Department of Health & Social Care

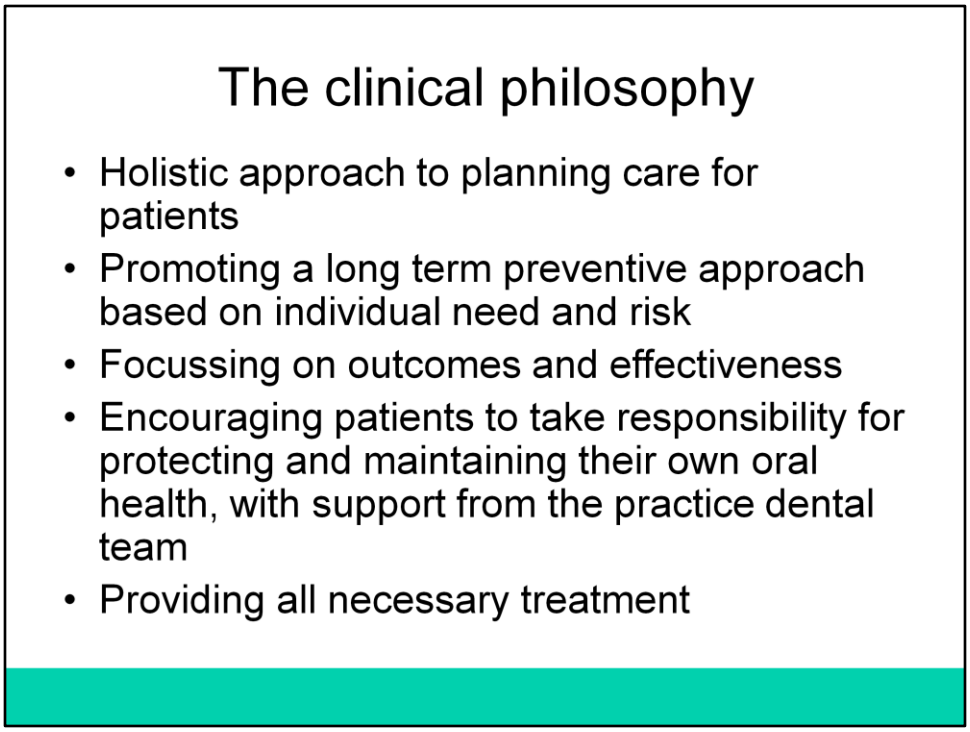
NHS England

Training pack for practices

Introduction to the clinical philosophy and pathway

Contents

- Introducing the clinical philosophy and the concept of care pathways
- The clinical philosophy in a wider NHS context
- The care pathway in the prototypes
- Patients under capitation / pathway. Patients outside capitation / pathway
- Key messages



The clinical philosophy is based on the principles set out in the slide above and takes a holistic approach to planning care. This does not replace the need for clinicians to provide all clinically necessary treatment.

Historically there has been a system that focused on individual items of care and with little focus on the long term care of patients. The pathway is about the lifetime of the patient and puts prevention at the heart of services that clinicians provide. This is not just important for dentistry but for the whole of the NHS.

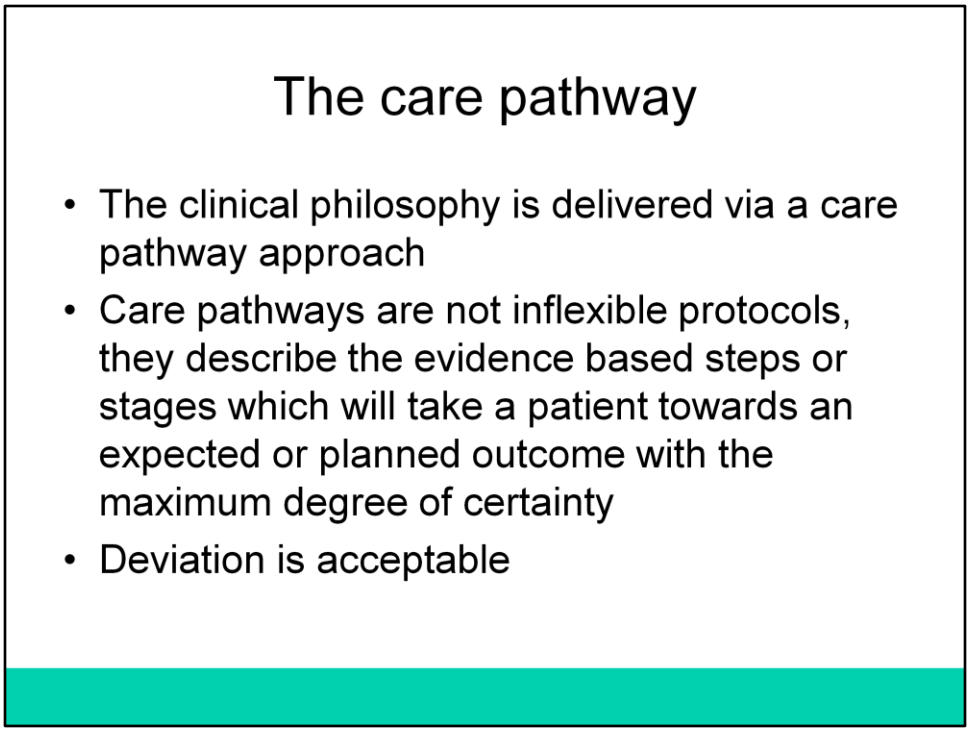
The focus is not just on the process but what clinicians achieve though their clinical interactions with the patients, the effectiveness of these interactions and their outcomes.

An important part of the approach is ensuring patients take some responsibility for their own care. Again this is a common theme of what is happening across the NHS as a whole.

The pathway works within the current regulatory framework. It is therefore important that all clinically necessary treatment that a patient is entitled to is provided as would be the case if they were attending a UDA practice.

However, it may be clinically appropriate to defer that care until a time when the

patients' oral health has improved to a point that the more complex care will be more successful. This should be done as part of in an informed conversation with the patient.

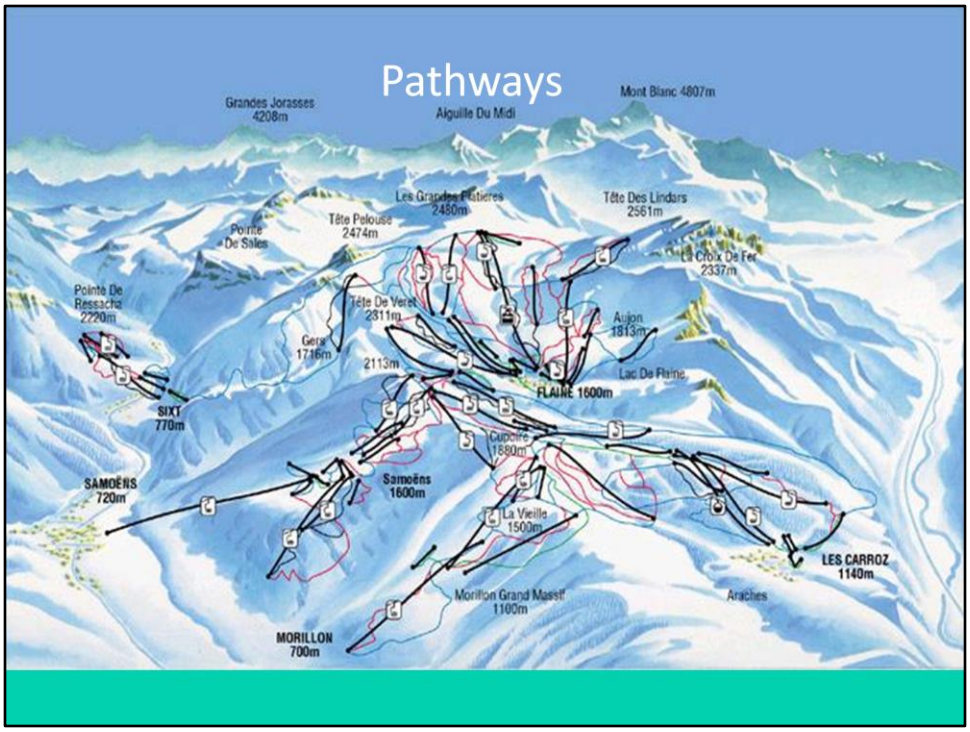


The clinical pathway has been at the heart of dental contract reform from the start of testing. No changes to the pathway approach have been made to date and this same preventative approach will continue in this phase.

The programme rests on the concept of the care pathway.

Pathways are not a unique idea to dentistry and are common across a number of clinical services.

The care pathway is the suggested journey a clinician takes the patient on to secure improved health for the patient. At each stage of the journey, the pathway provides the opportunity for the clinician to recommend/make interventions based on evidence that provide a degree of certainty that the proposed treatment will work. However it is important to note that deviation from the pathway is acceptable based on clinical judgement of the dentist.



The example of pathways looks at the routes a skier they may take down a mountain; these are pathways just like clinical pathways.

The skier gets up in the morning with objective of going to the top of the mountain and coming down to the bottom safely - that is the outcome. However, there are a number of suggested routes the skier could take dependent on their level of skill and they will choose the run appropriate to their skill. They can be certain they will arrive at the bottom of the mountain if they follow that track.

However, they might know that at a particular point in the system, eg 10am when the ski schools starts, that there will be a blockage. Experience tells them that, whilst theirs may be an obvious route, it may go through that area where there will be congestion. Because of the skiers knowledge and experience they may decide to take an alternative route that they are confident will get them to where they want to be.

It is exactly the same with the clinical pathways.

The programme and the software that supports clinicians has been developed to support some of the potential decisions that will take the patient through the clinical pathway. It is absolutely acceptable if, based on their knowledge, experience and the information they have about the patient and systems around them, for clinicians to decide to take slightly route. It is their clinical responsibility for the patient.

However, there is evidence that good evidence based guidelines will naturally lead to the outcomes that the pathway suggests, so in the majority of cases clinicians are likely to take the suggested pathway.

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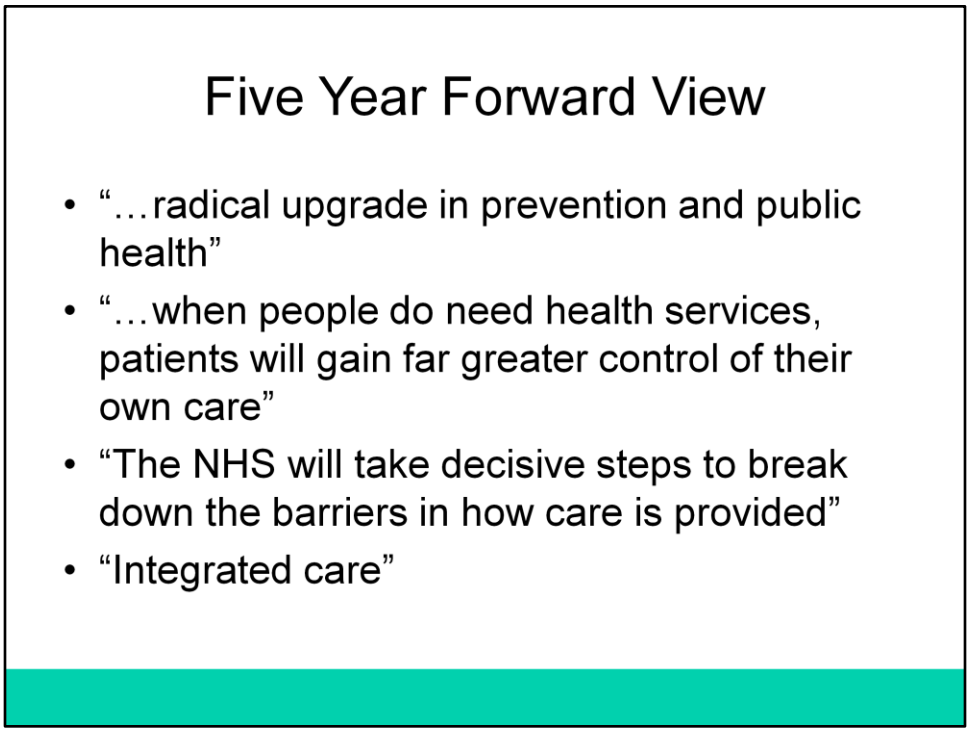
The clinical philosophy sits in the wider context of the direction of travel for the NHS that is set out in the *Five Year Forward View*, first published October 2014

The *Five Year Forward View* has been led by NHS England but it has been signed up to by all other key parts of the health system including Public Health England, Health Education England (workforce), the Care Quality Commission, Monitor, the Trust Development Authority.



The direction in which reform programme is moving is in line with the aspirations that are set out in the *Five Year Forward View* as the quote from the executive summary in the first bullet above shows. It is about a radical upgrade to prevention and public health and the programme has put this right at its heart since the beginning. The pathway is based on a proper risk assessment for patients being carried out, setting out the necessary prevention they should have and helping them to take responsibility for their own care as they move forward.

This links to the second bullet point, which sets out that patients will have far greater control of their care, and will be given the tools for this together with the help and support on a daily basis to do things that will make a difference to their oral health.

The *Five Year Forward View* says the NHS will take decisive steps to breakdown any internal barriers.

NHS England has developed commissioning guides and is looking at the interface between what happens in primary care, what is done in hospital, referrals that are made and the principles about when patients should have certain levels of care based on the complexity of their oral health.

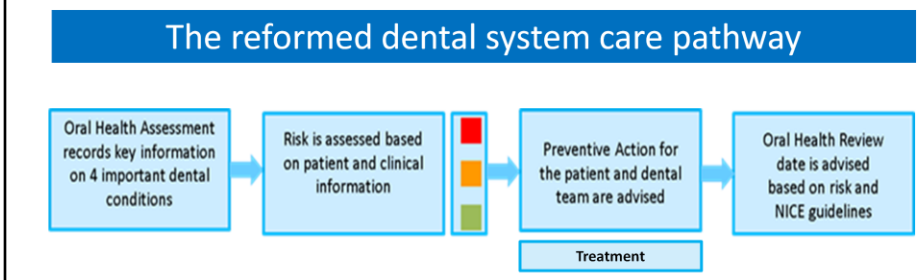
There is a framework within which practices have to work and rules and information that must be delivered back into the system for purposes of contract monitoring and evaluation of how the prototype arrangements are working. How this is operationalised is not specified by the programme but is for individual practices to determine but they must be able to show that they are following the care pathway approach

In summary the pathway philosophy approach is in line with broader NHS England policy.

