

Developing a care pathway in a high needs area

[Standfirst] Shazad Saleem and his three partners, Mukhtar Ahmad, Waqas Ahmad and Mohsan Ahmad, set up their practice in the new primary care centre in Glodwick, Oldham, in January 2008. This case study looks at how they went about developing and implementing a care pathway approach to delivering NHS dental services that would help them deliver high quality, efficient, cost-effective, personalised care in this challenging, high-needs area

For Shazad and his partners, winning the contract to set up a new practice represented a great opportunity to be involved in a service redesign project looking at different ways of delivering NHS dentistry within the current framework. 'We wanted to focus on delivering the right care at the right time, rather than on our UDA targets,' he explains. 'At the same time, we knew that levels of need would be high, especially as access to dental services had historically been poor. We needed to reconcile both factors with the need to develop a viable business.'

In Glodwick, Shazad faced a number of challenges. An ethnically diverse area, it had never had a dentist before and standards of oral health were low. 'At the start, we had 14-year-olds walking through the door who were already in need of 10 fillings and root canal treatments on front teeth,' says Shazad. 'We needed to get patients to engage with us, to start attending regularly and to commit to looking after their oral health between visits.'

Before setting up the practice, Shazad and his colleagues had joined a working group set up by public health consultant Colette Bridgman to promote clinical engagement and robust, evidence-based practice. The aim was to give dentists an insight into local patient needs and help them to develop ways of delivering care that would deliver high quality, evidence-based preventative dentistry and provide much needed access in deprived areas, at the same time as growing their business. The experience of working so closely with the primary care trust and sharing insights with other local dentists had a major impact on shaping the new service.

Creating the care pathway

As a result of their involvement with the working group, the new team was clear about the need to adopt a care pathway approach from the start. 'The *Delivering Better Oral Health* toolkit was really valuable,' Shazad says. 'It helped to focus our minds on the importance of gathering robust evidence and it created greater coherence and consistency regarding what constitutes best practice. Decisions about the kind of toothpaste children should be using, or when patients should be given fluoride varnish, should be based on evidence about what works best. That kind of information has helped us establish clear care pathways where all members of the team know exactly what each patient needs.'

The overarching aim of the Glodwick care pathway is simple: to deliver better oral health. Within that, the objective is to develop a programme of care that is tailored to each patient's individual needs. The first step is to analyse need and assess risk. 'With the help of practice staff, each patient completes a questionnaire about their social background and medical history as well as being examined by a dentist,' says Shazad. 'Then, taking an all-round view of the patient, we grade them red, amber or green according to an agreed criteria. The

process has thrown up some interesting insights – for example, that a lot of Asian women are smoking, while some Asian young men are starting to drink quite heavily. We can use that kind of information to offer people tailored information and advice as well as refer them to appropriate services.’

Initially, the team also set up thrice-weekly open access sessions in an attempt to make inroads into their 4,000-strong potential patients. ‘Anyone with a problem could come in and get emergency treatment,’ Shazad explains. ‘We did have a triage procedure but we were pretty flexible. Really, the aim was just to get people in so we could establish a relationship with them and begin to understand their needs. Following an emergency appointment they were offered a place on a waiting list.’

Following the formal assessment, a dentist puts together a prescription – using a standard format – outlining a treatment programme that will typically involve the whole practice team. ‘Most patients will see the therapist, the extended duty dental nurse and attend oral health education sessions,’ says Shazad. The prescription will also set the patient’s recall interval. ‘We make it clear to patients that they won’t necessarily see a dentist when they next come in,’ Shazad points out. ‘In some ways it’s easier setting up a new practice than changing an existing one. People have fewer expectations, which leaves us free to devise the most efficient and effective ways to deliver care.’ A bespoke IT system helps the practice to maintain and analyse accurate patient records, and to share information easily among members of the team.

Patients’ risk of developing disease in future is taken into account as well as their current state of oral health. ‘A classic example is where you’re dealing with a family of children and all except the youngest have caries,’ says Shazad. ‘For us, that child becomes a high-risk patient even though they may have no active disease. Our aim is to prevent disease rather than treating it when it has developed..’ Care pathways are then reassessed according to the category. Red patients are reassessed after one year and Green and Amber after two years. This allows us to evaluate the impact of the service and assess a patient’s progress.

