Piloting a local dental network across Hampshire and Isle of Wight Primary Care Trusts

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IN BRIEF

- Describes the process of establishing and testing a pilot local dental network (LDN) within Hampshire and the Isle of Wight.
- Discusses the difficulties of involving general dental practitioners without a source of funding, and communicating with the wider dental community.
- Considers challenges and opportunities faced by the new LDN, such as gaining credibility within the health system and influencing the oral health agenda.

RESEARCH

Aim To pilot a local dental network (LDN) within the Hampshire and Isle of Wight region. **Method** An LDN Coordinating Group was set up, which was chaired by the local consultant in dental public health and included representatives from dental commissioning and performance management teams, dental practice advisory team, finance, Oxford and Wessex Dental Deanery and the Hampshire and Isle of Wight Local Dental Committee. The LDN successfully led the organisation of a leadership training course for local dentists, and produced recommendations for local oral surgery and orthodontics care pathways. Key to the success was the collaboration achieved between the commissioners, local postgraduate dental deanery and local dental committee. **Results** There were challenges associated with involving non-salaried dental practitioners without a source of funding, and with communicating with the wider dental community. **Conclusions** The new Wessex LDN needs to be adequately resourced and integrated into the local commissioning structure, as well as the wider health system, to function effectively. Most importantly, the LDN needs local dental professionals to embrace the opportunities for leadership and use their skills to inform and influence local dental commissioning for the benefit of the local population.

BACKGROUND

From 1 April 2013, a new health system was established across the country. A single commissioning organisation, NHS England, was established to manage the commissioning of a range of services, including dental services. NHS England now has 27 area teams around the country that manage operations locally.¹ A single operating model has been implemented nationally to achieve consistency of approach.²

One aspect of the new arrangements is the development of local professional networks (LPNs) for dentistry, pharmacy and optometry.³ These networks were to be established as part of the NHS (England) area teams to provide a collaborative forum for clinicians and commissioning managers to deliver the best possible outcomes for patients. This model mirrors the development of clinical commissioning groups (CCGs), which brought together groups of general medical

practitioners to manage the commissioning of a range of primary medical care services.^{4,5} Unlike CCGs, LPNs do not hold a budget or have any commissioning responsibilities. Instead, the expectation was that LPNs would be advisory groups that would provide clinical leadership and expertise to NHS England area teams, who would be responsible for commissioning dentistry, pharmaceutical and optometry services.

In September 2011, there was a national call for Primary Care Trusts (PCTs), the then local commissioning organisations, to pilot local professional networks. The emerging national model included a core clinical commissioning team supported by local clinicians with wider engagement of all primary care providers/performers in the area (Fig. 1). In response to this, a pilot local dental network (LDN) was set up across the PCTs within Southampton, Hampshire, Isle of Wight and Portsmouth, which were then working together as the SHIP PCT Cluster.

The pilot LDN was based on an existing dental clinical team, which had been established in 2010 to provide clinical support to dental commissioning. The clinical team was led by the consultant in dental public health (CDPH) and included the local associate postgraduate dental dean and the honorary secretary from the Hampshire and Isle of Wight Local Dental Committee (LDC). This clinical team was expanded to

Fig. 1 Emerging DH model for LPNs

include other clinicians and managers to establish the SHIP LDN, which successfully delivered a number of local projects. This paper describes the experience of, and the learning from, the SHIP LDN.

AIM AND OBJECTIVES

The aim of the pilot was to establish an LDN that would provide a forum for clinicians and commissioning managers to work together to advise and lead on local dental commissioning.

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The objectives were to:

1. Establish a pilot LDN to include a range of clinician and managerial expertise to inform dental commissioning decisions
2. Involve local dental professionals in service development, including encouraging local dental professionals to take clinical leadership of work streams
3. Test the model with a selected number of projects to understand strengths and weaknesses of model and inform future development.

Objective one: establishing the pilot LDN

Figure 2 illustrates the structure and accountability arrangements of the SHIP LDN. The LDN was managerially accountable to the Dental Commissioning Committee, which reported to the board, integrating it into the local governance structure. Professional (clinical) accountability was through the chair (CDPH) to the Southampton Director of Public Health. The LDN acted as a hub that either initiated and managed projects or established working groups to do so on its behalf. The LDN did not make any decisions; rather its purpose was to make recommendations to the Dental Commissioning Committee, which then made a decision. The Dental Commissioning Committee also consulted the LDN on a range of commissioning issues. Integration into the local structures gave the pilot LDN credibility and direction.

