes.”* (Dentist)

*“Focusing on outcomes is definitely the end game. However during the adoption phase providing some indicators that will drive the process to become engrained would probably be a good idea.”* (Dentist)

### Process is important

14% felt process was a priority as this measures what dentists actually do. Respondents felt that outcomes can be difficult to measure (as well as being dependent on patient compliance) and so it was more important to make sure that the dentist was doing the right thing.

*“The measurement of process should be incorporated into DQOF as outcome measures often need to be measured over longer periods but process measurement can enable effective early monitoring at individual performer level. ... It is important that the process measurement does not increase the level of manual administration by the smart use of IT systems. The process measures need to be chosen to have upstream outcome benefits.” (Dentist)*

*“Outcomes should NOT be used because, again, a lot of the outcome is determined by the patient and how they manage their oral situation themselves at home, completely out of the control of the dentist. The dentist should be judged on whether they have provided the care that the patient needs, and therefore adequately equipped the patient to manage things themselves at home. If the patient then chooses to completely ignore this advice then that is their problem, and shouldn't impact upon the dentist. For clinical effectiveness, the focus should be completely on process indicators. The dentist should be judged on things like: Have they taken a BPE and informed the patient of what these numbers mean. Identified areas that the patient isn't brushing well and highlighted these to the patient with guidance on how to improve things. Screened for oral cancer and discussed results with the patient. Taken necessary routine radiographs and thoroughly searched for caries. These above points are things that are completely within the control of the dentist. They should be doing these things for their patients, and it is completely right that they should be penalised (financially) if they fail to do them because they are then not enabling patients to have the best chance of improving their oral health.” (Dentist)*

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

### Overview

Nearly half of respondents answered “yes”. Suggestions fell into 3 broad themes:

- there should be different indicators for vulnerable groups such as the elderly
- the same indicators should be used, but reported separately and with different thresholds
- the same indicators should be used, but with different weightings to reflect the additional time/ care required

### Different indicators for vulnerable groups

One theme put forward was that different indicators should be developed for people in vulnerable groups such as the elderly or people requiring sedation:

*“Consideration will have to be given to devising indicators for the delivery of any complex treatments: Perio for BPE 3+; Molar endo; Surgical extractions; Domiciliary treatment; Sedation treatment; Under 5 provision; Elderly care; Vulnerable groups in deprived areas” (Dentist)*

Others gave examples of the indicators that could be developed:

*“Examples might include plaque score improvement; dietary conformance and adoption of lifestyle changes – according to the ability of the individual patient” (Dentist)*

### Same indicators, but reported separately and with different thresholds

A second theme was that the same indicators could be used, but that the information for the vulnerable groups should be reported separately and with suitable allowances:

*“Broadly speaking the markers and indicators should be the same as aspirations are identical. However need to be realistic expectations for these groups and tolerance level especially for clinical effectiveness probably need to be broadened.” (Dentist)*

*“The clinical care pathway approach seems to work well in the community dental services. However, it is just difficult to demonstrate an improvement in oral health for many patients using the RAG system. Often the best thing that can be done is ensure that they are not getting worse rather can getting better. Due to medical conditions many of the patients will always be amber, for example a patient with dry mouth will always score amber with little chance of that ever changing. Even if oral health advice is provided with*

*prescriptions of fluoride toothpaste and applications of varnish the rating will remain at amber, albeit less amber. This is important if the RAG rating is used to be a way to measure and moderate payments to clinicians. There will always be some patients that will never improve their scores.” (Dentist)*

### **Weighting indicators**

Another approach suggested was to weight the data between vulnerable groups and the general population so that the care being delivered could be judged fairly:

*“Largely the same measures, but would require a weighted indicator to show degree of additional care required. The CDS is very different to GDS in a lot of areas ..... and would need to be commissioned differently to a GDS contract” (Dentist)*

*“The number of additional visits should be taken into account and the time needed at each appointment to explain not only to the patient but also the carers.” (Dentist)*

## Question 4: If you would like to see some process indicators what areas should the framework consider?

### Overview

Over half of respondents ticked the “No comment” box for this question. This may in part be because in response to earlier questions the majority of respondents stated that they were happy with outcome focused indicators.

Suggestions included:

- periodontal treatment visits
- oral hygiene instruction
- recording preventive measures eg topical fluoride application, high strength fluoride toothpaste prescriptions, fissure sealants
- volume of work/ patient numbers
- a process indicator for domiciliary visits
- restoration longevity

### Complying with best practice

Of those who responded to this question there was a strong theme that any process measures should be based on best practice. Respondents either suggested specific things they thought that contributed to best practice or referred to it more generally and cited DBOH as a good evidence base:

*“Are care plans issued to all patients with an explanation? Is there evidence of preventive interventions such as fluoride toothpastes and varnishes? Ability for Area Teams to monitor treatment items similar to what is happening currently.” (Dentist)*

*“The process indicators as outlined in DBOH eg Fluoride application. Process indicators that would support improvement in outcomes would be beneficial for example maintaining up-to-date patient registers on particular health conditions would be useful in under-pinning preventative care, e.g. diabetes and smokers.” (Dentist)*

### Dental Reference Service

A couple of respondents suggested that the DRS could be used to check process:

*“The best way forward, and I cannot believe that I am suggesting this, is to have a proper Dental Reference Service.” (Dentist)*



## Question 5: For the clinical effectiveness indicators, do you think the focus on caries and BPE is correct?

### Overview

The vast majority of respondents were in broad agreement that a caries indicator was the right focus for clinical effectiveness. For the BPE indicator, nearly half agreed with the focus with a further third being supportive while making comments:

*“As the two main diseases treated by dentists in primary care, we would support the focus on caries and periodontal health as indicators of clinical effectiveness. We would reiterate though, that focusing on these indicators leads to the measurement of outputs, rather than outcomes.”* (Dentist)

Some people also made comments on how both indicators could be revised and improved.

