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The shift to integrated care in the NHS: implications of the new care models for dentistry

Introduction

Since 2014 NHS England has been encouraging greater integration and collaboration between providers and commissioners resulting in various policy initiatives not least the piloting of new types of integrated care organisation, (1). There are a confusing variety of such organisations under development. Ham has usefully summarised them under two broad categories: (i) ‘integrated care systems’ (formerly accountable care systems), or (ii) ‘integrated care partnerships’. (2). Integrated care systems have been defined as organisations that:

‘take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care in their area,’ (2).

These include sustainability and transformation partnerships, (STPs), set up across England to provide impetus for integration and collaboration; and also a limited number of more advanced pilot integrated care systems that have evolved from STPs with the intention of providing more formal mechanisms for planning, funding, and commissioning, (2). Examples of the latter include the Greater Manchester and Surrey Heartlands Partnerships which are experimenting with a unified budget covering health and social care. Integrated care partnerships include the various ‘new care models’ being developed in the NHS across England. They have been defined as:

‘alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete,’ (2).

These include hospitals, community services, GPs, local authorities and independent providers that come together as either all community providers or both community and acute care providers, or all acute providers in a locality or other collaborative arrangements. They offer different ways to integrate services around a defined local population either by vertical or horizontal integration, (1). NHS England has stated that the NHS is too diverse for a ‘one size fits all’ approach, (1), therefore five types of care model are being piloted: (i) integrated primary and acute care systems, (PACPs); (ii) multi-specialty community providers, (MCPs); (iii) enhanced health in care homes; (iv) urgent and emergency care; and (v) acute care collaborations. There are also new models planned for other services, (1).

It can be argued that at least some of these new organisations may potentially have implications for the future of dentistry, particularly the provider new care models- PACPs, which are intended to achieve vertical integration by combining GP, hospital, community and mental health services; and MCPs, which are aimed at integrating community providers, and at shifting some care out of hospital settings. A more specific provider model of interest to dentistry- similar to an MCP- is the ‘Primary Care Home’ developed by the National Association of Primary Care, (NAPC), (3). This is aimed at delivering services to a smaller population and is characterised by an integrated workforce with a focus on personal care, (3).

Given that dentistry is a core provider in both primary and secondary care one would expect there to be mention of dentistry in the new policy guidance. However, it is surprising that

none of these policy initiatives specifically mention dentistry. In the case of STPs, for example, it is noted that most STP plans do not mention dentistry and;

‘the majority of dentists are unaware of the role of STPs and how they might integrate dentistry and NHS dental services into their planning’, (4).

Similarly, in the case of MCPs while there is mention of involving a wider range of clinicians no mention is made of dentistry, (1). One may speculate on the reasons for this omission, for example, it may be to do with the way in which dentistry is organised, how patients are registered, NHS charges, or the fact that dentistry has to compete for patients rather than collaborate, (5). It may be because of a possible perception of dentistry as a *‘poor relative’* in relation to general medicine, (6). Nevertheless, there is scope for considering the place of dentistry in the new emerging organisational architecture of the NHS and its place in the wider health and social care context.

Implications for dentistry in the ‘New Models of Care’

It is pointed out that, *‘there is a lot of evidence that supports the integration of dental services to the wider healthcare landscape’*, (4). Specific drivers for this integration include the need to address environmental determinants / risk factors associated with oral disease; links between oral health and general health; and the fact that oral health still represents a public health problem, (2). The link with general health is supported in the literature where there is an *‘ever growing body of evidence of associations between poor oral health and systemic and other conditions’*, (6). These various factors provide a strong rationale for the involvement of dentistry in the new collaborative organisational arrangements. However, such involvement of dentistry would require a considerable change to its current form and organisation.

This raises the question of the extent to which the policy of integration and collaboration and the new organisational arrangements are desirable and practical for dentistry and likely to bring about benefits given the characteristics of dentistry in the UK. In the rest of this article we discuss the advantages and disadvantages of pursuing this policy; alongside the potential barriers / enabling factors that may need to be considered in order to assess whether dentistry is able to work in such arrangements.

Advantages

The obvious advantage of involvement for dentistry is to ensure that it is not left out or sidelined in a major policy initiative that could lead to missed opportunities in terms of funding, or developing closer working relationships with other care sectors. Participating in the new collaborative organisational arrangements might provide greater ‘clout’ and influence for dentistry, for example, in terms of how health and social care is funded and provided locally.

