The Future of NHS Dentistry

Foundation Dentists Study Day
Blackburn Rovers Football Club
6 June 2014

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Overview

• Dentistry today
• Improving dental care and oral health – a call to action
• Dental contract reform
• Specialist commissioning guides
• Workforce planning
• Local professional networks
Adult oral health has been improving over time.

Data source/s: Adult Dental Health Survey 1978-2009

Percentage of adults with 21 or more natural teeth, by age group, UK* 1978-2009

*2009 figures exclude Scotland

Data source/s: Adult Dental Health Survey 1978-2009
International comparisons of dental health for 12 year-old children

Average number of decayed, missing or filled teeth, 12 year-old children, 2006 (or latest year available)

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Decline in average number of decayed, missing or filled teeth, 12 year-old children, 1980-2006

[Bar chart showing decline in average number of decayed, missing or filled teeth for various countries]
Children’s dental health has also been improving over time

Results of caries surveys of five-year-olds in England from the Children’s Dental Health Surveys and NHS Dental Epidemiology surveys*, 1973 to 2012

*The orange sections represent the Children’s Dental Health Survey results and the blue the 5 year old dmft surveys. For the 2007/08 and 2011/12 surveys positive consent was needed for children to be included and therefore these years are not directly comparable to the previous surveys.

$dmft$, seen on this graph, is a standardised way of measuring dental health, which involves visual-only examination for missing teeth (mt), filled teeth (ft) and teeth with obvious dentinal decay ($d_3t$).

Data source/s: Children's Dental Health Survey and National Epidemiology Dental 5-year old dmft Survey
Regional and deprivation variations in children's dental health – a survey of 5 year-old children

Percentage of 5 year-old children with decay experience including 95% confidence limits, by Government Office Regions, 2012

Correlation between the rate of decay among 5 year-old children and deprivation score. Lower tier local authorities in England 2012

For those 5 year olds with decay, the extent of the decay correlates with deprivation. The more deprived the area the higher the rate of decay found in the 5 year olds surveyed.

There is regional variation in the prevalence of tooth decay in the 5 year olds surveyed.

Data source/s: Public Health England National Dental Epidemiology 5-year old dmft Survey
On average, 5 in every thousand people are in a nursing home;

- Across the country, in CCGs, this ranges from a maximum of 16.5 to minimum of 0.6 people in every 1,000.

Data source/s: NHAIS mid-year extracts
The number of patients accessing NHS dentistry has increased steadily since 2008, to 29.9 million patients in December 2013.

Access is measured by the number of patients who have had visited an NHS dentist in the preceding two years.

This time period was chosen as NICE (National Institute of Clinical Excellence) guidelines recommended the public should visit the dentists at least once every two years.
A Call to Action - Survey

- We published “Improving dental care and oral health – a call to action” in February 2014. We wanted to stimulate the debate around NHS dental services. Our overall aims were to improve the oral health of the population, increase access to NHS dental services and reduce financial inefficiencies.

- The consultation closed on the 16th of May and we received around 160 online responses and a large number of organisational responses.
Next steps – Analysis of responses

• We will commission independent analysis of the call to action survey responses, as well as the feedback from the event this independent report will shape the actions that are needed.

• Gain your views on priority areas and what national products would most support local commissioners

• Use all the feedback to form part of the strategic framework for primary care to be published by the end of the year
Challenges for Dentistry

- Finance
- Population demographics
- Focus on prevention
- Improving outcomes
- Health Inequalities
- Equity of access
- Integrated care
Call to action – National event

• As well as a number of local events we held a national call to action dental event which more than 200 people attended a mix of front-line professionals, patient representatives, public health, NHS commissioners, regulatory bodies and professional associations on the 7th April 2014. The event was aimed at further shaping the future of dental care and oral health services

• Each delegate sat on three different tables in the morning session to discuss three themes. The discussions were structured around: Enablers, Barriers, Areas of significant agreement and Areas of significant disagreement
2. To improve the nation’s oral health the priority for NHS England should be:

- Encourage a preventative approach and self-care by patients
- Increase access and choice to NHS dental services
- Ensure all dental teams work to consistent quality measures
- Make a better use of the skill sets in the dental team
- None of the above
Event – Levers for change

3. The most effective levers for change are:

- Local professional leadership
- Contract reform and new funding formulas
- Higher priority given to dental services within NHS England
- Greater patient and public involvement in designing and commissioning NHS dental services
- Developing dental networks and the “pathway approach”
- None of the above
Focus groups - Seldom heard groups (Easy to ignore groups)

- We commissioned 10 focus groups to get the views from easy to ignore populations.

