South West Direct Commissioning

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Paper Title: Dental Transformation SPRINT Workshop 1: Output

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Purpose:

- To inform the Direct Commissioning Committee of the insights gathered at the first of three planned SPRINT workshops to collaborate with clinical experts, general dental practitioners and other specialised professionals together with patient representatives and local place-based non-clinical stakeholders to share and explore ideas to improve access to NHS dental services across the region and develop a long term dental strategy.

Background

NHS England and NHS Improvement South West are reviewing the dental services we commission, including high street dental services, hospital based dental services and the oral health improvement services we buy. The first of three multi-sector SPRINT was hosted in June 2021 to identify where services are working well, opportunities for improvement, quick wins as well as improvements that could be made in the longer term and ideas for how current barriers can be overcome (e.g. such as ways to attract dental professionals to fill gaps in workforce). This represents the first of three SPRINT cycles to inform the development of a regional Dental Reform strategy, improve access to dental services and tackle other determinants of poor oral health.

The SPRINT agenda and discussion topics were informed by the recommendations of the South West Oral Health Needs Assessment (OHNA) published in February 2021, an environmental scan of best practice in oral health in England conducted by the NHS Transformation Unit which we commissioned recently, and feedback independently gathered from the public in the South West by local HealthWatch organisations as well as an NHSEI (SW) region-wide public survey deployed during the early stages of the pandemic.

All of the above sources of intelligence highlighted the difficulties people across the region experience trying to access - NHS dental services and the declining oral

health of our population, which mirrors the rest of England. Moreover, access challenges have been further exacerbated by the Covid-19 pandemic Infection Prevention and Control (IPC) guidelines (8 June to 31 Dec – 20% capacity, 1 January to 31 March 45%) which has led to practices currently working to a threshold of 60% of contract.

In keeping with the OHNA recommendations, we recently hosted the first of three SPRINT workshops on 10th June to work with clinical experts, general dental practitioners and other specialised professionals together with patient representatives and local place-based non-clinical stakeholders to codesign oral health services for the future, aligned to the needs of our population and plans for other services in local areas.

The reports above have already eloquently outlined the case for change from the public's perspective based on their views and experiences of dental provision in the region. This report focuses on the case for change from the viewpoint of those who provide dental services, summarising their ideas for how we can better protect the oral health of our population and ensure people can access the right dental services should they need it, when they need it.

The dental team acknowledges the immense pressure the dental community has been working under given the extended shortage of dental staff nationally and concomitant recruitment difficulties locally, which have been further compounded by the pandemic. We wish to sincerely thank them for their continued loyal service and extend further gratitude to those who gave up their evening to share their thoughts with us so generously at SPRINT 1.

SPRINT 1: who came and what we discussed

Approximately 200 people attended the event, including volunteers from Integrated Care Schemes (ICS) and NHSE and NHSI national and regional teams that helped to deliver the workshop between 6 and 8.30pm on 10 June. During the 70 minutes of discussion time delegates were presented with three real life cases to capture their insights on access to NHS dental services, oral health improvement and workforce recruitment and retention that were identified in the OHNA as challenges that needed to be prioritised (see Appendix A for the case studies and some suggested questions that facilitators could draw on to guide breakout discussions).

Key findings

Just under 50 pages of insights were collected and interrogated for examples of best practice / brilliant ideas, opportunities for improvement, current barriers to optimum care and facilitators that could help overcome barriers.

Over 75 distinct themes covering everything from primary prevention to specialised oral surgery, recruitment through to retention were identified. 'Workforce',

'contracting', 'the public' and 'communications' were identified as both barriers and facilitators regardless of which of the three case studies were being 'solved'.

Access (how can we prevent anyone else from having Susan's experience?)

Barriers and Opportunities for Improvement

When examined, the main barriers to optimum dental access were:

- Capacity (linked to workforce)
- Integration (linked to partnership working)
- Communication (linked to the public in terms of choice, expectations and ability to access to information)
- Contracting and Finance
- Standard Operating Procedures since the pandemic

Each of these themes are explored here in turn;

Capacity and workforce

Nationally, dental practices are having difficulties in recruiting and retaining NHS dental practitioners, which has created longstanding access issues and delays for dental services that has increased demand for 111, minor injury units (MIUs), special dental care units (SCD), emergency departments (ED/E&D) and general practices (GP) in and out of hours (OOH).

> *'The number of calls being received by MIUs for dental care has increased significantly. MIUs are limited in the amount of treatment / advice they can provide (i.e. can't prescribe antibiotics and often don't know where patients can be sent for treatment because services are not accessible/ available)'.*
>
> *'We provide a specialist dental service in Wiltshire for vulnerable patients – in the past 12 months we have become an urgent dental provider as there is a lack of NHS dental provision in Wiltshire.'*
>
> *'The current contract passed the Out of Hours responsibility onto commissioners rather than primary care providers. The current OOH service often does not provide the capacity needed.'*
>
> *'In-hours as a GP I'm often seeing people who cannot access a dentist.'*
>
> *'111 call handlers, 17,500 calls but only 40% seen due to lack of capacity in Plymouth.'*
>
> *'People see their GP as can't get a dental appointment – they are prescribed antibiotics but will still need to get dental treatment.'*
>
> *'Not all dental pain needs antibiotics. Sometimes a patient needs treatment but Senior House Officers (SHO) in A&E are not permitted to deliver treatment*

(extractions) at A&E, it is usually analgesia and a request for a patient to find an appointment at an urgent care dental hub or a dental practice.'

People also highlighted limitations regarding what various dental practitioners could and could not do.

'Dental Therapists cannot see urgent care patients without supervision. Then once skilled, experienced Dental Therapists moves on to private practice.'

Lack of capacity also has a financial cost in addition to the clinical cost to the people who are unable to access the right level of care when they need it. Dental access issues also create additional workload for the wider system as well as negatively impacting on the wellbeing of dental practitioners.

'The cost of the failure demand is borne by the whole commissioning system with poor patient outcomes. This is costly to the system, e.g, 111 calls are paid for 'by the call', the more calls which are made, the greater the overall system costs. Plus, if this is a dental call to 111 it cannot close. They go down to the CAS (clinical assessment service) to speak to a clinician. This call costs as well. Then the patient gets sent to ED. This has to be paid for too. So, at each point of sub optimal care to the patient the failure demand costs the system dearly in terms of local commissioner costs.'

'My concern since COVID is that the patients we are seeing are high need due to the pandemic - more treatment needed but no time and no facility to take on new patients. Many people have not been seen since before lockdown so have teeth broken, pulp, missing teeth etc. Units of dental activity don't work as a way of trying to sort it out - we can't take new patients on NHS as we're so full with our own patients – there's a real capacity issue and very low morale.'

Integration and Partnership Working

Participants also highlighted difficulties in providing joined up care because of a lack of communication and working in isolation as individual businesses.

'Speech and language therapists have a hard time getting through to dentists so we can work with them as part of the oral health campaign we're currently exploring.'

'Historically, dental practices have operated independently and worked in isolation. Winning the hearts of practitioners and encouraging them to work together more is going to be key to this.'

'The lack of integration and clear relationship between primary dental care and secondary care makes primary dentistry care appear so inaccessible for

people that it's just not on their radar and, subsequently, means that they end up in urgent care instead.'