Skills mix

Successful delivery of the care pathway depends on having the right skills mix in place in the practice. Within the original working group, Colette and her colleagues carried out an in-depth workforce analysis, looking at each of the tasks involved in the pathway and identifying who was best placed to carry it out. ‘It’s easy to assume that the dentist needs to do everything,’ Shazad says. ‘But many tasks can be carried out just as well, if not better, by another appropriately trained member of the team.’

Education and training have played an important part. The need to further develop skill mix was recognised by Colette Bridgman and her colleagues, as part of the workforce analysis, and, as a result, approval was gained from the General Dental Council to allow the development of a course to train dental nurses to apply fluoride varnish. The first course was at Salford University. Dental nurses who have completed the fluoride varnish courses also receive a certificate in Oral Health Education and are able to run oral health education sessions and provide advice on smoking cessation. Dental therapists are also now recognised as having a key role in supporting the dentist to deliver a range of services including prevention, education, periodontal treatment, fillings and extractions for children.

Shazad and his partners have worked hard to create a culture where all team members feel they can make a positive difference. 'We want everyone in the practice to think of patients as the responsibility of the whole team, not just the responsibility of the dentist,' says Shazad. 'We've taken care to recruit people who want to extend and develop their skills and we've told them, you're in charge of this clinic. You're responsible for helping us understand and meet each patient's needs.'

Challenges and lessons learned

Opening a practice in Glodwick, a high needs area which had never had its own dentist before, presented some unique challenges. 'Many of our patients hadn't seen a dentist for years, and some had never seen a dentist at all,' Shazad explains. 'People didn't understand the importance of preventative care and maintaining good oral health. We had to be prepared to spend time with them, talking about things like smoking cessation and showing them how to brush their teeth properly. For us, that time is an investment in the future of the practice.'

The team has also had to learn to deal with high failure rates. All patients are sent a phone or text reminder before their appointment, and the practice has also made some practical changes in order to minimise the impact of poor attendance. Following careful monitoring, it was decided to reduce the number of open access sessions from three per week to two, cutting out a poorly attended Friday morning session. Oral health education sessions now run on a rolling, drop-in basis. 'We used to make appointments, but people just wouldn't turn up,' says Shazad. 'This way, people can just join in a session after they've seen the dentist or therapist. It reduces the administration burden for us and it also makes the whole thing more relaxed and less pressured for the patients and allows us to start the education and prevention process from day one.'

Looking ahead

The practice is currently carrying out a major evaluation of the data it has gathered to date. 'In time, we hope to be able to see how many patients have moved out of the red category,' says Shazad. 'At the same time, though, we're constantly taking new people on. Personally, I don't think it's realistic to look for a big reduction in the number of 'reds'. What's more important to me is we are delivering the high quality of care needed.. We're seeing real improvements in individual patients' oral health and I know – we all know – that we're giving our patients good, thorough dental care.'

In March the practice was accepted as part of the first pilot wave of the Steele implementation programme. 'It's a sign that our work has been recognised,' says Shazad. 'That's a testament to the hard work put in by everyone in the practice and the service redesign group. When we started, I warned the team that it wouldn't be easy and that we just had to stick with it and not get downhearted. Now the time and effort we've put in is paying off, and we're starting to see the results.'

Key learnings

Create the right systems: 'We put a lot of time into setting up our IT systems so we could gather the right information and evidence,' says Shazad. 'It's still not perfect. For example, ideally we'd be able to break down our patient classification even further – so, 'red with caries' or 'red with gum disease' – so that we could analyse data more easily. No one should underestimate the amount of time it takes to get right.'

Treat each patient as an individual: 'We consider all the evidence before we classify a patient,' says Shazad. 'A patient who rates 'red' for their social history, say, won't necessarily be a 'red' patient. The level of risk depends on a whole range of factors.'

Use your skills mix: Making intelligent use of the available resources can have a big impact on waiting lists. 'For each task, ask yourself – "Does a dentist really need to do this?"'

Don't be a slave to process: 'The care pathway we've adopted includes "treatment locks" – points at which something has to happen before the patient can move on,' says Shazad. 'But again it's vital to look at the individual. If you have a young patient with a missing tooth, is it right to leave them without it even if they fail to meet the conditions you've set? You could run the risk of losing contact with them altogether. So the term "treatment lock" is not meant to imply barriers to treatment, rather it's delivering the appropriate treatment at the appropriate time.'