Five Year Forward View

- "…radical upgrade in prevention and public health"
- "…when people do need health services, patients will gain far greater control of their own care"
- "The NHS will take decisive steps to break down the barriers in how care is provided"
- "Integrated care"

Clinical pathway



Clinical pathway

The reformed dental system care pathway

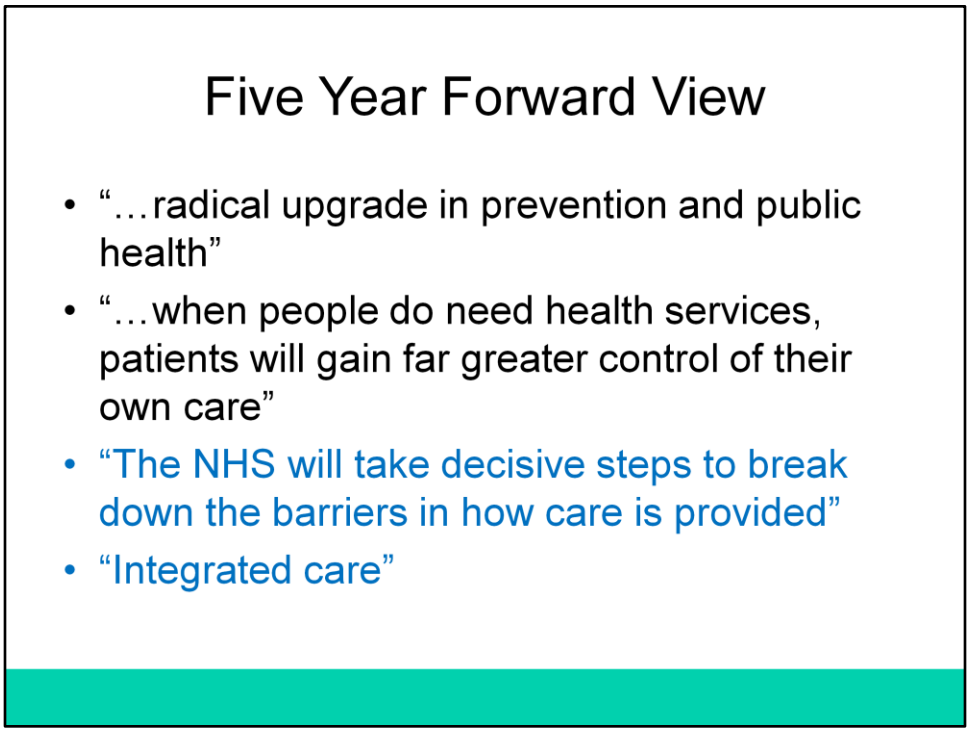
Oral Health Assessment records key information on 4 important dental conditions

- Caries
- Periodontal disease
- Tooth surface loss
- Soft tissues

Risk is assessed based on patient and clinical information

Preventive Action for the patient and dental team are advised

Oral Health Review date is advised based on risk and NICE guidelines



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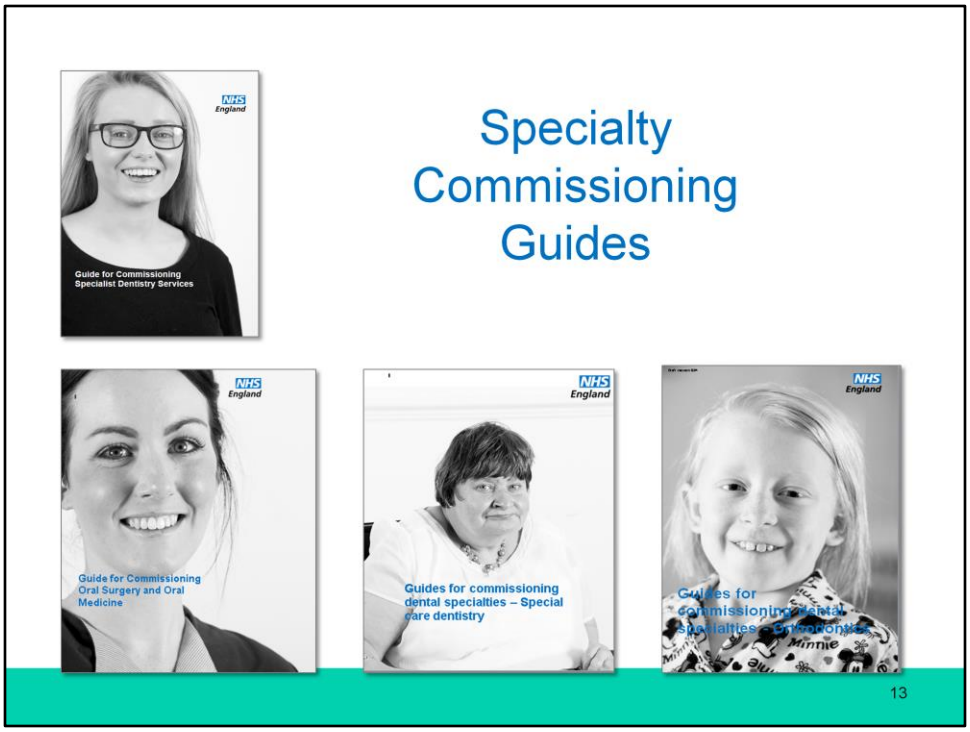


You will no doubt have heard about the specialty commissioning guides that are intended to create a new system of delivering complex care that clearly defines the relationship between primary care and delivery of specialist care.

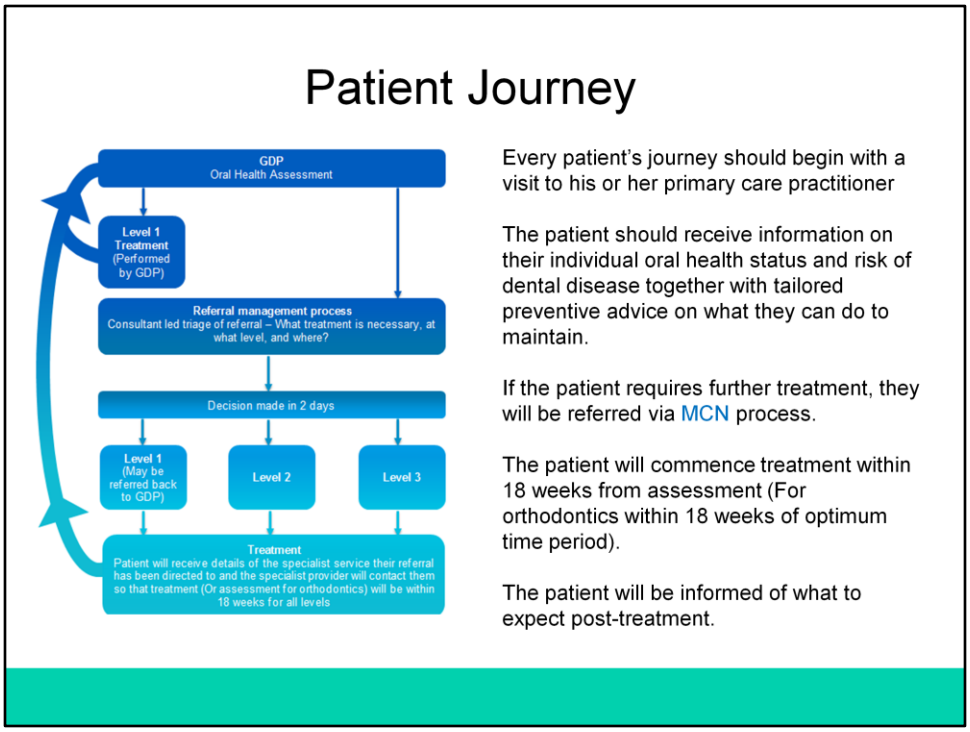
There is an overarching guide which sets out the common principles of each of the specialty guides.

Five have published to date:

- Oral Surgery
- Special care dentistry
- Orthodontics
- Paediatrics
- Conscious sedation

The web link to these guides is here
https://www.england.nhs.uk/commissioning/primary-care/dental/dental-specialities/

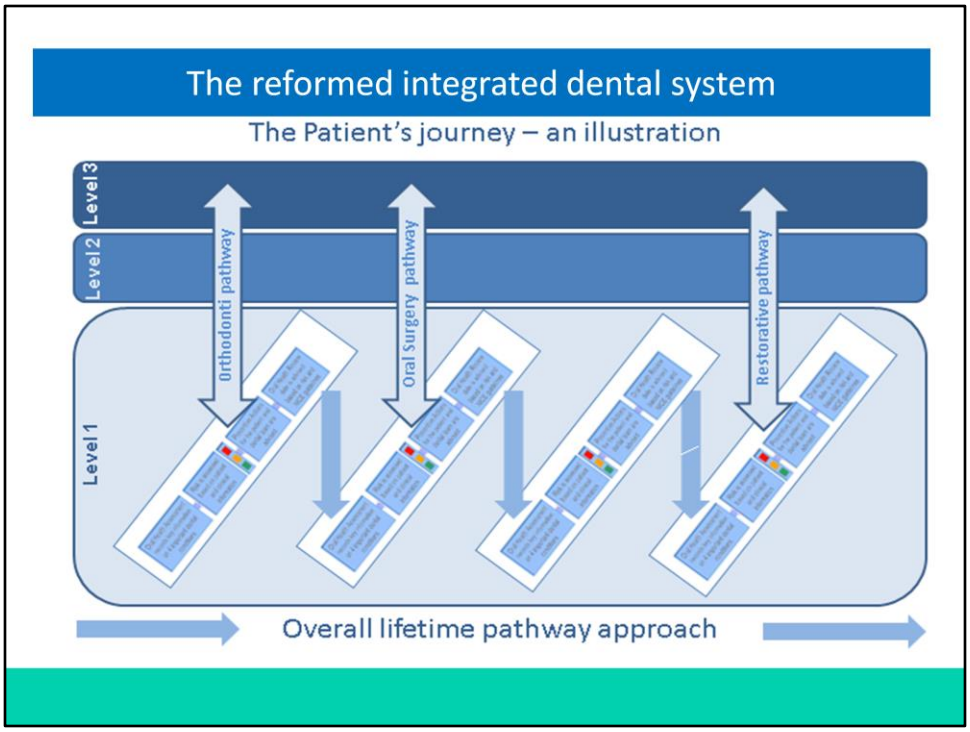
More will follow including restorative care.



The introductory guide contains an important diagram which captures how the patient journey (the care pathway) works.

The process starts with the patient visiting a primary care dental practitioner who will conduct an oral health assessment and provide the patient with information on their oral health status and risk of dental disease together with tailored preventive advice about what they can do to maintain their oral health.

A cornerstone of the pathway is that it must not be seen in isolation from the system development that is taking place alongside the programme reform


The reformed integrated dental system
The Patient's journey – an illustration
Level 3
Level 2
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Orthodonti pathway
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Overall lifetime pathway approach

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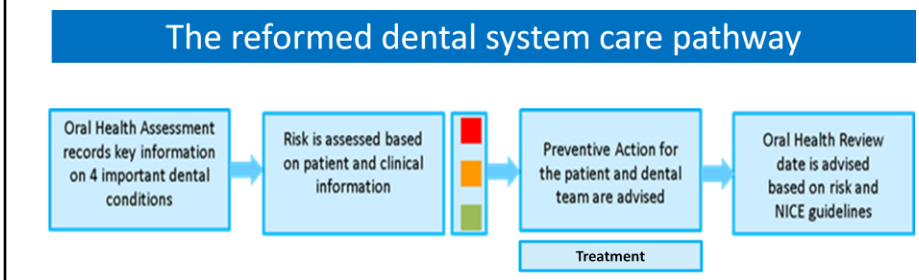
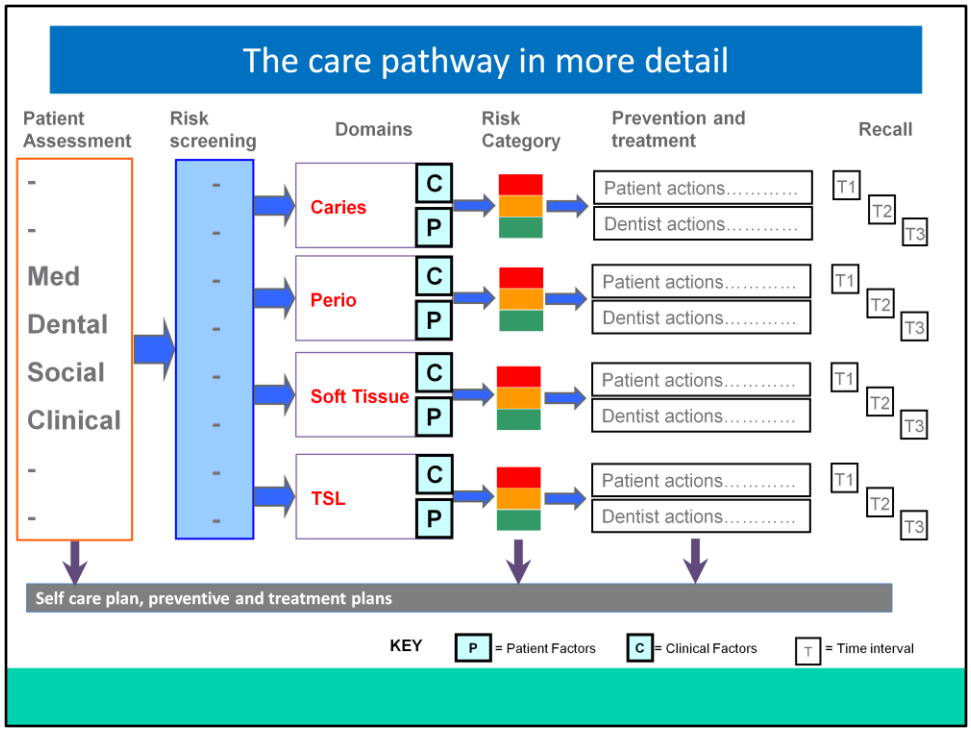
Clinical pathway





Whilst each clinical area has its own RAG rating with dentist and patient actions, an aggregated RAG score is given. Consolidated actions are provided via the software to help the clinician to determine the patient's risk status. It is up to the clinician to prioritise which areas to focus on with the patient.