'Corporate practices with dentists living elsewhere and driving into work are not invested in the health of their community so less willing to take on the more complex and time-consuming cases, but we individual practices can't afford to take them on because of the UDA (units of dental activity) situation.

Communications

People's discussions highlighted the need for better communication with the public to help them navigate the system and manage expectations regarding the difference between accessing general practice and primary (i.e. 'high street') dental services.

'There should be clearer local guidance so that the patient could have been treated in primary [dental] care. If patient attends A&E, it is likely the pathway has failed.'

'Lack of effective interface and information sharing means patients are 'bounced around' and leads to failure demand.'

'Confused messaging for patients about what is achievable and provided under the current contract arrangement doesn't help.'

'We get 60-70 calls each day from people who are not registered with us who are now displaced. Our receptionists can't keep up with demand.'

'Knowing how to access primary dental care 'isn't on the public's radar - it's too difficult to navigate the current system or, for example, know which toothbrush to buy while leading a busy life. The system does not make it easy for the public – they have to do the work.'

Contracting and Finance

The way that the primary dental service is currently contracted was also seen as a major barrier to being able to provide optimum care in all 12 discussion groups, with the current method of paying the same amount for each UDA (unit of dental activity) regardless of how long it takes to complete someone's dental care seen to create a perverse incentive to either increase the proportion of private complex care to subsidise the shortfall in NHS related income or prioritise people whose dental needs are least great so that a greater number can be seen in a day.

'Root canal treatment – no one needs it, it's a choice. Need to look at what is being commissioned as it is expensive. Businesses can't spend half an hour with urgent patients because the commissioning model is broken. Alternative is extraction in back teeth. Honesty is needed and time to be able to have conversations with patients i.e. I can perform an extraction or you can see a specialist colleague or go privately, but you will be paying £1000 for that.'

'The range in UDA (units of dental activity) targets is a key blocker to out-of-ours access and the cause of a variation in provision across practices. We have one practice which has a 50,000 UDA value where another practice has only 6,000. They said that the practice with the large UDA value would 'open on a Sunday, if it was asked to', and that 'anyone could walk in off the street' and be seen as its high UDA value means it receives the funds for that – 'practices can do anything if they have the money to do it. The 6,000 UDA value practice simply does not have the funding to do this.'

'It takes half an hour on the phone to decide whether to take on a patient, half an hour appointment for assessment, then a referral or rebook which could be another half hour and filling forms out on top of this – all for £23.80 – the funding just isn't there.'

'Under the current primary care dental contract arrangements (introduced in 2006) there is no formal patient right to registration with a dental practice. There is no obligation for a practice to continue treating a patient following 3 months from the end of their last treatment.'

'It's hard to recruit with non-recurrent funding.'

'In reality, private work supports a practice with their NHS provision and gives them the ability to offer a range of NHS services. Without it a lot of small rural practices wouldn't last.'

Standard Operating Procedures

Safety procedures since the pandemic were further restricting the ability of dental practices to meet demand, which in turn was reducing the morale of the dental workforce.

'The Standard Operating Procedures in place because of the pandemic have magnified the problems with access to NHS dental care.'

'As a private practice I have registered patients and over 12,400 NHS patients who unless having urgent treatment are not registered. There is enormous pressure to deliver and patients do not make an appointment for years and still assume they are patients, which is not expected of the practice. We would feel morally obliged to see non-registered patients, but for others this is very difficult i.e., the practice can't offer aerosol generating procedures and covid issues mean max of 4 appointments as PPE needed and full surgery clean down after each appointment.'

Proposed Solutions and Facilitators to increase access

To address the above five issues, participants proposed a vast number of potential solutions and facilitators:

- Policy regarding ownership of and responsibility for the whole patient journey with clear lines of responsibility and accountability for individuals needing urgent care
- Digital enablement
    - Greater use of digital platforms and remote consultation (linked to dental triage, open access clinics and outreach in areas of most need, MIU (minor injuries Unit) and OOH (out of hours) provision)
    - Shared care records online
- Needs led resource allocation
- Primary care model that feeds into community and secondary care
    - Mobile outreach clinics to provide treatment for homeless/travellers/those in care homes
    - Dental Clinics outside 9am-5pm
- Operational dental networks with patients registered with a network in their community
- Clear, pathway and access thresholds for patients so they don't bounce round healthcare system
- A regional dental helpdesk to act as first point of contact, staffed with dental nurses and general staff, with support from the VCSE (linked to 111)
- Dental team
    - Nurse practitioners for simple dental problems (oral thrush, abscess etc)
    - Use range of dental team hygienists, nurses and therapists to do dental work with dentists focused on complex cases (learning from GPs)
    - Practices to have dedicated urgent dental staff
    - Dental nurses to triage at first point of care
- Additional payments for urgent care

- Expand urgent dental provision
    - Open access urgent dental slots at practices available to 111 as well as Urgent Dental Hubs
    - Access to urgent dental advice in ED
    - NHS 111 linked to urgent dental triage (via dedicated helpdesk or online platform) for diagnosis and advice
- New and expanded roles for various health professionals to increase capacity
- Dental triage and prioritisation thresholds
- Adapt/adopt out of area or historic ways of working
- Expand pilots that have worked well
- Refresh communications and marketing strategies to help people navigate the system and attract dental practitioners to the region

A more exhaustive corpus of the potential solutions and facilitators people suggested is available upon request. The following paraphrased examples encapsulate the majority views in terms of the number of breakout groups that said similar things.

> *'Clear responsibility for patient care no matter where or why they enter the dental system is needed.'*
>
> *'There's no ownership of the whole patient journey. We need a designated port of call for patients and a shared repository for their dental history and we need to ensure NHS Digital are involved in this.'*
>
> *'In general practice they have a nurse practitioner specialising in diabetes, asthma etc etc. I want a team of nurse practitioners trained in being the dental nurse specialist. My understanding of nurse practitioners is that they can prescribe. They could be trained to recognise simple dental problems such as angular cheilitis, oral thrush, denture stomatitis, dental abscess, ulcerative gingivitis etc etc etc.' (via email post-workshop)*
>
> *'GDPs (general dental practitioners) have been offered additional payments to undertake urgent care during COVID. This needs to be developed further and linked to MIU (minor injury unit) and OOH (out of hours) provision.'*
>
> *'Given how many people end up going to their GP for help when they can't get a dentist we should offer training on basic dental care for GPs.'*
>
> *'COVID learning has accelerated the utilisation of IT and remote consultation which can be particularly effective in young people who are physically and or mentally disabled and access to dentistry.'*
>
> *'Everyone knows how to use 111, so it's the perfect place to help people navigate urgent/priority slots. Giving 111 the functionality to have tabs on dental urgent slots across practices in the area and the ability to allocate*

patients to those slots would create a really simple and coordinated communication channel for patients.'

'Divert dental 111 calls direct to a dedicated dental helpline that is staffed by expert dental nurses.'

'Practices could be held to account by being given enhanced/increased UDA rates for access and other UDA rates can be flexed so that there are no additional costs.'

'Don't forget the people with the greatest need don't tend to go to the dentist. Models of best practice is to go to where they are. I.e. Homeless and Travellers etc. Have a mobile service? How do they want to access care?'

