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Developing a person-centred approach in dentistry beyond NHS recall intervals: a commentary

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Developing a person-centred approach in
dentistry beyond NHS recall intervals: a
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Mills, I., Scambler, S., Neville, P., Asimakopoulou, K.,

31st January 2023

Key Points

- Person-centred care (PCC) is recognised as fundamental dimension of quality within healthcare. Models of PCC have primarily been developed from medicine, with little consideration of how they may, or may not, translate across to dentistry.
- Shared decision making (SDM) is an important feature of person-centred care and is highly relevant within many aspects of dentistry, including adoption of tailored recall intervals.
- The development of educational and training materials for shared decision making in dentistry are to be welcomed, but any content must be relevant to dentistry and seek to promote a person-centred approach, rather than simply be used as a tool to increase NHS access.

Abstract

Person-centred care (PCC) is acknowledged as a fundamental dimension of quality within healthcare and provides significant benefits for patients and clinicians. Models of PCC have primarily been developed from the medical literature, with limited consideration of their application within dentistry. The Personalised Care Institute (PCI) was established to deliver education and training on PCC and is working with the Office of the Chief Dental Officer for England to develop resources on Shared Decision Making (SDM) to promote tailored recall intervals.

This paper seeks to promote the value of PCC and SDM in delivering high quality care, but cautions against the use of generic models or training in view of the potential differences which may exist within dentistry, particularly general dental practice. The authors highlight the need to develop materials and training which are appropriate,

contextualised and relevant to dentistry. The capacity and desire to deliver PCC is strongly influenced by the healthcare system which is in operation. The current UDA system operating in England would appear to act as a barrier to the delivery of PCC. Unless significant and rapid changes are introduced to the NHS Contract, UDA targets will continue to take precedence over person-centred care, shared-decision making and tailored recall intervals.

(203 words)

Developing a person-centred approach in dentistry beyond NHS recall intervals: a commentary.

The past twenty years has witnessed an exponential growth in research into person centred care (PCC), which has led to increasing interest in how this relates to dentistry¹⁻⁶. There is little consensus on a shared definition of PCC, however there is broad agreement on the principles and values that underpin it. PCC has also entered the policy and political realms, as evidenced by its inclusion in the UK's NHS constitution. However, as PCC has become popularised and politicised as a metric for quality, there is little agreement on how to best operationalise it in a clinical setting. This contradiction can be attributed in part to a failure by both PCC scholars and politicians alike to acknowledge the complexity of healthcare delivery. One must also consider that healthcare is delivered across a wide variety of clinical settings (e.g. medical, dental, allied health), to a demographically diverse patient population with a variety of health (chronic or acute) and treatment (curative or preventative) needs^{7, 8}. As a result, what PCC means will differ depending on the health care context and patient populations, and healthcare's tendency to adhere to an homogeneous definition and model of PCC is counterproductive.

The Office of the Chief Dental Officer for England (OCDOE) has recently announced the Personalised Care Institute (PCI) has been asked to develop material on Shared Decision Making (SDM) to support dental personnel and patients as part of the dental contract reforms in England⁹. On the surface, this would appear to be a significant step forward in promoting a person-centred approach within dentistry, although at this stage the focus seems to be solely on implementation of NICE guidelines for recall intervals¹⁰.

This article highlights the importance of person-centredness in providing oral health care, but endorses the view that PCC requires a contextualised approach⁸. Training materials need to reflect the unique characteristics of dentistry and the authors would caution against relying on established PCC models developed in medicine, which do not necessarily translate to dentistry^{9, 109, 10910}.

This paper aims to provide a brief overview of Person-Centred Care (PCC), detail how the concept has been developed and refined within medicine and dentistry, and suggest how dentistry may need to be approached differently when developing training and educational material. To this end we begin with an outline of how dentistry is different from medicine, and why the existing model of PCC, as understood in medicine, is not appropriate for dentistry.

The Dental Context

Assessment of quality has become an increasingly important focus within UK health care and forms a central feature of performance management and quality improvement. However, within NHS dentistry in England, the primary focus continues to be on the delivery of Units of Dental Activity (UDAs) as the key performance indicator.

“Person-centredness” is viewed as an important component when measuring quality within health care¹¹ and is recognised as one of the key dimensions of quality according to the Institute of Medicine¹², the Health Foundation¹³, Royal College of General Practitioners¹⁴ and the NHS¹⁵. Darzi described quality in the NHS, in terms of clinical effectiveness, safety and patient experience¹⁶. Patient experience was subsequently defined within the NHS Patient Experience Framework¹⁷ and aligned closely with the Picker Principles of Patient-Centred Care¹⁸.