The risk assignment takes account of the levels of existing disease and modifying factors that could contribute to current or future problems.

Some modifying factors can be altered through changes in patient behaviour. Therefore, to provide care that meets the oral health needs of each patient, it is important to provide the patient with information specific to them which reflects the dentist's assessment of their individual risk of developing oral diseases and conditions. The self care plan includes appropriate preventive advice and treatment options to improve the patient's oral health and reduce the patient's risk level.

The left hand side of the slide shows the data set that has been captured from the patients – the patient factors (Medical and Social History). These are modifying factors which may or may not influence the clinical domains. Generally speaking the clinical factors take priority over patient factors, but it is possible for clinical factors to be modified by the others.

The next stage is the comprehensive examination of the patient, working through the template provided by the software

Dentists will complete information about the 4 domains; Caries, Perio, Soft tissue and Tooth Surface Loss and will see how the patient modifying factors can influence the ultimate RAG score eg for TSL the diet of the patient that the clinician has ascertained via the social history and conversation will all influence factors within those domains.

Dentists will recognise the clinical diagnosis for each of the domains from their normal clinical practice.

Combining the clinical factors and the modifying patient factors starts to drive the risk matrix that produces the RAG score. This will not decide the treatment given as this is a clinical decision for the dentist. The RAG score will inform the patient's risk status and preventive advice to be given and the possible recall period for the OHR.

The care pathway in the prototypes

- Oral health assessment (OHA) including risk assessment and planning oral health review (OHR)
- All necessary treatment/stabilisation if required
- A personalised self care plan
- Preventive care and advice
- Arrange for any further treatment including referral if required
- Interim preventive care and advice (if needed)
- Oral health review (OHR) (refresh of OHA)

This presentation will now take you through the pathway components. It will look at:

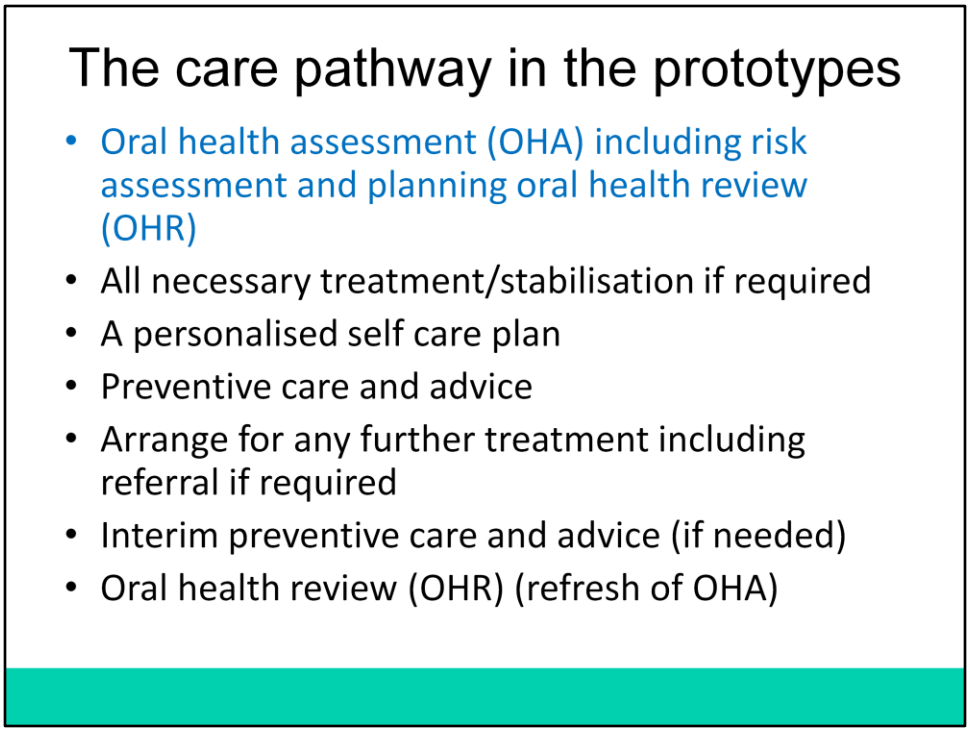
- the oral health assessment, what data is collected by the dental team and how that influences the matrices within the software as well as looking at suggested ways of managing clinical care following the OHA and the flexibility that is built into the prototype system

- the self care plan, this a written message tailored for the patient that reinforces what they have heard from the dental team and is given to the patient for their information and reference.

- how preventive care and advice can be given

- interim care visits which may be different to the way of working that you are used to under a GDS/PDS contract

- the oral health review (OHR) This follows the initial OHA appointment at recall interval recommended by the dentist.



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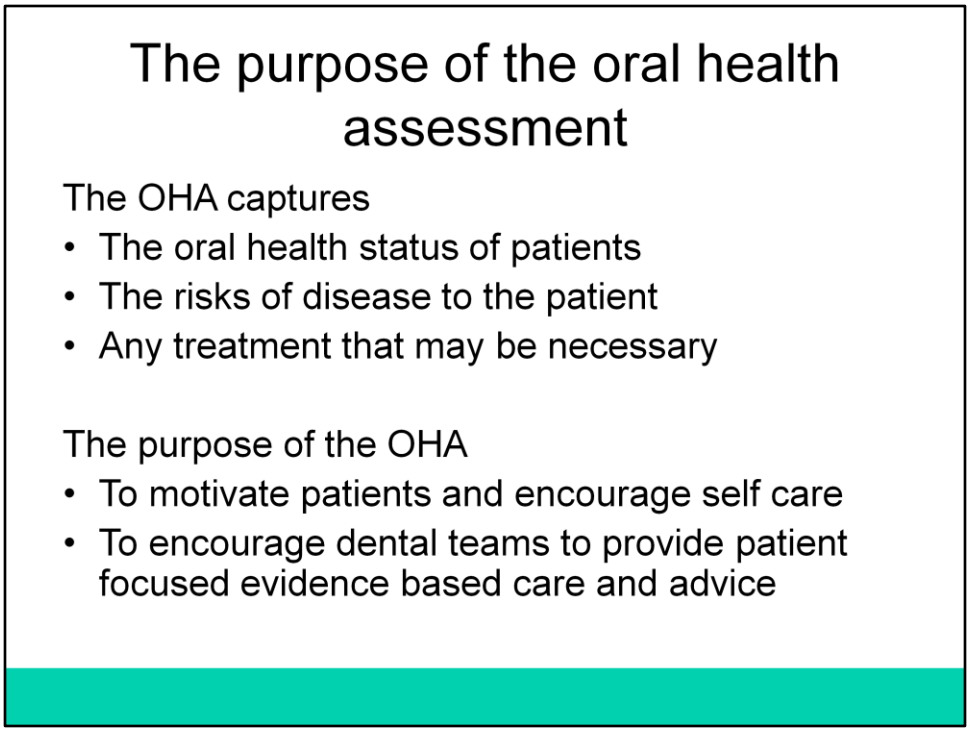


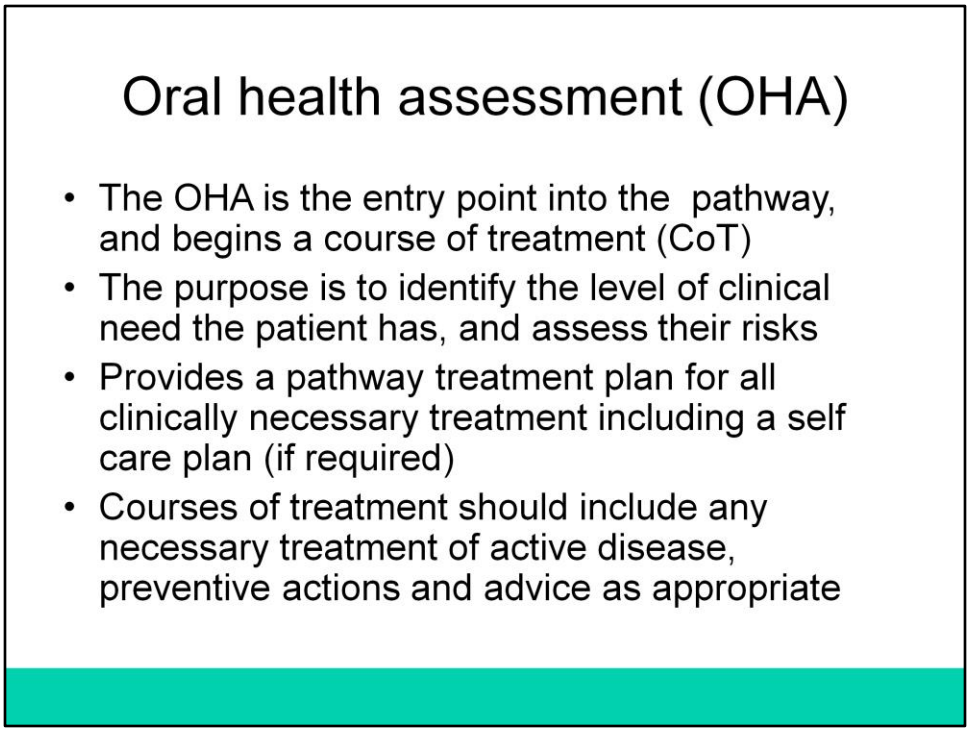
In summary the OHA will capture the oral health status together with the risk of disease for each individual patient.

The OHA provides the opportunity to motivate patients and encourage them to take ownership of their own oral hygiene as well as identifying if any treatment that is required.

It is important to remember that the dentist does not necessarily need to deliver all care.

The whole dental team can be involved in the patient's care. The contract holder may wish to consider how best to maximise the strengths and skills of the team to involve everyone in delivering the care pathway.

Practices vary hugely in size and shape so one size will not fit all, but this is an opportunity for a practice to think about how to flex and develop the team.



The level of risk for each disease area will suggest an appropriate interval for a further clinical assessment called the oral health review (OHR), this is driven by matrices.

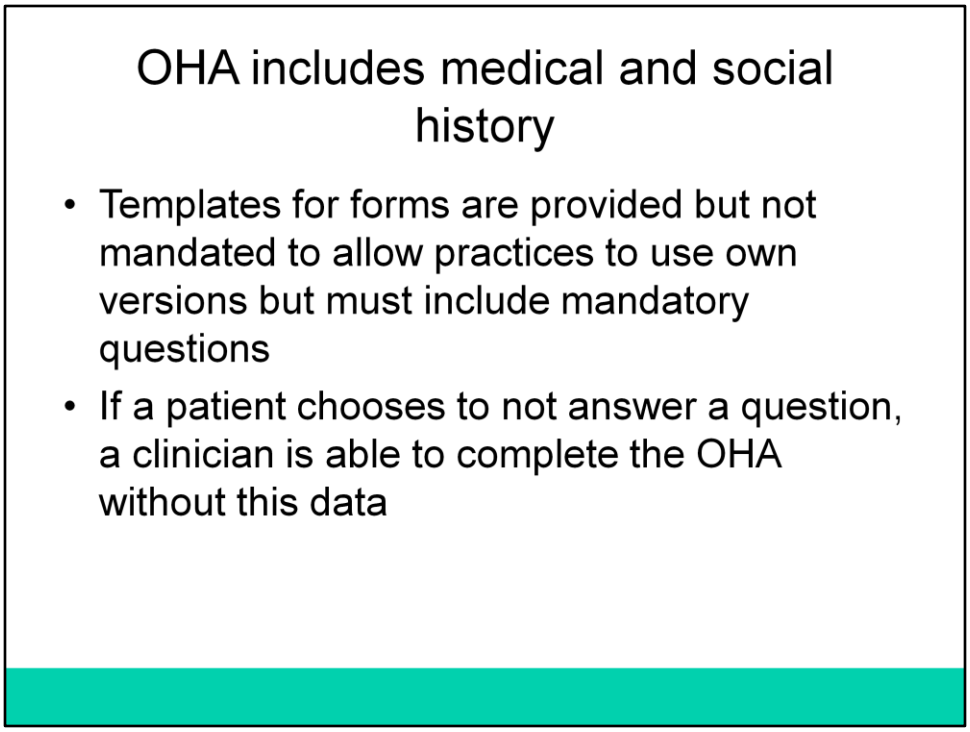
The software automatically generates a suggested OHR interval based on the information that has been captured about the patient. Where there is risk in more than one domain, there may be different OHR intervals suggested for each area of risk. For example, in the case of periodontal disease the level of risk may suggest an OHR of 12 months but the risk for caries may suggest an OHR at 6 months. In this instance the recommended interval for recall of that patient will be six months.

Where a practitioner amends the patient risk rating (RAG score) they may also need to amend the OHR interval accordingly.

The software gives guidance for treatment planning and subsequent patient visits based on the information collected about the patient. It is not intended to override good clinical judgement, but rather to support dentists to use their clinical experience and judgement. It is about prompting dentists to consider how they are going to deliver care which might be different to how care is delivered at the moment.

