In search of quality

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EDITORIAL

The recent review of dental services lead by Professor Jimmy Steele recommends that quality be addressed in dental service provision in England. Therefore the concept of quality needs to be made explicit in order to avoid ambiguity. The difficulties surrounding quality definitions saw the emergence of quality standards in the 1980s. The British Standard BS5750 became popular with organisations throughout this period and now through various revisions since the early 1990s it has been replaced by the ISO9000 standard. This is a written standard which has to be adhered to by any organisation wishing to be accredited with the quality ISO9000 kite mark.

One of the fundamental issues to be dealt with in any organisation utilising the ISO9000 standard is that of its product. Without knowing the product it is impossible for an organisation to know if its activities have resulted in effective product realisation. So what is our product as a profession? Historically, I would imagine that we would have defined it as activities reacting to the vast amount of disease present in the population. Today our product includes restorative care but that is only a small part of what we now consider oral health to be. Therefore, we can surely say that as a profession our product is oral health.

Contemporary definitions of oral health embrace a more three dimensional holistic 'social model of health' view rather than a two dimensional physical 'medical model of health' view. There is much in the dental literature demonstrating how the former contemporary definition can be measured using oral health-related quality of life measures. Should these measures not be fundamental to professional product realisation within a quality system?

THE CONTEXT OF DELIVERING ORAL HEALTH

Changes in disease trends and demography have to be taken into account in the context of delivering oral health. One clear example is the NICE guidelines on the frequency of dental recall. The greatest challenge for product realisation in oral health is recognising the need for redeploying organisational resources so as to address 'need' within the community. Section 3 of the Steele review, 'Principles for the delivery of oral health to NHS patients', describes the value of registration and a patient pathway in order to allow patients an opportunity for oral health.[1] Effective prevention is key to the pathway's success. Again written protocols demonstrating the above would be fundamental to a quality system.

Professor Steele has recognised the need for restorations to be placed that pass the test of time. He has gone as far as saying that the clinician should take responsibility for the restorations they place for a period of three years. Clearly, this should not present a problem for a clinician who places restorations that are fit for purpose, are reliable, consistent and value for money. The measurement of 'replacement restorations' is not as difficult to monitor as would be the measurement of other tangible elements of clinical decision-making eg numbers of routine scalings per 100 treatments; numbers of patients seen within a two year time frame; the interval between patient visits. 'Vital signs' and 'end of year profiles' generated from Eastbourne provide important quality data that can be monitored as part of the quality system.

Quality is more than merely satisfying a list of requirements set by an authoritative body. Quality as a concept involves defining what you as an organisation want to do, defining how you are going to do it and measuring whether activities have achieved the measurable outcomes described in your definitions. Clearly an authoritative body can validate whether what you want to do is appropriate and satisfies accepted standards. Auditing can assess whether activities and outcomes are being generated. To satisfy ISO9000 criteria, internal auditing is necessary and also structured external auditing by recognised auditors, eg BSi, SGS.

The ISO standard is written with continual improvement of the quality management system in mind. The three elements: fitness for purpose, reliability/consistency and value for money, underlie the quality principles. Criticism of the BS5750 standard was reported in the dental press by dental technicians in the 1990s in that the kite mark could be achieved providing dentures were produced consistently but it did not matter that the dentures were of a poor standard. This reporting demonstrated a lack of insight into the ISO standard. If the dentures were not 'fit for purpose' then that would show in the monitoring of outcomes which would in turn drive a change for improvements.

The starting point for any quality system is a desire to evaluate the present state of play, assess its appropriateness, adjust accordingly and monitor progress. In this way an organisation can assure its direction of travel will be in a desired direction. In our case improved oral health. The ISO standard has been developed for application in any organisational field and is recognised internationally. Could this be used more extensively in dentistry so as to satisfy the desire for improved quality?

1. Steele J. *NHS dental services in England: An independent review. June 2009.* London: DH Publications, 2009. www.dh.gov.uk/publications

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