NHS dental services in England

An independent review led by Professor Jimmy Steele

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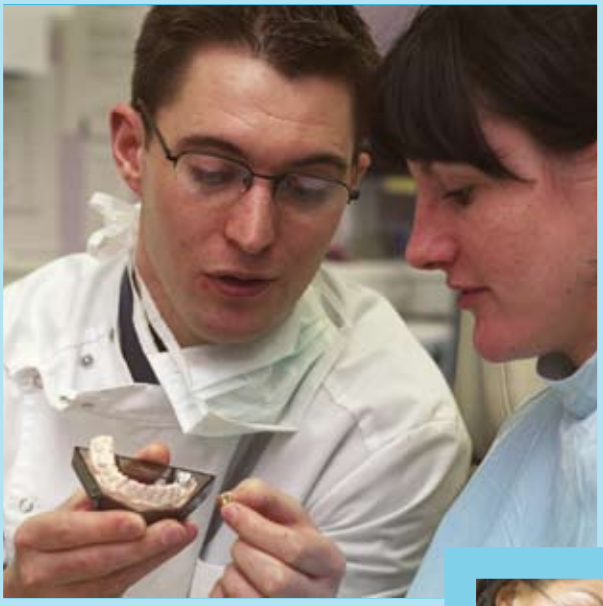

Executive summary and key recommendations

Oral health should be for life. The two common dental diseases, dental decay and gum disease, are chronic and the damage they cause is cumulative and costly. The NHS in 2009 is still dealing with, and paying for, the consequences of disease that developed more than 50 years ago. The trends in disease prevalence and the way it has been managed are visible in the oral health of different generations. We still need to deal with this burden of the past and manage the demands of the present, but keep a very clear focus on the future so that we can minimise the risk, discomfort and costs for future generations.

Almost everyone in the population is a dental patient at some time and, for many, a dental visit is a regular occurrence. But not everyone is the same and providing for the varying needs and aspirations of all of the consumers of dental care is a particular challenge. Clarifying what it is that NHS dentistry offers, what the NHS commissions, what dentists provide and what patients get is an essential step in this process.

Much NHS dentistry is already outstanding, reflecting the quality of the workforce. The basic structures we have in place now provide the opportunity to move on to the next, and most challenging, stage.

Just as health is the desired outcome of the rest of the NHS, so health should now be the desired outcome for NHS dentistry, while good oral health and the quality of the service should be the benchmarks against which success is measured. Through the NHS, dentistry could take a huge step forward but in order to do that, one concept is critical. So long as we see value for taxpayers' money as measured by the production of fillings, dentures, extractions or crowns, rather than improvements in oral health, it will be difficult to escape the cycle of intervention and repair that is the legacy of a different age.

Making the transition from dental activity to oral health as the outcome of the NHS dental service will be a challenge for everybody, but it is essential if NHS dentistry is to be aligned with the modern NHS. In this review we have tried to set out a framework for care and we have tried to provide a rationale for that framework.

In doing so we were also mindful of the current economic circumstances. Ensuring an efficient and well-aligned service was an underpinning principle in the way we approached our task.

A better service for patients: accessible and high quality

Access to care is a problem, but not a universal problem, as it tends to be concentrated in particular areas of the country. The Department of Health (DH) access team is working alongside the review team to address these issues. **We recommend the continuation of this process but that the access programme uses the opportunity for new procurement to pilot some of the key components of our recommendations.**

However, perceptions of problems with access are compounded by simple problems of information. People are uncertain how to find a dentist and the information they require is often not available in the right places, is not co-ordinated or is not kept up to date. **PCTs and the NHS should communicate clearly how people might find a dentist through the most appropriate media and what to expect from a dentist when**

they get there. This is much more a matter of organisation than resource and would make a big difference to patients and their perceptions of access. People have a right to access an NHS dentist; the NHS now needs to work to make this a reality and to extend this to a meaningful oral health service.

Good oral health depends on more than just access: prevention and high-quality provision are also essential. These are related concepts which depend on the dental profession and the dental team working towards a common oral health goal. The clarity of that goal is important.

We have identified an approach to allow the NHS offer to dental patients to be based on some basic national priorities. **We recommend that NHS primary care dentistry provision should be commissioned and delivered around a staged pathway through care which supports these priorities.** The proposed pathway allows and encourages continuity of the relationship between patients and dentists, for those who want it, built around the most appropriate recall interval for the patient and uses oral health as an outcome.