### Caries indicator

Some respondents were concerned that this indicator could be manipulated by extracting teeth. Others were content for the caries indicator to be the focus but thought it could be supplemented by other indicators e.g. extractions or success of root canal treatments:

*“The focus on caries is correct”* (Dentist)

*“Yes – Needs to be kept simple and relevant. Consideration and guidance on appropriate longevity of restorations needs to be discussed with future guarantees being set accordingly.”* (Dentist)

### BPE indicator for periodontal disease

This generated quite a lot of debate, as many people acknowledged that periodontal disease is a main aspect of oral health but questioned whether BPE was either appropriate or the best measure:

*“BPE is not (as stated by the guidelines) a good way to measure improvements or monitor perio. This can ONLY be done using a 6ppc. It is purely designed to screen for patients who are at risk or need intervention / ohi. Equally bleeding present in a sextant is highly unreliable and very simplistic.”* (Dentist)

There was no clear consensus and the comments below highlight the range of views expressed:

*“Yes, but when the BPE scores 3 a pocket chart is required.”* (Dentist)

*“I think recording of BPE alone is sufficient and the bleeding site index is superfluous .... And over complicates the computer work.” (Dentist)*

*“....., most patients will not comprehend a BPE score. Also it can be demotivating as in cases where an improvement is visible the nature of the BPE scoring does not always allow this to be demonstrated.” (Dentist)*

*“Largely these are out of dentists control especially BPE. One cannot force patients to improve their own diet or oral hygiene” (Dentist)*

*“for those working in CDS, it can sometimes be impossible to gain sufficient cooperation to do a BPE. We can't always catch our patients!” (Dentist)*

## Question 6: What other areas of clinical effectiveness could be included as an indicator?

### Overview

Almost half of the respondents ticked the “No comment” box for this question. Of those that made suggestions, there was little common ground on what the other areas should be. Ideas included:

- linking diagnosis of pain to the intervention delivered
- referrals (both rates and appropriateness)
- assessing 11 year olds for impacted canines
- tooth wear
- indicators specific to older people (recognising the increasing proportion of elderly patients)
- preventive measures
- long-term monitoring of regularly-attending capitation patients to ensure that the number of fillings or perio treatments is appropriate to the RAG band to which they have been assigned.
- integrated approach to care

These are discussed in more detail below.

### Areas of clinical effectiveness

Many respondents concentrated on specifics: rather than discussing general areas of clinical effectiveness they gave alternative examples of what could be measured:

*“The frequency of replacement of restorations that were placed within 12 or 18 or 24 months? The exact filter needs to be decided. It could be different for different types of restorations.” (Dentist)*

*“6ppc, BEWE<sup>3</sup> for tooth wear, bleeding indices (as per the literature, not a sextant present or not present), plaque scores etc. It’s all timely but it is the only true accurate method (perhaps a BPE score of 1 or more might instruct the dentist to do something more on the computer?)” (Dentist)*

One respondent wondered whether the indicators should take account of different patient groups (for example, age or differing needs) and whether indicators that captured /measured an integrated approach to care should be developed:

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<sup>3</sup> basic erosive wear examination

*“There should be a focus on older people which is not reflected in the indicators. And indicators that capture an integrated approach e.g. referrals to other services, smoking cessation, NHS Health Check etc.” (Dentist)*

A further theme was the limited extent to which dentist could influence the health of their patients – for example, patients living in nursing homes – and that to a great extent of the outcome was down to patient compliance:

*“Some FDs worried that they would be measured on outcomes they had little control over, such as patients’ compliance with home care regimes that they could only have a minimal influence upon. Other FDs felt that some form of independent patient inspection service would provide better evidence of delivery of good quality care.” (Dentist)*

Question 7:- For the patient experience indicators, do you think they cover the right areas?

Question 8: What other areas of patient experience, if any, should be included?

## Overview

Question 7 was a closed yes/no question on whether the patient experience indicators covered the right areas. 39% of respondents said "No", which is quite high while 59% said "Yes".

Question 8 then asked what other areas of patient experience should be included. There was no clear consensus on what the other areas might be.

## Areas of Patient Experience

Concerns were raised about individual questions used in the pilot patient experience questionnaire and, in one case, whether patients were focusing on the important areas of the service when giving their response:

*"Patient experience indicators should focus on the provision of patient centred care rather than patient satisfaction alone. We are also concerned about the inclusion of an indicator on patient waiting times. There are numerous reasons why a patient appointment may exceed its allotted time, and these reasons are almost exclusively for the benefit of the patient being treated. The idea that dentists might be penalised for spending the required amount of time to treat their patients appropriately is unacceptable to us, and would in our view, have the potential to compromise patient care, outcomes and safety."* (Dentist)

*"The communication skills of the treating clinician are often vital to the patient experience. Language skills are sometimes poorly tested and can lead to a dependence on translators or dentists who lack these skills. When a patient is confused or in pain translators and poor language skills can make it difficult to reach decisions based upon informed consent as discussed above. Also, more generally, there is always more all clinicians can do. Even those with good language skills do not always take the time and effort to communicate effectively and empathetically with all patients. This must improve and is a common source of patient anxiety and dissatisfaction."* (Dentist)

*"Our FDs felt that on the whole the areas covered were reasonable, but felt that the measures currently used were inappropriate. Some didn't think that a response of having less knowledge about how to look after your teeth was appropriate."*  
(Dentist)

*“Patient satisfaction is not a good indicator. At a recent check of our patient satisfaction questionnaires, one criticised us for not providing gaming consoles for them to use. Should this mean I get paid less? Unfortunately unless you are asking very specific questions, there could be problems with the system. How do you ensure compliance in responding? When do you ask the questions? I’m sure straight after a quite necessary extraction we would get a sarcastic response to asking if they could eat, smile and socialise after their treatment! Not all experiences are positive for patients, even when needed to improve their health and would be subject to a negative response from some patients.” (Dentist)*

## Question 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?

### Overview

This question had a fairly low number of responses. A range of suggestions were made with the most popular alternative or additional idea being the use of a DRO or some sort of practice inspection by a clinically qualified person. Other ideas included benchmarking or peer review type approaches. Some respondents made the point that some or all of this could be, or is already, being done by the GDC or CQC. A small number suggested clarification of service expectations under the NHS.

