What does it all mean in primary care?

Sir, I read with interest our colleague from public health's piece on integrated care systems and how they may work from this perspective.[1] I work in primary care and wish to reflect on ICBs from this perspective. I agree that the aspiration to integrate seems a sound, local solution based on health and social care collaborating in a geography as an opportunity to plan differently.

Moving away from competitive procurement cycles that seem from the outside to be based on efficiency saving with an ever-spiralling race to the lowest cost and an ever more unsustainable system can only be welcome. We can see across the four nations of the UK and in other primary care services that a nationally determined contract that is underfunded no matter how that currency is commissioned to deliver yields a diminishing service with disheartened and diminishing workforce. To avoid a destabilising 'big bang', contract reform is cautious with small marginal changes implemented and their effects analysed. However, the pace of change appears slower than the exodus of dental practices leaving or reducing contracts as they see their futures outside the NHS. The national contract will not be determined by the ICBs, so how much can they achieve without additional funding and contract reform?

While the ICBs have been given the NHS budget to manage services in their geographical areas, including dental services, it's important to recognise that the budget still comes through NHS England, which remains accountable for these services. The ICB have a 'triple aim' of delivering better health for everyone, better care for all patients and efficient use of NHS resources, both for local systems and for the wider NHS.[2]

This is a tall order in a system that has lost funding in real terms through a decade of austerity. During COVID the effects that mandated infection prevention control had on capacity in dentistry were recognised and funded but the aftershocks post COVID, and the backlog have not been recognised. There has been a lack of meaningful investment in recovery for dentistry with a return to targets that have contributed to dissatisfaction. It appears many have lost faith post COVID. The ICB are commissioning services from a workforce that is disillusioned and disengaged. Can they recognise and redress this with local initiatives? Is it too late? Is there an appetite to understand and redress why the current arrangements are not working.

The early adopters do recognise that across POD services the most pressing need relates to dentistry.[3] Early adopters of the ICBs acknowledge that dentistry is one of the most urgent needs across primary care services. MP letters, patient feedback, and advocacy by patient groups such as Healthwatch consistently highlight the importance of NHS dentistry and the lack of access to both urgent and routine care. However, it is crucial to remember that dentistry is just one of many services within each geographical area.

The ICBs are actively seeking engagement from the dental profession through existing local structures and networks, such as Local Dental Committees (LDCs), Local Dental Networks (LDNs), and nationally, the British Dental Association (BDA). They are guided by subject matter experts on commissioning from NHS England and are exploring what can be achieved locally within the constraints at the national level. This local engagement is encouraging but is not guaranteed and yet it may be increasingly important to reach out to ICBs, otherwise how can we influence significant change? How transformative can we be?

There are examples of flexible commissioning that have yielded positive outcomes and have been well-received by practices. Is this level of adaptability currently achievable? When outcomes align and stakeholders collaborate, meaningful change is possible. Examples from North Yorkshire and other regions demonstrate the cost-effectiveness of targeted care in exchange for a 10% substitution of the contract and, more recently, urgent access sessions.[4]

To make informed decisions, the ICBs require data, and it is evident that there is a paucity. The delayed Adult Dental Survey, which was due in 2019, is a significant loss. We, like our public health colleagues, must recognise the importance of surveys like these which have charted the nations' oral health once every decade since 1968. The child dental health survey in 2023[5] revealed that tooth decay remains a problem for almost a quarter of five-year-olds. NHS Digital data also show that access to dental care for children and indeed all age groups, remains well below pre-pandemic levels.[6]

At the other end of the age spectrum, the recently reviewed Care Quality Commission (CQC) Smiling Matters progress report for 2023[7] highlights the challenges faced by older people in care homes when it comes to accessing dental care. The number of care home providers stating that they can never access care has risen from 6% in 2019 to 25%. It is perverse that clawnback and underspend are at a record high when an access crisis is evident. Can the ICBs inject this funding into the system before it expires? Will future funding be ringfenced?

I realise I pose more questions than answers here. Perhaps that reflects where we currently stand. I hope that we will be heard, and I hope that we can collaborate with the ICBs and stakeholders at local and national levels to ensure that our population can continue to benefit from NHS dentistry, just as they have for the past 75 years since the establishment of the NHS. Despite the challenges, I believe there is a genuine willingness to adopt different approaches and that integrated care has the potential to improve the current *status quo*.

A. Tarnowski, via email

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