Improving access to NHS dentistry continues to be the central focus for commissioners and patients, and this has been identified as one of the key aims of the dental system changes. The gravity of the access situation was highlighted by Healthwatch in 2021¹⁹ and reinforced by data obtained by the BBC, which reported that 90% of practices were no longer accepting new adult patients²⁰.

In response to this crisis, NHS England have promoted the importance of adhering to personalised recall intervals as a means of increasing access, and aim to improve compliance by more effective monitoring of practices⁹. The drive for “cultural change”⁹ within NHS dentistry will be supported by materials and training developed by the Personalised Care Institute (PCI) as part of Dental Systems Reform (DSR)⁹.

Shared Decision Making

It is no longer appropriate or acceptable for doctors or dentists to make decisions about a patient's care without the full involvement and participation of the patient. Shared decision making (SDM) is a term frequently used to describe this process of participation²¹, with a significant number of academics proposing that SDM should be seen as “the pinnacle of patient-centred care”^{22, 23}. This view has also been expressed within the dental literature where a hierarchical model of PCC has been developed based on information and choice⁴.

Shared-decision making (SDM) has been recognised as an important element of person-centred care and a gradual shift has been evident within many areas of dentistry as we move away from a paternalistic model of care. This has been widely acknowledged within many dental schools where SDM is embedded within the undergraduate curriculum^{24, 25} and the importance of PCC seen as core to all patient interactions. However, a recent study by Hayer and Wassif reported that there was a

degree of confusion around the concept of SDM amongst general dental practitioners and that current guidelines and standards were considered to lack clarity²⁶.

Shared decision-making is defined by NICE as “a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about their care”²⁷. The NICE guidelines are explicit in the need for a person to understand “the risks, benefits and possible consequences of different options through discussion and information sharing”²⁷. SDM can be considered an important aspect of the consent process although SDM should not simply be considered as informed consent ²⁸.

It is important to acknowledge and understand that the desire of the patient to participate in the decision-making process can vary considerably, with some patients more eager to engage than others. Patient participation must be recognised as a fluid process where the level of involvement may vary according to a number of factors²⁹, including; the nature of the condition, personal characteristics of the patient and the dentist-patient relationship³⁰. A patient's reluctance to engage can present challenges for the clinician in terms of following NICE guidelines on SDM⁴, and this can also pose a potential issue in terms of consent.

Various tools have been developed and advocated to support SDM in clinical practice³¹ and the benefits of decision-making aids within dentistry have been highlighted ²⁶. Such tools can encourage patient participation, promote information sharing, improve patient satisfaction and ensure better informed decisions are made by patients and clinicians³¹. A notable example includes development of the Antibiotic Stewardship Tool for clinical decision making in the urgent dental care

setting³², which was co-designed to ensure appropriate clinical decisions were made in partnership between patient and dentist.

Self-management is an important element of PCC and SDM, and an excellent example of this in dentistry is the treatment of chronic orofacial pain including temporomandibular joint disorder ³³. The oro-facial pain self-management guide developed by the University of Leeds has been proved to be highly effective and is based on a person-centred approach with close collaboration between the patient and the clinician^{28, 32}.

At this stage, the focus of the PCI / NHS England collaboration appears to relate solely to recall intervals, but adoption of a person-centred approach, including SDM, can offer many wide-ranging benefits for both the patient and the clinician^{2, 4, 34-37} and this must be embraced.

Person-centred care in dentistry

In general medical practice, various studies have explored what patients most value in a family doctor, and the findings seem to be fairly consistent - health promotion, partnership and communication²⁵, where "a doctor listens and does not hurry me"²⁶, procedures were explained clearly ³⁶ and patients felt cared for and attended to ³⁷.

Chapple et al ³⁸ undertook a small exploratory study to investigate dental patients' preferred role in treatment decision-making. The results revealed that dental patients had distinct preferences towards the style of decision making, whether it be active, collaborative or passive based on various factors including time constraints, confidence in dentist, knowledge and trust. The study revealed that although patients preferred a collaborative role, a passive role was more commonly identified, which is consistent with the traditional paternalistic approach.