Whilst there is no change with regard to courses of treatment and the necessary clinical care being delivered to treat patients' active disease. However there is an

emphasis on preventive advice, and dentists have the flexibility within the system to give this advice as and when it is clinically appropriate

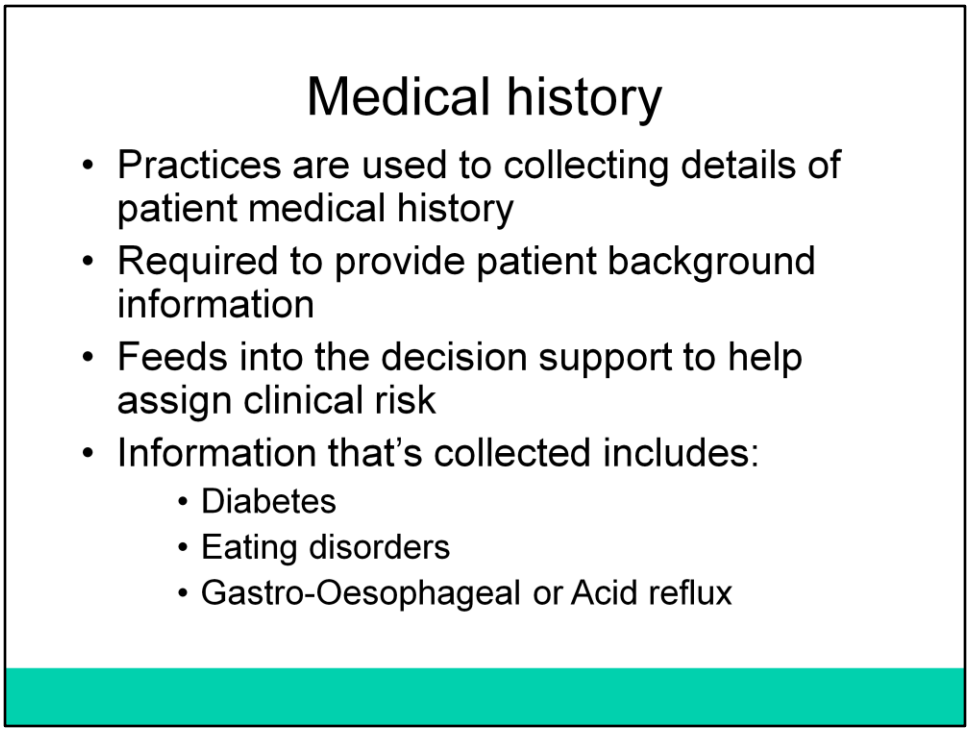


The matrices within the software generate the suggested care pathway for the patient based on the oral health assessment and the information contained in medical and social histories.

Practices can use their own medical and social history forms as long as the mandatory questions are included in both. Templates for forms can be downloaded from: http://www.pcc-cic.org.uk/commissioning/dental-contract-reform

If, for any reason, a patient chooses not to answer a question then the OHA can be completed without this data as the matrices should generate a risk rating for any given clinical domain based on the assessment information entered.

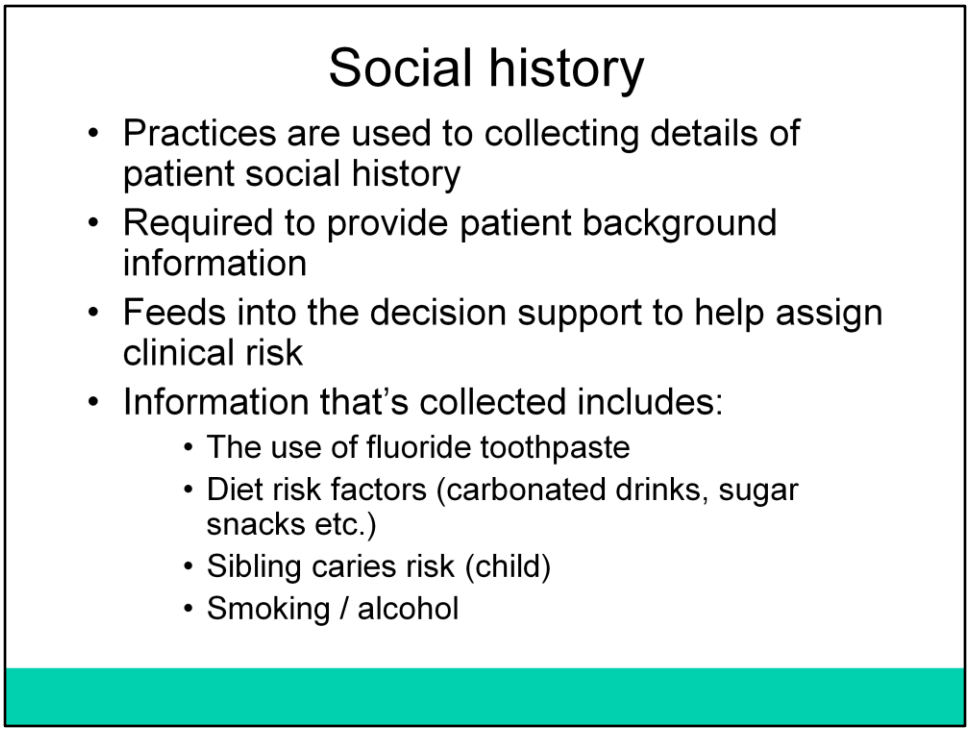
It is important to make a note of any questions that are not answered in the patients notes along with any reasons.



The medical history form is required to provide additional patient background information that may have an impact on the clinical domains.

It should be emphasised that it is not designed to be a complete medical history to meet all care requirements, but simply to enable the preventive care pathway matrices to function. Practitioners may wish to add to these forms as they consider appropriate.

The matrices should generate a risk rating for any given clinical domain based on the information entered.

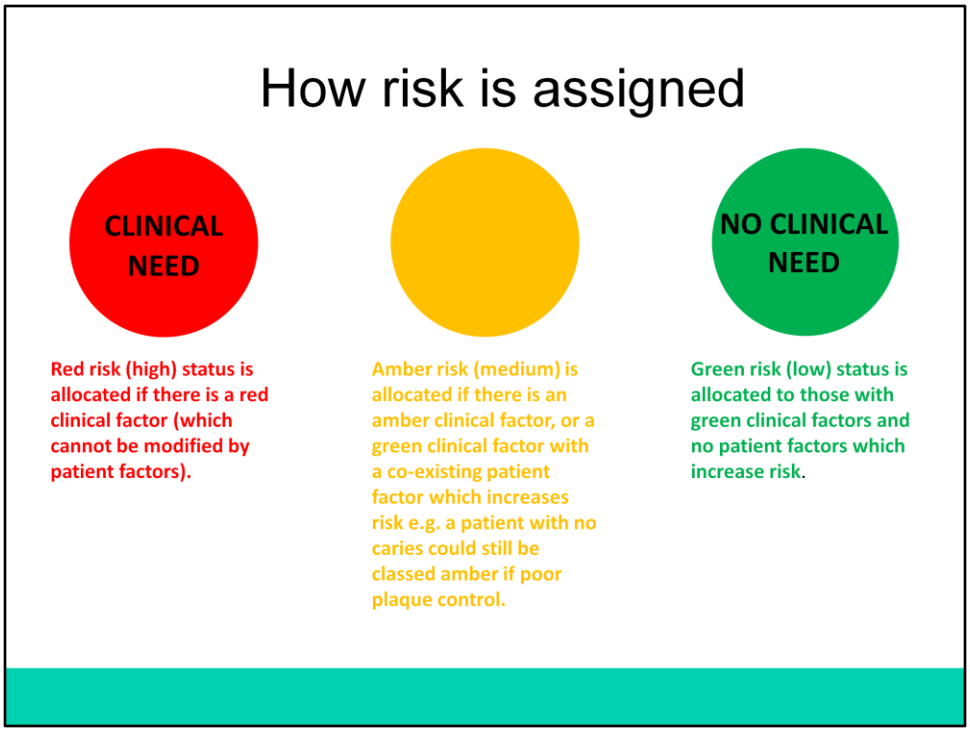


The social history helps to identify particular modifying factors that may have an impact on the clinical domains. These are factors that patients can control e.g smoking and diet.

It should be emphasised that the collection of information about these factors is not designed to be a complete medical and social history that meets all care requirements, but simply to enable the preventive care pathway matrices to function.

Practices may wish to continue using their own forms for collecting personal information but in order to ensure the pathway can be generated by the software, the questions included on the suggested prototype medical and social history forms must be included

Practices may use or adapt whichever form they consider appropriate to collect information. For example, alcohol and smoking questions are included within the questions for adults, but practitioners are likely to wish to ask adolescents the same questions, where it is deemed appropriate to do so.



A patient will receive a red RAG score if there are red clinical factors that are not able to be modified by patient factors.

A patient with a green RAG score will not have any clinical risk factors and that there will be no influencing or modifying patient factors.

The amber risk category is more complex, for example a patient may not have been diagnosed with active caries but if they have poor oral hygiene or other modifying factors such as poor diet / an orthodontic appliance etc this will tip the balance from them having a green rating with a low clinical risk having an amber risk.

RAG Scores

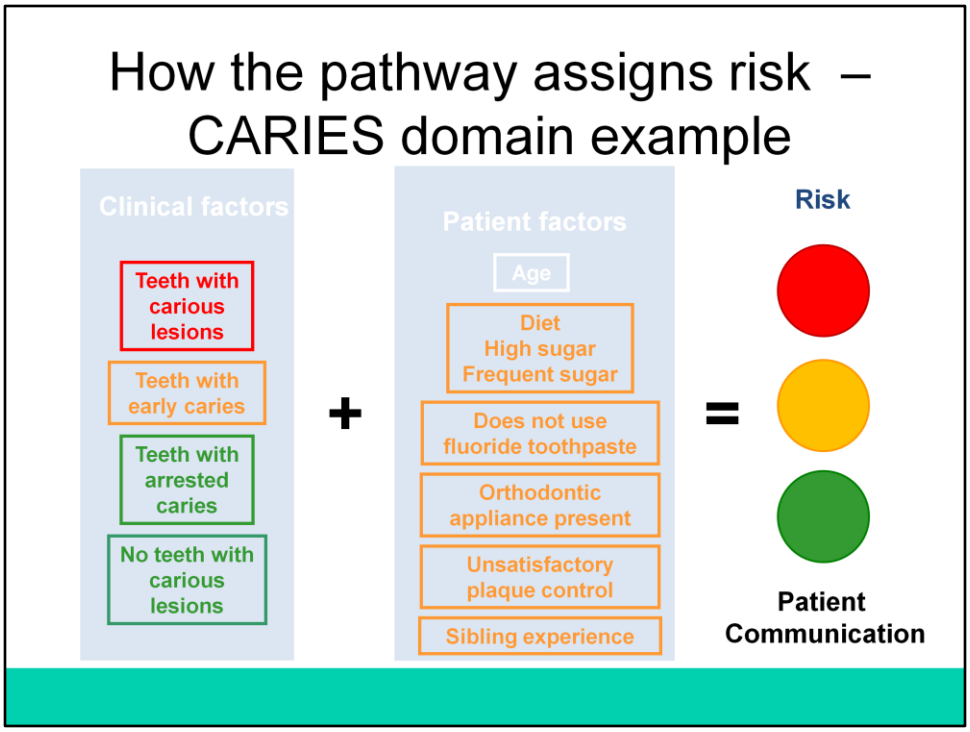
The various possible combinations and the resultant RAG status that are generated by the decision support

DISEASE OR CLINICAL FACTORS PRESENT	ARE PATIENT RISK FACTORS PRESENT?	SUGGESTED RAG SCORE GENERATED
No disease or clinical factors	No	
No disease	Yes	
Risk of disease or clinical factors	Yes*	
Disease present	No	
Disease present	Yes	

Remember: clinical factors take precedence over patient factors but there is **one exception** (see asterisk* in table above). This single exception is in the soft tissue domain, where presence of lesion in a high risk site triggers a red RAG.

The way the RAG rating is determined is dynamic, eg for a patient with a green RAG for clinical there may modifying patient factors that means their status is amber.

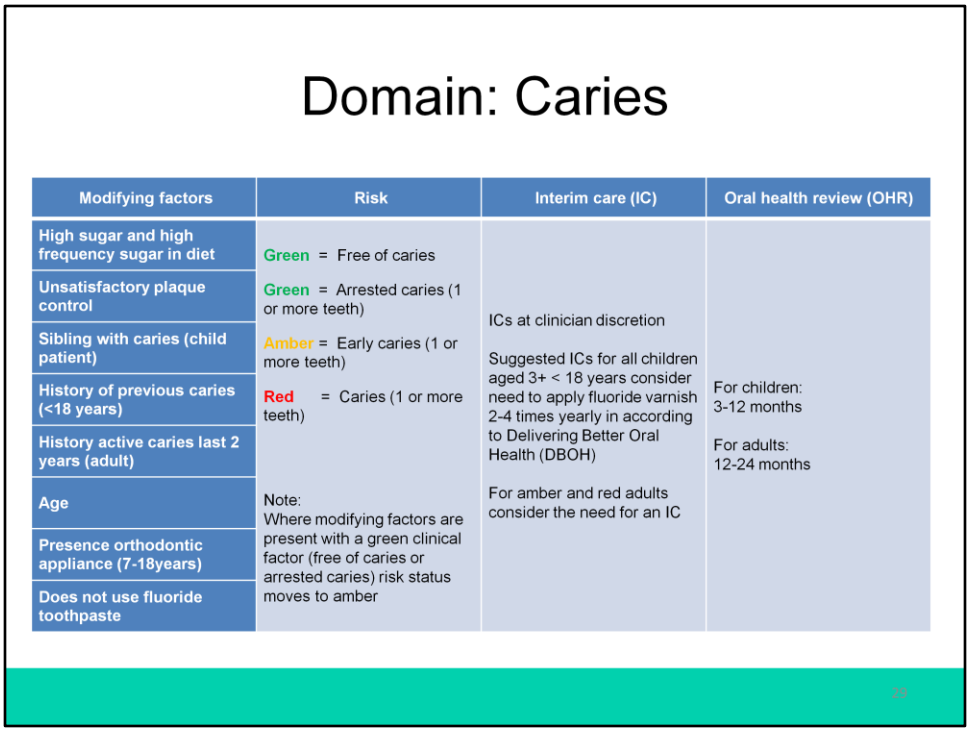
If disease is present this will take priority over everything else, even if there are other green or amber modifying factors and the overall status will be red.