Another advantage of involvement may be the scope it provides for tackling the wider determinants of oral health and disease as noted above. A holistic, ‘joined- up’, approach may be necessary, (7). The Chief Dental Officer, speaking at a conference this year, has identified the need for a more comprehensive and cohesive approach to tackle the current fragmented way of working in dentistry and the need to make *‘ [dental] networks integral to health’*, (8). Partnership working through an MCP or PACP offers a solution to this

particularly at local level providing a new way of organising for dentistry where a population or place- based approach may be appropriate.

Involvement in integrated care organisations may also bring the advantage of easier access to, and communication with, medical colleagues. For example, working with GPs in an integrated MCP might help to address the problem of patients with dental problems attending a GP rather than a GDP. It is said that this problem is potentially the result of patient concerns about dental charges, (9). Similarly, it may help avoid inappropriate hospital referrals or unnecessary attendance of dental patients in A & E, (3). More appropriate referrals could free up money to be re invested into better services for dentistry.

In the case of PACPs, the involvement of dentistry with a vertically integrated provider may have the advantage of facilitating better coordination between primary and secondary care dental and medical specialities, with easier referral to colleagues in the same organisation. It could bring advantages for the development of integrated care pathways. Likewise it might provide easier access to other healthcare professionals with an important role in treatment, behavioural, and preventative aspects of oral health such as dieticians, health visitors, paediatricians, social workers, and clinical psychologists. Improved access may also help skill mix in dentistry.

It might also be a suitable organisational arrangement to facilitate recent proposals to create a tier 2 level specialist service, for example, in oral surgery and endodontics, periodontics, and prosthodontics, which might reside in the same integrated organisation in the future, (10). Commissioning may have an advantage in that one commissioner may be able to commission services from a single integrated provider organisation providing primary and secondary care dentistry. A major advantage of this in the longer term might be the opportunity to establish a better way of funding dentistry using a contract that is compatible with current and future trends in oral health and disease.

Disadvantages

On the other hand there could be a disadvantage in that commissioners need to agree how to commission for the new care models without *'unnecessary cost and complexity and the prospect of legal challenge'*, (11). Changing to a new contract would be problematic. Other disadvantages are likely to include the requirement for dentistry to be accountable to a wider policy and practitioner community, and to be part of a larger bureaucratic machine. This brings with it potential changes to autonomy and clinical freedom in dentistry that may not be welcome.

It may also have implications for the current organisation of primary care dentistry. Experience with MCPs has indicated that GPs have come together in federations or partnerships which are larger than typical GP practices and this may be a necessary pre requisite for the involvement of dental practices, (11). Individual dental practices may lose independence in becoming part of a larger federation of dental practices although dentistry is already being affected by the growth of corporate dental organisations. This would depend on the extent to which the new models of care formalise working or contractual relationships.

Likewise, dental practitioners may be affected by new working arrangements that seek to establish multi-disciplinary integrated teams. Such teams may create problems for clinical accountability, or have implications for clinical leadership. Adopting an integrated approach

may also have an impact on under/postgraduate training of dentists such that it may require changes to incorporate training to support new roles for dentists, (6).

An important overriding consideration will be the extent to which dentistry is likely to gain financially by joining a new care model like an MCP which might mean loss of independence and control and less opportunity to be innovative and earn income that may be used by the practice. Such changes may have an impact on private practice and private income.

Consideration would be needed of these advantages and disadvantages to dentistry if the profession is to become involved in the new arrangements.

Potential barriers

Pursuing involvement in the integration agenda will require attention to possible barriers that may be present in dentistry. These may include individual, organisational, legal, contractual, and cultural barriers inherent in the nature of dentistry and the way in which it has evolved. Dentistry has evolved in a different way from general medical services and may not be amenable to new ways of working. Indeed, it has been suggested that '*oral healthcare remains largely contained in a dental silo*', (6). Dentistry is still organised around the idea of independent businesses that have to make money to survive although corporate dental organisations are beginning to have an impact. Such businesses by nature tend to compete rather than collaborate and may be incompatible with the principles of a new care model. This would be a major barrier to the involvement of dentistry.

Potential barriers may relate to the differences between medicine and dentistry, for example, there are different contractual and funding arrangements, payment systems, different training, and differences in terms of clinical freedom and autonomy. These aspects may be problematic in the context of an integrated organisation. There may be more general issues relating to cultural and political differences between different stakeholders and where there are different values and professional norms for each occupational group. In dentistry there is less emphasis on prevention in the current contract although new contracts are being piloted and may be rolled out in 2020. The existing contract and the way in which dentistry is funded may be a major stumbling block.

