Playing a well-tested long game

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EDITORIAL

One of my huge passions is chess. It's not a game you can play successfully by only focusing on one piece at a time. In the TV series *The West Wing*, Jed Bartlet plays chess with Sam Seaborn whilst they wait for the result of difficult negotiations in the South China Seas. President Bartlet, hinting at the analogy, explains what it takes to achieve strategic success. 'Look at the whole board', he says to Sam.

I really like the Steele Report. I like the way it has developed through genuine engagement with interested and relevant parties. I like the way it is written. I like the way the Secretary of State has given it enthusiastic attention, appeared in person at the launch press conference and accepted the recommendations - albeit in principle, subject to fiscal pressures. Mostly, I like the way Professor Steele describes priorities for public investment in oral health and recommends that NHS primary care dentistry should be staged around a pathway through care.

It's not a report you can dip into. It tells a clever story which demands a step back from the current paradigms. Genuinely to accept the recommendations, the responsibility to look at the whole board rests with everyone involved. Jimmy describes a long game and there is no place for implementers of the reforms or commissioners selectively to pick off quick wins.

The concept of a staged pathway of care makes considerable sense. A glorious section of Steele's report includes the description of the segmentation of patients' needs. For an intermittently attending, high-needs patient with poorly controlled disease, we all know there is necessarily investment of time, enthusiasm and resource from all parties to make a genuine impact on their oral health. Continuing care relationships are placed quite a long way up the pyramid of priorities in Professor Steele's model, with individually tailored steps for our customers before they and we can see a difference.

CLINICAL DECISIONS AND BUILDING RELATIONSHIPS

Apart from the UDA itself and its mystery content, we've given most criticism to the frustrating challenges to quality and prevention within a UDA target driven system. It emerges that the DH's Dental Access Programme led by Dr Mike Warburton and the work being carried out by the Clinical Effectiveness and Outcomes Group are not only exploring a reduction of the weight of the UDA within contracts but also the addition of new targets for quality measures. Whilst this arguably does demonstrate the flexibility of the current legislation for commissioners at least, and would appear to be a reasonable place to start with piloting a brand new contract, it clearly poses issues if existing contracts are simply tinkered with in the same way. I can't imagine anyone speaking against a well supported environment in which quality care can be delivered, but each quality measure must have an evidence base for a health improvement outcome. There is absolutely no point in using indicator measures based on activity in general medical practice or on flawed sets of historical data.

Steele tells us to play the long game. He wants us to make and take responsibility for clinical decisions and to build relationships with patients which lead to lifetime health improvements.

In describing the opportunity to use the Access Programme to pilot his recommendations, he warns,

'consideration needs to be given to ensuring that while the primary aim of the procurements is to establish additional dental services, sufficient effort is put into coordinating and designing the testing of the care pathways and the contractual models', and he recommends that an immediate priority is to, 'Cross check the quality measures against the pathway and the data needs'.

We've been promised the opportunity to work with the leaders of the strands of reform and, actually, John Milne, his GDPC team and the experienced BDA secretariat are a resource the Department of Health must not ignore. I'm wary though that, perhaps as a result of the Health Select Committee's highly critical report, or maybe just because after three years there is an opportunity to push agendas, much of the infrastructure for reform has already been put in place and there is an expectation that Steele recommendations can be landed onto the deck of a dental services oil tanker with its course previously set. I think that's to miss the point of the report but I'd love to be proved wrong.

The concepts in Jimmy's report are dependent on each other. Each piece in the game cannot be played competently without regard for the others. It'll be easy to miss the point. It'll be easy not to look at the whole board. For some, it'll be easy deliberately to miss the point but I urge John Milne and his GDPC team to insist on the point. If we are passionate about the oral health of the nation and our responsibilities in improving and advancing it, then we had all better go back to page one of Jimmy Steele's report and read it again.

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