Caries Domain

The clinical factors and their associated Rag status would be:

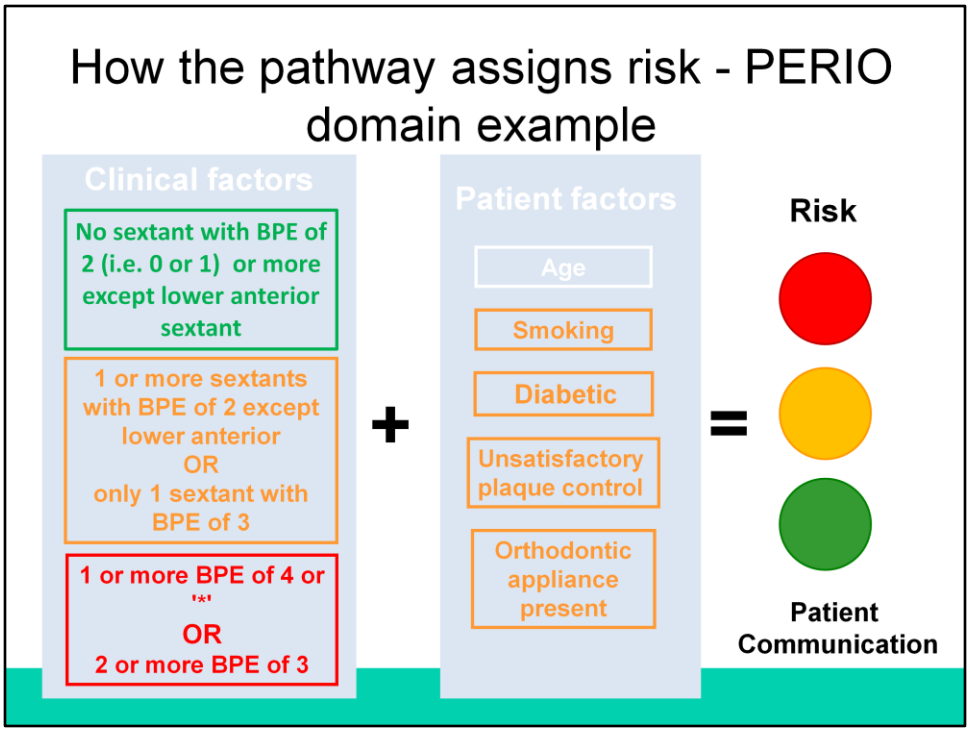
- Active caries lesions (Red)
- Teeth with early caries (Amber) – may be amenable to prevention. Prevent what you can prevent, treat what you have to.
- Teeth with arrested caries (Green)
- No teeth with carious lesions (Green)



The RAG score leads to possible next steps, eg an interim care visit but it is up to clinicians to determine the need for this based on whether it would deliver clinical value for the patient.

Delivering better oral health guidance suggests that patients may benefit from fluoride varnish or higher fluoride content toothpaste and so the dentist might want to consider including fluoride advice and or treatment into an interim care appointment to reinforce the messages given at the oral health assessment. It is at the discretion of the clinician.

The RAG rating will also influence the recommended recall interval.



Periodontal domain

BPE scoring codes and possible care options care will be recognised by dentists from good practice guidelines for example that published by the British Society of Periodontology.

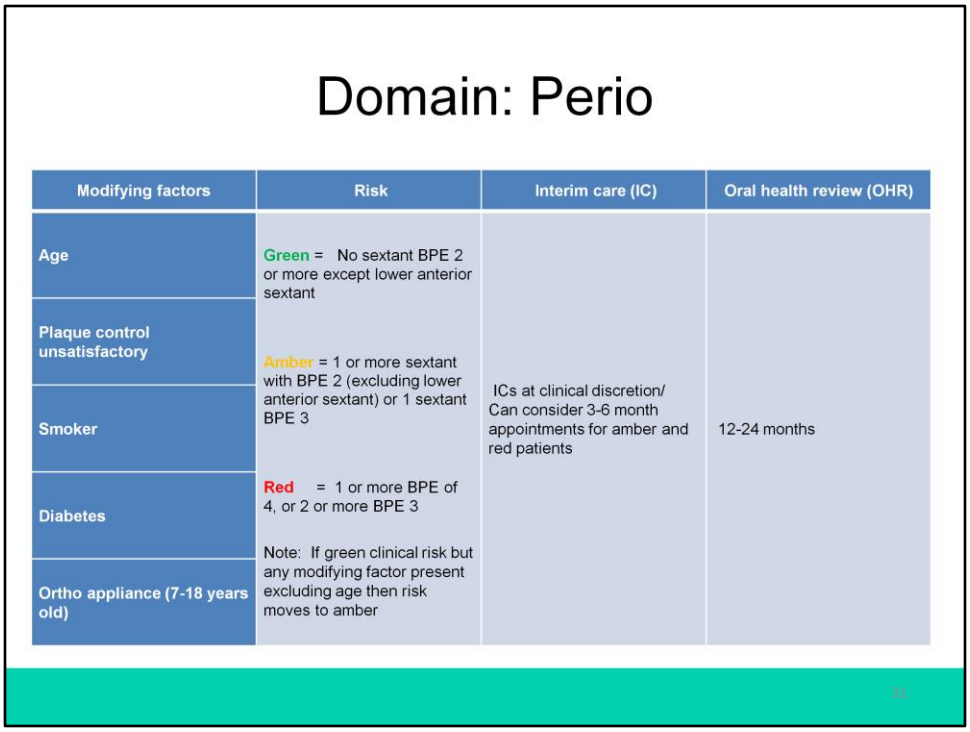
BPE scoring codes support the risk assessment of the patient including the modifying patient factors.

The modifying factors are:

- Smoking
- Diabetes
- Unsatisfactory plaque control
- Orthodontic appliance present

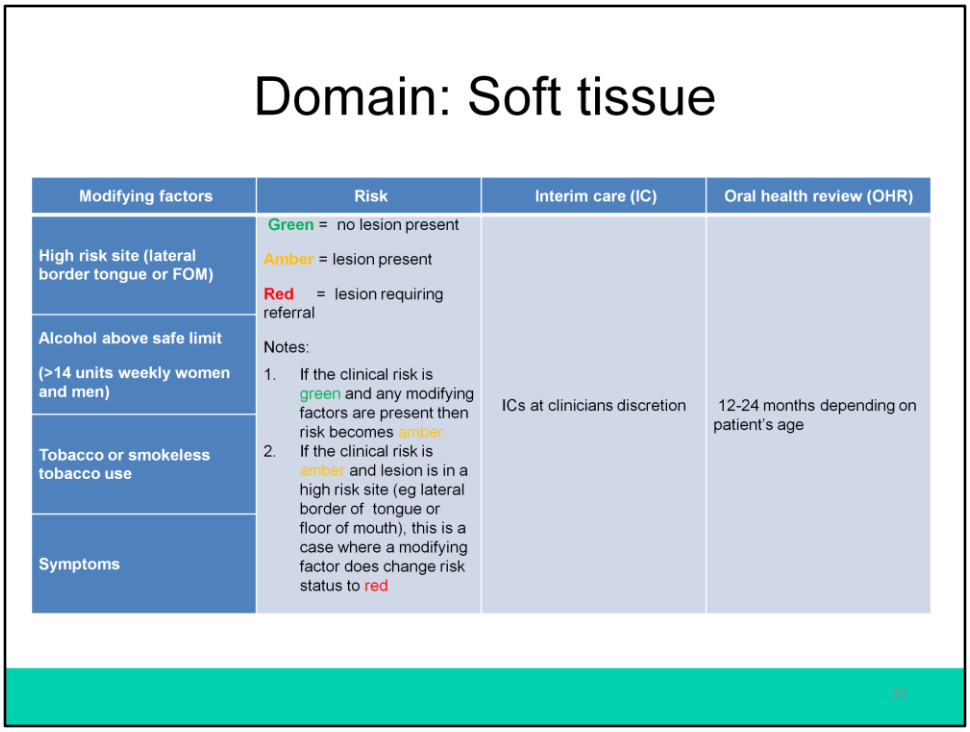
Early feedback from practices in the programme indicated that they found having a RAG status for this domain was the most useful because it helped them to communicate with patients. Clinicians were able to give patients a clear message that they needed to take responsibility for their dental disease and that there were miles stones that they expected patients to achieve. The

dentist would provide the treatment they needed but success relied on patients taking ownership of their own dental health.



Interim care (IC) is provided at the discretion of the clinician if it is thought that it will benefit the patient.

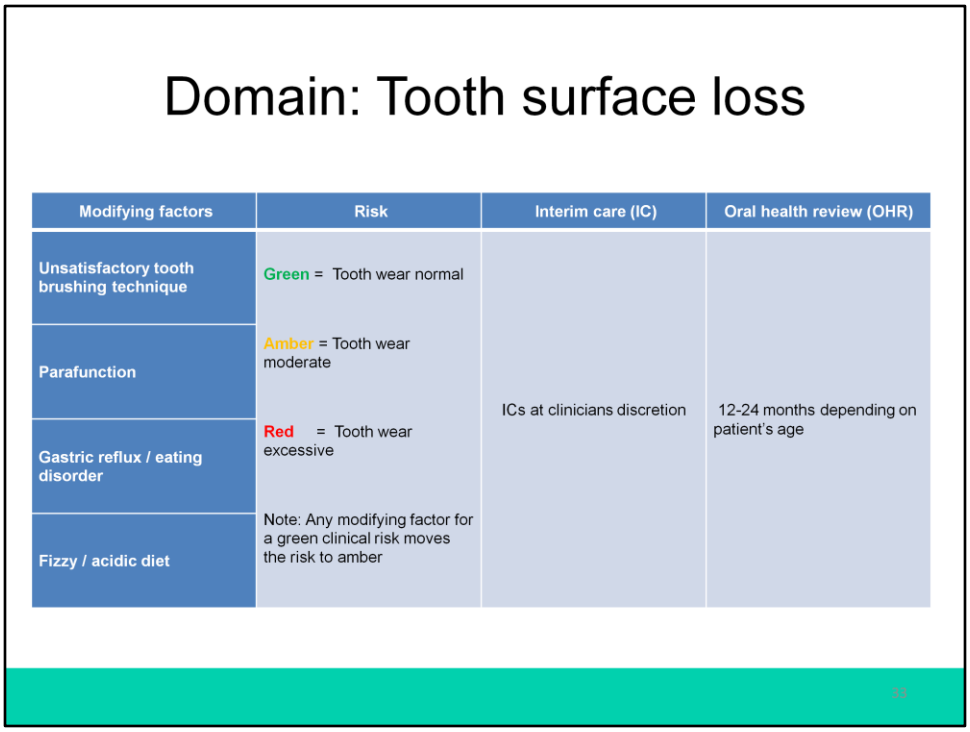
If there is need for an IC then the next step is to consider who is the best person to provide that course of treatment. It does not have to be the dentist, it could be a therapist, hygienist, or EDDN.



Soft Tissue Domain

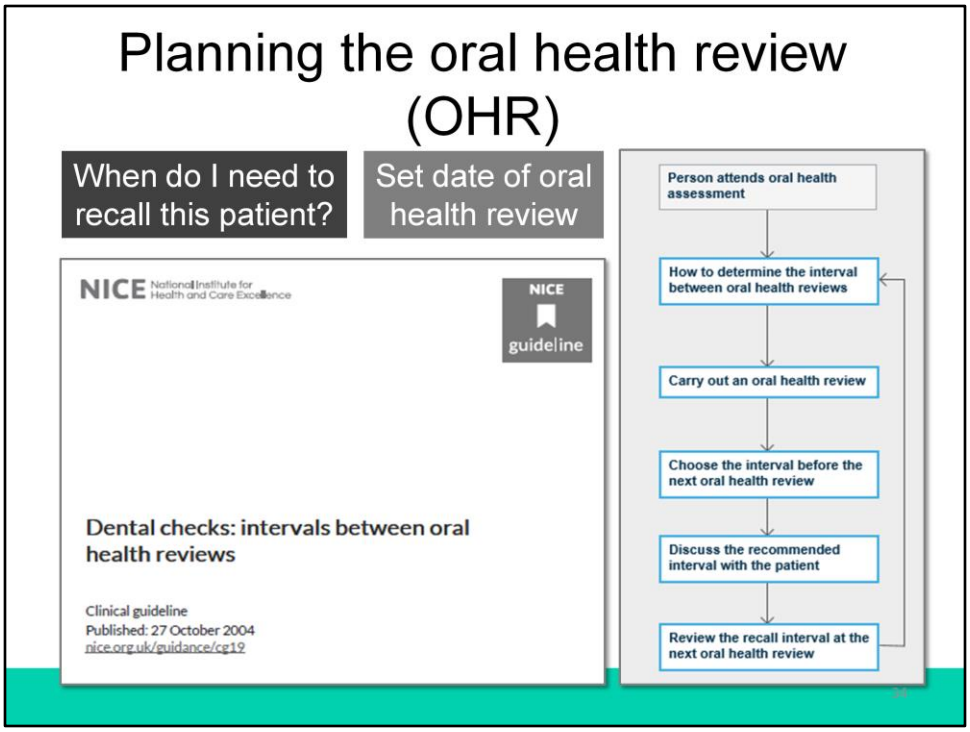
The software template divides the mouth into zones in accordance with the degree of risk in each area of the oral cavity. The matrices within the software modify the assessment of a lesion in relation to its location in the mouth and or, if there is a modifying factor within the patient's social history such as alcohol.

This is not overriding a dentists clinical judgement or experience in managing lesions but prompting them to consider the modifying facts and risk areas.



Tooth Surface Loss (TSL) can be a complicated area to fully assess and treat.

For the matrix it is simply normal (low), moderate (medium) or excessive (high). Some early feedback from practices indicated that practices felt this INDEX was not sensitive enough, dentists therefore may wish to collect additional information including further analysis of the patient's occlusion or another preferred wear index such as the Basic Erosive Wear Examination (BEWE). Again, providing the information required to drive the matrices is collected, dentists can make further assessments depending on their own clinical experience.