Another barrier may be the fact that, unlike medicine, in dentistry up to 95% of care is provided in primary care. This may need to be considered in the context of an integrated provider where the care distribution in medicine is nearer 50-50%, (3). There may be implications for this if dentistry becomes part of an integrated community provider. In the case of the Primary Care Home initiative, it has been argued that there are two specific obstacles to the involvement of dentistry, namely, patient registration and transfer of funding budgets, (3).

Such barriers will need attention if dentistry is to be part of any future developments.

Enabling factors

Enabling factors include leadership, organisation design, clinical engagement, and commitment and motivation to get involved. Funding of dentistry is a major overriding factor ensuring that the dental contract is compatible with a more holistic and preventative model in dentistry, away from the current system of '*drill and fill*'. Some of these issues would depend

on the extent to which dentistry became involved, for example, whether as a full member or more limited involvement with a partnership.

Early lessons from evaluation of the pilot new care models suggest that organisational and leadership factors are important, for example, the need to build effective relationships, develop a shared vision, test new ways of working, and establish governance and organisational changes required for partnership working, (12). It has been said that:

‘successful [new care] models are those based on trusting relationships and collaborative organisational cultures, often developed over time, which enable clinical teams as well as organisational leaders to work together effectively’, (12).

Developing effective working relationships may depend on providing open channels of communication, active involvement of ‘grass roots’ personnel in decision making, and ensuring appropriate governance arrangements are in place that fully involve dentists. This is supported by experience in establishing PACs, where developing effective working relationships, governance and leadership are said to be important enabling factors, (11). Similarly, in the case of involvement with an MCP, enabling factors are said to include leadership, good relationships, trust, and the active support of key staff, (13). Engagement of clinical staff generally has been an issue in the NHS in recent years. Achieving change in dentistry will be difficult if *‘there is lack of engagement and key stakeholders do not work together’*, (6).

Overcoming lack of engagement may require a change in leadership, (6). It is argued that *‘new styles of provider leadership’* will be required, (11). Working in one of the new collaborative care models may require a shift from an individualistic to shared leadership style in which leadership is distributed according to specific skills/expertise rather than formal position in the organisation. Any involvement will require dentists to engage with leadership and decision-making alongside other clinicians. There may be a key role for local dental networks. At the individual level, adopting new ways of working may require changes to dental education requiring dentists to undergo postgraduate training similar to GPs and offer the opportunity to develop special interests, (6).

Attention will need to be given to the above barriers and enabling factors if dentistry is to be a part of any future developments.

Conclusion

The various policy initiatives currently underway in the UK NHS are likely to have widespread implications for the way in which health and social care is funded, and how it is commissioned and organised. The initiatives are intended to address the problems of fragmentation of services, lack of coordination, and the need for a ‘joined up’ approach, problems that have existed for many years. Indeed, they are the result of the way in which the NHS was set up in 1948 as three separate services for primary care, hospital care and community services, (with social care provided by local authorities). This is set to change with the recognition that: *‘over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries’*, (1). Thus, the way forward has been clearly shown to be an emphasis on a managed system or network of care such as that provided by one of the new care models and not individual organisations, (1).

We argue that dentistry could play a key role in such networks and it would be wrong to ignore the implications of these initiatives for the future organisation and delivery of dentistry. They offer opportunities to have greater impact on the wider determinates of oral health and disease and the opportunity to have a greater influence on health policy and implementation at local and national level. This is important given the wider challenges faced by dentistry, and the common risks associated with both oral and general health. Indeed, it is said that the '*common risk approach provides a rationale for partnership working*', (7). However, there are potential barriers and drawbacks to the involvement of dentistry in these policy developments.

If dentistry is to be involved there is a need to take account of its unique characteristics, organisation, and history. Such involvement may need to be tailored to the particular requirements of dentistry. Ultimately the involvement of dentistry would depend on being able to overcome the obstacle of the current contract and system of funding dentistry in primary care. It may also mean a change in the way in which dentistry is organised ie a shift away from the small business model to a federated system based on collaboration and not competition.

Getting involved clearly depends on the dental profession itself and the extent to which it considers such involvement feasible and desirable but it can be argued that the advantages might outweigh the disadvantages and bring benefits for both the profession and patients and the wider healthcare system.

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