Summary of: A PCT-wide collaborative clinical audit selecting recall intervals for patients according to risk

P. J. Cannell[1]

VERIFIABLE CPD PAPER

FULL PAPER DETAILS

[1]*Senior Lecturer and Programme Lead for Oral Health Science, School of Health and Human Sciences, University of Essex, Elmer Approach, Southend on Sea, SS1 1LW
*Correspondence to: Dr Phillip Cannell
Email: pjcann@essex.ac.uk
Tel: +44 (0)1702 328 360

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Aims and objectives This audit was carried out to assess the level to which recall intervals were individually and appropriately selected for patients attending dental practices across a primary care trust (PCT) area in Essex. **Method** A retrospective audit was carried out by reference to patient records to assess various criteria, including whether patients were categorised according to risk of oral disease, whether an appropriate recall had been selected and whether a discussion regarding a recall interval had been undertaken. An educational event highlighting the issue of recall intervals was held. Subsequent to this a prospective audit was undertaken to assess relevant criteria. **Results** Prospective audit data showed a marked increase in the use of patient risk assessments for caries, periodontal disease, oral cancer and non-carious tooth surface loss (NCTSL). Recall intervals were also more often selected based on a patient's risk status and discussed with the patient compared to that observed in the retrospective audit data. **Conclusion** This audit was successful as a tool to bring about change in the behaviour of dentists regarding their determination of appropriate recall intervals for patients. Whether that change in behaviour is long-term or transient requires further investigation.

EDITOR'S SUMMARY

The gulf between macro and micro can be very large indeed. When dentistry was first conceived within the NHS the need for massive amounts of oral disease to be treated as swiftly, comprehensively and economically as possible was paramount. Treating the gross disease had to be tackled at the gross level. Not so much endodontics, complex restorations and rehabilitation as extractions and dentures; no so much periodontal therapies as diagnosis of 'pyorreha of the gums' ... extractions and dentures.

Thankfully, due to huge improvements in oral health, developments in techniques, materials and the preventive approaches of both dental professionals and oral hygiene products, notably fluoride toothpaste, the landscape is now completely different. From the macro to the micro takes time, resources and sophistication, so that the transition from the blunt instrument of extractions and dentures to analysis of caries risk and periodontal susceptibility needs education of both patient and dentist alike.

Quite where the 'six-monthly' check-up originated is one of those enigmas to which we may never know the answer but what we do know is the depth to which it is ingrained in the psyche of all concerned. So, attempting to break that habit and change the cultural reference point will take many, many years of careful explanation and understanding. This audit set out to try and analyse and clarify how we might begin to measure the progress towards a more refined and sophisticated approach to appropriate recall intervals and necessarily a greater appreciation of how to assess and convey risk. The authors question whether changes in dentist behaviour were transient or long-term. The cynical might chose the former, coupled with the proviso that much depends on the system of payment and how it is geared to diagnosis and to treatment provision. Doubtless we will be called upon in future to be more discerning in our risk assessment of patients and in our treatment provision but the shift of clinical emphasis will also have to be matched with a shift of resources and an understanding of patient perception.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 210 issue 6.

Stephen Hancocks
Editor-in-Chief

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IN BRIEF

- Shows readers how clinical audit can be used as a tool to explore the relationship between recall interval and risk in general dental practice.
- Describes a large collaborative audit design that can be used by many participants.
- Shows behaviour change in relation to recall intervals and risk among participating GDPs.

RESEARCH

COMMENTARY

Improving and defending quality of care in a time of cuts in public spending is a core responsibility of the dental profession. Defining quality is never easy but it is widely recognised that quality in health care encompasses several key domains including effectiveness, safety, patient experience and appropriateness of care. Changing behaviour is not a straightforward task: evidence-based reviews of the behaviour change literature have highlighted the failure of many interventions to achieve sustained change. What options exist to change clinicians' behaviour to improve quality of care?

Clinical audit has been used within the NHS as a means of engaging clinicians in quality improvement. There are relatively few published evaluations of the impact of clinical audit on quality of care or of its effect in changing clinicians' behaviour. However, it appears to provide a valuable opportunity for dental teams to review and reflect on their activities. With the dramatic changes that are soon to occur in NHS primary health care organisation in England, it will be interesting to see how such activities are supported and maintained.

This paper provides an interesting account of an audit of recall intervals in dental practices. Audit activities increased in the short term the use of patient risk assessments and prompted more discussion with patients about their risk status. It is not clear, however, whether this change in practice was sustained. For several years it has been recognised that dental recall intervals should reflect the needs of the patient and not simply follow the historical mantra of six-monthly intervals. In the Department of Health guidance on dental quality and outcomes framework, details are outlined on how to categorise patients into different risk groups, but gaps remain in our ability to differentiate risk status and predict future disease progression and thus determine appropriate recall intervals. In this paper it is not entirely clear what factors were used to assess risk status for caries, periodontal disease, oral cancer and tooth surface loss. Accurately collecting and recording socioeconomic, behavioural and clinical risk factors requires clinicians to have both sufficient time to undertake this role and the appropriate communication skills required. When the NHS dental contract pilots are evaluated, methods of risk assessment and frequency of recall intervals should be assessed to determine the best contractual way of encouraging practitioners to adopt evidence-informed decisions.

R. G. Watt
Professor and Honorary
Consultant in Dental Public Health,
UCL and Islington Primary Care Trust

AUTHOR QUESTIONS AND ANSWERS

1. Why did you undertake this research?

In October 2004 the National Institute for Clinical Excellence (NICE) published guidelines recommending that the interval between reviews of patients' oral health be determined according to their clinical need. Nevertheless, a move away from a routine six-month interval as the standard recall interval for a review of dental patients has proved a difficult one. Clinical audit can promote a change in behaviour of participants, though it would appear that its use in the GDS has reduced in recent years. This study was designed to explore whether behaviour change in relation to recall interval and patient risk assessment could occur through use of the clinical audit envelope.

2. What would you like to do next in this area to follow on from this work?

The findings in this clinical audit showed a change in behaviour of the participating dentists, but this may be transient. A follow-up study at some future point would indicate the level to which this change has persisted. Consideration should be given to the design of additional large-scale collaborative clinical audit projects on appropriate topics for use in dentistry. A development of the use of clinical audit in dentistry would be to roll out a large-scale collaborative clinical audit nationally and then to evaluate its success.