



NAPC | National Association
of Primary Care

Primary care home: exploring the potential for dental care to add value



#primarycarehome

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Foreword

The primary care home model is centred on the principle of integrated care – bringing together a range of health and social care professionals to work together to focus on local population health needs and provide enhanced personalised and preventative care for their local community.

The aim of the model is to bring a complete care community together drawn from professionals across the health and care system. Historically, independent contractor groups have like other parts of the health and care system evolved in an individual way.

One of the most obvious examples is the lack of joint working between medical and dental care. Despite both working in a primary care setting, collaboration between the two is limited. This is despite the growing evidence base that suggests that improvements in oral health can lead to better health outcomes.

This paper explores how collaboration can be improved. It provides an overview of the dental sector and the issues facing both professions to highlight how this could happen. It also looks at some of the potential mutual benefits through improving working practices. This is intended as an initial review, with more work to follow on dental pilots within primary care homes.

In the meantime, we encourage health and dental professionals to take the first step and start conversations with their colleagues in their local primary care home or Local Dental Committee (LDC) to improve the wellbeing of their local populations.



Dr James Kingsland OBE
President



Dr Nav Chana
Chair

Executive summary

There is a strong case for the inclusion of dental care in the primary care home (PCH) model and a spectrum of possible arrangements that could make this happen.

These range from full partnership structures to cover the registered population through to individual 'course of treatment' based contracts. Although there are considerable benefits to the full inclusion of dental care in the PCH model, the current contractual arrangements suggest that its adoption into a fully capitated budget would be complex.

However, there are alternative ways that can be explored where the PCH and the dental care sector work together more closely and the ongoing dental contract reform work may make these easier. Other possibilities include the more specialised dental services being integrated into the PCH model. Dental representation on PCH working parties and the ability to share patient data between parties are central to achieving the potential benefits.

Primary care home is an innovative approach to strengthening and redesigning primary care. Developed by the NAPC, the model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community. Staff come together as a complete care community – drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector – to focus on local population needs and provide care closer to patients' homes.

The model shares some of the features of the multispecialty community provider (MCP) – its focus is on a smaller population enabling primary care transformation to happen at a fast pace, either on its own or as a foundation for larger models.

There are four key characteristics that make up a primary care home:

- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
 - a combined focus on personalisation of care with improvements in population health outcomes
 - aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards
 - provision of care to a defined, registered population of between 30,000 and 50,000.
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Good oral health contributes to a person's well-being, their ability to fit in and feel part of the community. Poor oral health has been associated with lower education outcomes, increased levels of depression and a worsening of other health conditions.

All have resource implications. The most common reason for having a general anaesthetic in children is tooth decay, with the costs being met through medical budgets. There is also a growing number of people who are seeking advice from their medical practitioner or attending accident and emergency departments for oral health related conditions.

As with general health, the determinants of oral health can be categorised into two: those external to the current care system, for example, the environment that people find themselves in and the lifestyle choices made, and the quality of care within the system. An example of environmental factors includes diet, not least one high in sugars. This diet impacts on general health, giving rise to an increase in diabetes and obesity. A potential solution centres on what is termed the 'common risk' approach which recognises that many chronic conditions have common foundations. If all professions work collaboratively, positive outcomes are more likely.

The second set of determinants is the care activities carried out by each healthcare worker: the internal factors. These require the patient to be assessed by the healthcare provider and agree a treatment plan to improve their wellbeing and quality of life. They also provide opportunities to identify any issues and signpost the patient to other care workers. Better integration between all care workers would help to achieve this.

The dental sector, as with pharmacy, has evolved in different ways to other primary care centred teams. The key differences include ownership of premises, the extent of the legal framework through which NHS care is provided including co-payment arrangements, entitlements and the ability to exchange information.

Collaboration could also be achieved through NHS commissioners using the flexibilities in the General Dental Services contract to help the dental profession deliver integrated care activities.

How dental care arrangements can work within the PCH framework is worth further consideration and would be in line with the four key characteristics of the PCH.



Background

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Since its launch in autumn 2015 with 15 rapid test sites, the programme has expanded. There are now more than 200 sites, serving eight million patients, 16 per cent of the population.

The primary care home model is featured in the Next Steps on the NHS Five Year Forward View and part of the practical delivery plans to transform primary care over the next two years to provide high quality services for patients and staff.