'Look to expand urgent care provision and employ dentists – people don't want to do these jobs. Incentive is needed to get them to work here – money or reward needed for job satisfaction.'

'Within a practice one experienced dentist worked full time on emergency patients, dealing with one problem per patient, and patients booked at regular intervals. He could see 11 patients between 9 and 5.30. In doing this, he kept the rest of the practice working on routine dentistry without the disruption of dealing with emergency care.'

'Foundation dentists – if they had a day a week treating patients from 111 – they would be salaried so time doesn't matter – should it be part of the contract that they deal with some emergencies?'

'Utilise hygienists, nurses and therapists to carry out more dental work and work more to their full potential. This would allow dentists to focus on more complex issues.'

'Go to the people i.e. care homes. Have a mobile unit where people are due to be collecting food etc.'

'Can there be a network set up which links MIUs with some sort of dental triaging system enabling support for diagnosis and advice?'

'Dental care networks need to be part of the building blocks of ICS' (integrated care systems). Giving the public the opportunity to register for a network in their community would allow patients to navigate complaints and concerns as well as allow them to work with their local health network to take an active role to shape a new model of care moving forward.'

'Care integration and a population health approach is key to all of this. I would like to see relations between different parts of primary care (dental, pharmacy, optometry, general practice) being built as part of local Primary Care Network development.'

'Satellite hubs could be commissioned specifically to deal with the patient cohort that are not registered with a practice – meeting the needs of those patient groups by offering extended hours, weekend clinics.'

'Previous contract models based on a capitation payment system worked better than the current UDA model. A return to such a system may assist in greater numbers of patients being treated / accessing services and may attract more dentists to the area.'

'Is there a greater role for students in the provision of urgent care linked to their training?'

'Better use of dental registrants at the point of triage in urgent care (via helplines/111).'

'Expand the access plus model for OOH/urgent care. People have initial treatment e.g. prescribe antibiotics and are booked in to come back to 'complete' the treatment. In Plymouth with the urgent care plus initiative some spare capacity is being used in the building at weekends.'

'Dental therapists have a 'wide scope of practice' which would really benefit the system if we could improve the assurance of a salaried job at the end of training.'

'Establishing practices consisting solely of dental hygienists and therapists is a way to increase capacity, but this can't currently happen since hygienists and therapists need to work under a dentist and under a prescription but, by lifting this, whole practices dedicated to this aspect of dentistry could be set up.'

'Instead of being treated as emergency single episode, the whole mouth should be treated.'

'There is a prosthetic service offering single courses of treatment to patients requiring dentures, addition of teeth to existing dentures, reline, rebase. This work can be carried out by technicians with enhanced skills – denturists I think they are called and registered with the GDC.'

'The approach in Wales is an example of good practice. They have set expectations around numbers of NHS 111 patients to be seen based on annual contract value which helps share the responsibility by ensuring that emergency slots are based on contract size.'

'We could do more as a collective/federation. For example, we could take a blended approach to comms that can signpost people to their options – both NHS and non-NHS – via online and paper resources. Leaving leaflets around the practice explaining what a 'band 2' is and what a 'band 3' is etc. A

centralised template for such leaflets could be created which individual practices could then adapt/build upon.'

'Use salaried dentists, (not associates) to see patients. This would improve access for those patients that most high street practices would not want to see or treat. Dentists paid by the session would gain very valuable experience too.'

'Use of RAG/ACORN (Assessment of Clinical Oral Risks & Needs for Routine patients) ratings to ensure people are signposted to the correct service and don't slip through the net.'

'Learn from NHS emergency eye care as you can get an appointment on the day. Walk into an optician and they have the information about who is doing emergency that day. The emergency site then triage to relevant service.'

'Contract activity based on risk and need. Use different KPI metrics instead of a treatment driven process. The two main dental diseases are entirely preventable so we should co-produce care with service users. Practices should be able to maximise use of skill-mix and 'Make Every Contact Count'. Primary prevention is vital. Pre-school interventions are key. Keep a child decay free by the age of 5 and they are much more likely to be decay free at 12 than if they have decay at 5. Where treatment is needed then delivery should be based on biological methods such as Minimal Intervention Oral Care.'

Prevention (how can we prevent someone from having Caitlin's experience?)

As the above suggestion highlights, another way to address the gap between capacity and demand is to improve oral health such that the population's need for dental treatment reduces. Hence, we asked participants to discuss ways to prevent young children from having to have extractions under general anaesthetic using a real family's experience that had been highlighted in a Channel 4 documentary (see Appendix A).

Barriers/Opportunities for improvement

Participants said the following barriers prevented dental practitioners from taking a more proactive role in preventing dental disease:

- Contracting and finance
- Capacity (linked to workforce)

- The position of oral health on local education, health and care agendas
- Public opinion and compliance
- Health inequalities
- Communications
- Lack of integration with other institutions (schools, care homes, foodbanks etc)

'Public opposition based on the belief that fluoride is bad for you: Medication without consent etc.'

'Sugar is educated to children and the effect on teeth. But cheap food has much more sugar in it and this links to poverty.'

'Fluoridating water is redundant if children are still drinking sugary, fizzy drinks.'

'Telling them 'see a dentist every 5 months' and then not having a dentist available for them for 3 years makes the advice unhelpful - it feeds into the lack of understanding of the system that the public currently have.'

'Toothpastes have different levels of fluoride (cheaper brands often have lower ppm).'

'Information is not always available in a suitable format for all patient groups, (i.e. translated and culture appropriate). Current contracts do not enable this to be provided.'

'Rigid commissioning and contracts don't lend themselves to offering prevention. The contract doesn't reward oral health. There's no UDA for prevention.'

'We talk about improving health in communities, but dental is rarely part of the conversation.'

'Some parents insist that their children are referred to hospital for a general anaesthetic for teeth extraction rather than in primary care. They feel they have the right to the best possible care and do not want to see their children distressed despite the additional risks with GA.'

'Schools still struggle to give correct diet advice - raisins are still offered as a mid-morning snack and squash is allowed in bottles.'

'There's a lack of resource for prevention and a lack of connectivity to Education.'

'When you talk to anyone about fruit, they will say to eat 5 a day and that's what I give my child. Mixed messages from PHE (Public Health England) and everyone else. They don't give a preventive point of view from an oral health

perspective. Toothpaste – difficult to buy toothpaste without fluoride unless you go to a health shop where they actively stock fluoride free toothpaste. In my experience those with cartoon characters on them do contain fluoride.'

'Lack of appropriate information on food labels (i.e. cola drinks) and the effect these have on dental health. This could be improved if we could influence this.'

'We have seen a drop in consent for children to have a 'check' at school due to GDPR (general data protection regulation) changes meaning we now need consent, rather than parents opting out.'

'Like the NHS, schools are under pressure – in schools it's about academic performance outcomes, days out of school to attend to dental issues are not in the school's interest.'

'We are working so hard to meet our targets we don't have the time to build an education programme in our community.'