Until fairly recently, there was a paucity of research into PCC within dentistry, which contrasts starkly with other areas of medicine and health care. This is more likely to reflect the relative recency of the dental literature rather than a view that PCC is any less relevant in dentistry than it is in the rest of healthcare. There is little doubt that a person-centred approach within dentistry is likely to deliver similar benefits for patients to that which are experienced within medicine. This has been supported by work published by Bedos et al ³⁹ who state that “patient-centred clinical approaches may help dentists interact with their patients, especially those with different social or cultural backgrounds”. This approach can also improve patients' adherence to treatments and help to improve health-related behaviours such as oral hygiene and nutrition.” ³⁹ As highlighted by Bedos³⁹, a person-centred approach can be particularly impactful when providing care for vulnerable patients. An example of promoting PCC within vulnerable groups is the “Right to Smile Consensus Statement” which has been developed to address oral health inequalities in patients with severe mental health conditions⁴⁰.

Personalised Care Institute

In September 2020, NHS England established the Personalised Care Institute (PCI)⁴¹ to help staff involved in people's health and care develop the knowledge and skills to support the implementation of the NHS Long Term Plan¹⁵ and the “Comprehensive Model for Personalised Care”⁴².

The key aims of the Institute are detailed as follows:

- set quality standards for training, focussing on 4 of the 6 components of the comprehensive model for personalised care⁴³

- support the development of training programmes for the current workforce in order to help them to deliver personalised care to those quality standards
- support the development of training programmes for the new roles identified within primary care networks as part of the NHS Long Term Plan
- ensure that personalised care is represented in relevant undergraduate and post-graduate curricula.

The PCI model of Personalised Care is based on six components, which are included in Table 1⁴². The aim of the institution is to provide training for 75,000 health and care professionals by 2024, including members of the dental profession. The PCI steering group currently comprises more than 40 representatives from colleges, medical institutions, and healthcare membership associations.

The importance of a person-centred approach has been widely promoted within dentistry ^{2, 4, 6, 39, 44, 45} and the collaboration between the PCI and the Office of the Chief Dental Officer for England should be welcomed. It is hoped that the influence of this relationship will not be limited to simply communicating recall intervals, and will place PCC at the centre of DSR and mark a long overdue shift away from UDA-centred care.

The PCI has been invited to develop educational and training materials to promote SDM with the aim of improving adherence to NICE recall intervals. This may be seen as a laudable ambition, but the challenge will be to ensure the material is relevant to dentistry, is considered of educational value, and is seen to bring benefits to the patient, the staff and the practice. Aligning these goals will be key, and it is important

that clinical academics and members of the primary care dental team are directly involved in the development of the content.

Table 1 – PCI Components of PCC

<u>PCI Components of PCC</u>
Shared decision making
Supported self-management
Personalised care and support planning
Social prescribing
Patient choice
Personal health budgets

Why person-centred care is different in dentistry.

A comparison of the various models of PCC indicates that many of the descriptions and domains are likely to be highly relevant to caring for patients in general dental practice. However, it is the authors' contention that to simply transfer the PCI model to dentistry without challenge would be ill-advised and inappropriate. Original models of PCC were based predominantly on studies of patients in secondary care. Where PCC models were developed from primary care, the majority related to general medical practice, and did not seek to understand the views of dental patients.

There are currently six models of PCC in dentistry ^{46,45, 47-50}. Two of these were developed based on patients' perspectives or have incorporated patients' views in addition to dentists',^{48, 50} and the understanding of the patient dimension including their social context and how they experience health and disease is present in all the models. However, shared decision-making, was highlighted in most models ^{45, 46, 49, 50} but not in all of them. The importance and effect of the wider context of health care on PCC was also acknowledged in two of these six models ^{51, 50}. In general, the PCC models in dentistry seem to stress the importance of providing humane care to the patients and making a connection with them.

General dentistry has much in common with other aspects of healthcare in terms of supporting patients to achieve improved health. There are, however, a number of important differences with respect to general dentistry when compared to hospital medicine, or indeed general medical practice, which are worth highlighting.

- **Generalist**

The vast majority of dentistry in the UK is delivered by general dental practitioners who provide care to all age groups; potentially treat all oral conditions; manage acute and chronic conditions; and act as the diagnostician, the radiologist, the physician, the surgeon and the counsellor⁵²⁻⁵⁶. This is in stark contrast to the work of specialists, General Medical Practitioners (GMPs), or healthcare professionals working in secondary or tertiary care. The relationship which exists between patient and dentist often reflects this, and can be very different to that which exists between patients and other health care professionals⁵⁷.

- **Complexity of care**

Most dentistry undertaken within general practice is “routine”, elective and straightforward in terms of complexity, risk and impact on quality of life. This can contrast with admission to hospital or to long-term care with a GP.