To date, the PCHs and rapid test sites that have evolved have centred on using a framework that recognises the importance of collaborative working between medical, social care and the voluntary sector to achieve improved health outcomes and quality of care. There are potential further improvements through the inclusion of other sectors, for example, community pharmacy and dental care.



To explore how this might be achieved, the PCH programme commissioned a report on dental care involvement. The aims of the report were to review:

- How dental care could fit into the PCH model and, given current contractual arrangements, how could it add value?
- What changes would be needed to increase the value?

To address the two aims, this paper is divided into three sections. The first outlines the oral health of the population, associated demographic factors and the implications for general health care and provision. The second describes the current dental care sector arrangements and their implications for engagement with the PCH sites. The third suggests some differing models with associated issues.

To help produce the report, the membership of the working group has included several national organisations and individuals with expertise in both care provision, service organisation and policy. The members of the group are listed on page 22.

Oral health in England

Dentistry is almost unique in health care with considerable data not only on disease levels but on treatments. There are a variety of sources including national surveys of both children and adult dental health as well as local programmes aimed at children of various ages and more specific groups such as care home residents or those with special needs.

The data has highlighted the substantial improvements in oral health seen over the past 50 years¹. Until recently, the majority of the population would be expected to lose all their teeth (become edentulous) at a relatively early age. Today, increasing numbers of the population are retaining teeth for longer. The proportion of the population with some teeth will increase with each age cohort. However, the legacy of past oral disease remains. While the current rate of disease progression may have been reduced through the widespread adoption of fluoride-containing toothpastes in the early 1970s, the oral tissues remain at risk of disease throughout life.

Dental diseases are still a public health problem with considerable consequences for health resources. The most common reason for school children being admitted to hospital is to have multiple teeth extracted; more than 25,000 were admitted in 2013/14². More specific data from Berkshire highlights that over 50% needed pain relief whilst waiting for their appointment, 25% had missed time off school because of pain, and over 30% suffered disturbed sleep. More than 26% had returned to the dentist because of further problems and nearly 25% had swelling and needed antibiotics.

The impact of dental problems on medical practice is considerable. In 2015/16 more than 600,000 patient contacts in medical practice were for dental problems and 135,000 accident and emergency (A&E) attendances were related to dental issues. The resource implications are significant, A&E costs alone estimated to be at least £18 million.

The reasons for patients seeking medical rather than dental treatment is strongly associated with charges in the dental sector. There are also negative outcomes for patient care as well as financial implications. Training of medical practice staff in dealing with oral conditions is poor and signposting to dental services has had little impact.

The dental health of children can also be indicative of more general health and social problems. For example, neglect and safeguarding issues can be identified through dental attendance as well as early signs of more generic health problems. Examples include recurrent ulceration as an indicator of possible nutrition and other systemic diseases.

1. Reich, E. (2001), *Trends in caries and periodontal health epidemiology in Europe*. *International Dental Journal*, 51: 392–398
2. *Hospital Admitted Patient Care Activity, 2015/16 published by NHS Digital*

For people over 50 who had high levels of disease prior to widespread adoption of fluoridated toothpaste, their restorative requirements will only increase. When combined with other co-morbidities, for example arthritis and dementia, the management of such patients becomes far more complex³.

The distribution of poor oral health matches those of the majority of other health conditions and is strongly associated with socio-economic circumstances with higher levels of disease being found in the lower socio-economic groups⁴.

Equally important is the impact of poor oral health on each age group, which can be either direct or indirect. Direct impact examples include the link between levels of educational achievement at school, employment opportunities in school leavers, socialisation, and quality of life at all ages. Indirect links include food choices and a person's nutritional status (the condition of the body influenced by diet).

The determinants of oral health status can be grouped into two main categories: factors external to care arrangements and internal. External factors relate to the general environment that people are living in. Key among these are diet, for example, exposure to sugars, smoking and alcohol consumption and hygiene practices, especially the use of fluoridated toothpastes. These issues provide an indication of where the adoption of the 'common risk approach' would reduce the likelihood of disease occurrence⁵. For example, improvements in dietary practices will contribute to a reduction in the levels of tooth decay, diabetes and obesity. Smoking reduction will lead to improvements in lung conditions and reduction in a number of cancers not least the likelihood of oral cancers. Equally the adoption of safe sex practices will also lead to a reduction in the likelihood of oral cancers. Internal factors arise through a person seeking dental services, for example when dealing with tooth decay.

Other benefits associated with improvements in oral health range from a reduction in anti-depressant medication through to improved management of diabetes and other chronic health conditions although any causative link between the two remains weak. The contact with dental services may also provide the opportunity to encourage vaccination, screening for various general health conditions and for people to receive advice on where to seek help.