- Gypsy & travellers
- Homeless
- Mental health
- Older people in residential care home
- Low socio economic groups: unemployed, single parent families.

- Older people in residential care home
- Substance misusers
- Parents of children with long term health needs
- People with dental phobia
- People from black and minority ethnic groups
Dental Contract Reform Engagement Exercise 2014

Paper 1: Overview of the engagement exercise
Context

• Work on contractual reform is being led by the Department of health with close engagement by NHS England

• The engagement exercise has been informed by the discussions on contract reform in the “Call to Action” (February – May 2014)
Reasons for reform and general approach

• Coalition commitment to reform dental contract system to further increase access and improve oral health (especially children)

• Reformed system must:
  – include a remuneration approach that supports good clinical practice and access
  – work for patients, providers and commissioners

• Reform is focussed on 2 key areas:
  – quality of care
  – remuneration
What’s not likely to change

Reforms will need to:
• Support goals of increasing access and improving oral health
• Work with the current plurality in types of dental provision

Any new system must also:
• Be cash limited and operate within same financial envelope
• Include performance metrics and financial recovery for under-performance
• Enable service level variations (temporary or permanent)
• Raise same proportion of Patients Charge Revenue (and collection of charges will remain with practices)
• Offer same scope of NHS care
• Allow mixing of private and NHS care
Progress, Evidence and Learning – the pilots

Around 90 practices (including some Community Dental Services) have been:

• piloting a preventive pathway approach using first generation software
• using a shadow dental quality and outcomes framework (DQOF) to measure the quality of care delivered
• remunerated in one of three ways:
  – two types of simulated weighted capitation (some contract value at risk)
  – guaranteed contract value (no contract value at risk)
• since 2013 all pilots have been testing shadow registration
Progress, Evidence and Learning – the findings

- Clinical approach is showing improvements in oral health and is liked by both patients and dentists
- Access has decreased in many pilots
- Applying clinical autonomy in the use of clinical pathways can be challenging - the pilot software is decision-support, not decision-making
- Embedding pathway working involves significant cultural change for both patients and professionals
Progress, Evidence and Learning – the findings

• To move forward, therefore need to:
  – retain the clinical gains
  – understand what is taking longer, but not adding clinical value
  – gain a better understanding of expected treatment levels (getting the right balance between prevention and treatment)
Focus of on-going work

• Presentation of pathway that delivers clinical benefits efficiently
• Linking the pathway to a remuneration model that supports access, treatment levels and quality of care – getting the right balance of incentives (a “blended” system of remuneration)
• Performance metrics
• Possible mechanism to allow for any local demographic variations
• Evolution, not revolution – no big bang!
Engagement Timetable

- Earl Howe’s speech 11 April 2014
- Engagement starts 6 June 2014
- Comments to be submitted online by 31 July 2014
Dental Contract Reform Engagement Exercise 2014

Paper 2: The clinical philosophy
Professor Steele’s Independent Review of NHS Dentistry (2009) recommended a pathway approach, based on:

- Identifying and managing patients’ risk
- Creating a healthy oral environment through providing preventive care
- Encouraging and supporting patients to take shared responsibility for their own care
- Supporting children in engaging with dental services and improving and maintaining their oral health; and
- Ensuring that quality and consistency of care is at the heart of the pathway approach
Steps in the primary care preventive pathway

Step 1
Oral health assessment captures information on 4 clinical domains
Need & risk are assessed based on clinical and patient information = RAG status
Treatment & stabilisation (if necessary)