Proposed solutions/facilitators to improve oral health and reduce demand

As previously, the number of potential solutions and facilitators participants suggested greatly outnumbered the perceived barriers:

- Expanded roles (linked to training, recruitment, retention and CPD) - Every Contact Counts
- New roles (community oral health champions)
- Develop and strengthen relationships (link to outreach, ICS' and dental networks to bridge gap between population health management and oral health).
- Training (upskill midwifes, nursery leaders, school nurses, pharmacists and GPs in oral health)
- Digital (shared platform to provide widespread access to oral health information literature)
- Contracting
- Comms (linked to targeted prevention)
    - Health promotion and education
    - Marketing (linked to social media, health inequalities and central resource packs)
    - Central resource packs (information/guidance on correct toothbrushing methods and ingredients/ level of fluoride needed in toothpaste in various formats, food labelling)
    - Utilise social media and social influencers to promote oral health

- Targeted prevention, screening and education (link to outreach and health inequalities)
    - Care homes (link to Healthcare matters programme – training people to provide mouthcare in care homes)
    - Parent support groups
    - Schools, scout groups etc (supervised toothbrushing)
    - Food banks to provide dental supplies and oral health promotion
    - Early Years/nurseries (every child to see a dental clinician before the age of one)
    - Maternity settings, supermarkets and other community settings
    - Vulnerable/marginalised groups (link to outreach and drop-in centres)
    - Screening at age milestones
    - Prevention at dental drop-in centres alongside urgent dental provision

- Work with ICS' and PCNs (primary care networks) to get dental and oral health higher on health and care agendas and get oral health advice out into community settings/groups
- Establish processes and routines for patients to avoid urgent care
- Child friendly dental practices
- Dental advice provided in various clinical waiting settings (e.g. when waiting for COVID vaccine)
- Use regional social influencers to promote oral health

'Health visitors, practice nurses, specialty hospital nurses, community liaison personnel... could all help with oral health promotion. - This is an example where our voluntary sector could be supporting? - but it doesn't have to be just individual-based. Mass marketing works. Ask Coca-Cola.'

'What about having dental advice being provided when people are having to sit for 15 mins after having their COVID jab?'

'I'm involved in a community engagement project engaging scout groups, schools and providing training session. If a practice was paid or went to a units of dental activity contract this would raise morale. It would also get dentists out of the practice, get the dental message into the community and provide respite so is a win-win situation. Phobic parents are one of the reason's children don't come in – way of reaching people and encouraging them to attend. I do it because I own my own practice and know the community, but others don't have that privilege.'

'Educational information around prevention (and access) needs to flow through the whole system and reach support groups as well as patients so that everyone has access to the same information that's out there.' - 'Providing information in other formats is essential.'

‘Why don’t we add prevention/working with children to the curriculum of dental students?’

‘Have dental health campaigns which are hard hitting like the smoking ones, with warning labels on food and drinks which are bad for oral health.’ - ‘The labelling and marketing of children’s toothpastes (especially those that do not have the adequate amount of fluoride in) needs to come top-down from the supermarket.’

‘Encouraging dental practitioners to get accredited to level 2 in paediatric and special care dentistry would increase capacity. A level 2 dentist could have tackled Caitlin under sedation so that her situation never had to go as far as GA in a hospital. If we can think about how we can engage more dentists with paediatric and special care dentistry, then we’d have more resource to pick up cases like Caitlin and prevent them getting as serious.’

‘Peninsula Dental School and social enterprise students are supposed to provide oral health / toothbrushing advice as part of their dental course – could more be done for dental nurses and hygienists / therapists training also?’ - ‘Could we upskill health visitors / midwives etc.?’

‘Currently see patient and remove teeth, but then nowhere to send them once they are dentally fit – need somewhere to send them onto to do prevention or will just end up in same position in a few years’ time.’

‘We could incorporate prevention into a urgent dental drop-in centre – not just for urgent care.’

‘Thinking about health inequalities - there used to be a mobile "Tooth Bus" in Dorset, we worked with them a few years ago to run sessions at homeless support groups. Is there any capacity for supporting mobile dentists focussed on health inequalities in the SW?’

‘Have oral health e-learning as part of people’s continuing professional development.’

‘Go back to having dentists in schools’

‘Utilise the dental schools to see more children and give trainee dentists wider experience.’ - ‘Deaneries putting FDs (foundation dentists) into areas of deprivation – don’t just place them in affluent areas. Expose them to different types of dental treatment in areas with greatest need.’

‘When we can, we go into schools as part of the health syllabus and talk to children. The schools are keen to have us, and it is so much fun, the kids absorb a lot of information.’ – ‘Oral health care needs to be fun and interactive.’ – ‘We use Geoffrey the Giant Toothbrush, an oral health education story, when we visit primary schools.’

'We need adverts on TV, targeted social media about toothbrushing to overcome the practicalities of communicating with parents/guardians of those least likely to engage in self-care programmes.'

'Take opportunities to be part of community activities, fairs and agricultural shows and the like.' - 'Oral healthcare advice being provide at a variety of touchpoints e.g. pharmacies, GP practice, supermarkets, every interaction should emphasise oral health.' – 'Cultural approach is key – one size does not fit all.'

'Have a targeted campaign in areas where dental health is worse – use the same approach for reaching marginalised we have for COVID-19 vaccination – run a pilot in Swindon and Salisbury.'

'Special Care and Paeds MCN (managed clinical network) need to be driving this forward.'

Interdisciplinary working with dental should be high on the priority list.

'Linking with maternity services and health visiting to target early years: Dental to train the Health Visitors (HV), HV to train the parents, Parents to train the child.'

'There could be good scope to have a salaried system to get people dentally fit, if there is some way the practice could keep people going and keep up prevention this could work. A pre-registration MOT – patients could go to salaried dentist first to have the MOT. Some people are never dentally fit, I make people dentally fit and know they won't see an NHS dentist for years so money wasted.'

'Dentists 'don't have to be on their own - other health professionals (e.g. speech and language therapists) want to do a lot in oral health to push the prevention agenda.'

'An open-door surgery' that, with the partnership of local authorities, goes outside to the people who need it and works with them.'

'When I trained at Guy's we used to go out into the community to educate.'

'Contract reform in other areas of the UK has removed the UDA system and implemented routine fluoride varnish provision for children and adults.'

'Development of parent support groups for people whose children have poor oral health providing advice and support is needed.'

'Greater use of social influencers (sports stars / celebrities) via social media (Tic Tock and Instagram).'

'Expand the Healthcare Matters programme – training people to provide mouthcare in care homes. There is also a mini mouthcare matters – mainly aimed at children - in the hospital setting.'

‘Dental providers receive lots of free samples of dental supplies. Can voluntary sector be used to help transport those tooth brushing supplies for children in need via schools and foodbanks?’

‘Greater health promotion in supermarkets highlighting benefits of different types of toothpaste would be good.’

Early years curriculum now includes dental health, good to have some mechanism in place encouraging practices to go out to all nursery schools to engage with children but also parents. (RV)

‘Work with primary care networks and voluntary sector, nurseries and schools to provide clear and consistent advice.’

‘Water fluoridisation is the answer!’

‘Wales’ ‘Attend Anywhere’ system is an example of good practice in the digital space.’

‘In other parts of Europe where children undertook tooth brushing at school and were then incentivised by the school to also do so at home. This sometimes occurs in breakfast clubs so we could be linked into this.’