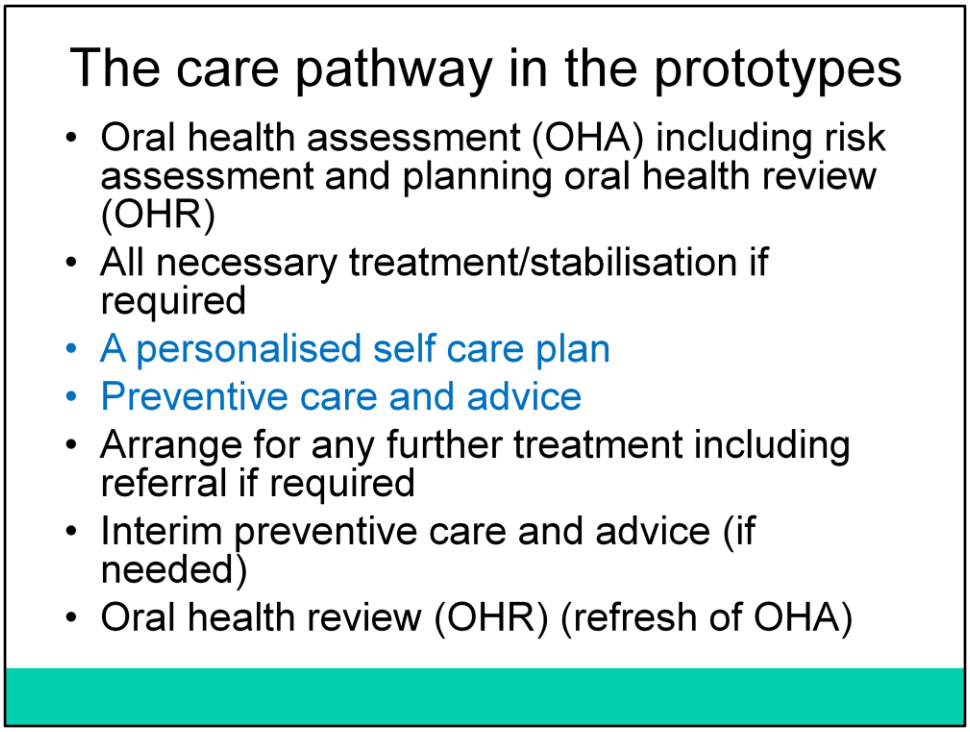
Practices will recognise the NICE guidelines on intervals between oral health reviews. There are variations between all practices about how these guidelines are applied

The pathway is based on NICE recommendations and the matrices suggest recall visits based on NICE.

There may be good reasons for modifying the recall period based on clinical discretion and informed discussion with the patient. However, if the guidelines are routinely ignored appointment books will fill up with patients who clinically do not need IC visits and short recalls.

Some practices manage their appointment books well and are very mindful of this. However others have not been so careful and have suffered the consequences of appointment books being congested with untimely oral health reviews. Clinicians need to be sure it is the right clinical decision for that patient.

Whilst clinicians can decide how NICE guidance is applied, they must ensure they can evidence the reasons why if they have not adhered to it.



This presentation will now take you through the pathway components. It will look at:

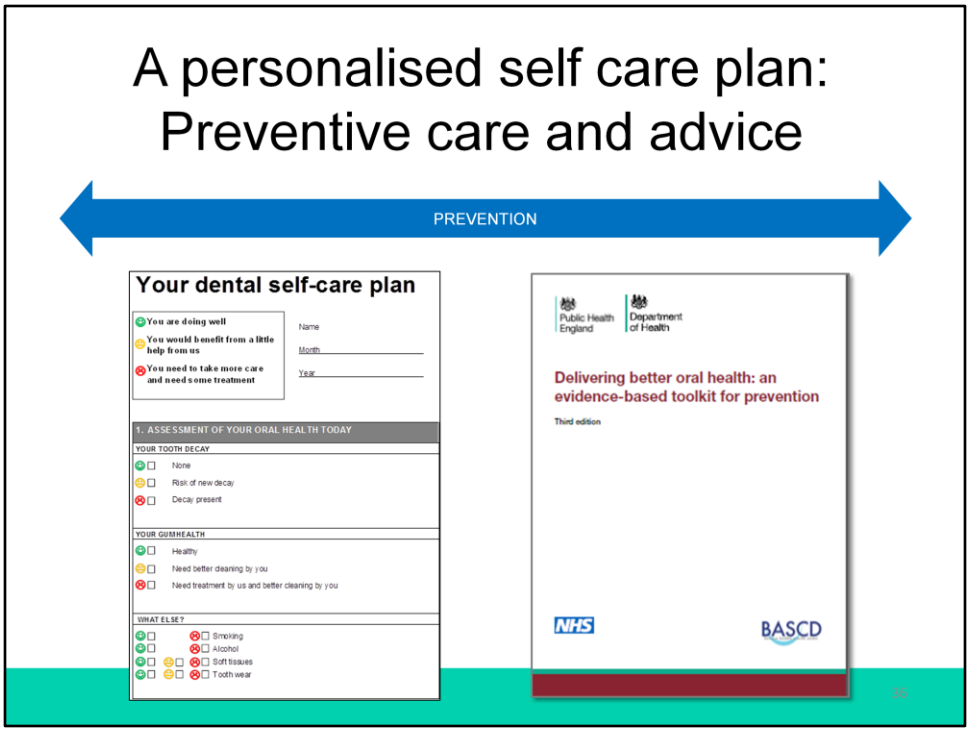
- the oral health assessment, what data is collected by the dental team and how that influences the matrices within the software as well as looking at suggested ways of managing clinical care following the OHA and the flexibility that is built into the prototype system

- the self care plan, this a written message tailored for the patient that reinforces what they have heard from the dental team and is given to the patient for their information and reference.

- how preventive care and advice can be given

- interim care visits which may be different to the way of working that you are used to under a GDS/PDS contract

- the oral health review (OHR) This follows the initial OHA appointment at recall interval recommended by the dentist.



At the oral health assessment information has been collected about the patient's medical and social history, will have been clinically examined and a provisional treatment plan will have started to form based on the RAG score and Self Care Plan (SCP)

The next stage is to communicate to the patient their level of risk generally and in each of the domains, and to discuss how their active or potential disease is going to be managed, including any treatment needed and prevention advice.

Evidence & Learning from the early practices involved in contract reform indicated that practices successfully encouraged patients to manage their own oral health when dentists spent a few minutes talking through the self care plan with the patient so that they understood what it meant and the expected milestones for managing their treatment.

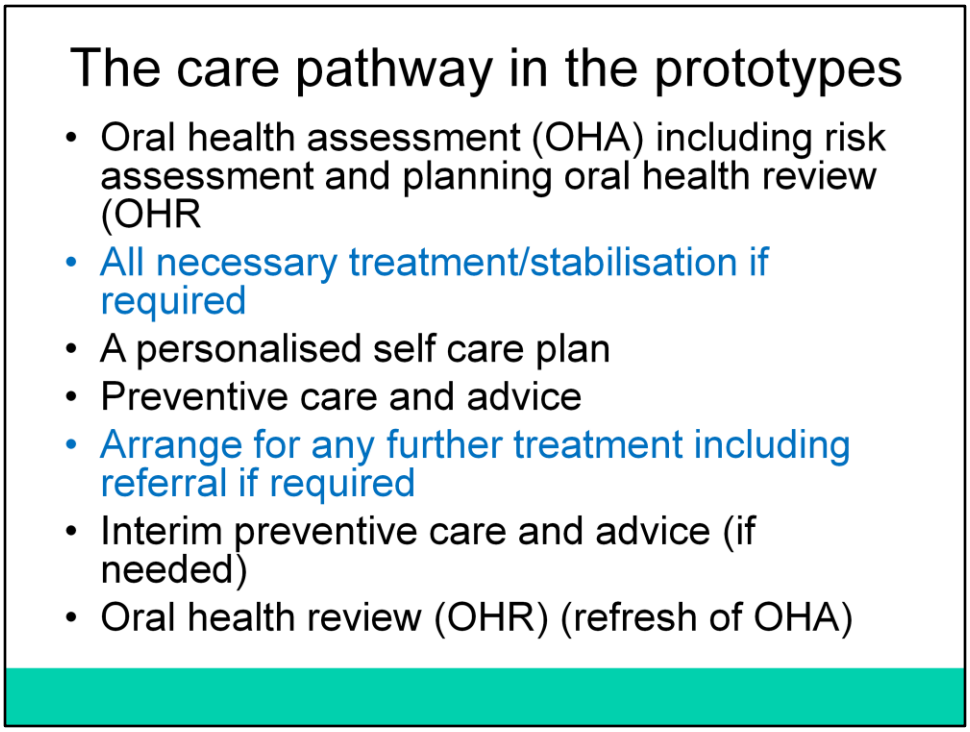
The self-care plans should be used as clinicians think appropriate. For example some patients may only need it at the OHA and not again. Other patients may require oral health advice to be frequently reinforced.

~~It~~ The self care plan should be used where most benefit will be gained. For example; for a family it may better for key messages to be given to all the members but the plan left with 'mum' as a driver at home.

Suggested patient actions should auto-map to the self-care plan. In order to keep the list of codes reasonably concise they are fairly generic but the self care template includes additional space for free text so the dentist may include more patient specific guidance such as targeted oral hygiene instruction. Software suppliers are advised to refer to the current version of the self-care plan documents: Self Care Plan Prototypes and Patient Action Codes Mapping to Self Care Plan

The self care plan, if used correctly, is a real opportunity to reinforce the preventive message and the risk the patient presents.

The Programme has provided a template for the self-care plan to be used by the prototypes, which can be found at: http://www.pcc-cic.org.uk/commissioning/dental-contract-reform



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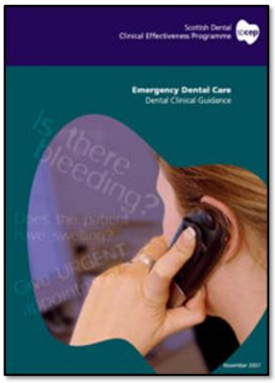
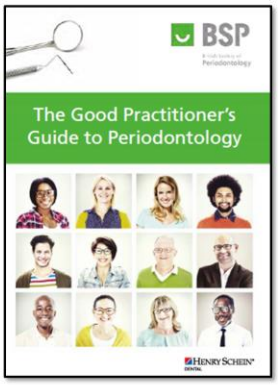
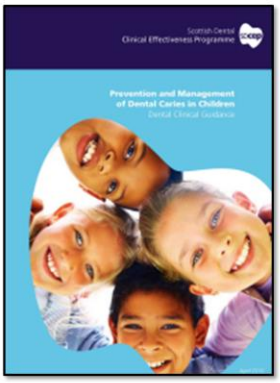
Treatment – your choice

Professional Guidelines





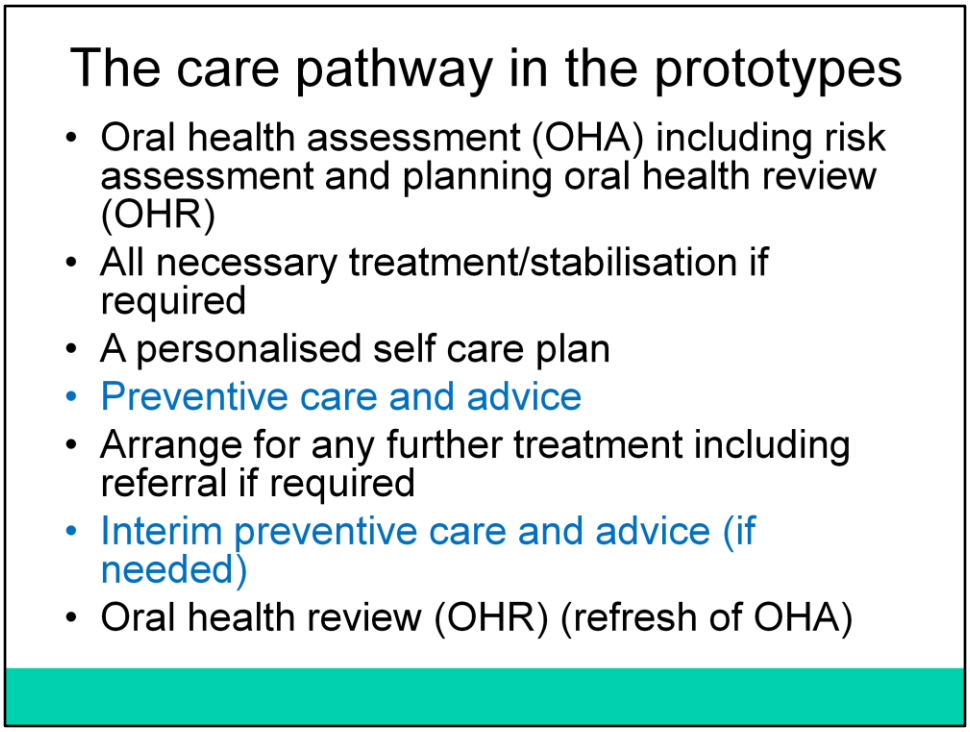


Complex care

- Evidence suggests that if complex care is provided when active disease is present the outcome is generally much poorer
- The care pathway supports decisions on when complex care should be delivered
- Should not be seen as restricting a practitioner's clinical judgement
- "NHS offer" does not change
- If, for sound clinical reasons, a particular treatment should not be offered to a patient on an NHS care pathway, then the dentist should also consider whether offering such a treatment under any other treatment arrangement might also be considered clinically inappropriate.

The pathway supports the decision about whether to progress to complex care or not.

The NHS offer of clinically appropriate care does not change. However, the pathway is intended to make the a dentist think and clinically justify why they are progressing to complex care if all the RAG score matrices indicate that the patient is not complying with treatment and that complex care may not be successful.



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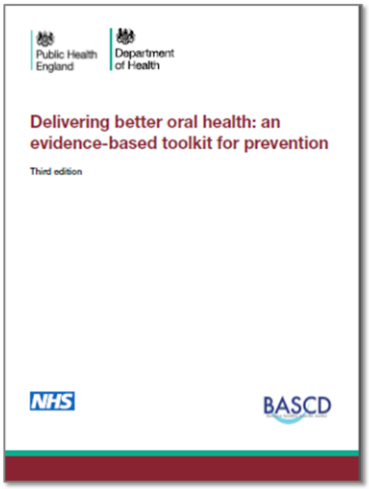
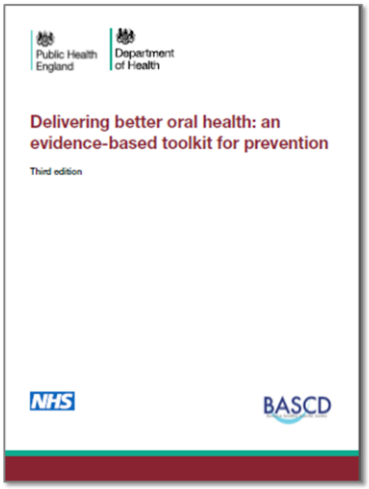
Prevention (including interim care)



- "Dental teams have an important role in advising patients on how they can make choices that improve and maintain their dental health"
- "all patients should be given the benefit of advice and support…not just those thought to be 'at risk' "
- "used by whole dental team"
  "useful in informing other health, education and social care work partners"

Delivering Better Oral health sets out the preventative approach which the pathway is based on.