### Dental Reference Officers

This was the most popular suggestion. Typical comments were:

*“The reintroduction of DROs would be of huge benefit to the probity of the dental work that is carried. There should be a reward for the longevity of treatments provided.”*

*“The reintroduction of the dental reference service where patients will be examined randomly following the delivery of care would be desirable. This will ensure that the correct processes, advice, pathways and outcomes are being followed and also increases compliance with these aspects.” (Dental body corporate)*

### Continual professional development

A number of respondents believed training and continual professional development was key to clinical quality:

*“It should start at undergraduate level – If a student does not follow the ethos of good clinical and professional care then they should not be graduating in the first place. A practice should be rewarded if it shows they have a good level of CPD run for all staff.” (Dentist)*

*“Improved support and long term training programmes specifically for NHS dentists that are a comprehensive study programme...similar to an MSc but that is affordable to all ( including part time and lower earners so patients are not disadvantaged due to their dentists financial situation).” (Dentist)*

### Peer review

While the use of reference officer was the most popular approach to assuring clinical quality some suggested it be done by fellow dentists through peer review:

*“The re-introduction of adequately trained assessors who have the ability to evaluate treatments provided for patients in terms of relevance of treatment provided and also quality of treatment result. This could be based around a peer review system provided by experienced GPs.” (Dentist)*

### **Role for General Dental Council / Care Quality Commission**

Some respondents felt this was covered by current CQC and GDC requirements. Within the current regime one respondent suggested the introduction of a revalidation procedure to ensure minimum standards are maintained:

*“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.”*  
(Dentist)

*“The GDC and CQC cover most requirements ensuring staff are adequately trained”* (Dentist)

*“Ensure that the contract adopts best practice as recommended by the appropriate organisations such as the GDC Standards and the CQC guidelines.”* (Dentist)

### **Clinical audit and benchmarking**

A small number of respondents suggested that better use of audit and benchmarking could improve clinical quality. This might require enhanced IT software.

*“The key to clinical quality is having the provider of care, the dentist, monitor their own quality and have systems in place for continuous improvement. The development of IT systems that make it easy to conduct audits of activity would make it easy for practitioners to monitor their clinical work. If anonymous data on audit results were available they could bench mark themselves. Systems that encourage practices to audit activity and work on improving quality should be encouraged/ incentivised.”* (Dentist)

*“Submission of examples of audit. This will cause practices to measure and reflect themselves on the quality of their work.”* (Dentist)



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

- Patient safety?
- Clinical effectiveness?
- Patient experience?

### Overview

Relatively few people gave specific responses to the parts on clinical effectiveness and patient experience – the view being that this question covered areas already asked in questions 6 and 8. Therefore many respondents either reiterated the answers they had previously given or referred directly back to the earlier questions.

For patient safety, many respondents suggested that safety was already a responsibility within other parts of the system rather than something that should be covered by tools or indicators within the contract.

### Patient Safety

For this question, respondents suggested that this was an area of responsibility of the CQC, or that DRS type inspections could play a role. Some said that patient safety could be monitored by complaints procedures and incidents or issue logs:

*“We have concerns about unnecessary and time-consuming duplication. The CQC already monitors patient safety.”* (Dentist)

*“CQC/ Medical emergency training/ Dental reference officers.”* (Dentist)

*“Complaints and significant issues log; currency of medical history; compliance with CQC fundamental standards.”* (Dentist)

*“DRO inspections and CQC inspections and infection control inspections and HSE inspections.”* (Dentist)

### Clinical effectiveness

Respondents felt that the reintroduction of the Dental Reference Service would be effective and that an area that should be looked at is the longevity of treatment:

*“Monitor number and type of post treatment appointments, questionnaires, longevity of treatment.”* (Dentist)

*“We are of the view that the main contribution can be made through the piloting and implementation of a DRO system to monitor clinical effectiveness. Patient centred care should be monitored as now by centralised survey or if another method is used at practice level, it must be*

*fully funded by NHS England. Practices will not be able to analyse data themselves.” (Dentist)*

### **Patient experience**

For patient experience, most respondents felt that a questionnaire based survey would be the most effective method of getting patient feedback:

*“Regular patient satisfaction questionnaires; comments books and compliment letters and robust complaints processes.” (Dentist)*

*“Audits of complaints and complaints management/ surveys as per experience approach in the pilots.” (Dentist)*

*“More regular surveying of patients, automatically done in practice or perhaps on line.” (Dentist)*

## Question 11: What quality measures would enable a practice to demonstrate that they are appropriately treating high risk patients?

### Overview

Relatively few people answered this question. Of those that did, a number of them wondered what was meant by “high risk patients” – which suggests that this term has emerged from the risk assessment element in the pathway and is not yet fully understood by the wider dental community. This uncertainty may have contributed to the low response rate.

Many respondents repeated the answers they had already given to previous questions. Measures of the care delivered was popular, while some respondents suggested a pot of money could be reserved for the high risk / high need patient group.