- **Preventative approach to care**

General dentistry is focussed on prevention of oral disease, primarily caries, periodontitis, erosive tooth wear and oral cancer. This has been highly effective and has contributed to significant improvements in the oral health of the population within the UK. Many patients embrace the screening process of the “routine dental check-up” and attend regularly for assessment despite the lack of symptoms. This approach to oral health is different to that of general health and can foster a different attitude towards, and relationship with, the dental healthcare provider.

- **Active care**

Alongside prevention, treatment is a routine part of dental appointments. This means that within a consultation, dentists may have to take a history, make and explain a diagnosis, outline the different treatment options, obtain consent and carry out the agreed treatment. This is compounded by the fact that, for at least part of the consultation, the patient will be unable to speak while examinations and treatment are carried out. All of these factors, we suggest, require a different approach to, and understanding of communication and shared decision making within the dental context.

- **Relationship**

Primary care dentistry is still based on the premise of delivering continuity of care with one clinician taking responsibility for long-term care. This has gradually been undermined by a number of factors but continues to exist for

many patients which is in stark contrast to many other aspects of health care⁵⁸.

⁵⁹.

- **Business and consumerism**

The majority of dental practices are privately owned businesses and operate within a free market in direct competition with other providers. This has resulted in an increasingly consumerist approach to oral health care which is much less developed in other health sectors.

- **Beauty**

Treatments involving tooth whitening, non-surgical facial aesthetics, orthodontics, veneers and tooth-coloured fillings have increased significantly in recent years. This has been driven by the demands of image conscious patients who place value on an aesthetically pleasing smile, but it has undoubtedly been encouraged by the profession through marketing and advertising which is rarely seen in other areas of health.

- **Money**

"Care free at the point of delivery" is only relevant for a limited group of the population, which is in direct contrast to most other areas of medical care in the UK. Paying for treatment has a profound influence on the attitudes and expectations of patients by introducing a transactional element which can impact on the relationship.

Dentistry, particularly that which is delivered in general practice, is profoundly different to many other aspects of health care. It would therefore be inappropriate to assume that models of PCC designed for geriatric medicine, secondary care or general medical practice could simply be generalised to dentistry. There are many aspects of existing models of PCC which relate to dentistry, but it is likely that differences exist in

both *content* (i.e. it differs in the underlying dimensions of the approach) or *emphasis* (the underlying approach is the same, but there is a different emphasis on the different elements).

Mills et al⁶⁰ undertook a comparison of a dental model of PCC against that of Picker, and reported that although there were a significant number of similarities, there were distinct and nuanced differences⁶¹. The situation is likely to be similar with regard to the PCI Model, and certain components are likely to have greater relevance within dentistry, than others. It is important that these are identified, acknowledged and accommodated as part of the programme development. Training and materials need to be context specific and failure to align the components of personalised care with practice-based examples will undermine the aims and objectives of the initiative.

Concluding remarks

NHS dentistry is facing considerable challenges, and the delays in dental contract reform in England have placed intolerable pressure on general dental practices, their patients and the wider public. The 2006 NHS Contract introduced a target-focussed approach to dentistry based on delivery of UDAs. This continues to be the primary concern for commissioners and dentists, with both groups interminably focussed on the delivery of UDA targets, often to the detriment of patient care ^{62, 63}. Such an approach and philosophy undermine the delivery of person-centred care, and risks patients being viewed as a source of UDAs rather than as individuals with specific needs.

While the motivation for this paper was stimulated by the OCDOE announcement on dental reform in England, the message pertaining to PCC and dentistry is widely applicable, irrespective of the country or healthcare setting. Should DSR finally be

delivered, additional bespoke training and support around communication, PCC and SDM will undoubtedly be useful. However, it must be tailored for dentistry and reflect the nuanced differences which exist within the provision of oral health services. Training must also reflect our aspirations to embrace skill mix within NHS Dentistry, with materials relevant and accessible for the whole dental team.

A move to embed person-centred care and shared decision-making into future dental contract reforms is to be greatly welcomed. However, there is little prospect of this being achieved as long as UDA-centred care continues to be used as a key performance indicator, with clinicians encouraged to chase spurious targets rather than deliver truly personalised care.

The essence of person-centred care is communication, and this includes active listening on the part of both the dental professional and the patient. Such interactions take time, especially if informed or shared decision making is the objective. The importance of time needs to be respected, valued and acknowledged by commissioners. No abundance of informative resources or personalised care training will effect change, if the dental team are not afforded the time to spend with patients.

Declaration of interests

The authors declare no conflicts of interest.

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Author contribution

Ian Mills prepared the initial manuscript and all four authors commented on and edited revised versions before submitting for publication.

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