‘Our approach to prevention needs to be more ‘upstream’ and look ahead to things like obesity since measures like fluoridating water will be pointless in the face of the larger dietary issues at hand.’

‘Identifying families with existing safeguarding concerns and allowing them to be referred to practices via health and social care professional and providing them with additional support.’

‘Have pupil tooth champions in primary schools. Flexible commissioning of local teams. Health Promotion - uni students could do some of this work as work experience.’

‘It would be good if following calls, enquiries and courses of treatment there were some prevention education resources shared. Family and accessible resources such as key messages animations on digital platforms but also available in other forms. A whole family approach to reduce further and future need.’

‘Commission child friendly practices, that sit outside of UDA system.’

‘We have oral educators in secondary care in Orthodontics so there's opportunities for us to expand who we are educating and strengthening links across all dentistry.’

‘In Cornwall some local businesses are sponsoring education and prevention initiatives.’

'Learn from Scotland with Child Smile and the prevention work in Wales. They both did great things on prevention.'

'What can we learn from Diabetes Colleagues – using prevention agenda to reduce foot amputations (modelling) – PHE Fingertips is a useful tool.'

'Tele-dentistry – not always needing a face to face appointment. - Often a patient can provide photos and seek advice and ideas on self-care.'

'Dental care networks need to work with ICS', local authorities, education and primary care networks so we're all working together in a coordinated way and can develop centralised resources that everyone can access.'

'Secondary Care - when patients are an inpatient you could have a nursing role that specialises in oral health and education in each hospital.'.

Workforce (Robert's experience - how can we make the SW the best place for dental practitioners to work?)

Running through all discussions was the ever-present capacity and concomitant challenges to recruit and retain dental practitioners. Hence, this section highlights in more detail the experiences of the healthcare workforce and the changes they would most like to see to help overcome the challenges they face.

Barriers/Opportunities for improvement

Participants said the following factors prevented dental practitioners from providing all of the services they would like to provide:

- Lack of capacity and skills (within the dental community itself and in the wider workforce to - e.g. GPs - help bridge the gap between capacity and demand)
- Recruitment and retention (linked to ineffective marketing strategies and complicated HR processes)
- Contracting and finance (and other bureaucratic processes)
- Training gaps
- Geographical variation in workforce concentration (not centred in areas with greatest need)
- Professional preferences and ambitions
- NHS processes and bureaucracy
- The cost of living
- Public expectations
- Communication

'The ever-increasing admin/behind-the-scenes work is a huge barrier to having a positive work experience for dentists, especially since pay has not changed. Dentists used to only write notes after an examination where as now, they have

to create lots of notes for all general check-up appointments but are being paid the same – 'they don't want to do that type of dentistry – they want to help their patients!'

'The process towards getting an NHS email address is too complicated and puts people off getting one.'

'The convoluted process for overseas aspiring dentists wishing to come to the UK to train is another barrier to recruitment.' – 'what with the pandemic and Brexit most EU staff have gone back, and we can't attract staff.'

'Not a strong enough value placed on relational care with oral health providers, and continuity of care is not valued enough under the current contract arrangements.' - 'Relational care has diminished, resulting in leavers from the profession.'

'We have funding for 84 posts, but we can't recruit to them because we can't find training practices.'

'We (GPs) are seeing people with dental problems and this is not sustainable.'

'Many OOH services do not have dental clinicians who can triage.'

'Improving the communication/signposting of NHS vs private provision within a practice (not just between practices in the system) so that internal staff understand a patient's options and can communicate them to patients clearly is essential.'

'Dentists are often declining having a training post as they need to be mentored and dentists don't have the time as if they don't see patients, they may miss their targets.' – 'The region has a national recruitment disadvantage because dentists often settle where they did their foundation year and we don't have enough foundation places.'

'Graduates often like to stay clustered around their support networks (families, friends, etc) so settling and setting up a business far away is daunting.'

'Many graduates are attracted to the big urban centres like Bristol which immediately makes the more isolated and more in-need parts of the region less attractive.'

'New dentists do not work fast enough to keep up and be able to deliver contracted activity.'

'Dentists are tired of battling the NHS system and want to leave the job. Dentists with skills are leaking out of our system.'

‘Dental school training these days only offers training in bread and butter dentistry.’

‘I don’t have the dental skills for some treatments (as have not had the experience) and so I have to refer them to a specialist.’

‘I often see 6-12 people in OOHs primary care who can’t access dental services.’

‘I only have a 'child only contract'. Most years I 'under-perform'. In previous years I have applied to redirect my NHS provision to adults (actually a care home up the road), always declined by commissioning who want the money back through clawback.’

‘Under NICE guidance it’s not profitable to teach undergraduates. If we upskill how can we use them? Space is still an issue. Primary care can do this but it’s not so easy for Dental.’

‘Confused messaging doesn’t help as patients must pay for their dental care.’

‘The pace dentists have to work at in the NHS is fast which can lead to burn out very quickly.’

‘Concept that dentists are highly paid therefore when they graduate, dentists think they should be earning at this level from the start. Dentists should work up to that level as they do in the medical world – no quick fix.’

‘I started work recently on foundation therapists but they don’t have NHS contracts so they can’t treat NHS patients directly. They have to treat on referral from a dentist.’

‘A salary is no bad thing, but why are DF (dental foundation) places all in the main towns?’

‘We have 2 urgent care slots for NHS patients a day. We have often not seen these people before and have 10-15 minutes to take their history, diagnose and treat. Can’t do this in the slot so end up seeing less of the others.’

‘Workforce morale is really low because we are paid the same if we perform one filling in 20 mins, as we are if we perform 20 fillings, 2 extractions and a root canal surgery on a nervous patient over 10 hours. You see a patient walk through the door who really needs your help, but you know it will cost you money - awful system! That’s why people are leaving, until that is fixed, they are fighting a losing battle. The public think dentists are greedy and want to earn more money. I worked in a high needs area in Bristol, and some days I would earn three units of dental activity which is not enough to pay the bills so you have to do private work to cover the gap.’

‘Funding decisions take too long – I asked for more money when I had the capacity to take on more patients, but by the time it came through, I only had one month left to spend it.’

‘Money is promised by the NHS, but the promise is never kept. I have built two new surgeries with investment from the private sector while I waited for an NHS contract.’

‘Commissioners do not go out and ask a dentist if they want an NHS contract. Instead they wait for dentists to come to them.’

‘NHS contract goes out for competitive bid based on the oral needs assessment in areas that need care commissioned but there is capacity in neighbouring areas and they cannot bid.’

‘Working in a hospital, if I get patient information from a business email address, I have to report them for a data breach as they are sending confidential information through an insecure channel.’

‘As a service manager I sadly have to often decline requests from our dentists to undertake ‘additional’ treatment for urgent care patients because we have to maximise the appointments we have to see unique patients and we are to ‘only get them out of pain’ and not have returning treatment – ideal world we should provide this and on a personal level makes me feel uncomfortable in telling them we can’t offer this currently. This was the same pre-COVID.’

‘If there are enough dentists in the South West, they are not in the right areas.’

‘In Plymouth they tried to run evening clinics but when the positions were advertised there were no applicants. Dentists don’t want to work after normal hours and younger dentists do not want to work in the current NHS system.’ – ‘Many staff no longer want to work full time.’