The extent to which the groups who attend for dental care and medical care are different is contentious. There is considerable variation in the ages of those who attend for dental care, with the lowest being the youngest and oldest age groups. The highest are those aged between 12 and 15. Currently just over half of the adult English population have an NHS appointment within a two-year period.

3. Batchelor P (2015) *The changing epidemiology of oral diseases in the elderly, their growing importance for care and how they can be managed.* *Age and Ageing*, 44: 6, 1064–1070

4. *NHS Dental Statistics for England – 2015/16* published by NHS Digital

5. Sheiham, A. and Watt, R. G. (2000), *The Common Risk Factor Approach: a rational basis for promoting oral health.* *Community Dentistry and Oral Epidemiology*, 28: 399–406

However, attendance is not directly related to clinically defined disease. One of the key differences between medicine and dental arrangements is when patients decide to access care. For dental care, the majority of people access services when they have no symptoms. It is the opposite for medical care – it is based on perceived need, when they have symptoms.

With the link between improvements in general and oral health and the different population sections who choose to access care, success requires collaborative working between the various health and social care partners – including dental care as part of the primary care home model would achieve this. At the very least it would add value to health promotion programmes as well as support best practice and improve treatment outcomes.

Closer working relationships between the dental sector and partners working in primary care homes provide opportunities to improve the patient health and experience. There are also potential efficiency gains with care provided in the right setting, a reduction in medication use through the benefits that dental care can bring to a person's self esteem, the broader support of public health programmes and conditions identified at an early stage.



Dental care delivery

Dental services were included as part of the start of the NHS, however, they have evolved in a very different manner to their medical counterpart. There are key differences in the system encompassing delivery, finance and governance.

The majority of personnel in the dental sector work in a primary care setting providing approximately 95% of care, a far greater figure than that found in the medical sector, where personnel distribution is nearly 50:50. There are approximately 40,000 dentists on the General Dental Council Register, far fewer per head of the population than the number of doctors. The numbers that hold an NHS contract are approximately 24,000 General Dental Practitioners (GDPs) with just over 2,000 full-time equivalents (FTEs) working in trusts (community dental officers and hospital-based dentists). Of those working under a General Dental Services contract, there are approximately 9,000 practice sites⁶. The extent of the non-NHS dental sector is substantial with approximately 50% of care in cost terms provided privately.

To provide dental care through the NHS, a contract holder operates through either a General Dental Services (GDS) or Personal Dental Services (PDS) contract, the direct equivalent of the General Medical Services (GMS) and Personal Medical Services (PMS) contracts in medicine. The essential difference is that the PDS is time limited and tends to provide more specialised services, the largest example being orthodontic treatment.

There are also a small number of PDS Plus contracts, largely a historical legacy of an attempt to address a perceived access problem but these are gradually being phased out as they terminate or transfer to a GDS agreement. An NHS GDS contract holder can choose the extent to which they provide care through non-NHS arrangements. Although both contracts use personnel with independent contractor status, there are some important differences. PDS contract holders tend to be providers of more specialised care. Besides orthodontics, they can include special needs, domiciliary care, other hard-to-reach groups and more specialised areas of activity or care management that GDS contract holders choose not to or cannot provide.

The major holder of PDS contracts are community dental services that have evolved from being the school dental service (based then in local authorities) to providing specialised services. They provide dental care to priority groups, for example those with special needs or people with a fear of dental care.

The community dental services have been responsible for the collection of survey data and for oral health promotion. However, the move of health promotion budgets to local authorities had an adverse impact on the scale of such activities.

6. *NHS Dental Statistics for England – 2015/16 published by NHS Digital*





Staff in these services tend to be salaried and employed by trusts. There is considerable variation in the size of community dental services across England as there is in the number of NHS GDS contracts. Unlike medicine, there has never been any attempt to control the number of contracts in an area until fairly recently. The manner in which the 2006 contract was introduced meant that existing contract holders were automatically awarded the right to a new contract.

While there is some variation in the funding to local NHS England offices, which are responsible for contract governance, recent figures highlight that the GDS dental budget was underspent by all 26 areas in England. The majority of the unallocated dental monies were retained for other healthcare services in the locality.