Step 2
When do I need to recall this patient?
Date of oral health review

Step 3
Does this patient need to be seen for additional preventive care/advice between now and oral health review?
Steps in the primary care preventive pathway

- Entry point is the oral health assessment (OHA) which captures information across 4 clinical domains: caries (tooth decay), periodontal (gum) disease, tooth surface loss (TSL), conditions affecting soft tissues of the mouth.
- Risk status is calculated using a red/amber/green (RAG) rating for each domain (aggregated to a single RAG score for each patient).
- Any treatment or stabilisation needed is carried out, along with any appropriate preventive care.
- Recall interval is based on RAG status.
Evidence on preventive pathway approach

• RAG ratings
  – distribution broadly as would be expected from the epidemiology
  – not all patients remember being advised of their RAG status; but those who did felt it was very helpful in understanding their oral health

• Patients and dentists like the approach

• Around 75% of patients felt they had a better understanding of their oral health

• Around 75% of patients said they had changed their behaviour

• Overall, oral health has improved
Dental Contract Reform Engagement Exercise 2014

Paper 3 –
The measurement of quality & outcomes
The principles and framework used

**Principles**

For a patient to be in “good oral health” we mean that they:

- are free from pain
- have good functionality & aesthetic form to their teeth
- have clinically assessed good oral health and we are confident that this will continue into the future

**Outcomes (patient view)**

The patient’s view of being free from pain and having good functionality should be covered by patient experience and PROMS rather than clinical effectiveness

**Outcomes (clinical view)**

The clinical view focuses on outcomes:

- improvement of oral health
- maintenance of good oral health

**Measures**

**Patient satisfaction**

**Patient experience**

**Measures**

**Clinical components from 2 of the 4 domains:**

- Caries
- Perio
2014/15 pilot DQOF indicators

- **Patient experience** – assessing the views of patients on their experience of care provided
- **Clinical effectiveness** – assessing whether patients’ oral health has been maintained or improved between oral health reviews
- **Patient safety** – assessing whether practitioners are confirming whether there have been any changes to a patient’s medical history at each oral health review
- **Data quality** – assessing whether complete and timely data is being submitted by providers
Learning

• Most pilots scored highly on most of the indicators
• Data quality is key (therefore, in 2014/15 data quality timeliness indicators for transmission of appointment data and FP17 data have been added to the indicator set)
• Professional consensus on the main areas of measurement is important – the indicators used need to be recognised as the “right” ones
A suitable remuneration model

To be fit for purpose, the remuneration model must:

- support the preventive pathway approach
- reward appropriate levels of treatment and patient health outcomes
- increase patient access to NHS dental services
Required features of any new system

- Same overall spend on NHS dentistry
- Scope of NHS dental care unchanged
- Commissioned system – remuneration capped
- Metrics to measure delivery and financial recovery for under-performance
- Service level variations (temporary/permanent) must be possible – so any new remuneration system will have to have this flexibility
- Same proportion of Patients Charge revenue raised (and collection of charges will remain with practices)
- Mixing of private and NHS care
Remuneration based on quality and outcomes

• Some remuneration will be based on quality and outcome measures via a DQOF

• It is envisaged that, as in the pilots, practices will be paid based on their relative performance against the DQOF – this rewards better performance whilst ensuring total spend (for commissioners) and total income (for providers) as a whole remains unchanged
The options: remuneration based on activity, capitation or a blend

- **Full activity**
- **Full capitation**
- **Blended** (part capitation, part activity)
Full activity

Benefits
- relatively easy for commissioners and providers to understand and manage

Challenges
- inadvertently can incentivise providers to over-treat existing patients, which can lead to reduction in access and inefficient use of resources
- not an ideal fit with a preventive approach (because it is difficult to remunerate preventive advice via activity)
- does not align with the changing needs of the population where disease prevalence is reducing
Full capitation

Benefits
• incentivises a provider to care for a certain number of patients - therefore can be used to increase access to their services
• can create an implicit financial incentive for providers to deliver preventive care as this should reduce subsequent levels of treatment required