### Measure care delivered / compliance with DBOH

Respondents noted that a key challenge when treating this patient group was getting the patient to engage with their care and to comply with treatment / advice. This led to the view that outcome measures are not ideal to demonstrate appropriate treatment of high risk patients. The most commonly suggested alternative was to use process indicators:

*“In patients with significant dental need, process indicators could include advice given, onward referral to appropriate skill base e.g. smoking cessation services, application of topical fluoride. In elderly patients this could include carer information supplied, education of carer, as well as indicators above. This would also apply to socially deprived groups. This would allow teams to demonstrate that all feasible steps had been taken to engage with the patients and that the failure to achieve the desired outcome was outwith the control of the dental team. This will also encourage these groups to be treated more readily in a primary care environment.” (Dentist)*

*“RAG score monitoring, plaque score measurement. Auditing of the preventative measures; Fluoride varnish applications, incidence of high strength fluoride prescriptions, fissure sealants etc.” (Dentist)*

### Dedicated funding

Some respondents suggested that it may be appropriate to have a dedicated funding stream or a ring fenced pot of money for this group. This would provide an incentive for dental practices to take on difficult patients and give them the confidence that they had the resources to provide the care needed:

*“Specific remuneration package for this group. Evidence base care pathway approach with staged treatment planning to address disease in a logical fashion.” (Dentist)*

*“Bonus payments” (Dentist)*

*“Pay them more to do so.” (Dentist)*

### **DRO / monitoring**

A number of respondents favoured the use of reference officers (or similar dental clinical experts) to ensure that this patient group received appropriate care:

*“The FDs were also keen on some sort of spot checks on dentists records and random patient examinations.” (Dentist)*

*“Long-term monitoring of interventions by BSA as appropriate to the RAG category.” (Dentist)*

*“Examine practices by dental officers rather than people who know nothing about dentistry.” (Dentist)*

# The engagement exercise: Detailed findings

## Qualitative analysis of responses

### Paper 4: The remuneration approach

This paper posed 4 questions:

1. What percentage of the 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 that element, what are your views on the options for remuneration and how the challenges associated with them can be managed?
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 are needed so that high need patients continue to receive the care they need?

There were 128 valid (ie where data had been entered) responses to the questions in this section. The breakdown of these responses was as follows:

Question 1	84%
Question 2	83%
Question 3	81%
Question 4	84%

## Question 1: What percentage of contract value do you think should be used for DQOF?

### Overview

This was an open question and respondents were free to suggest any percentage figure, as well as being able to provide additional comments and suggestions.

Overall, respondents broadly agreed the need for quality measures to be part of the contract reform with an associated performance payment mechanism:

*“The DQOF provides the minimum risk to the clinician – but potentially – safe guards quality” (Dentist)*

A few respondents did not feel that DQOF was an appropriate mechanism, citing the increased workload and risks to contract value as reasons. Others offered alternative suggestions for applying DQOF:

*“DQOF seems fundamentally flawed as [it is] mostly subjective, or can be easily circumvented / exploited” (Dentist)*

*“A DQOF does not need to be linked directly to payment in order to be effective. Simply reporting the results and practice positions in comparison with other practices might be a good way to incentivise practices to satisfy any DQOF. Linking the DQOF to contract values is unhelpful and serves only to threaten practices into a certain way of behaving.” (Local Professional Network)*

### Percentage of contract value to be applied to DQOF

The majority of respondents agreed approximately 10% was appropriate: nearly a quarter of respondents answered 10%, a third of respondents suggested less than 10% with a further quarter suggesting more than 10%. Nearly two thirds of respondents identified the level of DQOF should range between 5-15%.

Some responses went further and suggested a much higher percentage. Conversely, some felt attaching any financial incentive would be counterproductive and result in dental professionals “gaming” the system:

*“The % needs to be high enough to make it worthwhile for practitioners to put effort in this area, but with few indicators so there is a reasonable chance of attaining the DQOF funding, between 2-5% and possibly up to 10% might be appropriate but the group had mixed views on this issue” (Dentist Group)*

*“10% would be a realistic figure, but if NHSE are serious about achieving quality and have correct outcome measures in place this could be higher.”*  
(Dentist)

Contained within responses were comments and issues respondents raised in support of their answer or as a general comment. The key themes identified were:

- concerns over the use of patient feedback in DQOF
- increasing incentives and bonuses
- exploitation
- development of DQOF over time

These are discussed below.

### **Use of patient feedback in DQOF**

A number of respondents were unhappy with DQOF indicators based on patient feedback or outcomes because these factors are often outside of their control. It was felt patients are more likely to report their negative experiences than positive ones:

*“My concerns are around patient questionnaires – as historically, patients that are slightly unhappy with the service tend to respond whereas those that are happy tend not to – would this not skew the stats?”* (Dentist)

Regarding outcomes, if a patient chooses not to heed preventive advice, and their oral health deteriorates in consequence, this deterioration would affect the dentist’s DQOF performance:

*“Outside of the dentists control despite the amount of effort he/she may put in e.g. patient motivation”* (Dentist)

### **Increasing incentives and bonuses**

A few respondents suggested that the current bonus of 2% was too low and should be increased to provide a greater incentive.

Carrots were preferred over sticks: an incentive- based system was felt likely to deliver better results than a penalty based system, with additional money in the system to support this. It was also suggested that the proportion of contract value allocated to DQOF (currently 10%) should be steadily increased over time:

*“Really should be some element of “new money” for this. The current plan does indicate the possibility of an actual fee cut as 1000 points is likely to be unobtainable.”* (Dentist)

## **Exploitation**

A few respondents stated that the current DQOF scheme was subjective and open to fraud and 'cheating'. Any system would therefore need to include robust monitoring and reporting mechanisms:

*"Insufficient resources have been invested in contract monitoring in primary care, and this increases the risk of fraudulent claims being made to meet the targets set."* (National body)

*"The frameworks are not really indicators of actual quality of treatment. They are a tick-box exercise. Practices can alter data to fit in with targets."*  
(Dentist)

*"People are going to cheat and give misleading or outright untrue figures if their livelihood depends upon the numbers."* (Dentist)

## **Development of DQOF**

Some respondents suggested that the format of DQOF should not be set in stone but could vary from year to year. The percentage of contract value could change as well as the indicator set:

*"Should not be fixed and able to change as the contract develops to the benefit of the patient."* (Dentist)



Question 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:

- Full activity
- Full capitation
- A blend of capitation and activity

## Overview

The options for remuneration were split into 3 areas and just over half of the indicated that they would prefer a blended system for remuneration, made up of a blend of capitation and activity.