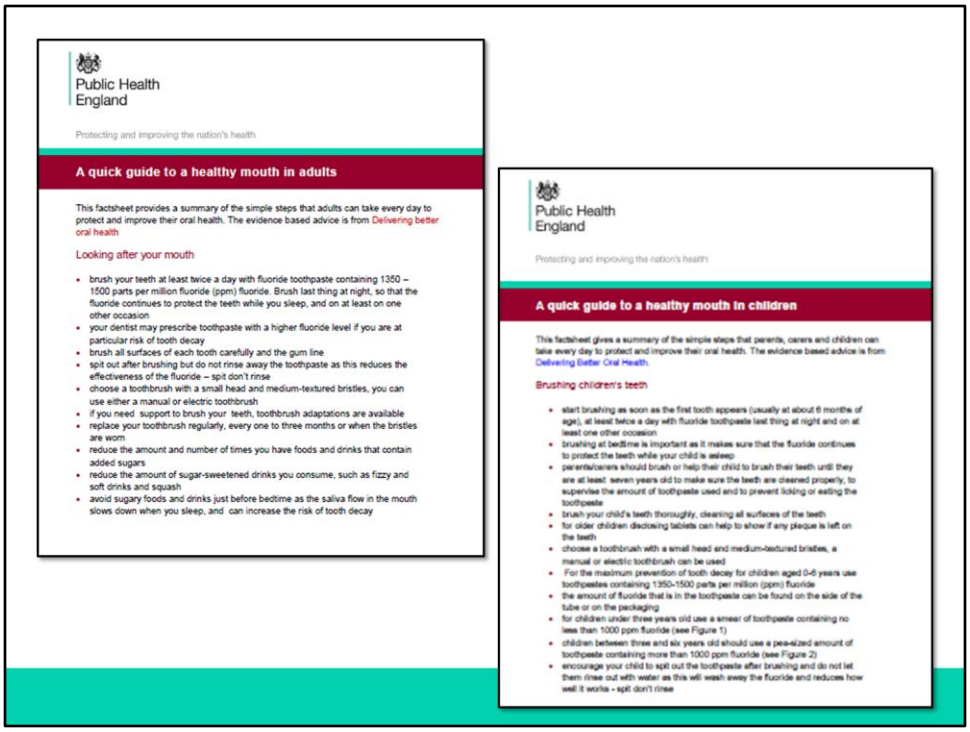
Prevention (including interim care)



- Prevention, both advising and reinforcing self care and delivering professional clinical interventions can and arguably should happen at multiple points along the pathway

Delivering Better Oral health sets out the preventative approach which the pathway is based on.


Public Health England
Delivering better oral health: an evidence-based toolkit for prevention
Summary guidance tables
Third edition
Department of Health
NHS
BASCD



Public Health England

Protecting and improving the nation's health

A quick guide to a healthy mouth in adults

This factsheet provides a summary of the simple steps that adults can take every day to protect and improve their oral health. The evidence based advice is from Delivering better oral health

Looking after your mouth

- brush your teeth at least twice a day with fluoride toothpaste containing 1350 – 1500 parts per million fluoride (ppm) fluoride. Brush last thing at night, so that the fluoride continues to protect the teeth while you sleep, and on at least on one other occasion
- your dentist may prescribe toothpaste with a higher fluoride level if you are at particular risk of tooth decay
- brush all surfaces of each tooth carefully and the gum line
- spit out after brushing but do not rinse away the toothpaste as this reduces the effectiveness of the fluoride – spit don't rinse
- choose a toothbrush with a small head and medium-textured bristles, you can use either a manual or electric toothbrush
- if you need support to brush your teeth, toothbrush adaptations are available
- replace your toothbrush regularly, every one to three months or when the bristles are worn
- reduce the amount and number of times you have foods and drinks that contain added sugars
- reduce the amount of sugar-sweetened drinks you consume, such as fizzy and soft drinks and squash
- avoid sugary foods and drinks just before bedtime as the saliva flow in the mouth slows down when you sleep, and can increase the risk of tooth decay

Public Health England

Protecting and improving the nation's health

A quick guide to a healthy mouth in children

This factsheet gives a summary of the simple steps that parents, carers and children can take every day to protect and improve their oral health. The evidence based advice is from Delivering Better Oral Health.

Brushing children's teeth

- start brushing as soon as the first tooth appears (usually at about 6 months of age), at least twice a day with fluoride toothpaste last thing at night and on at least one other occasion
- brushing at bedtime is important as it makes sure that the fluoride continues to protect the teeth while your child is asleep
- parents/carers should brush or help their child to brush their teeth until they are at least seven years old to make sure the teeth are cleaned properly, to supervise the amount of toothpaste used and to prevent licking or eating the toothpaste
- brush your child's teeth thoroughly, cleaning all surfaces of the teeth
- for older children disclosing tablets can help to show if any plaque is left on the teeth
- choose a toothbrush with a small head and medium-textured bristles, a manual or electric toothbrush can be used
- For the maximum prevention of tooth decay for children aged 0-6 years use toothpastes containing 1350-1500 parts per million (ppm) fluoride
- the amount of fluoride that is in the toothpaste can be found on the side of the tube or on the packaging
- for children under three years old use a smear of toothpaste containing no less than 1000 ppm fluoride (see Figure 1)
- children between three and six years old should use a pea-sized amount of toothpaste containing more than 1000 ppm fluoride (see Figure 2)
- encourage your child to spit out the toothpaste after brushing and do not let them rinse out with water as this will wash away the fluoride and reduces how well it works - spit don't rinse

Prevention

- As with treatment, any preventative treatment or advice needed forms part of the same course of treatment that includes the OHA/OHR
- Some patients – particularly those in the red or amber group may benefit from further prevention delivered as interim care between the OHA and OHR course of treatment
- Interim care courses of treatment are for the provision of preventive treatment, and/or tailored preventive advice only
- They form a course of treatment in their own right – Band 1A
- ICs may be delivered either by a registered dental care professional (eg hygienist, therapist, extended duty dental nurse or oral health educator) or a dentist
- ICs do NOT include an examination or assessment

The prototype regulations contain an amendment that enables interim care courses of treatment to take place without requiring an examination to be undertaken. This frees up the dentist to deliver that care and means IC treatment can be delivered by non GDPs.

ICs can be used in a number of ways including:

- To bring back a patient to check their compliance with oral health instruction (OHI) - this may be done by the EDDN.
- To bring back a patient to check their periodontal status after a course of treatment or to provide further intervention – this can be done by a therapist.

However, patients will only attend the IC if they see the value in it, so if it is not clinically appropriate there is no point booking them in.

ICs form a course of treatment.

Interim care courses of treatment

- IC CoTs include the following:
  - Oral health promotion/advice
  - Checking patient compliance
  - Preventive treatments
  - Scaling and polishing and follow up root surface debridement
  - High fluoride toothpaste/mouth rinse prescription (when delivered together with one or more of the above)
- An FP17 should be opened at the start of an IC CoT and closed at the end.
- The patient charge is band 1A unless the CoT is advice only. There is no patient charge in this case.

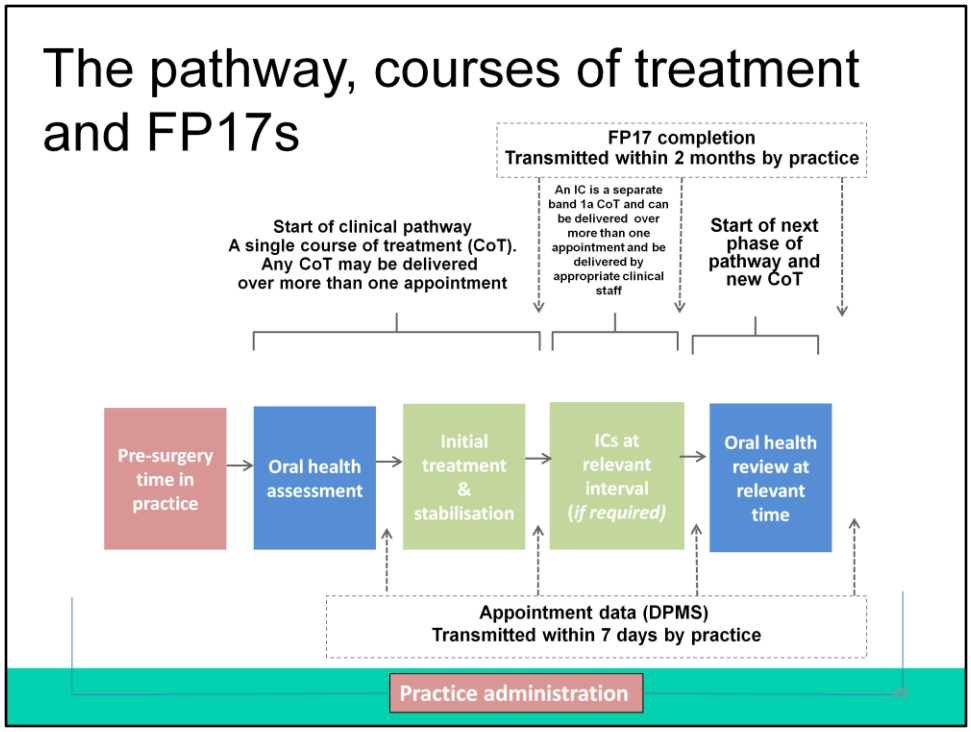
It is important to note that where the interim care course of treatment is advice only there is no patient charge. However where one or more of the treatment items listed is delivered and the patient is not exempt, a Band 1A patient charge is applied.

IC s are reported through FP17s and the software is set up to recognise whether the CoT includes chargeable treatment or not.

Possible interim care appointment

Prevention of caries in children aged from 7 years and young adults

	Advice	EB	Professional intervention	EB
All patients	• Brush at least twice daily, with a fluoridated toothpaste	I	• Apply fluoride varnish to teeth two times a year (2.2% NaF-)	I
	• Brush last thing at night and at least on one other occasion	III, I		
	• Use fluoridated toothpaste (1,350-1,500ppm fluoride)	I		
	• Spit out after brushing and do not rinse, to maintain fluoride concentration levels	III		
	• The frequency and amount of sugary food and drinks should be reduced	III, I		
Those giving concern to their dentist (eg, those with obvious current active caries, those with ortho appliances, dry mouth, other predisposing factors, those with special needs)	All the above, plus: • Use a fluoride mouth rinse daily (0.05% NaF-) at a different time to brushing	I	• Fissure seal permanent molars with resin sealant	I
			• Apply fluoride varnish to teeth two or more times a year (2.2% NaF-)	I
			• For those 8 years upwards with active caries prescribe daily fluoride rinse	I
			• For those 10+ years with active caries prescribe 2,800ppm fluoride toothpaste	I
			• For those 16+ years with active disease prescribe either 2,800ppm or 5,000ppm fluoride toothpaste	I
			• Investigate diet and assist to adopt good dietary practice in line with the eatwell plate	I



Practices need to consider how they will manage patients through the various elements of the care pathway.

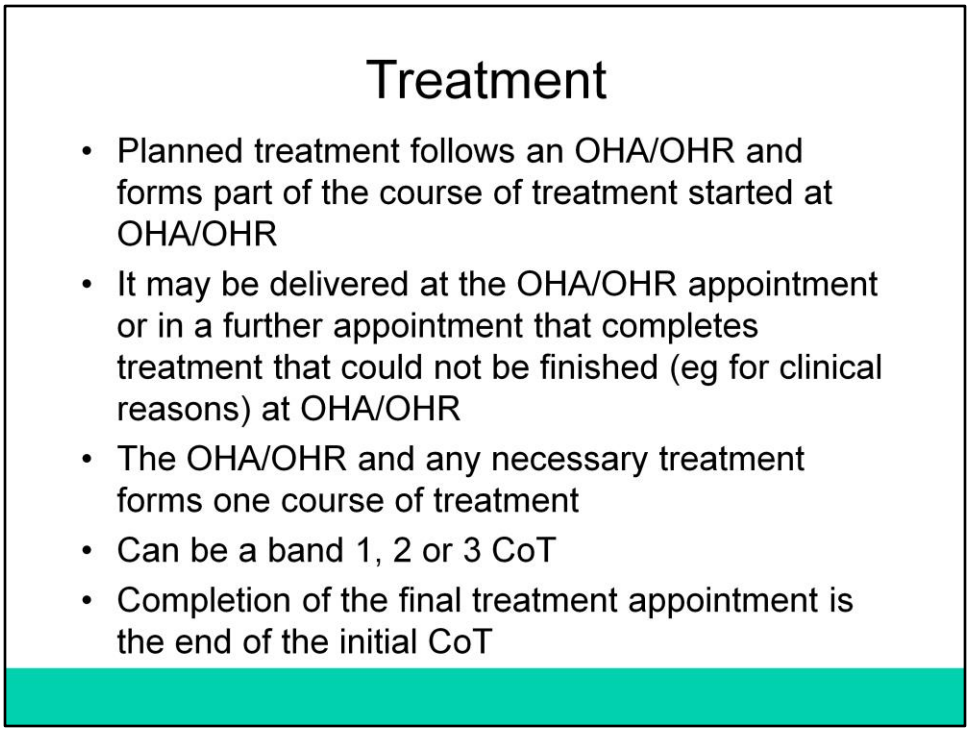
Thought needs to be given to how the patient's medical and social information will be collected. Practices may consider if this can be collected and input to the system ahead of the appointment possibly by reception staff. Alternatively, a treatment co-ordinator and/or an EDDN could collect the information and relate important factors to the diagnosing clinician who will check and countersign the questionnaires/forms.

Once the OHA has been completed and any treatment and/or stabilisation within the appropriate banded course of treatment carried out, it is closed and the FP17 is submitted

A dentist may or may not consider an interim care (IC) course of treatment clinically appropriate for a patient. If it is then these ICs may be scheduled. If an IC course of treatment (CoT) is provided then it is a course of treatment in its own right and an FP17 should be submitted on completion of the IC CoT.