Challenges
• risk for providers / individual performers effectively having a single band payment for a particular cohort of patients where the needs of individual patients may vary significantly from cohort average
• insufficient understanding of whether weightings based on age, gender and deprivation status sufficiently predict needs
• risk of appropriate treatment not being delivered if outcome measures too unsophisticated
• risk of disadvantaging practices delivering greater proportion of NHS treatment compared to those delivering more private treatment to NHS patients
• PCR drop if treatment currently offered on the NHS is offered privately at same / lower charge
**Blended approach**

**Benefits**
- A blended approach seeks to harness the best features of the capitation and activity approaches so that the negative aspects of each one is reduced.

**Challenges**
- Including an element of activity may incentivise providers to over-treat.
- Providers need to manage the delivery of two remuneration metrics - patient numbers and activity.
- Providers will need to develop performer remuneration models that reflect the provider remuneration.
The pathway approach

- *Securing Excellence in NHS Dental Services*, February 2013 made a commitment to a pathway approach for dental services.

- With NHS England as the single commissioner for the entirety of dental services there exists a unique opportunity to strategically plan services at a national level and to really transform the way we deliver services to improve the outcomes for patients.
Principles of the pathway approach

- This allows clarity, consistency and equity in service delivery
- Increase integration across primary, community and hospital settings
- Levels of care and procedures (building on OS advanced care work)
- Consistent competencies for each level of care (building on OS advanced care work)
- Consistent environment/equipment standards for each level of care
- Consistent clinical outcomes and/or patient reported outcome measures (PROMS) for each level of care
- Consistent approach to coding and costing measures for care pathways
- Equitable access
The preventive care pathway

Oral Health Assessment records key information on 4 important dental conditions.

Risk is assessed based on patient and clinical information.

Preventive Actions for the patient and dental team are advised.

Oral health Review date is advised based on risk and NICE guidelines.
The Patient’s journey through care – an illustration

Overall lifetime pathway approach
Workforce

• Need to match workforce to needs
  • Numbers
  • Skills
• Education and training needs to correctly support workforce
• The vision is for larger, more integrated dental teams within primary care
• Primary care preventative pathway can be delivered by DCPs
• Prevention is implicit in all pathways
• The role of DCPs will vary within each specific pathway, some will have significant potential for the use of DCPs such as periodontal care and orthodontics.
3 levels - for what purpose?

- For the purpose of clinical governance
- Need to be sure that patients are receiving best care from appropriately competent clinicians
- Existing structures define competencies

- **LEVEL 1** Procedure/conditions to be performed or managed by a dentist commensurate with level of competence as defined by the Curriculum for Dental Foundation Training or its equivalent.

- **LEVEL 2** Procedures/conditions to be performed or managed by a dentist with additional competencies but below the level of a professional recognised as a specialist by the GDC.

- **LEVEL 3** Procedures/conditions to be performed or managed by a professional recognised as a specialist by the GDC.
Dentists with Enhanced Skills

- Work on developing the assessment framework for DES is being led by the Faculty
- The Faculty will Quality Assure the process for assessment, they will not deliver the training
- The process must be simple and deliverable
- It must not discriminate against practitioners who already carry out level 2 procedures, however, it must be robust to ensure that these are practitioners are competent to deliver the care.
- It should provide a career pathway approach for dentists who do not wish to embark on a formalised training pathway route.
Time series and future projection of adult dental health: 1998-2030

Healthier is defined as those having 18 or more sound, untreated teeth.

Less healthy is defined as those with less than 18 sound, untreated teeth.

Data source/s: Adult Dental Health Survey, 1998 & 2009
Local Professional Networks

• ‘Securing Excellence in Primary Care’ (June 2012) committed to the development of Local Professional Networks (LPNs) for dentistry, pharmacy and eye health.

• Local Professional Networks will:

• Support the development and implementation of national strategy and policy at local level.

• Work with key stakeholders on the development and delivery of local priorities.

• Provide local clinical leadership which is essential to ensure a strong clinical voice in commissioning decisions.