‘Many new up-coming dentists see botox and Invisalign as their job and therefore do not have the skills or confidence to cope with that aspect of the role when it arrives.’

‘Young dentists cannot afford to buy into a practice, so they are happy to drift in and out of practices so there is no continuity.’

‘We have a lovely location, but we are asking them (newly qualified dental practitioners) to set up here rather than Bristol / London. Most young people want city life.’

‘In the past year people have got used to salaries. Graduates don’t want to be practice owners, and women in the field need more time off compared to men. Youngsters don’t want the hassle of owning a business, and just as many males are requesting to work part time.’

‘Places like Cornwall are now becoming too expensive for people to live in. This could put off someone who was perhaps coming from the North East, or West from applying for a job in the South West. This also impacts on local workforce, with lower salaried roles – local people being driven out of local housing market and rental property equally as challenging.’

‘It’s hard to recruit with non-recurrent funding. I employed extra staff in a new surgery and then the funding was not continued and 600 patients had to go elsewhere.’

‘Dentists are now ‘more worried about over and under-performing – which they didn’t used to care about… it used to just be about what the patient needed. The need to meet targets is ‘stifling the working experience’ of dentists and making it a less positive one.’

‘The lack of capacity for dental hygiene and dental therapy roles is also a recruitment challenge.’ - Many train in both therapy and hygiene but end up in a private role looking at just hygiene which is not what they trained – or perhaps wanted – to do.’

‘Dentists are ‘empathetic, sympathetic and want the best for their patients but have been so up against it due to COVID… we’re the workforce that continued to work even though it was a respiratory virus.’

‘I think we need to be careful as we already have a skills deficit for oral surgery so there is limited capacity for them to widen their role to primary care.’

‘Clinicians want more time with patients and the private system can offer them that.’

‘Recruiting more staff may not solve the current problems… even with fully staffed practices I think the patient demand/need would still outstrip capacity.’

‘Emergency appointments are difficult. You need more time to do the work. In general dental practice you don’t get that time.’

‘The ‘walk away’ project escorted people from the GP practice but people still didn’t attend.’

‘UDA value is less than patient charge. The NHS is no longer profitable. We need the private patients to top up the NHS income.’

‘The nurse gap is restricting us from the access we want to deliver’.

‘Lack of NHS provision and asking CDS (community dental service) to cover more urgent care, using a SOP (standard operating procedure) from March 2020 to triage is stifling CDS recovery and our ability to see more complex patients on referral.’

'A boy in Somerset can play a video game with someone in China but his dentist cannot talk electronically to the hospital consultant!'

'Associate Dentists are given a certain amount of equipment and resources and are expected to deliver the contract, any additional equipment they are expected to fund themselves. NHS dental provision is bad business.'

Proposed solutions/facilitators to help make the SW the best place for dental practitioners to work

Solutions and facilitators that participants proposed to help overcome the issues outlined above included:

- Intelligent, modern services based on prevention and biological methods - more practitioners will want to work in the South West
- Improve SW work culture so dentists feel part of regional networks like medics
- SW recruitment campaign to attract people to region, target trainees
- Attract dentists working privately to take on 10-20% NHS work
- Portfolio careers
- Flexible working
- Roles
    - Expanded roles (linked to increased training opportunities, digital and access to CPD)
    - Salaried roles across the dental team
- Education and support to develop special interests among dental team and more post-grad posts
- Dental therapists focused on prevention, education and children
- Skill mix – practice teams well-supported with therapists, dental nurses and enhanced care leaving dentists to concentrate on the complex
- Recognise and reward more rounded services for vulnerable rather than UDAs
- Recognise that providing care for patients in deprived areas is rewarding
- New patients see salaried dentists for an MOT first
- Dental part of every contact counts
- Greater linkages between primary and secondary dental clinicians to spread expertise, work more flexibly, create development opportunities
- Good digital communication between primary and secondary care for advice and guidance with access to high quality digital images and notes
- Greater links between Bristol and Peninsula Dental schools and those elsewhere in the country to attract clinicians to the SW
- Dental training opportunities in areas where more urgent care needed
- Creative dental placements
- Dental services in multi-disciplinary hubs/integrated dental workforce

- Career development including CPD and research opportunities (linked to partnership working with Deaneries, developing a Fellowship/Federation, and health inequalities)
- Greater partnership working with wider healthcare systems, dental networks and local authorities
- Offer dental relevant alternatives to dissuade leavers from leaving
- Digital access
- Career progression
- Contracting and finance arrangements (linked to salaried positions)
- Increase capabilities for oral surgery in primary care
- Flexible working hours
- Relocation incentives (linked to partnership working with local authorities)
- Clear strategies to retain graduates.

'Put together a "sales offering" and sell the SW, the geography, the people, the interesting work, the opportunities. Trade journals, professional associations, conferences etc.'

'Capitalising on those students (though few) who do their PLVE (Performers List Validation by Experience) outside of London or are drawn to the area because of Peninsula Dental School might help us retain them in the South West area'

'Develop roles to expand practise to include things like education, training and prevention. Provide opportunities for Dental Nurses and Therapists to follow their interests.'

'Develop a model where there is a process in place for practitioners, who are thinking of leaving due to burn out, to make contact with someone who could look at alternative employment within Dental (e.g. research or education) so we don't lose them entirely.'

'Getting dental on the curriculum for other healthcare professions. Oral health could be added to the curriculum for other professionals in the space (partnering with dieticians and dietician training was picked up as a natural opportunity).'

'We need to have good digital communication between primary and secondary care for advice and guidance. Must have access to high quality digital images, x-rays and notes.'

'Hygienist and Therapists go straight into private practice – need some sort of stipulation that they work in the NHS for a few years post qualification.' – 'Stipulate that all dental grads must work in the NHS for 5 years following qualification.'

'More use of MSTeams/digital platforms for training and development. Especially useful in South West as would remove need to travel for CPD.'

'Graduates often settle where their placement was located, so if we were to increase the vocational training and dental foundation training opportunities in the South West and, in particular, in those areas with recruitment shortages like Cornwall and charm them into returning when they finish their studies, we'd attract and retain more up-and-coming talent.'

'Maxfac and Oral surgery should work more closely together.'

'Greater development of intermediate services linking secondary care consultants with primary care providers enabling 'upskilling'.'

'We run a very successful mentoring programme (in Holsworthy) and have mentored over 15 dentists in primary care. I think the mentoring criteria is a bit over restrictive. The wider workforce is essential to the mentee's and a lot of their learning comes from the team, yet the team is not recognised in the criteria. The wealth of knowledge of the wider team needs to be recognised and utilised by the system - good for retention of longer-term dentists and all feel valued and it's something we do well. – The wider team needs to be recognised within the UDA structure.'

'Dental schools should have large outreach units with oral surgery training, restorative and urgent care upskilling and DCPs (dental care practitioners) and GDPs (general dental practitioners) as well as other oral health educators being able to access this.' - 'When I worked in community, we used to get the medics from the oil rigs observing dental care. They were taught how to place a temporary filling, what to do if a tooth was knocked out, how to manage facial trauma in the first instance. Could we ask if anyone in the wider health care workforce want to do similar?'