Those contracted to provide NHS GDS dental care have far greater independence than their counterparts in the medical sector. They are entirely responsible for the business including staffing, maintenance, premises and equipment. GDS contract holders (known as “providers”) can operate on their own or through the use of other dentists (“performers”) engaged usually as associates and having access to the NHS pension scheme. Some “providers” use assistants, dentists working on the same contract, to ensure delivery of the contract which raises a number of legal issues. The terms and conditions of the contracts between “providers” and “performers” who service the NHS contract vary. This can lead to a situation where the same care provided on a patient in the same setting at different times by different “performers” is rewarded at different rates.

The acute sector employs a range of consultants trained in one of the 14 dental specialities with the overriding majority working in either oral surgery or orthodontics. There is considerable variation in the distribution of the consultant workforce. The implications of this for the primary

care home model are not considered further in the present report.

For patients, there are some important differences. There has always been a legal requirement in the NHS for the contract awarding body to find a resident a GP for life unless either party seeks to terminate the agreement. This has never been the case for general dental practitioners. Also, until recently, a patient had to register with a GP in a defined geographical area.

While registration previously existed in dental care that covered an 18-month period, this ceased with the introduction of the most recent contract in 2006. Patients may believe they have their own dentist. However, there is no legal responsibility at the end of a course of treatment except for a guarantee for a fixed period on certain items provided during the course.

One of the major developments that has impacted in dental care but is yet to be seen on any large scale in the medical sector is the growth of corporate structures.

There appears to be a reduction in the number of dentists who want to be involved in the running of a dental practice. This can be attributed to a number of factors included the increased burden to comply with the regulatory framework, different attitudes to work in the younger generation as well as rising equipment and premises' costs.

While any individual dental practitioner could technically incorporate (form a limited company), there are four major providers of dental care who operate through such business structures with dental practices in numerous locations.

In the NHS, the largest of these corporate providers have full-time management structures and cover considerable geographical areas. This may have implications for the inclusion of such practices in a PCH model.

The contractual arrangements, the non-existence of registration, the decision by the government to use co-payments, the considerable size of the non-NHS care sector all provide barriers to the broad adoption of dental care providers as partners in the PCH model.

There are differing contractual models being tested that may impact on the extent dental care can be included in any model in the future. It also needs to be considered that any arrangement must consider that one of the key characteristics of the PCH model involves a capitated budget in the long term.

Given that dental care is outside this arrangement, patients are not registered, and legally the same body cannot provide dental and medical care, full integration seems unrealistic. There are opportunities, however, arising from the existence of more specialised contract holders to work with primary care homes to address problems as well as tackle the social determinants of health in an efficient way.

Models for dental engagement

Given the four characteristics behind a primary care home as referred to on page 7, this chapter explores some of the issues arising in meeting them.

At present, two issues would appear to prevent the whole scale inclusion of NHS dental care into the PCH model: registration and any transfer of financial budgets to a new 'holder'.

The current legislation prevents a legal entity from providing both NHS medical and dental care. Even if this changed, given the ownership of dental premises, there would be a need for the PCH structure to agree a form of goodwill to cover the premises to bring it in line with medical premises arrangements.



As far as registration is concerned, the major advantage for collaborative working in an area covered by a primary care home centres on the geographical boundaries of the partners. Where PCHs and local authorities share the same boundaries, there are opportunities for working together to improve population health outcomes⁷.

For dental care, the problem may be more in theory than in practice. The size of a PCH of between 30,000 to 50,000 population and the average dental contract holder looking after around 2,000 patients, would require between 15 to 25 dentists if all their PCH population were to be covered. Given the current nature of practices, this would involve around 10.

An alternative model would be based on the nature and scale of dental problems that each PCH faced. Given the variation in PCHs, this would appear to be a sensible way of moving forward. Co-operative working arrangements between the dental profession and the PCH can be established, for example through the Local Dental Committee structures and Local Professional Networks (LPNs) (the former covering a far smaller area and therefore more suited to a PCH arrangement). The aim would be to address the external determinants of dental health combined with development programmes to assist collaborative working to meet local needs.

Fleetwood is one PCH that has already made plans to improve oral health outcomes. It is working with a local dental provider and the Lancashire Local Dental Network as part of its elderly care pathway.

Under the pilot – which also involves NHS England, Public Health England and the University of Central Lancashire – dentists and their teams will visit care homes and support them to improve people's oral health and nutrition, and promote general health.

The PCH, supported by the dental team, is also working to promote young children's oral health, particularly the under twos, with health visitors and other health professionals encouraging parents to take their children to the dentist for early prevention.