The patient will then return for their OHR at the appropriate recall interval which then starts a new course of treatment which may be completed at one appointment or more within a course of treatment, as is the case with an OHA.

What is different in prototyping is the transmission of pathway data. This is the extended clinical data set used for evaluation purposes but it also form part of the information needed to manage a practice



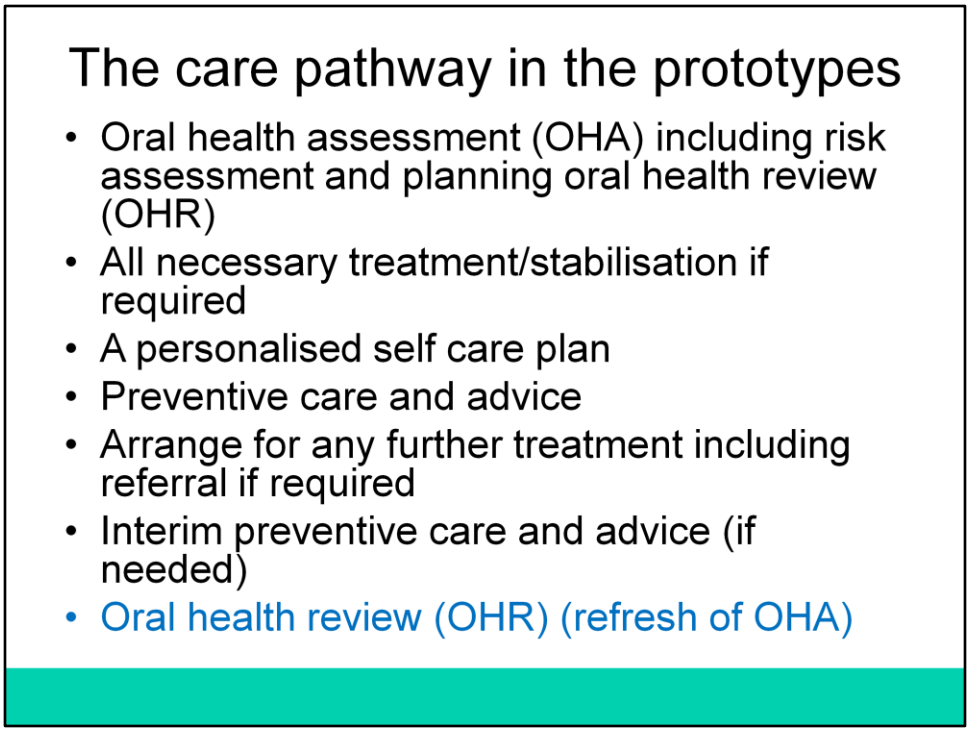
This is where any treatment identified at OHA/OHR is undertaken, and can be band 1, 2 or 3 as defined by regulations.

Clinically necessary care must still be provided but as part of the treatment planning, progression to complex care may be deferred until a time when the patients' oral health has improved to a point where the intervention is more likely to succeed. This must be recorded, discussed with and understood by patients as pat of their overall treatment planning and expected outcome.

Treatment is the responsibility of the dental team. How dentists make treatment decisions and the delivery of that treatment does not change.

There is still a start and end to a course of treatment as in the UDA system.

It is worth considering when and how the elements of care will be delivered and by which team member. Some dentists undertake preventive actions or give advice themselves and others ensure that another member of the team takes responsibility for this at the OHA/OHR appointment.



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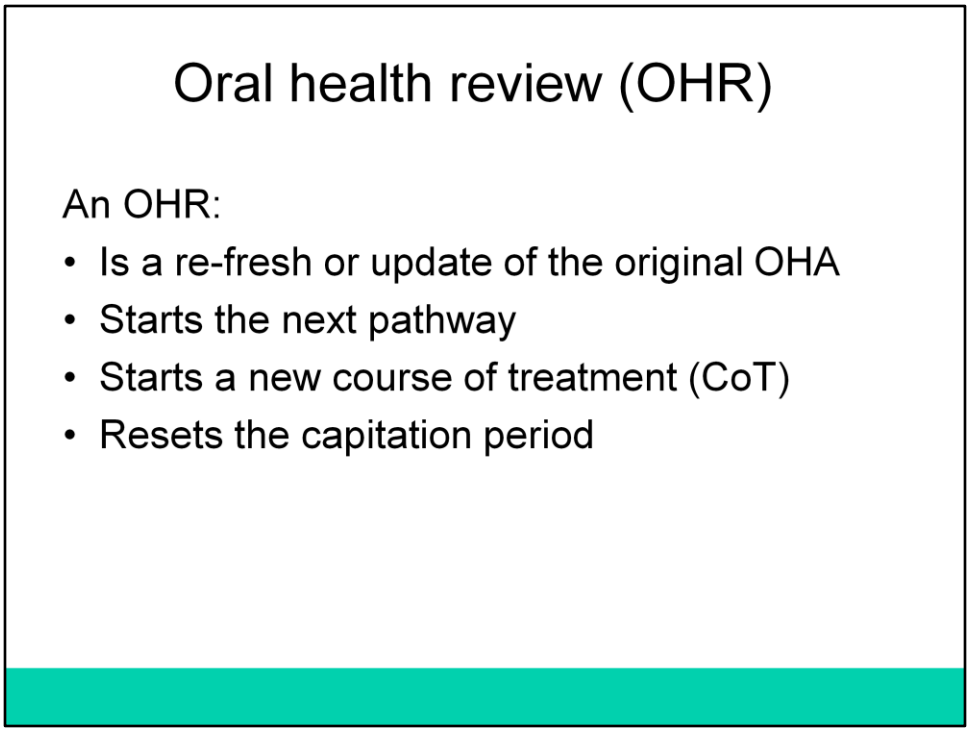
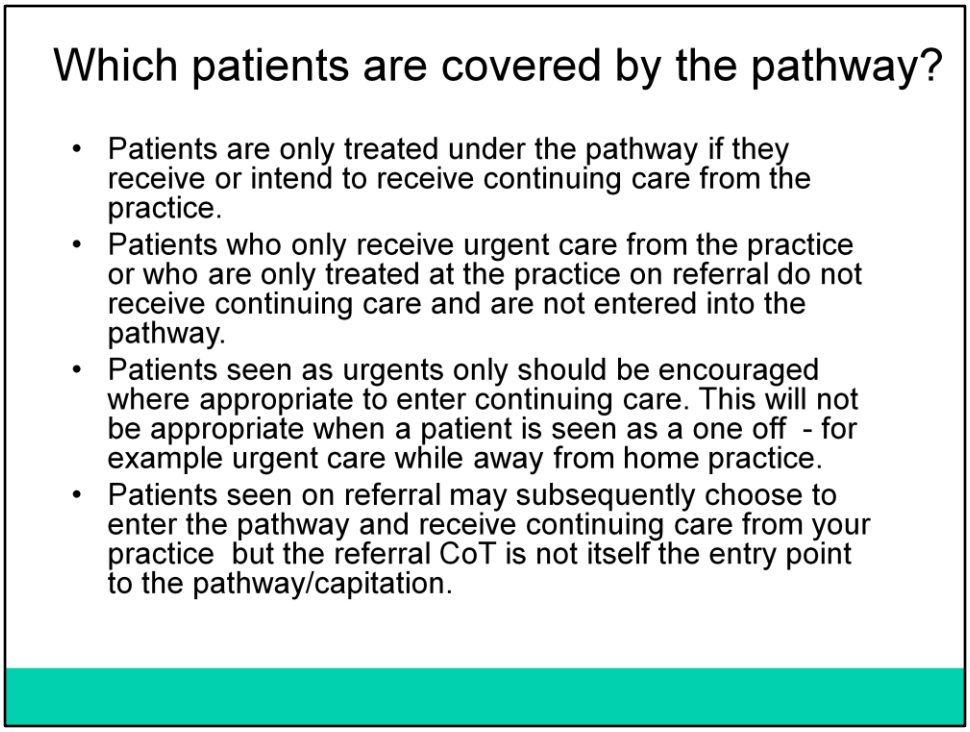


The oral health review is a refresh and re-examination of the patient to assess if the condition of their oral health has changed.

The software refers to the information from the OHA for clinicians to review, update and refresh.

Contents

- Introducing the clinical philosophy and the concept of care pathways
- The clinical philosophy in a wider NHS context
- The care pathways in the prototypes
- Patients under capitation / pathway. Patients outside capitation / pathway
- Key messages



With regard to your list of capitated patients remember that this list is for a period of 3 years. Patients will only remain on your capitated list if they are in a continuing care relationship with your practice.

Practices will receive payment for patients in relation to the capitation payment of the blend they have been allocated by the programme – Blend A or Blend B.

It is important for practices to ensure they are managing their list effectively to at least maintain the number of patients that were on the list at the inception of prototyping.

The following patients are covered by the pathway:-

- Patients are only treated under the pathway if they receive continuing care from the practice.
- Patients who only receive urgent care from the practice or who are only treated at the practice on referral do not receive continuing care and are not entered into the pathway.
- Patients seen as urgent only should be encouraged where appropriate to enter continuing care. This will not be appropriate when a patient is seen as a one off - for example urgent care while away from home practice.
- Patients seen on referral may subsequently choose to enter the pathway and receive continuing care from your practice but the referral CoT is not itself the entry point to the pathway/capitation

Patients not seen under the pathway

- Two key groups are not treated under the pathway:
  - Urgent care
  - Referral appointments
- An OHA/OHR should not be performed at these appointments
- Patients should receive the appropriate banded treatment and the treatment should be carried out as appropriate, over one or more appointments.

Patients receiving urgent care courses of treatment and referral patients do not trigger capitation.

Additionally, patients receiving a charge exempt courses of treatment (eg prescription, arrest of bleeding, removal of sutures) may already be on a pathway but this appointment would not trigger capitation.

Use of clinical systems

- Software is decision supporting, not decision making – the clinician can override RAG status, associated actions, as well as recall intervals
- Built around a set of logic statements developed by clinicians and academics and evidence informed
- OHA data is fed into your dental software system which will generate:
  - Suggested patient RAG status
  - Suggested recall intervals
  - Suggested patient and dental team actions
  - Allow clinicians to set any required ICs
  - Support the Dental Quality and Outcomes Framework (DQOF)

The software is there as a support tool, it does not take over from the clinician as the decision maker.

Clinicians may override some or all prompts if in their clinical opinion it is correct to do so.

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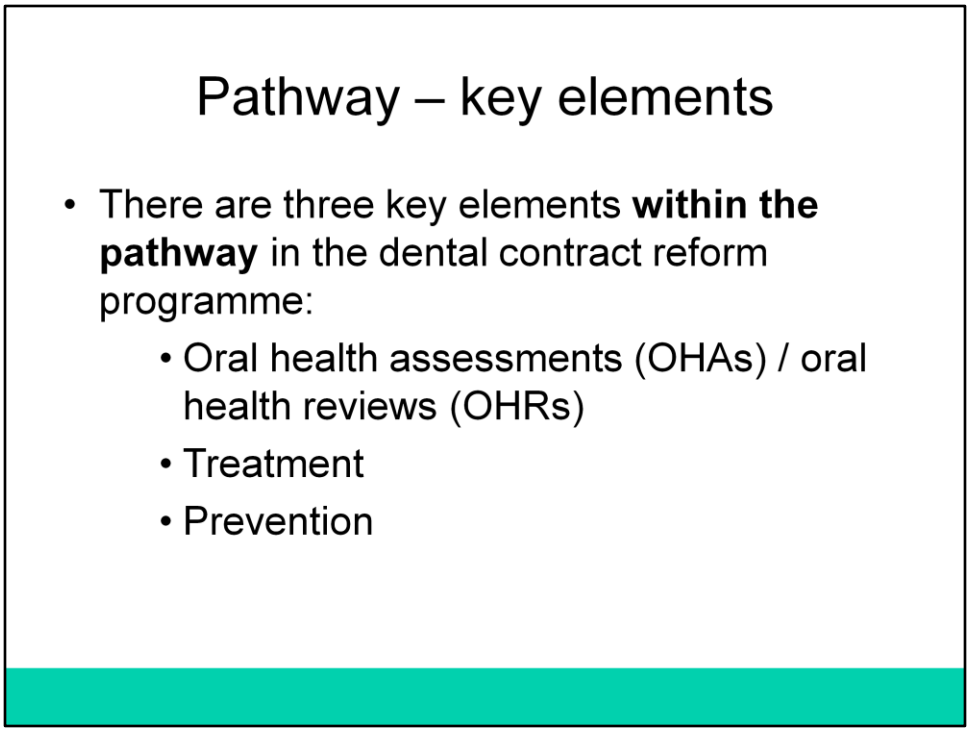
Key messages

- Pathway approach is the accepted approach to care
- Software is decision-supporting, not decision-making – use your clinical judgment
- ICs should be scheduled only when the patient need is there.
- No need to do an examination at IC CoT, if an examination is done it is no longer an IC CoT but a banded CoT



A patient's journey begins with the oral health assessment (OHA). This is a full examination and an assessment of the patient's risk of disease.
This is the point of entry into the pathway, and may be the start of a course of treatment (CoT).

The information captured on the medical and social histories together with the clinician's oral health assessment is used to assign risk in four clinical areas, namely:

• dental caries (tooth decay)
• periodontal disease (gum disease)
• tooth surface loss (worn teeth)
• conditions affecting the soft tissues of the mouth, for example oral cancer.

The OHA is patient focused with the dental team gaining and understanding of the patient's expectations.

Together this provides the patient's RAG score - a red/ amber/ green traffic light system which in turn generates the self-care plan (SCP). The clinical team will use the self-care plan to explain to the patient the condition of their oral health, reinforce prevention advice and make the patient aware of their responsibility for their own oral health.

It is important to note that at this point all necessary treatment might not include the more complex care that a patient will ultimately require because their oral health may not be sufficiently good or stable to ensure it will last. In this situation, the dentist should explain to the patient that he/she is deferring the complex care, to allow the patient's oral hygiene to improve to give a better result.

The OHA is about gathering information from and about the patient in a holistic way. The aim is to gain an overview of how the patient's oral health is driven and the expected outcomes from their dental treatment. Interaction with the patient at this initial assessment is likely to take more time than under the current system.