The next most popular option identified by respondents was full capitation. Full activity was the least preferred option for remuneration.

It is worth noting that those respondents who did not support the full capitation highlighted 2 key risks: patient access and under treatment / supervised neglect.

Nearly a third of respondents either indicated that they did not have a preferred option or did not answer the question.

## A blend of capitation and activity

Of the majority that preferred this option, many respondents commented that it was the “*most appropriate choice*”, “*a good compromise*” or gave little explanation for their response:

*“A blend of capitation and activity is the only sensible solution. The need to get patients registered with a practice so they have the obligation to see and treat which they don’t under the present system balanced with the incentive being there to provide treatment...”* (Local professional network)

*“Full activity and full capitation are far too open to abuse and would work against the preventive philosophy with either over-treatment or supervised neglect risks. A blend is the only sensible option.”* (National body)

A number of respondents felt that this option would work well as long as the blended system supported the treatment of high needs patients and there was a focus on preventive approaches and improving oral health:

*“Potentially a good system provided this allows payment for prevention and not just nominal lip service”* (Dentist)

Whilst identifying the blended approach to be the preferred option many respondents identified further considerations, including:

- the need for appropriate testing
- proposed percentage splits between capitation and activity
- the need for effective monitoring and management
- suggestions for refining a blended model

*“I think this has the potential to work well. It would need to be piloted in the correct way to ensure the correct blend is achieved as otherwise we would end up with a similar situation to our current plight.”* (Dentist)

### **Proposed percentages for the split between capitation and activity**

A number of respondents suggested percentages for capitation and activity. Most of these favoured more weighting on capitation and less weighting on activity. A few respondents proposed larger activity percentages of 30% and 55%:

*“activity no more than 10%”* (Dentist)

*“Probably best model but more weight on capitation.”* (Dentist)

*“This initially appears to be the most equitable option but it depends on the split as to how it will work for practices.”* (Dentist)

### **Effective monitoring and management**

A few respondents commented on the need for effective management and monitoring, arguing that this would be essential if such a complicated approach was to work properly:

*“Blend is probably the model with the most potential to deliver best outcomes across the board but likely to evolve into a complex maze if not ruthlessly managed.”* (Dental software supplier)

Reintroducing the DRO or similar system was suggested by a number of respondents to prevent any possible exploitation in data and reporting that might occur:

*“A blended approach covers benefits of both systems but to ensure actual good care of patients must involve the reintroduction of DRO visits where patients are spoken to and dental care received is inspected...”* (Community Dental Service)

### **Further suggestions for refining the blended approach**

A number of respondents provided suggestions about how the blended approach could be refined, including the ability to flex the percentage between activity and capitation:

*“Recommended as a balance, but there must be flexibility between the [two], so that in high need areas more treatment is rewarded compared to stable patient base where more patients should be registered. This is crucial to ensure high need irregular attenders are welcomed and rewarded appropriately in practices.” (Dentist)*

Examples were suggested from other models in primary care, such as the pharmacy contact. Other suggestions included the modification of the existing bands e.g. adding more bands for high needs patients and splitting some treatments over bands. Some respondents provided detailed suggestions of how the blended system could be applied:

*“Sounds ideal. But complexity of how much is capitation and how much activity based likely to be a problem. However, could have weighted capitation and weighted UDA pricing to encourage dental teams to take on and treat higher need individuals.” (Dentist)*

Those respondents who did not prefer the blended system gave a range of reasons for their answer:

- UDA system preferred
- too much change would destabilise practices
- a blended approach might not help access and would burden practices with more work and complexity

*“Seems overly complicated, would be easier to stay with UDA’s.” (Dentist)*

*“A blended approach would run a high risk of being too complex and introducing an unnecessary burden on practices.” ( National association)*

Concern was raised by a number of respondents that the blended system would be difficult to implement fairly, too complicated (and therefore difficult to implement and manage on an ongoing basis):

*“This would be complex to administer at practice level and the % split would be crucial” (Dentist)*

*“Difficult to implement fairly” (Dentist)*

A few respondents felt that more information was needed on the blended approach, and some said it was difficult to comment without clear and specific models available.

### **Full capitation**

A full capitation option was the next most popular, for the following reasons:

- improve patient access and preventive care

- provide a steady income
- incentivise efficiency to keep the patients in the practice
- create clinical freedom for practitioners

*“Yes this will allow dentists to exercise clinical freedom and provide what they see as necessary” (Dentist)*

*“This seems to be the best option if you really want dentists to focus on prevention.” (Dentist)*

*“...I have worked with capitation before and it liberated me to really put the patient at heart.” (Dentist)*

Alongside the positive views there were some caveats:

*“Potential for under treatment. Hard to measure. However this is the most ideal form of dentistry.” (Dentist)*

*“You must have effective policing to avoid supervised neglect.” (Dentist)*

A number of respondents made further suggestions for improving the full capitation approach. These centred around the need for monitoring – for example by reintroducing DROs or other external regulatory mechanism to ensure the correct amount of treatment and care was given to patients. This topic also features in question 4 of the remuneration section:

*“Our view is that as much of contract remuneration as possible should be based on capitation with Dental Reference Officer monitoring to provide reassurance on activity levels. We believe that full capitation would work, given appropriate monitoring.....” (Local Professional Network)*

Other modifications suggested to make full capitation more practicable included: increasing the DQOF percentage; clearly defining the range and complexity of treatment covered under capitation; using different methods of applying capitation such as DMFT.