'Championing research could attract graduates to an area because where there is research, there is innovation and that attracts the young and ambitious.'

'Offering more of a range of services, including routine procedures like tooth ache, urgent cases and also the cosmetic cases like botox/teeth whitening which attracts young graduates, across practices would make a job less mundane and more appealing to younger generations.'

'Introduce larger regional conversations around culture, resilience, supporting staff through workplace stresses was suggested as a way to really ensure our current staff do not leave the South West. Medics, for example, are made to feel much more 'part of a network' whereas dentists 'turn up on their own.' There is therefore an appetite for increasing the networking and conversation spaces between dentists so that we can retain them.'

‘Develop a fellowship programme.’

‘Offer intensive emergency care training to young dentists.’

‘NHS should fund overheads for practices.’

‘Offer Dental nurses the opportunity to do more training to become therapists. Improved use of Dental Therapists can help like in Orthodontics.’

‘Working in a wider multidisciplinary team is very rewarding. Create those roles to attract people to work in the region.’

‘Emergency dental care should be a career pathway the same as acute medicine is for doctors.’

‘When a dentist hands back a contract the funding should go with the patient to a new dentist. The patient should be funded not the practice.’

‘Build in recognition to secondary care contractors for clinical advice and guidance to high street dentists on digital platforms. Make part of consultants’ job plan. In return, multiples/corporate providers should encourage specialist in oral surgery within their group so more surgical patients can be managed in primary care.’ - ‘Opportunities for dentists to work across primary and secondary care would be attractive to professionals and breakdown barriers between primary and secondary care.’

‘20 years ago when people dialled 111 one course of treatment was given and we worked with other local NHS practices saying we have made this patient dentally fit, will you take them on and can they join your list? The patient then has somewhere to go to so that next time they need urgent care they don’t need to call 111 but instead the practice they are registered with.’

‘Greater Managed Clinical Network (MCN) input and support being developed.’

‘Need to develop / create better job satisfaction with more rounded roles providing greater level of service provision, not just a service linked to targets. - Clearer career progression and opportunities to develop career and skills in primary care is needed to retain staff.’

‘Could we strike whilst the irons hot and recruit from cities? Our GP campaign was a success and we could do the same for Dental.’

‘Could we have a salaried career development post offered to foundation level staff in the SW?’

‘Have conversations with dental schools around how to take the resource of the dental school to the places where the population needs it most.’

‘Join up dental with blood pressure, diabetes, and general health.’

'MyDentist offers salaried positions and works well for a stable income. Salaried offers a way out and people can stay in foundation training a little longer with work 2 years after training and salaried contract.'

'Funding for a multi-surgery premises in certain areas – a hub of sorts could attract salaried dentists to work from one day per week for example.'

'Access plus model for OOHs – more interesting for dentists working in urgent care.'

'Introduce incentives to relocate to the South West. Relocation packages. Work with local authorities on ringfence affordable housing opportunities (linked to local dental positions).'

'Offer flexible working, part time opportunities and interesting work areas.'

'In Plymouth we could utilise final year students to carry out outreach work, both within the city but also wider. In Torbay we spoke about them coming here and using a community dentistry van.'

'We shouldn't see the fact dental care practitioners can't open a course of treatment, the assessment and submit a referral. The therapist model works very well in orthodontics and I don't see why learning can be taken into general dentistry. Look at how to do that via referral, sign posting or under flexible commissioning.'

'What can we learn from Primary Care (GP's) and Secondary Care about things like group clinics (prevention and education, or patients undergoing certain treatments)? Contracts would need to change to incentivise this.

Next Steps

It is incredible the number of ideas and suggestions that people shared with us in just over an hour, which reflects people's appetite for change and desire to work with commissioners to provide the kind of care they want to be able to provide. To help do this we want to explore the ideas for new models of care that participants said would help us increase access whilst targeting the people and marginalised groups that the OHNA flagged as priorities in further SPRINT workshops in September 2021:

- Outreach (to care homes, schools, homeless shelters, food banks)
- Primary care hubs (one stop drop-in centres housing dental, general practice, optometry and pharmacy)
- Out of hours and urgent access provision
- MyDentist

- Digital platforms to enable the sharing of records, with up to date information regarding where there is current capacity and where there is none to help 111, GPs, Healthwatch etc. signpost people to the right level of care that is available when they need it.
- A salaried MOT pre-registration process (akin to the patient charter model in Wales)
- Community based screening and self-management for families with poor oral health that are linked with work already going on in communities to prevent limb amputation in diabetes and preventing heart attacks and stroke by working with organisations that already work with those most at risk (such as older and obese populations).
- Consistent triage models based on ACORN

The report above also highlights the sense of isolation that some small practices are experiencing, which was reflected in the number of groups that expressed a desire to form a ‘Federation’ with a clear point of responsibility and governance structure for everyone that needs dental support regardless of where they access that support. Hence, another topic we could discuss during further SPRINTs is how we can support our existing dental networks to develop into and function as the kind of Federation they would like to be part of.

The third topic for discussion during cycle 2 could be training and CPD to better support the expanded, blended and new roles that have been suggested.

ENDS

APPENDIX A: Topic Guide for Discussion Facilitators

Susan's experiences (Access)

"On the 12th of August I called my local dental practice, where I am a registered patient, as I was experiencing mild toothache. I was advised that my own dentist was on leave and that the dental practice could not carry out aerosol generating treatment such as drilling due to Covid-19 restrictions. They offered me an appointment on 9 September with a view that this treatment would likely be available by then.

"In the early hours of Saturday morning, two days later, I woke with excruciating pain which worsened through the day. I experienced swelling around the lower jaw. I called 111 who had a dental consultant call me back. This person advised that there was no availability for emergency treatment that day and gave me a number to call for 9am the next morning. The pain worsened by the evening and another 111 call said my only option was A&E. But I was advised it would not be treated as a priority and would probably mean a long wait and strong painkillers, so it would probably be best if I sat it out until morning, so I did not go.

"I managed to see a dentist on Sunday 16 August, who advised I would need root canal work to treat a suspected tooth abscess. They referred me back to my dentist with a prescription for antibiotics which I immediately started to take. I tried numerous times the following day from 8.45am to get through to my dentist and it went to voicemail straight away. Eventually, late afternoon someone picked up the phone as I was leaving a message. They said they couldn't provide any more emergency appointments that day and to call in the morning but booked me an appointment for Friday 28 August.

"That same evening, I noticed a red patch down my neck and called 111 again. The doctor I spoke to advised I had developed cellulitis and prescribed stronger painkillers and additional antibiotics which my husband collected immediately.

"I called my dentist in the morning and the receptionist arranged a call back. The dentist was reluctant to see me but offered to have a quick look. She said I did need urgent treatment but was unable to do root canal work. She referred me back to the emergency dentist at the Dental Access Centre who told me the best option was an extraction at my own dentist. Again, I called my dentist and she said that they could not do an extraction due to the swelling and she didn't think the anaesthetic would work. By the afternoon I had developed a temperature and tried calling my own GP for advice and was told that the best option would be to try 111 or go to A&E.

