Summary of: Introducing care pathway commissioning to primary dental care: measuring performance

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FULL PAPER DETAILS

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Care pathways have been used in a variety of ways: firstly to support quality improvement through standardising clinical processes, but also for secondary purposes, by purchasers of healthcare, to monitor activity and health outcomes and to commission services. This paper describes a secondary use of dental care pathways: to commission and monitor performance of primary dental care services. Findings of a project involving three dental practices implementing a system based on rating patients according to their risk of disease and need for care are outlined. Data from surgery-based clinical databases and interviews from commissioners and providers are reported. The use of both process and outcome key performance indicators in this context is discussed, as well as issues which arise such as attributability of outcome measures and strategic approaches to improving quality of care.

EDITOR'S SUMMARY

As human beings, we live our lives according to regulations and guidelines learning about rewards and penalties. We participate in games and so experience the consequences of playing outside the rules with the opprobrium of our peers and the penalties allocated by authority. Watch children at play and you will observe them making up their own rules as they go along, testing the viability by checking the reactions of their fellow conspirators, varying, amending and developing the course of the pastime until it becomes an established, agreed format or is temporary and then forgotten in favour of another activity.

As adults we continue to apply this learned process into many of the systems that provide the limitations of our lives and livelihoods, dental treatment and payment systems included. Consequently, when as dentists we encounter a new system we 'play to it' that is to say we inevitably test it to its limits, work by its rules and behave according to the constraints it applies. This is not

to say that the behaviour is inherently wrong or misdirected although it might also not be carried within the spirit of the system or that which it was set up to achieve.

All of this is true of any system of care pathway, commissioning, remuneration, outcome measure or other tool of checks and balances where payment for a task is the central transaction. In setting out to discover whether such behaviours within a system could be utilised as a method of commissioning in primary dental care the authors found that the search for outcome measures is not an especially practical goal. As Paul Brocklehurst notes in his Commentary, 'the relationship between the structure of the remuneration system and clinical activity is well established'. Given that there are currently pilot schemes in progress that are seeking to test the viability of a new national contract, the ability to adapt this to a local situation and to individual clinicians within the context of a care pathway becomes of increasing importance.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 211 issue 11.

Stephen Hancocks

Editor-in-Chief

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IN BRIEF

- While the NHS dental contract is being revised, this paper describes data from a pilot use of a blended contract using key performance indicators.
- Describes the growing emphasis on outcome measurement in healthcare.
- Reports on the differing perspectives of commissioners and practitioners concerning performance measurement.
- Discusses strategic approaches to quality improvement in primary dental care.

COMMENTARY

Recent Governments have been placing increasing weight on the latter element of the Donabedian taxonomy, ie outcome measures, and key performance indicators (KPIs) are one such example. As this paper identifies, given the proposed introduction of a new NHS dental contract in 2014, it is apposite and prudent to consider those KPIs that will be appropriate for primary dental care.

However, even useful indicators like the number of patients transferred from high need/risk to medium need/risk pathways, require careful thought. Approaches to risk assessment rely on epidemiological studies that identify associations between risk factors and the disease process, not causal relationships. As a result, accurate models of risk for caries and periodontal disease continue to remain elusive and for children, the critical transition appears to be the shift from being 'disease free' to being 'disease active'. This suggests that vigilance and prevention would still be required for those patients shifting down RAG categories. As the authors highlight, the search for the most useful set of KPIs is ongoing. They also need to be informed by the results of randomised clinical trials, like the ongoing Health Technology Assessment trial on risk assessment and recall frequency, to set future policy decisions on an evidence base.

The paper also highlights the difference in perspectives between practitioners and commissioners in respect of their understanding of quality and makes the observation that care needs

to be taken when contracting is based on a simplistic understanding and application of KPIs. Again, this is particularly apt given the current development of Local Professional Networks and the importance being placed on locally and clinically led services in the future, rather than a reliance on a 'top-down' approach. However, the influence of a nationally agreed contract will be a significant factor to consider in this context, as the relationship between the structure of the remuneration system and clinical activity is well established. What will be key is the development of a more collaborative approach between dental commissioners, consultants in dental public health and general dental practitioners in the future, with clinical leadership becoming a key attribute for the profession.

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AUTHOR QUESTIONS AND ANSWERS**1. Why did you undertake this research?**

Data were gathered as part of a service evaluation concerned with the implementation of a new system of commissioning care from general dental practices. The system was the first of its kind which meant that the dental teams and commissioners involved had to tackle issues as they arose, and systems of collecting and extracting activity data from clinical databases had to be set up. Information from dental team interview transcripts collected during the implementation of the system as well as quantitative data on activity and outcomes helps to inform others implementing similar types of systems. It also informs the commissioners as they consider the implications of extending the system to other practices in their area.

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

We have already started to develop the work further in the same pilot practices. Commissioners identified that data on patient reported outcome measures (PROMs) would be a useful addition to dental practice performance data. We have therefore devised a simple system of collecting data on patients' assessments of their oral health (pain, function, aesthetics) at the beginning and end of treatment. PROMs data are being collected using a postcard system and will be put together with data extracted from the clinical record held on the practice IT system.