### **Problems with patient access**

A number of respondents worried that full capitation could create difficulties with patient access and the ability to maintain a patient list. There was also concern that it could generate competition between practices and potential hostility. A small number of respondents felt there would be a risk of “cherry picking” with dentists discouraged from accepting high need patients:

*“... impossible to maintain patient numbers due to new working approach. Cannot see how it can be cost neutral for dentists without replacing associates with therapists or foreign dentist prepared to work for less - but big concerns here that if language issues patients [will] not understand the prevention message..” (Dentist)*

*“There would be little incentive to accept high needs patients. This would reduce access to treatment.” (Dentist)*

### **Risk of under treatment / neglect**

Nearly a third of respondents cited concerns that full capitation was open to abuse, including the risk of under treatment and supervised neglect (as the focus / payment would be on the volume of the patient list):

*“Risk of supervised neglect and teams registering very large list sizes that they cannot effectively manage.” (Dentist)*

*“A remuneration system based entirely on capitation has the potential to encourage supervised neglect without very close monitoring and thus is not desirable.” (Dentist)*

*“Will lead to dentists doing the bare minimum amount of work that they have to do.” (Dentist)*

Other reasons cited against adopting a full capitation approach to remuneration included:

- there was insufficient funding to apply this approach
- the approach was unlikely to work in dentistry
- it did not promote quality amongst all practitioners
- it could disadvantage associates
- it had not worked well in the past
- it did not promote incentives for treatment

*“Would promote pressure on associates to under treat and will not place any emphasis on quality of clinical work.” (Dentist)*

### **Full Activity**

This was the least preferred option. Those in favour felt that this was the fairest method as dentists would get paid for exactly how much work they did. Some dental practice owners also felt that this was the best method to encourage their employees to treat patients and produced greater efficiency in their staff:

*“I personally prefer this as it is much fairer to both dentist and patient.”  
(Dentist)*

*“As a practice owner this is the best method to get productivity from the dentists that work for me.” (Dentist)*

*“Most fair system as you get paid for the work you do. However this must be monitored by inspectors to prevent over prescribing.” (Dentist)*

Suggestions included modification of the current UDA system to make it more effective by expanding the current banding system; classifying preventive care as a treatment activity to receive UDAs; addressing the differential UDA values; and applying a weighting system to UDAs:

*“Full activity could be made to work better going forward if dentists were better rewarded for preventive effort (which may not just include treatment).”  
(Dental software supplier)*

*“Rather than a direct fee-per-item system a UDA approach is preferable as it does have less perverse incentives and is relatively easy to understand and does provide a fairly predictable patient fee structure. We are not convinced that there is a lot wrong with UDAs. However there are inherent perverse incentives with any full activity system, particularly in low need areas. A tweaked UDA system may offer the best way forward. Where there is weighting applied to UDAs, based on factors such as additional care needs, high dental needs and potentially area based measures of deprivation. Also scope to increase the range of bands and attached number of UDAs. For example could have an additional banding between current band 1 and band 2 to cover prevention and another band between Band 2 and Band 3 to cover relatively high unmet dental needs (e.g. for people with four or more decayed teeth requiring extractions or restorations or for endodontics.” (Dentist)*

Not all respondents who were against the idea of using full activity for remuneration gave an explanation for their views. However, some stated that this would be no change from the current system whilst others felt it was similar to the pre-2006 contract and that dental contracts should avoid heading back into that direction:

*“This would be the system of remuneration that was present prior to April 2006. There were issues with that which is why it was changed.”(Dentist)*

*“.....Full activity along the lines of the current contract would not be in the interests of patients or professionals and would be inconsistent with a prevention based system.....” (Local Professional Network)*

Some of the respondents gave further reasons for not considering the full activity approach for remuneration. The 2 key themes identified were the potential problem of over treatment / over prescribing and the management of preventive care:

*“Introducing an activity-based element could introduce difficulties of how preventative advice could be remunerated and raises potential problems of over-treatment.” (National association)*

*“With respect to full activity we already have this and does not incentivize treatment of disease, which should be a goal of NHS dentistry.” (Community Dental Service)*

### Question 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?

#### Overview

There was no limit on the number of suggestions that could be made in answering this question. Some responses included one or more of the key themes listed below:

- preventive care and advice
- band 1 basic dental care
- examinations / routine treatment
- oral health
- urgent /emergency care
- everything including complex care
- everything excluding complex care.

Each of these is discussed in more detail below.

#### Preventive care / advice

Over a third of respondents felt that prevention should be covered by capitation. A number of respondents mentioned that preventive advice and care should be placed under capitation rather than activity because there can be a lot of variation in how much time a dentist could spend with a patient giving preventive advice:

*“Capitation should cover prevention based aspects of care as these would be very hard to monitor if they had been done. If prevention was remunerated on an activity basis some dentists may spend 30 seconds others 10 minutes giving oral hygiene advice. If dentists knew that if they gave excellent preventative advice and this was rewarded by an increase in the patients rag score this would give an incentive to do it properly.” (Dentist)*

*“All preventive aspects – can be measured by codes or time spent. It will allow practices to develop skill mix model and resources required can be paid for from capitation fees. If the remuneration is heavily biased towards treatment, it will limit the potential to use EDDNs and implement skill mix. For skill mix to work, the Provider must have the ability to configure the practice (in terms of HR) to the most appropriate configuration.” (Dentist)*

Other respondents believed having preventive care under capitation would encourage patients to take more responsibility for their own oral health.