Membership of the LDN included the CDPH (nominated chair for the duration of the pilot until March 2013), Postgraduate Dental Dean, the lead dental commissioner, the lead for dental performance management, a finance representative, and an LDC representative.

It was intended that the group would eventually include a representative from secondary care and a dental care professional, but this did not happen in the lifetime of the pilot. There was also an intention to include a patient representative and there was much discussion regarding how best this might be achieved. There was already patient representation at the Dental Commissioning Committee, so the decision was deferred until there was more clarity on what patient representation would add to the LDN.

Discussions were informed by public health and service data coupled with clinical expertise and local knowledge. All partners, the SHIP Cluster, Deanery and LDC, remained committed to the initiative throughout.

Objective two: involving local dental professionals

Unfortunately, the LDN did not include a local general dental practitioner (GDP). Clinicians were involved in the task and

Fig. 2 SHIP pilot LDN governance arrangements

finish groups but these were all salaried staff from the local community dental service and secondary care departments. As GDPs make up the majority of the dental clinical workforce, this was disappointing. This was primarily due to the lack of resources available to fund backfill arrangements. All the stakeholder organisations permitted their staff to participate in the LDN. However, for self-employed GDPs managing their businesses, the priority is always to deliver on their contracted activity. Taking time out to participate in the pilot would impact on this and potentially on patient care, as well as their contract income.

Lack of funding was only one issue. Engagement with the wider dental community was also a challenge. A range of communication methods were discussed including mailing out letters and newsletter-style updates, using e-mail and organising both face-to-face and web-based meetings. All methods had advantages and disadvantages and using a wide variety would be resource-intensive. The geography did not help with the area covered by the SHIP Cluster extending across all of Hampshire and the Isle of Wight. Meetings were held in Southampton, which was reasonably accessible from most areas, but still a long way from some areas such as the northern parts of Hampshire.

Objective three: testing the model

Organising leadership training

One of the priorities for the LDN was to identify training to upskill local dental

clinicians to take on clinical leadership roles. This was considered key for LDN success. The LDC agreed to provide backfill funding to a number of their members to enable them to participate. The local deaneries (Wessex and Southwest) developed an LDN dental leadership development programme, which was offered at no cost. Six sessions were planned between December 2012 and April 2013. The programme ranged from discussions on leadership and self-assessments of personal strengths and weaknesses to understanding oral health indicators and dental commissioning. A key part of the training was providing an opportunity for participants from a range of backgrounds, including general dental practice, salaried dental services and dental public health, to interact in a 'neutral' environment.

Redesigning local care pathways

The LDN made recommendations for the redesign of two care pathways – orthodontics and oral surgery. In both cases a pilot care pathway was already in place, which included centralised management of referrals. The Dental Commissioning Committee requested the LDN to assess the available information on both care pathways and make recommendations for the future.

Evaluations of the clinical effectiveness of both pathways were carried out by the dental public health team, such as trends in patient numbers and quality of information on referral forms. A task and finish group was set up for each of them, which included dental

clinicians involved in managing the triaging of referrals and the specialists who provided care to patients who needed advanced care. The task and finish groups produced reports that were then referred to a clinical team (dental practice adviser, CDPH and LDC secretary). The clinical team used their combined skills to pool and interpret the available information and produce recommendations for each of the care pathways. The recommendations were sent to the Dental Commissioning Group and the information used to establish both care pathways in the local area with added changes to further improve the service for patients.

LEARNING POINTS

Developing local clinical leadership

Clinical leadership gets much mention within the new structures of the health system, including in relation to LPNs. There has not been much information about what this really means in practice. There is general agreement that dentists need to take up the opportunities within the new health system to take up wider leadership roles.^{9,11} This was not really tested in the SHIP LDN, as it was chaired by the CDPH. The task and finish groups were chaired by the LDC Secretary who was a retired GDP, but who already had experience of leadership at national level groups.

There are different theoretical models and definitions around what is leadership, and more relevant in this context, what defines a good leader.^{9,10} There are some general personality traits that are listed as potentially important to leadership, such as confidence, emotional intelligence and drive.¹⁰ During discussions within the SHIP pilot about a future chair for the LDN, there were comments about finding the 'right' individual, with the requisite qualities to facilitate getting the LDN 'accepted' by local clinicians and commissioners. Indeed, the prevailing view was that the chair should be a GDP for the LDN to garner support from local clinicians, the majority of whom were GDPs. Dentists are used to taking a lead within their own teams or practices and some take on regional or national leadership positions within associations and organisations. However, taking on the role as chair of the LDN, or leading work streams as part of the LDN work programme, requires the ability to engage more widely with individuals outside the dental profession, including commissioners and patient advocacy groups. A key reason for prioritising the leadership training was to facilitate development of these skills. Indeed, all members of the pilot acknowledged the need for training in order to develop good leaders, which the literature supports.^{10,11}