"So I went to A&E. After a two hour wait, the triage nurse said I had done the right thing in coming and admitted me. I was X-rayed, the infection drained, put on IV antibiotics overnight and put on the emergency surgery list for the following day. Fortunately, I didn't need to go for emergency surgery, but they had to put me through four courses of antibiotics with a potential second night for observation.

“The doctors allowed me to leave hospital on the grounds the dentist had agreed to treat the tooth within seven days. I managed to book an appointment for Wednesday 26 August. I received a text saying this appointment was cancelled and again struggled to get through to them. When I did get through, my own dentist spoke with the hospital and agreed to go ahead with the root canal which happened a week later.

“If the emergency dentist had treated me, it is unlikely that the follow-on events would have happened!”

1. What could we do differently to improve Susan’s experience?

Break it down into components to help the flow if conversation is slow to start..

If the info Susan received was incorrect, what could we do to ensure the info people receive is accurate and consistent everywhere?

- Is there a role for technology?
- How is information sent to 111, GPs and other parts of the system to ensure people receive the same info. no matter what their point of entry is?

What could we do to ensure people aren’t left in pain while they wait for an appt.?

- Is there anything other clinicians could do to manage pain and control infections?

What could we do to improve access to routine care/emergency care/specialised care and allied services?

- Explore the role of GPs in helping with infection control and pain relief.
- Explore any delays to provision because labs have capacity issues or some other backroom process that is clunky.

Can you think of any other groups or organisations that should also be informed of access criteria and referral routes?

How much pain does a person need to be in to be considered eligible for emergency care?

- If someone's situation is an emergency what is the longest amount of time they should have to wait?

How could we improve referral routes to ensure people receive the right type of care sooner to prevent exacerbation of symptoms?

Are there any actions we as a health community could have taken to address the cause of someone's pain more quickly? (role of GP; A&E)

When is it ok to make someone wait and when is it not? (are the thresholds the right ones?)

What if this person had LD or no fixed abode or a nomadic lifestyle, would your ideas for service improvement work equally well for them?

Can you think of any other ways we could improve the experience of people in Susan's situation in the future?

Robert's experiences (Workforce)

"My partner and I have been registered as NHS patients at [Practice] for four decades. Under [Dentist] for much of that time, we've received truly excellent dental care, but since his retirement we have been unhappy with the Practice. Recently, my partner was given an incorrectly priced plan and received a different, though equally, priced option when they challenged it.

When I asked for an emergency appointment while in great pain – I have fibromyalgia – I was seen three weeks later for a cursory examination, given no treatment, told it was a dead tooth that could not hurt me, and then charged for the visit. When I did have the tooth out and suggested that I was grateful for him removing it, he replied that someone has to do the job. My old [dentist] would have smiled and said it was a pleasure to offer me relief. I think that comment shows the kind of dentist we now have.

I have booked a check-up for six months' time although he says it will cost more […] I was told that the practice will no longer offer NHS dentistry after the summer and that I should read an article in the Daily Mail that explains the situation if I wanted to find out why. We subsequently heard from another patient at the practice who was on means-tested benefits and had also been informed that they could no longer attend as an NHS patient.

We no longer trust the [Practice] not to charge us hidden costs. While I was sitting in reception, I heard another patient being quoted £65 for a hygienist with no mention that, in reality, it's closer to £90. He – like us – will find out the true cost after he's had his treatment.

We're approaching 60 and our teeth are failing us. Being severely disabled with schizophrenia, my partner worries for the future. I have tried every dentist within 15 miles (we don't drive), and I've failed to find another practice that will accept us. We have purchased a tube of tooth-fill to sort out painful holes and are resigned to using this in the future."

How do you think this dentist feels?

- What do you think has made them feel that way?
- What could we do to increase this person's job satisfaction?

What tasks could we safely take away from dental staff to reduce stress and increase their capacity and enthusiasm for clinical work? Is there a role for technology; GPs; VCSE; A&E?

- What else could we do to relieve the pressure on dentists? Explore the role of prevention at treatment level; public health promotion; assisted toothbrushing; working with schools and families at risk.

What can we do to entice more dental practitioners to work for the NHS in the SW?

- What could we do to encourage students to work here after they qualify? (marketing the region; reaching out to students; providing more enjoyable placements)
- How could we make dental JDs more attractive (clinic/outreach mixed models of delivery; opportunities for high street dentists to learn about/work with dental practitioners in secondary care & vice versa; opportunities for R&D; CPD packages; new roles; attractive career paths; sabbaticals?

How could we ensure pricing arrangements and costs are consistent, accurate and transparent?

How do you think Robert and his partner feel about NHS dentists now?

- What will this experience have affected the likelihood they will seek help again? Trust?
- How might this effect his partner's mental health?

How can we better meet the needs of people who are vulnerable to health inequalities because of poverty; mental health; disability; race; religion; gender identity etc.?

- What training is given to prepare practitioners for working with vulnerable group?
- How adequate is this?
- How could it be improved? What would you like covered in the syllabus?

Can you think of any other ways we could improve the experience of people in Robert's situation in the future?

Caitlin's Story (Prevention)

Link to full video: Bad Teeth: children's stories - Bing video

"My daughter Caitlin is just seven years old. She started having a bit of toothache, and now we've ended up in hospital and she's having six teeth out. She's an intelligent little girl, but I don't think she quite understands the bit about the needle and being sent to sleep. I'm heartbroken for my daughter, and what she's going to have to go through.

I was told off because I gave her too much fruit. You're told to give your child a healthy diet, but then that has, in turn, put Caitlin in this situation. It makes me feel ashamed because I think people probably assume that she's been eating too many sweets, or that I've not been looking after her teeth. When you go shopping with your child and they see all the toothpastes with all the characters on, they'll say, mum, we'll have this one or that one. But because I didn't know they didn't have enough fluoride in, I did the wrong thing. Marketing these children's toothpastes is wrong."

How do you think this experience at such an early age is going to affect this person's willingness to go to the dentist as they age?

What could we do differently to prevent children like Caitlin from needing to have their teeth removed?

- Are there any new initiatives like supervised toothbrushing you can think of? Thank sounds interesting, please tell me more.
- Are there any other initiatives you know about from outside our region that might work here? Thank sounds interesting, please tell me more.

What support would the guardians of a child with poor oral health need to have to be able to adequately support the child's oral health?

- Education and information (healthy eating on a budget; assisted toothbrushing; access to dental hygiene products); what else?
- Who is best placed to ensure parents/guardians have the best information?

Who is responsible for preventing people from developing dental problems?

- Other than public health, what other people and organisations could help?

What other work could consultants do if they did not have to spend time taking our children's teeth?

- What would you like commissioners to spend the £40million per year we could save if we did not have to remove children's teeth?

What do <u>you</u> currently do to help prevent people from needing dental treatment?

- What works well and why?
- What have you tried in the past that didn't work as well as you had hoped so we don't repeat it?

What would you like to be able to do to prevent people from needing dental treatment? (they might want to do more outreach; education in schools and children's centres; support the campaign to donate toothbrushes and toothpaste to foodbanks)

- What currently stands in the way of you doing that?
- How could we overcome these barriers?

What role could local communities play in preventing poor oral hygiene?

- What role could GP patient participation groups and members of CCG/ICS citizen advisory panels and other groups of volunteers have?