Advice, fissure sealants, fluoride applications, simple cleaning, and scale and polish were mentioned as being included as part of preventive dental treatment by respondents:



*“Preventive advice. Preventive treatment to include, fissure sealants, fluoride applications, and radiographs. Patients value active treatment and are happy to pay for it. They are not happy to pay for prevention.” (Dentist)*

### **Band 1 / Basic dental care**

Just over a quarter of respondents expressed a desire for core services in Band 1 to be covered by capitation, though not all of them explained why they believed basic dental needs should be placed under capitation.

However, some stated that the basic dental needs of patients will never go away, so the most common disease processes should be covered by capitation as that is what dentists are trained for. Fillings, extractions, x-rays, prescriptions and periodontal treatment were mentioned as items to be included as part of the capitation element:

*“Capitation should cover basic oral examination and X-rays only. Anything else becomes complex and unfair to categorise.” (Dentist)*

*“Examination and radiographs. All other treatment needs are subject to variation depending on patient needs, even preventative advice. Patients will vary in their ability to understand or comply with things as “simple” as oral hygiene instruction. They will have varying desires for a successful outcome and the need for treatment.....” (Dentist)*

### **Examinations / routine treatments**

A number of respondents suggested that routine examinations should be covered under capitation. The rationale was that this would allow the immediate maintenance of a reasonable oral health level for the “responsible” patients and are basic repeat services that will be performed again and again for each patient:

*“Examinations, X Rays, and prevention. Possibly a limited number of simple fillings if there is an appropriate level of capitation and allowance is made for the time this will take out of the week. NOT lab work, and not root canal treatment as clearly these are more involved and should be remunerated appropriately.” (Dentist)*

*“Capitation should cover examination at all recalls which can be justified within NICE guidelines as well as advice / oral hygiene instruction to patients and prevention – fissure sealants and fluoride. It should cover issue of all prescriptions and immediate management of genuine emergencies which should be defined, e.g swelling/ trauma/ bleeding.” (Dentist)*

*“Examination and preventive advice, simple cleaning, treatments fee per item. Total capitation system for children tried in 1990s didn’t work, blend of capitation + fee for treatments did.” (Dentist)*

### **Oral Health Assessment / Oral Health Review / Oral Health Instruction**

Several respondents stated that the OHA / Oral Health Review (OHR) and Oral Health Instruction (OHI) could be covered by capitation. Some felt these areas were important and should be provided for every patient. Others simply stated they believed OHA / OHR / OHIs should be under capitation and gave no further explanation:

*“The number of OHAs should reflect your capitation then the items carried out should reflect activity.....”* (Dentist)

*“OHA and OHR should be included along with regular indices to back up both. OHI, PI [Plaque Index] and BL [bleeding], these are the areas that are important and should be covered for every patient regardless. By covering the OHI and assessments NHS dentistry is showing how important prevention is to them.”*  
(Dentist)

### **Emergency / urgent care**

A minority of respondents indicated that they wanted emergency / urgent care to be covered under the capitation element. None of the respondents explained why they wanted emergency/urgent care capitated.

### **Everything under the NHS including complex care**

Several respondents wanted the full spectrum of NHS dental care to be included within capitation, although most of these did not elaborate as to why this should be a way forward.

### **Everything under NHS excluding complex care**

Several respondents want the full dental care spectrum under the NHS as capitation apart from complex treatments / Band 3 treatments. Most respondents believed dentists needed flexibility to deal with their work and that complex treatment required more time, infrastructure and resources and was more costly to manage. Therefore, it should be recognised by being classified as activity under the blended approach.

Items that were identified as complex treatment by respondents included: Band 3 procedures, molar endodontics and surgical removal of 8s, oral surgery, orthodontics, sedation, special care dentistry and advanced restorative care:

*“If DH decides that there must be an activity element, then everything that is mandatory under the current contractual arrangements with the exception of complex care (which we define as current Band 3 procedures, molar endodontics and surgical removal of 8s) could be covered by capitation....”*  
(National association)

*“Full spectrum of care should be covered within capitation apart from more specialised care including oral surgery, orthodontics, sedation, special care dentistry and advanced restorative care.....”* (Dentist)

**Additional observations**

A number of respondents felt that more information was required before they could respond to the question or believed other organisations such as the BDA would be able to provide a more appropriate answer. Some felt that a clearer definition of the NHS offer / treatment variety was required before they could make suggestions of what elements of the care spectrum should be covered by capitation. A few respondents also questioned how the patient charges system would operate with a system that includes a capitation element.

Other respondents felt unsure about how much funding would be available for this new scheme. One respondent also mentioned that monitoring of outcomes and treatments needed to be introduced to prevent any abuse of the system from happening, as it could under full capitation or under full activity.

## Question 4: What safeguards need to be in place to ensure that patients with high treatment needs are appropriately treated in any remuneration system?

### Overview

This was an open question and respondents were free to include as many suggestions as they wanted. Answers may therefore have included one or more of the following key themes identified from all the responses:

- monitoring
- appropriate remuneration
- capitation weighted to higher needs patients
- additional resources
- payment per item to safeguard higher needs patient
- amended UDA banded system
- refer high needs patients to specialist clinics

The main findings for each of these areas are detailed below.

### Monitoring

Nearly a third of respondents suggested that regular monitoring, possibly including random checks / inspections, should be used to ensure high needs patients are treated appropriately:

*“Auditing of computerised clinical records. Methods introduced for outliers to justify their clinical decisions.” (Dentist)*

To do this, many respondents proposed the re-introduction of the DRO system (or similar) as well as the re-instatement of the prior approval system.