Resources to provide care to agreed levels for sections of the registered PCH population, based on reliable economic data on savings, for example, in pharmaceutical spend or care referrals, could be established.

One of the key aspects to providing opportunities for dental participation in the PCH models lies with ensuring NHS commissioners recognise and use the flexibilities in the current contract to enable dental practitioners to not only deliver some of the activities suggested for an integrated care model, but also enable them to attend PCH meetings where the planning, development and monitoring of any care programmes take place.

7. NICE Oral health: local authorities and partners. Public health guideline [PH55] Published date: October 2014
(available at: www.nice.org.uk/guidance/ph55/resources)

Conclusion

It has been suggested that the involvement of dental care could add considerable value to primary care homes at a time when we have seen a growing number of patients with dental problems accessing medical care with resource implications and poor outcomes. This is despite improvements in oral health overall.

There is also considerable merit in strengthening the working relationship between dental and other sectors involved in primary care home sites, not least in helping ensure better and more efficient outcomes for patients.

The current contractual and structural arrangements make the wholesale incorporation of dental care into primary care home sites unrealistic.

However, the development of collaborative projects to tackle problems such as the growing dental demands on medical care resources and the focus on specific population groups or conditions would be a good way forward.

To achieve this, addressing current barriers to the sharing of information and educating all those involved in primary care homes of the opportunities of closer working and its benefits will be central to progress.







Case study

Revive Dental Care

Homeless people tend to have poor dental health

The challenge

Homeless people tend to have poor dental health and many have not visited a dentist for years. It's common for the homeless to alleviate dental pain with alcohol or drugs instead of seeking treatment. When the pain becomes too severe, many will either attend A&E or resort to pulling out their own teeth. Homeless people often lead chaotic lives and have complex mental and physical health problems, with dental care low on their priority list despite appalling levels of decay. A significant number have no teeth. It can be hard to find an NHS dentist willing to accept homeless patients.

What they did

Since 2009, Revive Dental Care has been working closely with GPs, statutory and voluntary services in Manchester to improve dental services for homeless people. With funding from NHS England, the practice set up "pop up" dental surgeries at various drop-in centres in the city, where staff carry out examinations, referring patients who need treatment to a weekly clinic in the practice. There are more than 400 patients registered with this "hard-to-reach" service and eight drop-in centres with up to 18 patients attending each session. The practice works closely with the Urban Village Medical Centre – the designated "homeless" GP surgery – running dental treatment sessions alongside the surgery's own drop-in clinics. The dental team accepts referrals from GPs and also the "Helping the Homeless into Housing" charity run by Stockport Homes.

The impact

The first step of seeing a dentist and "getting their teeth sorted" has led many patients to want to turn their lives around. In some cases, the dental team has identified suspected oral cancer and made quick referrals to a GP. Many patients have found a new sense of self worth enabling them to start seeking work or form relationships. Staff have found the work stimulating, interesting and rewarding. They've experienced the satisfaction of seeing someone come in upset and unable to smile because of stumps caused by tooth decay and walk out with new teeth and confidence.



Lessons learnt/success factors

The work by Revive Dental Care – in collaboration with GPs, partner agencies and several charity and church projects – demonstrates the opportunity that exists for primary care homes to target hard-to-reach patients and help them not only with their dental problems but also other factors affecting their health. These include addiction, malnutrition, homelessness, unemployment and social isolation. By going out into the community, practice staff have built trust among patients, including many who have only ever had a bad experience of dentistry.



The members of the dental working group were:

- **Paul Batchelor**, *NAPC Dental Lead (Chair)*
- **Dr James Kingsland OBE**, *President NAPC*
- **Ben Atkins**, *General Dental Practitioner, Trustee of the Oral Health Foundation, NAPC Council Member*
- **Shawn Charlwood**, *General Dental Practitioner and member of the General Dental Practice Committee, British Dental Association*
- **Onkar Dhanoya**, *General Dental Practitioner and Board member Faculty of General Dental Practice (UK)*
- **Helen Pailthorpe**, *Head of Service, Berkshire Community Dental Services*
- **Eric Rooney MBE**, *Deputy Chief Dental Officer (England)*
- **David Ward**, *General Dental Practitioner, Clinical Director, 543 Dental Centre Ltd and member of the Association of Dental Groups.*

Further information


For more information about primary care home, visit the National Association for Primary Care (NAPC) website: www.napc.co.uk

For Local Dental Committee (LDC) contacts, visit the British Dental Association (BDA) website: www.bda.org



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