Engaging the local dental community

One of the key issues with the pilot LDN was the inability to involve general dental practitioners due to the lack of funding. Finding funds for any programme within an already difficult financial climate was always going to be challenging, but it is difficult to imagine how the LDN will function without some investment. It will be difficult to involve GDPs without allocation of resources to support backfill arrangements. Equally, the LDN cannot function well without involving GDPs who make up the majority of the dentist workforce and are, therefore, an important stakeholder group. Busy clinicians and managers will find it difficult to participate without administrative support to organise meetings, set up project groups and circulate information to relevant members. CCGs are allocated funding annually for running costs to enable them to function effectively.⁸ Similar levels of funding may not be available but area teams will need to allocate some resources if the LDN is to involve local practitioners.

Funding is certainly needed for communications. There will need to be a strategy and concerted efforts made to engage with and involve the wider dental community, not just dentists, but also dental care professionals and support staff who are all integral to dental practice. It is unclear what communication methods will be successful but every avenue should be explored and a range of methods employed to achieve this. Without local engagement, the LDN will not be able to function successfully as a group, which harnesses the expertise and experience of the local dental community to maximise the effectiveness and efficiency of local dental services.

All the new LDNs are established within NHS England area teams, making them part of the local NHS structure. The Wessex Area Team has gone a step further and appointed a dental clinical commissioning lead (VES) to support the chair of the LDN. Some administrative support has also been made available. These resources have been invested by the Wessex Area Team following the outputs achieved by the pilot LDN and the support and commitment shown by local dental professionals. There are high expectations for the added value that the new Wessex LDN can bring to the local commissioning landscape.

Establishing the LDN within the local health system

The general medical professional-led CCGs are commissioners of a range of primary care medical services and hold corresponding

budgets with accountability to NHS England local area teams. As commissioners, they are important players within the local health economy. None of the LPNs, including the LDN, have any commissioning responsibility or budgetary control, making them much less visible locally. For example, CCGs are represented on local authority health and wellbeing boards, which play a key role in developing joint strategic needs assessments and joint health and wellbeing strategies, both of which guide the commissioning of local services.⁷ However, none of the LPNs have a statutory role within this forum and will have to negotiate involvement in these discussions.

Dental practice has evolved considerably just over the last 10 years. Dentistry has already moved from caring for patients and managing the practice, to dealing with contract requirements, quality criteria and the plethora of regulations that currently govern the practice of dentistry. Within the new system, there is a further step change, calling for dentists to understand the oral health needs of their local population, work to reduce inequalities within it and generally be advocates for oral health.¹² Dental teams need to embrace this new role and develop it within their practices, the community and the new health system. It is essential that the LDN is seen by the area team, the health and wellbeing board and other local organisations as the source of evidence-based and credible dental expertise if it is to influence dental care locally. It also needs to gain the trust and respect of the local community including the patient population, important stakeholders in their own right.

There will be issues of conflicts of interest during discussions about local services for both GDPs, who are managing their own businesses, and salaried employees, whose organisations hold contracts with the commissioners. It will be challenging when livelihoods and careers are involved, particularly when discussions may seem to be disadvantaging personal interests. Transparency will be important both for reasons of governance and also to maintain the credibility of the LDN with the local profession, local authorities and other stakeholders. Most importantly, clinicians will need to rise above their personal interests and think more widely about oral health and dental services in the local area, and ensuring safe, effective services for local communities.

FINAL COMMENTS

The SHIP LDN delivered some important outputs in the short time it was established.

The successes were due in large part to the commitment of all stakeholder organisations to the pilot and the high level of trust and collaboration achieved. There was learning for all members involved and for the organisation.

The task for the new LDN is potentially more challenging. The Wessex Area Team covers the counties of Hampshire, Isle of Wight and Dorset. The Wessex dental LPN will need to develop a model that is 'owned' by clinicians and engages with stakeholders across the area to be successful. A new chair has been appointed using an approach that involved the area team, local dental committee representatives and the CDPH (from Public Health England, Wessex). There is much support for, and expectation, from all local stakeholder organisations that the Wessex LDN will harness the range of skills and knowledge available from local clinicians, managers and patients/public to develop dental services locally that truly reflect the needs and requirements of

local patients. Dental professionals have the opportunity to change the way dental commissioning, and indeed dentistry, works within the health system. We need to grasp that opportunity to make a real difference for our patients and ourselves.

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