*“... You need mandatory yearly practice inspections by equivalent to the DRO’s. Without these, there is no way to monitor the standard of actual care. The CQC can’t do it. Monitor can’t do it. You need dentally qualified individuals actually looking at patients.” (Dentist)*

*“Allowing dentally qualified inspectors to inspect practices to ensure that there is no “supervised neglect”. This would ensure the profession is delivering high quality care to its patients.” (Dentist)*

*“Some sort of prior approval type mechanism for patients with high initial needs. Bring back the DROs for this?” (Dentist)*

### **Appropriate remuneration**

Nearly a quarter of respondents stated that treatment for high needs patients could be safeguarded by remunerating appropriately. It was felt that the remuneration of dentists and clinical teams would be appropriate if it covered the time taken, skill employed, and quality of care provided to treat the high needs patients.

Time taken was the most common factor mentioned as an appropriate measure for remuneration. Some of the respondents believed remunerating time would encourage longer and more thorough treatment for patients, as well as covering the extra time required for high needs patients' appointments. It could also incentivise and be used as a reward mechanism to help preventive care and advice:

*“Time taken to treat these patients needs to be reflected in the remuneration system. A dentist who does a lot of complex treatments needs to be paid for the time and effort.”* (Dentist)

*“Remuneration should be related to the amount of treatment that needs to be provided. Remuneration should be appropriate to the amount of time, quantity and complexity.”* (Dentist)

### **Capitation weighted to higher needs patients**

A number of respondents believed higher needs patients accorded a higher weighting in capitation would provide a suitable safeguard. It was identified that this approach would provide dentists with more suitable payments and could possibly incentivise them to look after patients with high treatment needs or patients who take longer to treat because of anxiety or other special needs:

*“Capitation payments need to be linked with deprivation and perhaps there should be weighting for patients identified as high needs at the oral health assessment. This would need monitoring by the DRO system”* (Dentist)

### **Additional resources**

A small number of respondents mentioned additional funding and resources could be used as a safeguard for high needs patients. This could help increase the amount of dentists treating high needs patients as the extra funding and resources would cover the advanced treatment, extra work and more time that the high needs patients require:

*“Reward dentists over and above their closed contract value to treat them. Maybe an intro payment. Allow for open contracts so that dentists can grow their practices. They would welcome these patients.”* (Dentist)

*“In addition to the contract value, there should be a prior approval system for patients with high needs.. the money coming from a centrally kept pot and paid as extra to the contract.”* (Dentist)

### **Payment per item to safeguard higher needs patients**

A few respondents commented that dentists should be paid per item / treatment to safeguard high needs patients' treatment. They believed this method would provide dentists with adequate payment for each item of treatment – some dentists felt that under the current contract “*the more they work the less they earn*”.

Others considered that it was impossible to treat high needs patients appropriately if dentists were being paid on a fixed income. Being paid on an item of service basis was a more suitable method of payment and provided better safeguarding of this patient group:

*“It is important to avoid a “one size fits all” approach with any remuneration system and the adequate provision of treatment for the high need patient requires additional funding arrangements. By introducing fee for item funding arrangements for the following treatments would help to ensure that high needs patients are offered equitable access to dental treatment: Perio for BPE 3+, Molar endo, Surgical extractions, Patient requiring 4 or more treatments in a course, Sedation, Domiciliary treatment...” (Dentist)*

### **Amended UDA banded system**

A few respondents suggested that modifications could be made to the current UDA system as a safeguard for patients with high treatment needs.

Most mentioned that extra charge bands could be created to cover the complex care that high needs patients required, e.g. extensive crowns, bridge work, multiple restorations or multiple root canal treatments. One respondent also suggested having a weighted system for UDAs:

*“Give them more value i.e. increase the amount of UDA for extensive treatment root fillings and multiple fillings and multiple crowns.” (Dentist)*

*“The majority of payment should be on activity, and UDAs are a perfectly sensible measure of this. The opportunity should be taken to add some new bands to accommodate complex cases with significant treatment needs. It would be essential that the pathway shows clear demonstration of having followed clear treatment pathways to avoid inappropriate treatment. The system needs to firmly emphasise patient responsibility – and excluding certain treatments from the NHS whilst maintaining a commitment to clinical oral health – is likely to reinforce this.” (Dental Body Corporate)*

### **Refer high needs patients to specialist clinics**

A very small number of respondents suggested that it would be sensible to refer patients who require high levels of treatments to specialist clinics. Those respondents stated that small dental practices with small contract values could not be expected to provide and cover complex care because they did not have the appropriate time or resources available:

*“... Or special clinics which will have specialists working who will make decisions and treat these high demanding cases. Afterwards these patients can return to GDP for regular care.” (Dentist)*

**Additional observations**

A few respondents felt that more information was needed before they could suggest any safeguards for high needs patients.

It was also suggested that a clearer definition of what is and is not available on the NHS was particularly important for this patient group. Lack of clarity about the NHS offer made providing treatment more difficult.

# Appendix 1 – Responses to the engagement exercise

Appendix 1 is published as a separate document.



## Appendix 2

### Glossary

BDA	British Dental Association
BL	Bleeding
BPE	Basic Periodontal Examination
NHS BSA	Business Services Authority
CDS	Community Dental Service
CQC	Care Quality Commission
DBOH	Delivering Better Oral Health
DCP	Dental Care Professional
DH	Department of Health
DMFT	Decayed, Missing, Filled Teeth
DQOF	Dental Quality and Outcomes Framework
DRO	Dental Reference Officer
DRS	Dental Reference Service
EDDN	Extended Duty Dental Nurse
FD	Foundation Dentist
GDC	General Dental Council
IC	Interim Care
LDC	Local Dental Committee
LPN	Local Professional Network
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OHA	Oral Health Examination
OHI	Oral Health Instruction
OHR	Oral Health Review
PCR	Patient Charge Revenue
PHE	Public Health England
PI	Plaque Index
RAG	Red Amber Green
UDA	Unit of Dental Activity