Continuity of care matters to patients and to dentists. It is important in building a relationship of trust and a philosophy of lifelong care. This is at the heart of the pathway, but a continuing care relationship implies responsibilities and rights on both sides. **We recommend that patients registered in a continuing care relationship with a practice have an absolute right to return to that practice for both routine and urgent care.**

Not everyone wants to have a continuing care relationship with a dentist and it is important that their needs are met too. Provision of urgent care is a fundamental responsibility for the NHS and for PCT commissioners and **we recommend that urgent care services should be accessible and commissioned to a high and consistent level of quality**.

While meeting local need is important, the level of variation in the quality of care is too great. The basics of good practice are well understood. **We recommend that strong clinical guidelines are developed to support dentists and patients through specific pathways of treatment.** These would allow determination of thresholds for treatment, ensuring that some of the costly and complex care can be targeted to the patients where it will provide greatest benefit.

As dentists are paid as professionals to perform high-quality services, neither the patient nor the taxpayer should bear the cost of unnecessary premature failure of restorative care. **We recommend that the free replacement period for restorations should be extended to three years and that the provider should bear the full cost of replacement rather than the PCT or the patient.**

Aligning the contract to improve access and quality

The incentives for dentists are not as precisely aligned as they could be to a goal of oral health and consequently there are inefficiencies within NHS dentistry. The pathway we describe should be supported by an altered contractual structure for dentists.

We therefore recommend that dental contracts are developed with much clearer incentives for improving health, improving access and improving quality. The basic structure of the existing contract is quite flexible and we suggest that much could be achieved within existing regulations or with relatively minor adjustments. **We recommend that the current contract is developed specifically to allow payments for continuing care responsibility, blended with rewards for both activity and quality. We further recommend that these are piloted and then nationally applied.**

There are limited incentives for dentists to see patients and to take on new patients. As part of the blended contract system **we specifically recommend introducing an annual per person registration payment to dentists within the contract** to provide greater security for dental practices, and greater accountability on all sides.

For the 60 years that NHS dentistry has been in existence the focus of the service has been mainly on treatment rather than prevention or quality. This means that there is little visible reward for good dentists who are improving oral health and providing a service that patients like, and little sanction for poor ones. **We recommend that the quality of a service and the outcomes it achieves are explicitly recognised in the reward system of the revised contract.**

To do this there will need to be robust measures of quality. These will need continuous development and should concentrate on oral health outcomes and patients' perceptions of quality. This process has started and **we recommend that a high priority is given to developing a consistent set of quality measures**. Local PCTs should not need to develop their own quality measures – this represents a waste of resource that could be used elsewhere.

What the NHS has to do

The process and skills in commissioning dental services have been highly variable. There are excellent examples but the standard of all commissioning needs to be brought to the level of the best. In the best there are structures and processes in place to ensure good communication with the profession and advice from specialists in dental public health. **We recommend that PCTs should be required to demonstrate good organisation and structures, including in senior leadership in the PCT and strong clinical engagement, and that strategic health authorities (SHAs) and DH oversee this process.**

There is relatively little information available about what is happening in NHS dentistry, who wants and gets NHS care, what happens when they receive it and, crucially, whether the services they receive are making a contribution to oral health. A rich body of information is critical to our ability to monitor progress, reward quality and learn what works best for patients and what does not. **We recommend that DH develops a clear set of national data requirements for all providers.**

Technology can help to facilitate the collection and organisation of data. Software systems are available to record what happens chair-side and link it to national datasets. Around 25% of practices do not even have the very basic computer hardware that can

allow this to happen. **We recommend that PCs are used in all dental surgeries within three years and are, ultimately, centrally connected to allow clinical data to support shared information on quality and outcomes.**

Historically, money has followed activity, not patients' needs. The process of reallocation of the resource to align it with need has already begun. **We recommend that this process continues and we have proposed a basis for a funding formula that can allow that to happen.**

Implementation challenges

While it may seem relatively easy to set out a vision and possibly even to get agreement on high-level principles, achieving change and remembering why we need it is much more difficult. The real task now is to implement that vision and this will require dedicated work and commitment across the dental profession and the NHS.

The next chapters set out the above in more detail, giving further background and a suggested timetable for implementation.

- Chapter 1 sets out some of the background to NHS dentistry today.
- Chapter 2 examines the different perspectives of dentistry (patient, dentist and NHS).
- Chapter 3 looks at what we have a right to expect from NHS dentistry in the 21st century.
- Chapters 4, 5 and 6 cover the key findings and recommendations from the review and are grouped and organised according to what the patient should receive, what the dental team should deliver and what the supporting healthcare system needs to do to support this.
- Finally, Chapter 7 suggests how this review might be taken forward to make a difference to people.

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